SECTION 59 INVESTIGATION

DATE: 2019-08-01

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 SAMA:

DR WILLIAM OOSTHUISEN

MS HANNEKE VERWEY

DR ASLAM VALLEY

DR NORMAN MABASA

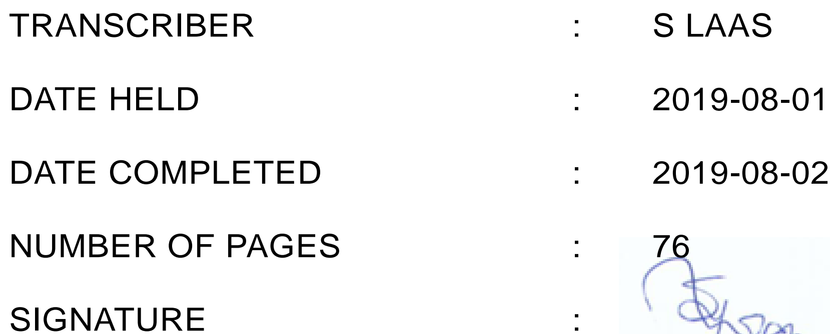
DR MVUYISI MZUKWA

DR VUSI NKLAPO

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
DATE HELD	:	2019-08-01
DATE COMPLETED	:	2019-08-02
NUMBER OF PAGES	:	76
SIGNATURE	:	

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 01 AUGUST 2019

CHAIRPERSON: This is a continuation, what's that noise? Alright anyway, a continuation of the inquiry set up by the Council for Medical Schemes under Section 59 of the Medical Schemes Act.
5 Today we are scheduled to hear evidence from the South African Medical Association. It's scheduled for ten o'clock to eleven thirty. Can we start with introductions?

DR OOSTHUISEN: Dr William Oosthuisen, legal advisor.

CHAIRPERSON: Thank you.

10 MS VERWEY: Hanneke Verwey …[indistinct 00:00:42].

CHAIRPERSON: Thank you.

DR OOSTHUISEN: Sorry, can we have our microphones switched on so we can go on record?

CHAIRPERSON: Okay.

15 DR OOSTHUISEN: Okay, Dr William Oosthuisen, legal advisor SAMA.

MS VERWEY: Hanneke Verwey, legal advisor SAMA.

DR VALLEY: Aslam Valley, Dr Aslam Valley, private practitioner.

20 DR MABASA: Dr Norman Mabasa, the board member of the South African Medical Association, chairing the general practice private committee.

CHAIRPERSON: Thank you.

DR MZUKWA: I'm Dr Mvuyisi Mzukwa, I'm the vice-chair
25 of the South African Medical Association.

DR NKLAPO: Dr Vusi Nklapo, acting general manager for the SA Medical Association.

CHAIRPERSON: Thank you, so who will be making the address on behalf of SAMA?

5 DR MABASA: We have decided to lacerate our presentations into some several areas of expertise and knowledge.

CHAIRPERSON: Lacerate you say?

DR MABASA: Yes, what we will do is, I will present first. Mine is much more a spiritual preaching about the issue, then
10 Hanneke will come with the meat of the legal references which are related to this issue, which I have written, which are in writing and well written, and then Dr Valley, being a veteran practitioner like me, he will be coming with the experience of a practitioner. So we shall make sure that within the time given we are able to accommodate
15 this …[indistinct 00:02:27] that you feel like only one person spoke.

CHAIRPERSON: Okay, let's do this. I just want the names of those who will be speaking so that I can administer the oath.

DR MABASA: Okay, the names are; Hanneke Verwey.

CHAIRPERSON: Okay, so let's start with, Dr Oosthuisen
20 are you going to be talking?

DR OOSTHUISEN: I might climb in every now and again, so [intervenes]

CHAIRPERSON: Okay, let's make it easy then. I will take the oath of everyone so that it's easy. Shall we start with you then Dr
25 Oosthuisen? Will you just say, will you take the oath or an

affirmation?

DR OOSTHUISEN: Affirmation.

CHAIRPERSON: Affirmation, alright. Will you then say after me, I and your name.

5 DR OOSTHUISEN: I William Oosthuisen.

CHAIRPERSON: Solemnly affirm.

DR OOSTHUISEN: Solemnly affirm.

CHAIRPERSON: That the evidence that I shall give.

DR OOSTHUISEN: That the evidence that I shall give.

10 CHAIRPERSON: Shall be the whole truth.

DR OOSTHUISEN: Shall be the whole truth.

CHAIRPERSON: And nothing but the truth.

DR OOSTHUISEN: And nothing but the truth.

CHAIRPERSON: Thank you, and is it Dr Van Wyk?

15 MS VERWEY: Hanneke Verwey.

CHAIRPERSON: Vanvey? Verwey?

MS VERWEY: V E R W E Y.

CHAIRPERSON: W E Y, okay sorry. Dr Verwey, alright will you also be talking?

20 MS VERWEY: Yes.

CHAIRPERSON: Alright, let's take, would you take the oath or the affirmation?

MS VERWEY: Affirmation.

CHAIRPERSON: Alright, will you just say after me? I am

25 your full name.

MS VERWEY: I Hanneke Verwey.

CHAIRPERSON: Solemnly affirm.

MS VERWEY: Solemnly affirm.

CHAIRPERSON: That the evidence that I shall give.

5 MS VERWEY: That the evidence that I shall give.

CHAIRPERSON: Shall be the whole truth.

MS VERWEY: Shall be the whole truth.

CHAIRPERSON: And nothing but the truth.

MS VERWEY: And nothing but the truth.

10 CHAIRPERSON: Thank you, and Dr Valley will you take the oath or [intervenes]

DR VALLEY: I'll take an oath.

CHAIRPERSON: Alright, will you say after me, I and your name.

15 DR VALLEY: I Aslam Abdul Kadar Valley.

CHAIRPERSON: Swear that the evidence that I shall give.

DR VALLEY: Swear that the evidence I shall give.

CHAIRPERSON: Shall be the truth.

DR VALLEY: Shall be the truth.

20 CHAIRPERSON: The whole truth.

DR VALLEY: The whole truth.

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

DR VALLEY: So help me God.

25 CHAIRPERSON: Thank you, and Dr Mabasa will you, what

will it be, the oath or the affirmation?

DR MABASA: It will be the oath

CHAIRPERSON: Alright.

DR MABASA: The oath.

5 CHAIRPERSON: Thank you. Will you say after me, I and your full name.

DR MABASA: I Norman Mabasa.

CHAIRPERSON: Swear that the evidence that I shall give.

DR MABASA: Swear that the evidence I'm about to

10 give.

CHAIRPERSON: Shall be the truth.

DR MABASA: Shall be the truth.

CHAIRPERSON: The whole truth.

DR MABASA: The whole truth.

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

DR MABASA: So help me God.

CHAIRPERSON: Thank you, and Dr Mzukwa?

DR MZUKWA: Yes?

20 CHAIRPERSON: Will you, what will you take, the oath or the affirmation?

DR MZUKWA: Oath.

CHAIRPERSON: Yes, will you say after me, I and your full names.

25 DR MZUKWA: I Mvuyisi Mzukwa.

CHAIRPERSON: Swear that the evidence that I shall give.

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

CHAIRPERSON: Shall be the truth.

DR MZUKWA: Shall be the truth.

5 CHAIRPERSON: The whole truth.

DR MZUKWA: The whole truth.

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

DR MZUKWA: So help me God.

10 CHAIRPERSON: Thank you, and Dr Nhlapo are you going to take the oath as well?

DR NKLAPO: Affirmation.

CHAIRPERSON: Affirmation, sorry. Alright, will you say, go after me and, I and your full names.

15 DR NKLAPO: I Vusumuzi Nklapo.

CHAIRPERSON Solemnly affirm.

DR NKLAPO: Solemnly affirm.

CHAIRPERSON: That the evidence that I shall give.

DR NKLAPO: That the evidence that I shall give.

20 CHAIRPERSON: Shall be the whole truth.

DR NKLAPO: Shall be the whole truth.

CHAIRPERSON: And nothing but the truth.

DR NKLAPO: And nothing but the truth.

CHAIRPERSON: Thank you, so Dr Mabasa I think you

25 should lead us then, in prayer you say?

DR MABASA: Indeed it's a prayer. Honourable committee members and chairperson, I have been a practitioner, not for as long as I knew about medical aids. I started hearing about medical aids in 1983. But when I became a doctor, then I joined
5 SAMA. Then who is SAMA? SAMA is an association of about 17 000 doctors, which is almost more than half of the practising doctors in the country, if you put it that way, we can be argued, which was formed in 1927. It was, it remains the biggest association in the country. Chairperson, honourable committee members, the problem
10 of the medical schemes in this country, I am aware of the terms of reference, but I think history will assist us to understand where things went wrong, for us to now deal with what we call Section 29, 59.

The problems started in 1983 when Minister Rina Venter at
15 the time of the previous regime, to put it that way, pronounced that medical aids will be deregulated. It's very important to know that things started with the deregulation, and indeed in 1998 Minister Nkosazana Dlamini-Zuma gave birth to that pronouncement by deregulating scheme, and I will explain what this deregulation is
20 about. We then had a problem from there. What does it mean? What happened is, when they were regulated there used to be discussions between the hospital group, the medical aid group which was RAMS, it used to be called Representative Association of Medical Schemes.

As well as SAMA, which was MASA at that time, and that
25 continued when we were SAMA where the three groups will talk, will

discuss tariffs, and the reason we were discussing tariffs was because you wanted to have certainty about what kind of service you will get, and how much it will cost. At that time SAMA, I'll refer to it as SAMA because it's no longer MASA, designed codes to, for
5 medical aids to be able to claim and identify the diseases that people have.

So for example, if you had an eye infection it would be given a code, and that code, if you did an operation on, the book look like this, but at that time, that is before deregulation, it was that the
10 government will gazette the fee that has been agreed by the three parties. It used to be gazetted fee. There was a famous Christmas on the 15th of September every year, or working day just after or just before. A working day related to the 15th of September, we called it Christmas September, because it was the time when the
15 government would have received and processed and gazetting on that day the fee that has been agreed between medical aids, hospitals, and SAMA.

There was an advantage in that practice. Chairperson I should also as well add that there was certainty as well. If you were
20 to go to the hospital and have a small growth cut on the finger in Johannesburg, it was the same price in Durban, it was the same price in Cape Town, it was the same price in Musina. When they deregulated, the Competition Commission gained interests in the area where there was no regulation of medical aids, and introduced
25 a philosophy that says patients must negotiate their price with each

doctor they see. So if you pay me R2000 today, tomorrow I may charge you R3000, depending on the results of our negotiation. You will see how that system fails immediately, because once you start doing that, when you come to me, I remove that growth, I will charge
5 you 10 000.

Then Dr Valley comes, he negotiates and pleads poverty, I will charge him 1000 for the same thing, the same time taken, the same material used. This is where the deregulation became a problem, which was announced initially, and not implemented by
10 Minister Rina Venter, and then when our Minister Nkosazana Dlamini-Zuma introduced this they even nullified negotiations which were there. Up to 2003 they were still there, you can, this is the book that we used to have. This was a product of discussions or negotiations that would have happened.

15 Now where are we? We are now in an area where people are complaining about fraud, waste and abuse, and indeed it was, it, abuse would have been there, because as you say, as you hear, if you come to me and I charge you so much and I charge somebody different, it's almost like abuse of the patients because they don't
20 know what they are going to pay. That led to the formation enquiry, by the same Competitions Commissioner. In 2004 SAMA was fined R1 million by the Competitions Commission which said there can't be certainty in prices of disease, there should be negotiations.

So if you are in a coma, I should make means to wake you
25 up to say how much do you think I could charge you. That's how,

basically, it looked like. They found it in their wisdom, to equate bread with disease, and if, unfortunately human life is completely different from any other commodity that people buy voluntarily. You don't volunteer to be born, you don't volunteer to be sick, you might
5 be reckless to be sick but you can't volunteer. You, so now if you then have, don't have that certainty, the words fraud, the words abuse and waste will be used and this is what has brought us here, and the question is; is it, is there any racial profiling.

That's a different matter I will talk to as I finish. I don't have a
10 long time to talk, but having said that, we then found ourselves having to define this. Today the medical scheme aids work like this, when you, patients that come to my practice today, benefits are exhausted. For something that I would've cut in my practice or treated in my practice, a simple ear infection, simple eye infection, I
15 send to the hospital to an ophthalmologist. So that they get specialist treatment in a five-star accommodation, and pay maybe 20, 50, 20 000 when they leave, and the reason is, with the deregulation and everything else, benefit design was also affected.

The design for benefits for out-patient treatment, ambulated
20 treatment at the doctor's surgery, the doctor's surgery was also affected. Benefits are so low that you admit one member of the family January, in April none of that family member will be able to be treated because the benefits were finished by the one that was seen. These issues cannot be ignored Mr Chairman, it can, counsel
25 this is serious because then people, it's actually abuse and possibly

waste for me to send to the hospital.

Because let me tell you, at the hospital the medical aids pay very well. Even if it's R190 000 for something they cannot explain, they pay very well. They are not queried on fraud in the hospital.
5 They've never queried abuse and waste at the hospital. Instead the person who referred is the one who will be said to have abused, because he should have treated there and not be paid, so that's guaranteed, so if their benefits are exhausted they say be a Jesus, treat, but don't be paid. Now what do I do, I say no, no, no, I know
10 doctor so-and-so he's an ophthalmologist, he will treat this eye infection. Then a waste happens, because now you're paying money on something that you should have paid less, perhaps not even R800, because we are not even paid that.

The consultation for a doctor it's about 450 for a hospital, for
15 a medical aid that is very generous. At the hospital even R1 million can be paid. So these are the things that lead to this. Now, what did we, now then came the Medical Schemes Act [intervenes]

CHAIRPERSON: Can you just tell me about your association, it's 17 000 members?

20 DR MABASA: Yes.

CHAIRPERSON: What are they, specialists, GP's?

DR MABASA: Oh, ja I should have given you that Chairperson, and it, I'm talking without reading, you tend to trust your memory very badly. Now we are, we have GP's, specialists,
25 and public sector doctors who are a union now, but they are under,

we are the one association.

CHAIRPERSON: And then what are the numbers of GP's, specialists, and public sector doctors?

DR MABASA: Those numbers I will request that
5 somebody gets us those numbers, but I can tell you that for now it, at one stage there were 4000 GP's, about 5000 specialists, and then we had 8000 public sector doctors. But these numbers I'm giving you just to assist you on what it was. But the GP's in the whole country, we are about 10 000.

10 CHAIRPERSON: And what is the racial breakdown of your members?

DR MABASA: The?

CHAIRPERSON: The racial breakdown.

DR MABASA: I wouldn't know immediately now, but
15 what I will give you is an indication of what could be the case. It could end up being a 40% Black and maybe 50% White, I don't know. That number I don't have, but there's some simple, there's a short story that I'll give you about the numbers. In 1979 this country had 10 000 doctors. 9000 were White, 1000 were black. So if you
20 think that you want to calculate it, you can actually compute it very easily by looking at how many people were graduating. It would've taken, because we produce 1200 doctors per year, or 1300. If you took from 1979 producing that 1200, it depends on what stage have Blacks overtaken the number of Whites in doctors, for us to cover a
25 bit of the gap if any.

So that, I wouldn't have that, the HPCSA would have been probably better to do that, because it knows the number of doctors. But be that as it may, the majority of GP's who are solo, who work in disadvantaged areas, are those that are not White if I could put it
5 that way. You could say Black, African, Indian and Coloureds.

CHAIRPERSON: Yes, and can you just explain this, the structure, I mean I know you mentioned that medical schemes tend to pay preferential rates to private hospitals, but the doctors are finding themselves at disadvantage because they refer and they get
10 punished. So I just want to understand that relationship between schemes, hospitals and the doctor.

DR MABASA: It's not preferential Chairperson.

CHAIRPERSON: Yes.

DR MABASA: It's not preferential, they charge as billed.
15 So the hospitals bill as they wish and the medical aids pay without questioning, but when it comes to doctors the problem that you have is that your benefits are so limited that they are 5% or 6%, or even 7% if you like. But if I were to say to you, we have got more GP's than we have specialists in private practice, it's in private practice to
20 put it that way. However, I know you have heard about these figures and I'm only mentioning to the extent that they're relevant, if you then take this 6% that GP's get, it includes what you will say genuine claims and fraudulent claims, so when you combine them fraud plus genuine is 6%.

25 So if you say so, you ask yourself, where is the cancer here?

Is it in the 6% or is it in the 94%? Because if medical aids are complaining that they're being defrauded by GP's, the maximum the GP's can do, good and bad, is 6%. So I'm saying this, and hospitals [intervenes]

5 ADV WILLIAMS: Sorry to interrupt Dr Mabasa, just to understand, because it's a useful figure, where do we, did you get that figure of 6% from?

DR MABASA: It comes from the authors, or the owners of this book. Those that own this book, called Council for Medical

10 Scheme Amendment Act, own their figures.

ADV WILLIAMS: So we should as the CMS for that information?

DR MABASA: Yes you can, actually if you go high and get eight, it's a great anomaly. In history we, GP's used to have 18%

15 because their benefits were enough to last the whole year. So you don't refer unnecessarily, when you have got enough benefits. But when you don't have enough benefits, like exhausted now as I speak, you'll refer to those doctors who will be very costly. So GP's are carrying the flack, getting the flack for the sins of others. I think,

20 I'm not saying it's sinful, so unfortunately the law also talks about the fact that when a person holds hospital benefits I shouldn't, I should be unlimited, and indeed that makes sense.

Because if you are sleeping at the hospital, and you are very ill, and suddenly the money meter starts running down and out, then

25 that meter when it's empty, then it's take him home we have finished

his money. It's like you were there to give them the money. After the money is finished, you are sent home. So that's, that makes sense, but do we admit necessarily correctly, and the bloods that are taken nobody monitors, all that abuse. The issue of fraud, and we have 5 had it, that it's about the people bending figure between 22 billion and 30 billion when they like, it depends on who talks.

But the reality is, if GP's are getting five billion, which is genuine plus fraudulent, I'm using the word fraudulent very guardedly. If GP's are using that, and their taking that five billion 10 only, who is taking the other 25 billion, and where is it going to? Are they being investigated? That's the other issue, because these investigations become abnormal. I have now to wind down, you will get other, the meat as we proceed, but has been very interesting for me to indicate to you that we, the way they come to your practice is 15 very inhumane. Because it is on suspicion that you are earning a lot. Why are you earning a lot, that's the question?

So we thought we should see you, and they don't do it just like that. They come with a camera literally on their chest as if it's a beautiful shirt that they want to display. But the reality is they will 20 come there and, and look for that, and ask you how you are, I'll give you one, only one example of somebody who was summonsed in 2003 from Giyani in Limpopo, next to Zimbabwe, if you'd like me to put it that way. He was doing caesarean sections, but they realise the other doctors in Giyani don't do it, are not doing it. So he's an 25 outlier. He was the only one. So he was summonsed to, at that time

Randbank, to come and account for why he is earning for caesarean sections.

There are human beings in Giyani, men and women, and children are born, and this man was the only one who knew how to
5 do caesarean sections. The other 10 or 15 doctors didn't know how to. But because he was the only one doing it, it was deemed to be fraudulent. He then drove from Giyani in the morning, and met me in Medscheme at nine o'clock.

CHAIRPERSON: Do you have the details of this particular
10 doctor?

DR MABASA: Yes I have, I can give you Dr Dombo, yes I can give you this and I'll even talk to him and say I mentioned his name, because it's clear he was, then I was there luckily to represent him at the time, and I said to them; why do you think he's
15 an outlier because he's doing a lot of caesarean sections. I said; has any lady ever complained that they were never pregnant, and they were never [intervenes]

ADV WILLIAMS: Which scheme? Sorry Dr Mabasa, which scheme?

20 DR MABASA: It was Medscheme, then it was Medscheme, I think it was Bonitas, but all the Medscheme, Medscheme had a lot of schemes under it. So any Medscheme patient who would have been there, the majority were Bonitas because they, you know, they work for government. So what I'm
25 trying to say is, if you think of the fact that this doctor was suspected

to be fraudulent because he's doing a procedure, because people were giving birth, and he was assisting them to do so because he was the only one, and the other 10 or 15 couldn't do it. Then you, I will find that to be harassment.

5 I would actually be offended if I was not offended on that day, I was. I was offended because I was the one who went there with him. There was Ms Fiona Van Zyl, and then other investigators who were busy querying that. So I'm just giving you an example of arbitrary investigation. There are so many things I could say, but
10 time is not mine. It belongs to yourselves, so [intervenes]

CHAIRPERSON: Can you just tell me, because you represent both GP's and specialists, maybe your evidence could be helpful here. Is it your experience that GP's and specialists are treated the same by medical schemes, or there is a disparity of
15 treatment?

DR MABASA: There's an anatomic disparity that obviously they earn more. Then let me just start, take it from there. I've said there are more GP's than specialists, now if you say there are more GP's than specialists, you then say the specialists earn
20 about 24 billion, and GP's earn about 6 billion. I don't know whether you would describe that as a disparity, but it's not because of that. There should be a disparity in terms of experience and paying, the payment. I wouldn't say that it's a deliberate one. Even when we were negotiating specialists were earning, there was a general
25 practice tariff, and a specialist practice. The only thing that

advantage specialist more than GP's now, it's what we call prescribed minimum benefits.

Because I mean once you're at the hospital, it's you, once you're admitted, it's like you have visited a lion in its den. It will eat
5 you and even lick its own teeth, so if you, I'm trying to put this so that we understand. What happened is this, when you're at the hospital the specialist will come and see you twice a day, or three times a day. A GP doesn't have that privilege, if you ask me that question. So as you can see in the morning, and you can phone me
10 there, he can see you in the evening. He may even phone from home and ask how you are doing. So you are charged for those consultations. So the disparity is not necessarily an anomaly, it's an irregularity of the system itself.

But it's worse now that GP's are forced to refer, because they
15 are not given enough benefits, and it's another topic for another day, I know it. It is another topic for another day, which I think it will see us in the official offices of the country, which are the courts, at some stage. The offices of the country where we see people debating eloquently, nicely, and I think we shall ask those to help us, because
20 we were about to do that on Section 59, but if you were not here, you saved the day, you would have represented us possibly at the other level, because we wanted to go and challenge this section, which I must comment on towards conclusion.

That our view at that time was that Section 59 says to the
25 schemes; you can pay anyone of the two, you can pay the patient or

the doctor. If the doctor claims and you feel he has exceeded the amount that you want to pay yourself, either way it's not set by anybody it's set by the scheme, with no agreement with anyone, if you, if you do R100 and he claimed 120, we shall pay 120 to the
5 patient to save money. How are you saving, because you are paying the same 120? Why don't you pay the doctor R100, and leave the patient with the 20 if you're feeling …[indistinct 00:29:21] generous?

Or you don't get paid at all, the doctor will then …[indistinct 00:29:27] hard to finish, but they don't do that. they pay the patient,
10 and doctors end up, and then lastly on the gist of your Section 59. We've, the choice to choose to pay should not be an option to whether you pay a doctor or a patient. If I have claimed in my name, pay me. If the patient has paid me the patient will be given a receipt, and claim in his or her own name, pay them, and this section needs
15 to be amended without doubt, and it's emphatically so.

Signs that is so clear that pay the one whose name appears on the bill. That's what we want on Section 59, because it's one of the disadvantages, and something I've used. Sorry for that. Lastly, the abuse by medical aids of this section is that they choose, they
20 choose to investigate you, and when they think you are not cooperating, they blackmail you by invoking the misinterpretation of Section 59 as it's written now, and say; we are not going to pay you until you pay us money, we are going to pay the patient, or we are going to withhold your money and Section 59 empowers us to do
25 that.

You know Section 59 it's a salad of languages, that's my worry. It must have one language. Who do you pay, and the answer should be the one who gives you the bill? I'm being made aware of something, maybe a meeting.

5 (background conversation)

DR MABASA: Oh ja, so then they say …[indistinct 00:31:21]. No, no, it's fine, they will read this, they will cover this. Thanks a lot, I think generally I've stated what I wanted to say, and I hope that [intervenes]

10 CHAIRPERSON: Dr Mabasa just tell me, because you represent all of these doctors, you might help us with the complaints coming to you from your members about the conduct of schemes.

DR MABASA: Yes.

CHAIRPERSON: I mean, do you have data that you can

15 share with us that tells you that we see in proportion more Black doctors then White doctors, or statistics of that nature?

DR MABASA: We, whilst we cannot comment fully authoritatively in that regard, but we, judging by the fact that the majority of doctors serving underprivileged areas are Blacks, one

20 could just say so. But we, if it exists anywhere it would be condemned to the fullest, but however you'll have examples of names. Hanneke as she presents, I guess that she has examples of names that are there to answer your question.

ADV WILLIAMS: Can I, sorry just the [intervenes]

25 DR MZUKWA: Chair, if we could assist in this regard, we

will probably go back to the office and then maybe go back over the last few years and do a stat of all the complaints that have been presented, and we're happy to present that to the committee.

ADV WILLIAMS: So you will do a table of, because you

5 represent your member practitioners in these disputes, so all Section 59 disputes and then a breakdown by race?

DR MZUKWA: Absolutely.

CHAIRPERSON: Thank you, who will be the next?

DR MABASA: It's Hanneke.

10 CHAIRPERSON: Dr Verwey, okay.

MS VERWEY: Yes, Ms Verwey that would be me. Just to confirm again, as stated earlier, I'm a legal advisor at the South African Medical Association, so the presentation that I will be giving is based on my department's experience, and the issues that we

15 typically encounter when we assist SAMA members with these claims, audits, and forensic investigations. We are furthermore then taking the liberty of putting to your committee our interpretation, in terms of the law, with regard to Section 59, and I'll do that briefly. Sorry about that [intervenes]

20 DR OOSTHUISEN: It's a technical difficulty with the slideshow. You guys can we get some assistance?

MS VERWEY: Sorry about that. In summary, the main issues that we encounter are one; the divergent interpretations of the Supreme Court of Appeal Sechaba judgement, especially,

25 obviously when we are confronted by the schemes in that regard.

Then secondly; procedural fairness in the manner in which the schemes are conducting these investigations. Furthermore related thereto, the manner in which the schemes collect some of the evidence in preparation, or during the course of the investigations.
5 Then the quantification of claims on the part of the medical schemes, with the eye on, obviously, settlement or acknowledgement of debt.

Then lastly, related to the acknowledgement of debt agreements, the issue of hard bargaining versus cohesion
10 potentially. Insofar as it relates to the, and I want to start with our legal opinion on the interpretation of Section 59, and then in particular then in the context of the Sechaba judgement.

ADV WILLIAMS: Ms Verwey, sorry to interrupt immediately. Can I just take a zoom out on Section 59(2) and the
15 Sechaba judgement, just to ask you about its relevance and I've asked this question before, but as I'm beginning to understand it, particularly from a doctor's perspective, 59(2) is relevant because if a doctor's placed on indirect payments, the only claim he or she can have to direct payment is if 59(2) gives you that claim.

20 MS VERWEY: Exactly.

ADV WILLIAMS: Is that correct?

MS VERWEY: Yes.

ADV WILLIAMS: Okay, thank you.

MS VERWEY: So it really all revolves around the,
25 largely regarding the interpretation of Section 59(2), because that's

where a lot of the trouble lies, and it's also a vehicle that schemes use to allow them to sometimes very arbitrarily suspend direct payment. So you are all no doubt very familiar with the wording of Section 59(2). Primarily it's the; or pay to a member, or pay to a
5 supplier of service that is the contentious part of Section 59(2). So the question essentially boils down to the question whether 59(2) grants the schemes an absolute discretion as to whether they want to pay the provider directly, or the patient.

Now in SAMA's view we have biding authority answering that
10 question for us, and that is the Supreme Court of Appeal judgement in the Sechaba case. What we also often encounter then is that the, we, or the Polmed ruling from the accounts for medical schemes is also sometimes cited by the medical schemes when bring up the Sechaba authority.

15 ADV WILLIAMS: And just to be clear, is that the Umfumetsi case? Umfumetsi Pharmacy, when you say the Polmed case?

MS VERWEY: Sorry, just repeat that?

ADV WILLIAMS: The Polmed case, who is the doctor or
20 complaining entity in that case? Is it Umfumetsi Pharmacy?

MS VERWEY: I will just check again. I have, I have the written judgement so I will just forward that to you. Very briefly, once again I trust your committee is already familiar with the facts of the case, but it arose in the context of liquidation proceedings of the
25 administrator, and claims that were submitted by the hospital

provider and the issue primarily revolved around whether or not the payment should be made to the scheme, or rather to the patients directly, or to the provider. So that was the crux of the matter. Now the scheme arguments were essentially that 59 of the act grant an
5 absolute discretion.

They merely assume a liability to reimburse the member for the amount of the benefit once quantified, and that the act doesn't entitle a provider to claim directly from a patient's medical scheme, even if the patient authorised the provider to submit an account
10 directly to the scheme and pre-authorisation was obtained. The provider arguments on the other hand were that these claims are underpinned by contracts, concluded in relation to each patient and member, between the provider and the scheme in terms of which the latter then accepts liability for, and agrees to pay for the services
15 rendered to its members. So essentially the argument is that a contract is concluded between the medical scheme and the provider, if pre-authorisation is obtained.

Now the judgement, if one has a look at that, in essence the following was held. The provider seeks authorisation in its own
20 interests, not those of the patients, so that in and of itself suffices to establish a contractual foundation for these claims. In addition thereto, the court referred to Section 26(1)(b) of the Medical Schemes Act, in particular the reference to the word "guarantee", which I will come to in a moment, and the court felt that the meaning
25 of guarantee should be instructive in the interpretation of 59(2). The

court furthermore, in terms of the manner in which the act should be interpreted and the purpose of the legislator, referred to the ordinary way in which medical schemes function in this country, and then also social realities. Then lastly, we feel this is quite important and the
5 court was also very explicit in this, you know what is then the alternative referred to in that section?

What is meant, what does the or refer to, or what is the purpose of that then, and the court, and I quoted this directly; “the position is different where the member pays the service provider
10 directly and seeks reimbursement”, and that is the alternative contemplated in Section 59(2). That is what the or refers to, or the purpose of the or. So and just to SAMA’s comment there, our interpretation of that is that; “59 thus does not grant a blanket discretion”. I felt prudent, or necessary, to actually refer, draw your
15 committee’s attention to specific paragraphs in the judgment. After the fact I can also refer you to the specific paragraphs, but the court’s reasoning was as follows.

It felt that the services are rendered, firstly upon a declaration by the member concerned, that he is a fully paid up
20 member of this scheme, and then secondly an authorisation by the provider, via its administrators, that the services may be provided and will be paid by the scheme. This is then the basis for the, the decision, or the submission that was made that these claims are underpinned by contract between the scheme, and between the
25 provider. In this regard the court also [intervenes]

ADV HASSIM: Sorry Ms Verwey, could you just tell me what paragraph number you find that in, that there's a contractual relationship between the provider and the scheme?

MS VERWEY: Would it be in order if I send that to you
5 later? I have the judgment, and then I will refer you to the specific paragraph.

ADV HASSIM: It's fine, I'll, I mean I have read it, I just wanted to know where you [intervenes]

MS VERWEY: Ja, ja.

10 DR OOSTHUISEN: Sorry, we think it's paragraph 12 and 13, but we'll get the details to you.

MS VERWEY: So the fact that the provider seeks this authorisation and does it in its own interests, not those of the patient, alone suffices to establish a contractual foundation for these
15 claims, and then we think something that is quite instructive is the court's reference to Section 26(1)(b), and the meaning of guarantee, and the fact that this section states that these benefits are guaranteed. The court stated that the expression guaranteed, does not make sense in a situation where the scheme's only obligation is
20 to reimburse its member for the amount of any benefit. What would one then be guaranteeing? A guarantee is an obligation given by one party on behalf of another, to discharge that other liability to a third party.

So it is an obliged guarantee to its members that it will
25 discharge to the extent of the benefits set out in the schedule of

benefits, their liability to the healthcare providers who render services. Once again this approach accords with the ordinary way in which medical schemes function in the country. Construing the obligations of medical schemes in that way constrains them to
5 function in a manner that is consonant with the social realities, and we also state that one should consider what would have been the purpose of the legislator, and when one takes these social realities into account that makes a lot of sense.

The court went on to state that this construction of 26(1)(b) is
10 not the only basis for reaching the conclusion that medical schemes are obliged to pay their member's medical bills in accordance with the scheme benefits. The court then went on to provide its interpretation of Section 59(1) and 59(2) of the act. The court felt that it's clear, based on 59(1), that this obligation is one owed to the
15 service providers themselves. Now the court, in relation to 59(2) stated that it expressly recognises that the medical scheme may pay the service provider directly. The argument on the part of the scheme during litigation that it was only obliged to do so when the service provider was a party to a designated service provider
20 agreement, and this is also an argument that we find very often when we deal with schemes.

The court however stated, this is a direct extract from the judgement; "there is nothing in the language, or the context of this section that warrants us reading such a limitation into it". If one has
25 regard to this shift in language between 59(1) and (2) this also

points to this being the correct interpretation of this section. Then as to the court's interpretation of why then is a differentiation, in 59(2) made, in payment to the provider versus the patient. The court explained that the position is different where the member pays the
5 service provider directly and then seeks reimbursement, and that is the alternative contemplated in 59(2), namely payment to the member. Again, this reflects common practice in the industry.

We are often, when we refer to Sechaba when we liaise with schemes, are then confronted, or a counter argument is made
10 referring to the Polmed ruling, which I will forward to your committee as well. Now the appellants argument in the Polmed ruling was essentially that, and this is also an extract from the ruling; "Sechaba is no longer good law as it infringes on the right to exercise due diligence with regard to ensuring proper procedures on the part of
15 the scheme". It was argued then that the, this should be balanced with the trustees duty to ensure proper control mechanisms, and then lastly the ruling was, it was argued that the ruling cannot be applied to claims that have already been paid, as it was in that case.

The relief requested was a direct payment of claims already
20 paid out to the members in that particular case, and it was argued that that would amount to double payment. Then lastly it was argued that the obligation is discharged upon payment to either the provider or the member. So once again there's a discretion. Now the Appeals Board ruling, if one looks at it carefully, does actually not directly
25 address Sechaba or Section 59(2). Although it does at some stage

say, or conclude that a service provider has a right to claim from the member, and that should provide the solution.

So the inference there then can be made that the Appeal Board does in fact think that 59(2) grants a discretion, and that it's
5 as simple as the provider simply needs to then approach the patient directly and claim payment from the patient. Now SAMA's view on this is, with respect, the Supreme Court of Appeal judgement is binding, and it can't be sidestepped or overruled by the Appeals Board, or by medical schemes. Furthermore we are of the view that
10 the judgement, as we've illustrated with the extracts that we've just quoted from the judgment, is very clear and unambiguous regarding its interpretation of 59(2).

Lastly, the argument raised in the Polmed ruling regarding the fact that it would amount to double payment, speaks to the relief
15 claimed in that particular case. It wasn't the Appeals Board interpretation of Section 59(2) per say. Now when SAMA deals with the medical schemes, we've noted typically their attitudes are one; Sechaba is distinguishable on the facts. We often get the argument; well, it was decided in the context of liquidation proceedings, so it
20 can't, you know, it's not generally applicable. If you have a look at the judgement there's no indication in it all that the application should be limited. Furthermore it's often argued that; well, have a look at the scheme rules, the scheme rules grant us a discretion as to who we should pay.

25 Now SAMA's view is that you can't contract out of the act,

and our reasons are the following. There's a public interest involved if one has regard, once again as also referred to in the Sechaba judgement, how do schemes typically operate in our country. Patients are not typically able to pay themselves, and it's thus 5 difficult for the provider to, after the fact, claim it directly from the patient. And then furthermore if one has a look at the Margate Clinic judgment, which is also quoted with approval in Sechaba, the authorisation is subject to, or limited by scheme rules not the application of Section 59(2).

10 This extract from the Margate judgment, also quoted in Sechaba with approval is that; "when the scheme gives the hospital an authorisation to treat, that authorisation must clearly be limited by the scheme's own rules". So what the scheme undertakes to do, as against the hospital, is it undertakes to comply with its contractual 15 obligation against its member. The upshot of this is that what the scheme undertakes to do, is to pay the hospital in accordance with the applicable tariff provided it is bound to do so against its member. So in argue then, when Section 59(2) states that it is applicable subject to the act and the rules of the medical scheme. That can't be 20 interpreted as discretion to contract out of Section 59(2).

It simply refers to the, as stated in Margate, applicable tariff and the, the authorisation. The upshot of this is that withdrawal of direct payments is often arbitrary and unfair. It's used as a punitive measure often against doctors, to enter designated service provider 25 agreements. It facilitates the procedurally unfair forensic

investigations. So in that sense it's a vehicle to disproportionately potentially disadvantage certain practitioners. So it could be discriminatory. Then in practice what we encounter very often is procedural unfairness. First of all there is an issue with the onus of
5 proof, that is often simply ignored. Matters are not to HPCSA or [intervenes]

ADV WILLIAMS: Ms Verwey, sorry. Can I ask a question before you move on to your procedural fairness points? Just in relation to this, it's actually not directly, it's only indirectly related to
10 your explanation of Sechaba. Can you just explain to us, there obviously are a number of ways in which providers contract, or are in contractual relationship with the schemes? I mean the vulnerability of providers seems to be that sometimes they aren't in any legal relationship with the scheme. But can you explain to us, when they
15 are in a formal, legal relationship with the scheme, what the options might be?

So we've heard evidence around DSP's, we've heard some evidence around pre-authorisation, which seem to be two examples of a contractual relationship. Are there others?

20 MS VERWEY: In my opinion, or my experience, based on Sechaba the first option or first possibility is a contractual relationship concluded, as you say, with pre-authorisation, and then I agree, then the second possibility is if there is in fact a contract, a designated service provider contract. So I, that is my experience, I
25 don't think there are any other grounds for a contractual relationship.

CHAIRPERSON: Any other grounds for any relationship, even if it's not underpinned by a written contract?

MS VERWEY: Well, I don't think the contract needs to be in writing obviously. The circumstances sketched in Sechaba,
5 what it boils down to is just pre-authorisation per say is contractual, even though it is not in writing, the contract exists in meeting of minds.

ADV HASSIM: Wouldn't there be another ground though, which is not contractual, and that's statutory obligation?

10 MS VERWEY: Yes [intervenes]

ADV HASSIM: So, because what the scheme is doing is that it's indemnifying, it's not indemnifying it's guaranteeing payment.

MS VERWEY: Precisely yes.

ADV HASSIM: Provided that the member, the patient is
15 a member of the scheme.

MS VERWEY: Yes, I [intervenes]

ADV HASSIM: And that the treatment that's provided is within the benefits that are allocated to that member. Isn't there a statutory obligation that arises between the scheme and the
20 provider?

MS VERWEY: I agree, that make a lot of sense. I absolutely think that's a valid argument.

ADV WILLIAMS: And just to push that example to its limits, because I think the schemes may argue that if there's a fraudulent
25 claim with that contractual relationship, would that statutory

obligation still exist?

MS VERWEY: Well, the Sechaba judgment at one point states that the provider should be entitled to advance the claim. So perhaps the argument could be made that in the context of a
5 forensic investigation, that entitlement might, could potentially be placed in dispute. But that would be, you know, a matter of interpretation. But I suppose that is an argument that could be made.

CHAIRPERSON: Isn't part of the problem that that paragraph in Sechaba says that if the benefit is owing, so it's a
10 qualified entitlement?

MS VERWEY: Ja.

CHAIRPERSON: So the question is when is the benefit owing to the service provider?

MS VERWEY: I think the benefit is owed to the service
15 provider if it's owed to the member, and pre-authorisation was obtained.

CHAIRPERSON: But what happens when it's disputed on the grounds that it's fraudulent, is it still owing?

MS VERWEY: Not, I agree that might be an issue, but in
20 the context of a forensic investigation I think the issue is then on what basis can you suspend direct payments for future claims as well. On what basis can you then say all future claims are fraudulent as well, because that's primarily the context in which the issues with 59(2) arise? It's future claims, and suspension of direct payments
25 pending these investigations. So claims, future claims that have not

even been submitted yet. So the assumption is simply made that, you know, there is possibly fraud and therefore no future claims can be paid directly.

CHAIRPERSON: Does someone have a view on this?
5 Yesterday we heard from the National Health Practitioners Council of South Africa, and they say that if you look at Section 59(3) it refers to an amount. But what the schemes do is to average, and they don't specify the amount that they're claiming. Does your association have any view on how that model of recovery, which is
10 based on averaging, is to be applied?

MS VERWEY: We haven't specifically considered that, but we could maybe go back and digest that and, you know, provide your committee with a more detailed opinion on that, if that would be in order, or of any assistance?

15 CHAIRPERSON: Yes?

DR MABASA: What the schemes do is they work on two examples, and tell you that you are owing 20% of these two examples. So 20% of your claims the past three years must be paid back, which is obviously troublesome I just wanted to.

20 CHAIRPERSON: Well that's exactly what I'm trying to point towards. It's that, what they do on this example that we had yesterday of Medscheme, is that they take a sample, and on that sample they will say we are looking at the claims from 2016 to 2019. We've paid you a million bucks, 20% was fraudulent, therefore you
25 must return R200 000.

DR MABASA: That's exactly, that's what they do.

CHAIRPERSON: What is the view of SAMA on that averaging that is done by schemes, that is not specific, based on specific accounts and specific amounts?

5 MS VERWEY: I think it's arbitrary and there are in fact rulings from the Council for Medical Scheme that explicitly condemns that practice.

DR MABASA: I wonder what's that, if that should only be condemned. It should be unable to stand the tests of law.

10 MS VERWEY: Alright, shall we proceed then? So the onus of proof is a major issue. If there, for example, are allegations of unethical conduct or even fraudulent conduct it's really [intervenes]

ADV HASSIM: Sorry, sorry Ms Verwey, I need to

15 interrupt on this point of the quantification, because 59(3) talks about amounts that are paid *bona fide*, and where the scheme subsequently has reason to think that the provider was not entitled to that money. It may claim, and the language of this statute is it might, it can deduct such amount. So it's talking about a specific

20 amount, and it's talking about the amount that it has determined was paid *bona fide*, but should not have been paid, right? So when SAMA represents its members in these disputes, is that one of the issues that's raised in defence of your members?

MS VERWEY: It is, yes.

25 ADV HASSIM: And what is the response by the

schemes to that defence that you present on behalf of your members?

MS VERWEY: Ja, we often insist that we should be furnished with a line by line summary, not just a benchmark amount
5 or you know, some sort of a percentage of claims submitted during the period of review, and it's honestly, it's very difficult to negotiate with the schemes. It's not an argument that is accepted, it's not typically successful when we raise that with them, and it's sometimes an exercise of utility. So the quantification thing is a
10 major, major issue and we are simply never furnished with evidence of a detailed data, or detailed audit from that perspective. So that's a big issue.

ADV HASSIM: And then how do you, how do you defend the, how do you assist the member, your members to defend that
15 then going forward if that's the position that's taken by the schemes?

MS VERWEY: Well, we would [intervenes]

ADV HASSIM: Do they then just enter into the AOD's and say well, there's nothing more I can do, or, because one of the things here is about practitioners who don't have access to legal
20 services in audit, you know they don't have bottomless pockets in order to take this up legally, and to defend themselves. So I'm just trying to understand SAMA's role in being able to provide that assistance to your members.

DR OOSTHUISEN: What frequently happens in these types
25 of situations, there's a, a big disjoint in the bargaining position

between the individual practitioner and the medical schemes. So when they come forward with this information, the practitioner would sometimes feel that it would be less of a burden to just sign whatever they give them, to have the direct payments continue. So
5 there's that sense of cohesion almost, that it's not worth fighting it, and the direct payments stop, and therefore I lose half or more of my practices income.

So they use this, as my colleague has said, as a punitive measure to induce these practitioners to often times sign contracts
10 etcetera, that are not in their best interest, and what happens sometimes is that these practitioners go to the schemes and they sit in on these meetings, without, unfortunately, coming to us first, or their legal practitioners first and they're not taking advice signing these documents, and we only find out about that later after they
15 have signed that. So that is a big problem that some of the members aren't aware, but there's also that disjoint in the relationship between the practitioners and the schemes, where they induce them to sign these documents that might not be in their best interest.

MS VERWEY: But we do also have a number of matters
20 that we have referred to the registrar, or that we are in the process of referring. Amongst others, for exactly that reason. We just felt that that quantification stage of the investigation was problematic. Even if there might be some merit in the allegations, you know, often *bona fide* mistakes that were made, the issue also often comes into the
25 quantification stage then, and that's very often where the unfairness

also lies in our view. So in all, you know, throughout the entire process, there are issues.

But, you know, particularly then with the quantification as well. So what we often find as far as the onus is concerned, to get
5 back to that, if for example there are allegations of unethical conduct, or fraudulent conduct, or whatever, these matters are not referred to the body with the relevant jurisdiction. So for example, an allegation of unethical conduct is not referred to HPCSA, where it will then be proven or not, or to the police for example, and I can
10 furnish your committee with this ruling. But this is in fact in contravention of one of the Council for Medical Schemes rulings, by the appeals committee, and once again I'm quoting from the ruling.

"A scheme is burdened with the onus that payments were irregular, before amounts may be deducted, and it would be
15 considered fair practice to allow for the discussions and feedback from the regulators" meaning HPCSA "before a scheme applies a Section 59", and we think that's just right, whoever makes allegations should bear the onus. That's just fair. There's then a second ruling as well, from the registrar, stating that a scheme is
20 liable to fund any claims in the event that it does not have any proof of allegations and in the event that said conduct was not reported to the relevant authority for further investigations and recommendations".

Meaning for example, HPCSA or the police [intervenes]

25 ADV HASSIM: When was that ruling made?

MS VERWEY: Let me have a look, I have a hard copy with me.

ADV HASSIM: Do you know against which scheme it was made?

5 MS VERWEY: I can have a look for you, I have hard copies with me so I can just hand it [intervenes]

ADV HASSIM: Alright, I'm just trying to establish, I'd like to know that information so when you have an opportunity to do so please, whether the scheme is then compliant with the ruling going

10 forward or not.

MS VERWEY: Okay, I will, I have the hard copies so I'll just hand it over to you. Okay, further issues with procedural fairness, we often find that payments are immediately suspended the moment an investigation is lodged. So even if it's pending, or

15 hasn't been finalised, and no definitive findings have been made, payments are just immediately suspended in any event. So there's, the presumption of innocence is, we think, compromised there. So we think procedurally that's also a major point of unfairness. But we also find from a procedural perspective is, obviously the doctors get

20 invited to meet with the schemes once these investigations are lodged, and we often, in order to allow ourselves to prepare for the meetings, request all of the available information.

You know, on what basis was the scheme of the view that there might be problematic aspects, if they used patient records, can

25 they be disclosed to us, if specific patients are involved which

patients, what is their identity so we can, so that our client can draw those records and check, and this is often refused. We are told this is a without-prejudice meeting, it’s just an informal discussion so there’s no need to share that information with us. So often doctors
5 are sort of led into the lines then, without really having had an opportunity to properly prepare, and you know, investigate the patients that are involved, have a look at the records, see how they can answer the allegations.

So the way these meetings are approached, is in our view
10 also very problematic. It’s difficult, it really is difficult to prepare for the meetings. Then in our view at least, we think some of the requests made by the schemes when they are trying to procure evidence to do an investigation, is unreasonable. Specifically we find this a lot with the request for patient records, and A what we find is
15 that records are often requested even in the absence of a designated service provider contract, and if that’s the case you have to get consent from the patient to disclose and the issue with that is there isn’t a prescription period tide to these investigations. So oftentimes you’ll have four years or five years for the review period
20 and then you, you know, you need to approach patients in respect of that review period and it’s often dozens of patients. So, how it’s, we think it’s unfair to expect the provider to do that and the issue is also, practically it might not be possible or you, patient might refuse or, you know. There are many issues with that and if a provider then
25 for a truly *bona fide* reason is unable to furnish all of those records,

adverse inference are made and they are not given the benefit of the doubt, even though it really is not practically possible to procure those records at that stage.

Or there's simply not enough time. We are often given two
5 weeks or whatever the case may be to procure those records and that's just not possible for somebody with a busy practice. And during those two weeks obviously then you need to approach all of those patients to get consent and it's just not possible.

ADV HASSIM: But legally it would have, claims that are
10 older than three years would have prescribed?

MS VERWEY: Prescription doesn't apply to, well at least the schemes argue, prescription doesn't apply to these audits.

ADV HASSIM: But your view is as far as prescription goes, can a scheme, can a scheme claw back for payments that it
15 says, a provider was entitled to more than three years earlier?

MS VERWEY: Well, if you have a look at the Act, and this is the scheme argument as well, it states irrespective of any other law i.e. the prescription act that, that is their argument.

DR MABASA: If you don't mind. It seems like they trying
20 just to avoid the prescription rulings and then that's why they claim three years, up to three years and they don't go beyond that.

ADV HASSIM: If they do not, you're saying they do not go beyond three years?

DR MABASA: Four years, or five years. They stop at
25 three years.

ADV WILLIAMS: Sorry, Ms Verwey. Can I just ask you again to give us some more detail about what doctors should keep and do keep? Because we've heard evidence, particularly around diaries and patient records, and I assume by that you mean clinical
5 notes.

MS VERWEY: Yes. Clinical notes, we get request for, primarily for the clinical for the notes. Sometimes the diaries.

ADV WILLIAMS: May I just ask the question. I'm not aware of anything in legislation which requires a doctor to keep a diary. Am
10 I incorrect?

MS VERWEY: No. No, if you have a look at HPCSA guidelines, legislation, there's absolutely nothing along those lines.

ADV WILLIAMS: And on the clinical records, what governs that? I assume there is something in legislation which requires
15 medical records.

MS VERWEY: Well, there is, the HPCSA guidelines requiring you to keep the records for six years following date of last contact, or following, ja, essentially the last time you saw, as from when the records became dormant.

20 ADV WILLIAMS: Okay.

MS VERWEY: My colleague is also drawing me attention, drawing my attention to the National Health Act, which [intervenes].

MALE: It will also apply to the keeping of
25 records.

ADV WILLIAMS: And is the obligation, and obviously we will check this thoroughly, but is, in your knowledge, is the obligation to keep let's say records, detailed records? Because anecdotally you know, you could, I see doctors writing one line about, you know, the
5 service I might be needing. And I ask the question because often I understand these patient records are scrutinised for whether you saw the patient for a particular length of time or something along those lines. So [intervenes]

MS VERWEY: You know, that's also an issue. I mean it
10 depends from, it various from one provider to the next. Not everybody keeps proper clinical records. So that is an issue as well.

ADV WILLIAMS: But is there anything in legislation which stipulates what a clinical record should look like?

MS VERWEY: No. No. So, yes, that is an issue as well
15 and further in relation to these meetings, what we find sometimes if, is the meetings are recorded but we are not allowed to obtain a copy of the recording. Which is problematic as well. Especially if the provider isn't legally represented because there might be allegations or the provider might feel that there was coercion during the meeting
20 and then if he or she wants to take it to the Registrar for example [intervenes]

CHAIRPERSON: Have you attended, I mean has anyone from SAMA attended any of these meetings? What we've heard are harrowing stories that the doctors are bullied. They are coerced,
25 they are made to sign, they ask questions, the questions are not

answered, there are four men attending a meeting with one woman out in Limpopo and that they're ex-policemen extracting information. So, I don't know if any of these meetings you've attended them and what have you observed?

5 MS VERWEY: Oftentimes we find that after the fact our members tell us about the fact that they felt they experience the meetings as coercive. So, these would be members who approach us too late, essentially. After they've already met. So in those cases we sometimes find that members tell us, well, I was steamrollered

10 during the meeting. Obviously when we assist members then we would never, ever make any admissions or have any agreements signed at the meeting or immediately following the meeting. So it might be different if the provider isn't represented. Certainly we have attended meetings that we felt were very aggressive. Obviously that,

15 you know, by all means I suppose if the scheme wants to take that approach but it's not inherently unlawful, but absolutely the meetings can be quite antagonistic and intimidating to the doctors and there is sometimes, it feels like it's a witch hunt, and a decision has already been made.

20 CHAIRPERSON: Is it true on the meetings [intervenes]

DR MABASA: Sorry. I wanted to say I've attended more than 10, just to say to be conservative. I have seen it with my own eyes.

CHAIRPERSON: What have you seen with your own eyes?

25 DR MABASA: Yes, what I've seen is they come with,

they tell you that we investigated, they come with affidavits that are signed by patients in your absence, without patients [intervenes]

CHAIRPERSON: Is it true the schemes come to this meetings with ex-policemen who have no clinical experience and
5 they start questioning the professional judgements made by doctors?

DR MABASA: Yes. Actually the person who is hired, they are hired, they are actually and embedded employees, they are ex-policemen. So they, I've seen them, I know them by names.
10 Some of them.

CHAIRPERSON: What's a typical meeting like? I mean the allegations of bullying and harassment and coercion are serious allegations. So we just need something tangible, because so far we've got anecdotal stories.

15 DR MABASA: I will elaborate.

CHAIRPERSON: Oh, you will elaborate on that?

DR MABASA: Yes, I will.

CHAIRPERSON: Thank you, alright.

MS VERWEY: I just want to chip in there as well in so
20 far as it relates to the attendees of the meeting. I've had a recent experience and we also procured an affidavit from this doctor, it's included in the bundle that we submitted earlier to the CMSA. The doctor is a physician and certain clinical aspects were challenged by a doctor investigated the matter but she is a general practitioner. So
25 our member was very upset about the fact that he, as a specialist,

did not have, have a specialist from the same branch of the profession having a look at his records from a clinical perspective. So, we feel also if a clinical review is conducted, it, and a specialist is involved, it's problematic then if it's a GP doing the clinical review.

5 ADV HASSIM: Ms Verwey, you said that the meetings are recorded but the recordings are not provided to the health service provider. What is the reason the schemes provide?

MS VERWEY: Sometimes it is provided, other times it's not. You know, oftentimes the recordings are deleted or it might be 10 stated, well, it was a without prejudice meeting so therefore there's no reason for you to get the minutes. So, not really very convincing excuses in our mind. I think I've already covered the immediate suspension issue, even though it's still a pending investigation. We've covered the sharing of information prior to meetings, and then 15 also we have covered the unreasonable request regarding the large volumes of patient records. Now, the collection of evidence is also potentially an issue. We have a lot of doctors who have the experience of probes being sent to their practice, which as far as we are concerned, or our interpretation of the law, there's nothing, 20 there's no legislation prohibiting that, but practically what we feel is potentially problematic is, there can a very thin line between a probe doing a legitimate investigation and entrapment.

So, it would depend on the probes approach but anecdotally I've also heard stories, not cases that I personally dealt with, but 25 from my colleagues, doctor colleagues, who felt that it really actually

amounted to entrapment. Unfortunately I can't put that on record because it is anecdotal. It wasn't an investigation that I personally dealt with.

ADV HASSIM: Are your colleagues willing to provide
5 that evidence?

MS VERWEY: I'll query. And then obviously surreptitious recording are often made as well, not just during the probing but also when the schemes meet with the member at their practice. Those meetings will then be recorded and later used as evidence
10 and also I've had a case where that recording was not shared with me. So, the issue with that then is also, it's difficult to determine then whether the scheme complied with the relevant legislation. It is permitted to make a surreptitious recording but there are certain requirements and then, you after the fact you're not really able to
15 determine whether those were complied with. And then lastly, and we have an affidavit actually in respect of Dr Valley's case regarding potentially coercive measures taken when procuring evidence from patients.

In Dr Valley's case particularly, affidavits were drafted for
20 patients to sign and after the fact and the patients also submitted affidavits to this effect and those are attached to our submission that what is in fact reflected in the affidavit is not really what happened. That's not, not in fact their version necessarily. So, and we do have it, this at least one example on record supported by an affidavit.
25 Then also major, major issue is the quantification stage of these

investigations. Really, really if ever are we furnished with line by line calculations. We are furnished with benchmark amounts or oftentimes they'll say we're going to subtract a percentage of the value of allegedly undue claims during the review period. So, for
5 example if the issue that the scheme has relates to a certain medication or whatever the case may be, all of those claims during review period would be deducted without any regard for the potential that some of those claims surely are legitimate and were correctly submitted.

10 So, I think that also again speaks to a lack of a proper forensic audit. So, ja, the quantification is arbitrary a lot of the time. And once again I'll just refer your committee to the earlier CMSA case that is quoted in or referred to in the presentation, where the council condemned this practice and I'm reading from the ruling:
15 "Whilst the scheme is within its rights to recover money due to it, what is due to the scheme is not an average or benchmark amount, and further the scheme is to provide the actual claims which it believes were claimed and paid for in error. Further to furnish the provider with raw data is not acceptable."

20 And this is, I would say 99% of the time we get these benchmark amounts. It's, we simply don't get enough detail. So that's also very problematic. It makes it very difficult to arrive at a fair quantification. As I've said earlier, allegations might have some merit. Sometimes, you know, claims are submitted incorrectly,
25 especially when it comes to coding interpretations, you know. There

might be *bona fide* issues there, but nevertheless, then you must give us a proper quantification that makes sense so that we can double check and that is fair. And then lastly, and this is something, as I've said that we typically hear from providers who approach us
5 too late, is they feel that they are coerced into signing these acknowledgement of debt agreements.

As my colleague stated earlier, often time you're confronted with the decision, you either sign this agreement for, you know, R100 or R200 or whatever thousand rand or you are permanently
10 deprived of your direct payments which, that can be devastating as well for your practice. So, it's difficult decision to make and once again I think there's a fine line there between hard bargaining and something that is really actually coercively or, you know, pushed into a corner is, it's almost not really possible to make that decision. It's
15 very difficult for the providers we often hear. And then if the providers feel that there was duress at the meetings, as we stated, if those recordings are deleted, it's, it's difficult to proof and then it's a he said, she said thing. And it should be acknowledged obviously that from the, from the beginning you're confronted to a, with very
20 unequal bargaining position. So, once again I think that speaks to potential coercion or at least, it's difficult.

And it's aggravated by the fact if it's not proceeded by a fair process obviously. So, in conclusion it's our respectful submissions. We've let out thoughts go a little bit as to how one could address this
25 and primarily the issues arise as a result of the procedural

unfairness of these investigations. So, we would suggest guidelines on how these investigations, binding guidelines on how it should be conducted. Schemes shouldn't be able to contract out of this in there scheme rules. Suggestions were made, I know, by the CMSA as well
5 regarding legislative amendments or reform but we're of the view this will take some time. So more immediate intervention is required. So, we thought maybe something like guidelines would be useful but that's simply a suggestion.

Of course entirely within your discretion. It's just something
10 we thought would be, for us to be able to confront the scheme with a guideline would be extremely helpful. Because at this stage we have very little to rely on except something like, you know, principles of natural justice or whatever the case may be.

CHAIRPERSON: Thank you. Alright. Okay, my colleague
15 has one question for you.

ADV HASSIM: Sorry, Ms Verwey, just, regarding your solutions going forward and guidelines. You've, there are CMS rulings that do provide, I just want to probe why you're saying there needs to be guidelines when the CMS has ruled, one, that there is
20 an obligation to pay the service provider in accordance with the Sechaba Judgement. Two, that where there's allegations of fraud or wrongdoing on the part of the health service provider, that the scheme must, bears a burden of proof. That's a ruling from the CMS. The CMS has also made ruling in relation to quantification and that
25 there must be a specific amount. So those, on those rulings what

applies, why is there a need for further guidelines beyond the CMS rulings?

MS VERWEY: Well, they should apply. They should be binding but that's not what happens in practice. That's obviously
5 something one could take on appeal. You could take it to the Registrar but the fact is, you know, at the initial stages of the investigation it's ignored.

MR OOSTHUISEN: And some of the decisions you refer to as well, we, in an appeal decision for example they would veer away
10 from the Sechaba Judgement as we have interpreted it and we feel wrongly so. So, we get divergent decisions that sometimes replace some of what we feel should be in a more solidified document that speaks to some of these issues and would address some of the issues that happen at an earlier stage before it gets to, become a
15 council matter. I don't know if that could perhaps be contained in regulations or something like that, but, ja. Something to consider. Thanks.

CHAIRPERSON: Alright. There's one more question.

ADV WILLIAMS: Short question from my side, and you
20 might have to follow up with us on it. Paragraph 5 of your submission says: "Cases of allegedly unprofessional conduct of fraud are rarely referred to the bodies with the appropriate jurisdiction i.e. the Health Professions Council and SAPS." Can you either explain how you know this now, or give us further information
25 about why they're rarely referred or how you know they are rarely

referred?

MS VERWEY: Well, sometimes the schemes might refer it after the fact, after they've already settled on amount and the claw back are in effect because, especially if it's fraud, they have a, 5 legally they are obligated to do it. But the referral is not made for purposes of proof in the context of the forensic audit. So, sometimes schemes, after the fact will refer it to the Police, sometimes they don't. Even, I mean they are in fact, they should and even HPCSA, they have a duty to do so. But it's not done for purposes of obtaining 10 proof in relation to the forensic audit. So you know, they might indulge the practitioner and say, well, we're not going to refer it to HPCSA that, you know, we won't do that to you, but, you know. We're signing the acknowledgement of debt.

CHAIRPERSON: Thank you. There are still more 15 presenters. I think, yes. Dr Valley is it you now?

DR VALLEY: A little introduction. I'm 62-years old today and my nightmare [intervenes]

CHAIRPERSON: Is it your birthday?

DR VALLEY: No, no. I mean, a few weeks ago. And my 20 nightmare started when I was about 45, 46-years of age. I actually come from humble beginnings. Was a bit of a political activist, had to run away from university at Durban Westville. I took away broad. I got a United Nations-scholarship and I studied medicine in Pakistan. Alright. So when I returned to South-Africa, it was 1980, at the end 25 of 84. And I started working for the state in 1985. You must forgive

me, I've travelled. It was at short notice. I came in at half past four. I made all the arrangements. It was my intend to drive down but fortunately my son managed to get me tickets, and I'm a bit exhausted and of course quite anxious. Anxious, not only because
5 I'm amidst so many people here, but anxious [intervenes]

DR MABASA: Dr Valley is one of those that I assisted in my previous life when I said I was attending to this, when he had problems. So, I know him well.

CHAIRPERSON: Thank you. Well, let's carry on. We have
10 the time.

DR VALLEY: Because this is what the years have [indistinct - 1:29:49.2] to. Anyway. Sorry, about this emotional outbreak. To me I felt that this steering committee was a prayer answered because I always wanted to explain how I felt. And
15 unfortunately, I kept all documents, did lots of research, until 2015 and in 2015 when I moved rooms it just crossed my mind that this is just a bad moment so I burnt most of them, or rather I should say I burnt almost all of them.

But just to give you an understanding of how things work.
20 And this is, this nightmare started in August 2002. It starts simply. You get a letter from, in this case, my case, from Medscheme, saying that they need to do a forensic audit on my practice. Now, at that time I had left state practice round about 1992. The [indistinct - 1:31:04.5] limited state practice at that time and I was going fulltime
25 into practice as a private practitioner. There were no obstetrician

gynaecologist in my town. So, I had spent about seven or eight years doing obstetrics in teaching institutes. I offered the service together with my private practice. Inevitably, because you're doing obstetrics your volume and your time of work increases.

5 You're out at all hours of the day, all hours of the night and you're trying to keep things sane. So, yes the practice was making good money. I was seeing lots of patients. Probably between 45 and 50 a day. But I worked. I worked extremely hard. I mean, I would do an average of about 20 deliveries a month. Now 20 deliveries, or

10 rather I should, yes, 20 deliveries a month which, the vast majority obstetricians gynae's are doing now. I would do lots of procedures, gynae procedures, ectopic pregnancies and stuff like that. But, when a medical aid judges you, it does not judge you by what quality or what kind of work you produce. It judges you in comparison to the

15 other people around you as to how what, how much income you generate. So, because you are earning more than the average person around you, you come under scrutiny.

And initially it was just, I was trained, I was, you know, there was concern, there was anguish. I was not so worried. And I didn't

20 think that, I mean I know I haven't done anything wrong, so I kind of wants it to just follow the pattern. So they requested that you come with your attorney, which I did. But it's an expensive exercise now to get an attorney from Durban. I'm based in Port Shepstone. I travel from Port Shepstone to Durban. I got an attorney from Durban to

25 come down with me. But the beauty of it is that you will sit in a

meeting and there's never a point at which your attorney needs to intervene because the meetings are conducted in very, you know, sophisticated manner without any intends to offend anyone but the questions that you get asked are, what percentage of your clientele
5 belong to this medical aid? What percentage of your clientele, you know, have this problem?

So what they do, and this I saw in my second meeting, they have a means of how to calculate what they're going to ask you for. So, there is a page, I had that, unfortunately I destroyed it. I had that
10 they will ask, according to the questions you answered randomly, this is not even questions that you prepared for. You're just coming for a meeting. You answers, and I mean, you ask me what percentage of clients that I see are Bonitas? I mean, I could probably say 50, I could say 80. I don't know, and because that's not
15 a true reflection. But this is what they did. And subsequently they asked me to give me my purchase slips for medication over a period of time. Which I did.

Now, in 2002, there was a lot of medication that was given to your, or for, if you purchased 100 of something, you could probably
20 get 300 of something and this is what they did. At that time the purpose incentives, the ruling only change in 2005. So, I would buy 100 Augmentin for instance and I'll get 300 because that is the deal. For every one you buy, you get two free. And it's how we lived. All the doctors did that. So, I gave my invoices knowing that there was
25 nothing wrong. But of course they came back with all their

calculations. They asked for a second meeting. Unfortunately, I couldn't afford an attorney for the second meeting so I went. Now, during all this time, I continued to see patients. And I continued the bill the medical aid. I continued to purchase medicine and give it 5 because I'm, I've got a dispensing licence to do so. And I'm in a rural area or now a semi-rural area.

At my second meeting I sat there and they told me that you know, you owe us R300 000 and you need to pay us R300 000. And I said now how did you come to such a judgement of R300 000? And 10 you know, and on the desk they threw me this piece of paper which, and I said but these are the questions you asked me randomly. I gave you random questions. This is not, you know, it was just something you asked me. You know? I didn't have a true, it's not a factual answer. No, but that is what you owe us. No problem. I came 15 back home and I thought about it and I said, ay, you know what? I did not commit this offence. Doctors unfortunately are secretive when they get called up for investigations. So I didn't have any assistance from colleagues.

Though, and at that point I actually didn't know that so many 20 of them had already been called upon and fees were already extorted from them. So I innocently decided, you know what, I need to proof my innocence. Why should I take the route of paying them R300 000. I said no, let's go to court. That was my answer. I want to go to court. I need to resolve this issues. And I went to court. This is 25 what the investigators give you. The investigator gives you his card.

It's either a Van Heerden or a Van Tonder or it's one of the Vans. They come there, they are all ex-policemen. They have no discipline, no principles in their methodology. There is an FMU. This is what, these are the Board of Health Funders, have a policy of how
5 an investigation took place. Certainly they do not follow the rulebook. They do what they choose.

But interestingly, at that point in time, I, they were actually not only, they were getting 36 to 37% other than, over and above their salary. If they brought in R100 000, 36 to 37% went to the team
10 that brought in that money. So, their intent was to get maximum out of you. Anyway, when I chose to go court, they started visiting patients and started trumping up charges. And like you said, they have no medical expertise. They have no medical knowledge. So they will ask a patient, the doctor gave you medicine A. Did you go
15 for this illness for backache to the doctor? The patient says, no, I had tonsillitis. So the doctor gave me that medicine for pain. So they go on to write that the patient did not see the doctor for a backache.

All these affidavits that so-called got from my patients were affidavits without a Commissioner of Oath present. They took
20 statements. They drew the statements in the room. They came back, gave the patients the statements and asked the patients to sign it, then got it commissioned in their offices. I have got, I managed to find, or by luck, I found two affidavits of my patients dated back then. Which I will give to you guys. Alright.

25 ADV WILLIAMS: May I just ask a question. Because you

went quite fast over it. But you said that the team doing the investigation got paid a percentage.

DR VALLEY: At that point in time, and I know this from another case that went to High Court where a doctor, unfortunately
5 he lost, because of Section 59, because at High Court it was then, and that's where he took, it came about on that case, I can't recall that case now.

ADV WILLIAMS: So what, just give us a timeframe for that, so we understand [intervenes]

10 DR VALLEY: That was roundabout, this is probably 20, in the year 2000, 2001, 2002 somewhere around there. And that, in that documentation it was said that they got fees of 36 to 37%. Okay? So that was, it's not just hearsay, I've taken it from the notes of that case and that case I think probably we'll find in some of our
15 files. Ja. Anyway, the people, you'll hear names like Fiona van Zyl. You'll hear names like Lynette Swanepoel. But there was one miserable character. If I had a gun I'd probably want to shoot him, even today. He was a medical doctor and his name was Dr Engelbrecht. He was their kingpin. He was the one that called the
20 shots. He was the one that was the most arrogant and most difficult from the lot.

Nonetheless, we're innocent people. We hear things. We go back home and we decide what is my approach. I went to court. They trumped 186 charges against me. Subsequently they came to
25 my rooms with a warrant of arrest one day, it was a Friday I recall.

Funny how investigators love Friday to create problems in your life. You know? So, they thought probably they'll have me kept in prison for the weekend because they came in there, with charges of fraud, they uplifted my, all my computers and my computers were the same
5 thing they had already knowledge of because that's what I referred my claims through. Probably they got their averages better you know, if they did their work right. They would probably know exactly what percentage of which patients I saw from which medical aids.

Nonetheless, we went to court and by that time, you know,
10 you start getting depressed. In the interim again, I was living on hope that I know I didn't do anything wrong, I know my money will come back to me. So I continued providing the service. And I continued spending my pocket money to purchase medicines to give to my patients. And during all this time, the money was not given to
15 the client. Nor was it given to me. It was kept and withheld by Medscheme. That's the difference. The problem went on. In March of 2003 I had, I had to apply for bail. So, I went to court and thereafter I went to court several time, costing me money each time. I went to court, I think probably about between 11 and 13 times
20 maybe to the court and standing like a common criminal amidst everyone because I chose to proof my innocence. And each time it's postponed because they don't have evidence. It's postponed because they don't have enough evidence and interestingly you couldn't get a Magistrate from town because most Magistrates were
25 my patients. So, you had to get outside Magistrates. So they got a

Magistrate from Durban. Each time. Anyway.

But the interesting thing is from the 186 charges, the Senior Prosecutor, he was not known to me. The Senior Prosecutor of, came up with this finding. He said, this was addressed on the 15th

5 September 2005, where the State versus Doctor Valley and the case number being, given in Port Shepstone and the letter was sent to Barnard's Attorney in Kempton Park, they represented Medscheme at that time. And it says: "Please be advised that after carefully considering all the facts in this matter, and after consulting with the

10 state witnesses, I have decided not to prosecute the accused. My decision is based on the fact that although there is *prima facie* case against the accused, there is no reasonable prospect of a successful prosecution. I have consulted with the witnesses in this matter and of the opinion that the evidence will not stand in Court. Now, some of

15 the problems I found with them are the credibility of the patient. Memory: The patient said that they, the investigators, pointed out to them where they, they investigators, thought false claims were submitted. Some witnesses say that they did go to the accused on the dates they pointed out as so-called false claims, which the

20 investigators pointed out to them as false claim, for consultation but they, and they did see him whether it be for five minutes but they did not considered this to be a consultation. The patients thought so. And the last one, that there is possible support for the accused's version."

25 Now each time these so-called trumped up charges were

brought forth these are my first appearance in court. I couldn't get the finger prints unfortunately. The amount was R300 000. I've got affidavit from two patients, which I think may be lengthy if I'm going to, or would you like me to read them out?

5 CHAIRPERSON: Yes.

DR VALLEY: Would you like me to read them?

CHAIRPERSON: Ja, carry on.

DR VALLEY: The one says that, this is by a female called Tabisila Anagretta Mkuno (??) and she says that on the 28th

10 May 2003, two white gentlemen came to my office and told me that they were from Medscheme investigating Dr Valley. I told them I would not be able to assist them as I was very busy. They then left. At about 1PM, they came back and asked me to come with them to a place where there'll be no interruptions. They went to Regional

15 Court D, where they asked why I go to Dr Valley so often. And I told them that I was very sickly and I needed to see the doctor often. They pressurised me with questions, eventually getting me to disclose my illness. Now, these are investigators. I was upset about this as what I suffer from ought to be confidential and they had no

20 right to get to, get me to disclose this to them. I informed them that I had severe back problems for which I was hospitalised and for my backache I received the medicine in the Indomethacin. I was comfortable with their questionings. Sorry, I was uncomfortable with their questioning and felt intimidated. They also threatened that if I

25 did not agree with their statement they would use it against me in

the event of a court case. They then went to their car to write my statement which they brought back for me to sign. As I was busy, I signed and initial each page without reading the entire statement. On the 30th March 2004 a Black gentleman came to my office and
5 informed me that he was from Medscheme. He presented to me an affidavit and requested that I change some statements which I made the first time and must sign and initial each page. This man did not show me the entire statement and instead only turned the corners of the page, requesting me to sign and initial. However a quick glance
10 at the statement showed a sentence, I did not receive the medicine Clindahexal [indistinct - 1:48:56.3] tabs from the doctor. This is a lie because I received both those medicines for my sinus and my back problem. I told the gentleman that I would inform my doctor about this and he told me not to ever go back to Dr Valley and in the event
15 that I am sick and I must go to another doctor Desai."

Now this is what they advice patients, not to come back. And this is how they damage you. "I was suspicious and also busy so I requested that the gentleman come back after lunch. The man left and I never saw him thereafter. This is all I have to say." And signed.
20 The other one is almost similar to this. Now, what I, this, the events followed like this: In 2003 they stopped direct payment, rather I should say [intervenes]

CHAIRPERSON: Will you just tell me about this two statements. The one you've just read of Mnchunu [indistinct -
25 1:49:57.9] and [intervenes]

DR VALLEY: Yes. Do you want me to read the other?

CHAIRPERSON: No, no, not necessarily. The other one is [indistinct - 1:50:03.0]. Under what circumstances were these obtained? I mean I see they're both dated 17th [intervenes]

5 DR VALLEY: Well, look the patients [intervenes]

CHAIRPERSON: May 2004 [intervenes]

DR VALLEY: Presented at my rooms to inform me of what happened and I said to them, you know what, you rather go and give the statement to the Police.

10 CHAIRPERSON: I see. So were they [intervenes]

DR VALLEY: There were several other, there were several other, there were several other affidavits that I had. Like I said, in 2015 I thought this was it. I was getting rid of a bad omen and all the files and facts were destroyed. I didn't think I'd ever have

15 a problem again.

CHAIRPERSON: Yes. So, what happened is, they came to you but they had been interviewed by the Police?

DR VALLEY: They have been, by these so-called interrogators, investigators.

20 CHAIRPERSON: Okay, by Medscheme [intervenes]

DR VALLEY: But these are Medscheme's investigators.

CHAIRPERSON: I see. And then you asked them, because they thought a police [intervenes]

25 DR VALLEY: I then asked them to go to the police

station and write an affidavit to that effect of what transpired. This is what they have said basically.

CHAIRPERSON: Alright.

DR VALLEY: Now, the things that happen is first, they
5 withheld my payment. Right? And in order to survive, things were getting tough now. I had no money coming in to my, I had no resources. So, I offered to sell my practice and I sold my practice to an associated practice called Imam Induna and they asked me to help out doing the locum while Dr Iman [indistinct - 1:51:34.0] who
10 was based in Cape Town, was making preparations to come down to Port Shepstone. He couldn't just leave there because he was contracted to the state. Subsequently they started paying on the new practice number but when they found that I was the locum doctor, they stopped the money immediately. Again, not giving it to the
15 patient nor giving it to the practice. I was subsequently forced to take back my practice.

In 2006 after receiving the letter that I got from the prosecutor, I mean after querying with the prosecution and receiving this letter, I asked an attorney Abrahams in Durban to approach
20 Medscheme because it was time that they paid me back. They were holding a good couple of million rands of mine. And it was time that they paid me back what was due to me. So he went on a negotiation spree. I really don't know what transpired. All I know that I was paying for senior counsel, paying for senior counsel, R20 000,
25 R30 000 each time and eventually money's, they held back,

Medscheme paid a small portion of it. They attorney took the biggest portion of what was coming in and I probably got a very minute portion for myself.

At that point in time I realised that, really, there were, 5 following the legal channel was a hopeless channel. But I must also admit, during this time I came to learn because I spoke about what transpired with me. And I learned from my colleagues about how money was extorted from them by Medscheme. And it became a two-year cycle for the same colleagues who were extorted the first 10 time. Two years later they'll get a visit and each time the amount start varying. So it becomes like a repetitive cycle. They know who are the guys that will pay. Now, the question was asked as to why is it that the doctors are made to settle? It is when these investigators come to you, they will tell you straight, this police do not help you, 15 know how to investigate. We will do the investigation. In my case they did the investigation. They presented it to police, but the investigation was fraud.

So, the vast majority of the people prefer that they pay the extortion fee. The reason being at least payments will not be 20 stopped. After my attorney got the payment which was a meagre amount not, Medscheme then applied Rule 59.2. During this time now I needed to earn money. In 2004 my daughter needed to go to university. In 2003 my twin needed to go to university. And two years later my other son needed to go to university. So I started working 25 extremely hard. I mean I used to, I was working extremely initially,

but now medical aids were not paying me, the vast majority of them, so I started working doing sessions for state hospitals. Not at one. I did sessions at several state hospitals. I used to assist in theatre work. I stopped doing theatre work myself, simply because I won't
5 get paid. So I would rather go and assist a surgeon and he collect on my behalf and pay me. And this is how it went on.

And you ran your small private practice on the basis of those medical aids that would come to you, that would pay you. The rest of them you lost as clients. For two reasons. One is, medical aid won't
10 pay you and if the patient wants to see you, they needed to pay cash. Two is, they were asked and told by these investigators that I am corrupt and they should not come to me. So, from 2005 onwards, they applied Rule 52. And this continued. I worked in the casualty. If I saw a Medscheme patient, patients never had money. They come
15 within trauma. They come in with heart attacks. They come in with sick children. So I would see them. In the, with the hope that they would pay me cash. Truthfully, I never saw the money. Again, I billed the medical aid. I never saw the money. If I gave the patient the bill to pay, to claim and pay me, I never saw the money.

20 So, I was getting kind of claustrophobic and with this, you know, the depression, but worse is the anxiety that comes and it kills you. To date I think my biggest nightmare is my anxiety disorder that I've inherited from all this post-traumatic stress disorder, secondary to this investigation that took place. Secondary to the fact that I had
25 to stand in court so many times, like a common criminal, it's really,

it's not something I would wish upon my enemy. Nonetheless, I continued to practice. I continued to practice and after the Sechaba case that was in 2016, in October 2016, then from January 2017, now I should go back. When Medscheme took over the
5 administration of GEMS at the beginning of 2014, until then GEMS paid me wholeheartedly, but the moment they took over the management of GEMS which was not very long period of time. I think it was called my-care, my, again they applied Rule 52. I was not paid from January until the middle of April.

10 I wrote several letters. Eventually they started paying me but I don't think it was, Medscheme had by that time, I think, fallen out of GEMS and GEMS took the decision to pay me, which was fine. In 2016 they took over the management of Polmed. From January 2016 until end of June 2016, again, they did not pay me. Now, like I
15 said, some of my patients are Generals in the Police. So, I had high ranking officials. Some were senior people in POPCRU. So I tried to master some help from my patients with, you know, trying to get to the CEO of Polmed to say, come-on what's the problem, you know. I, you were paying me properly and now ever since Medscheme has
20 taken over, you stopped paying me.

So I receive, eventually they sent a mail to the Police, to Colonel Venter, saying that: "Kindly communicate to members that Dr Valley who was indirectly paid by Polmed is now a direct paid doctor." But I think the problem that came in thereafter was that they
25 suddenly when the Police sent, gave me this, he sent me thread of

emails that followed. And one of this read like this: “Hi Boston.” I think this was sent by Sebokeng and he was from where? I think he was from Polmed. He said: “Hi Boston.” Boston is from Medscheme. “The aforesaid service provider was placed on indirect payment by
5 Medscheme having issues with him in other schemes that they are administering. Last we had a meeting on this issue and discussed that Dr Valley should be placed on direct payment with immediate effect and because Polmed didn’t have any issues with him. I was in an impression that he was placed on direct payment unfortunately
10 my thought was wrong.” So this is something that was sent much earlier to Medscheme. Right? And this has caused a noise until it reached the PO’s office. This is now a thread of email that landed on my desk. Right? “Please could you please place this aforesaid service provider on direct payment and send me proof.”

15 One of the shots in that proof states that I’m actually a direct service provider from the 8th January. I’m supposed to be paid directly from the 8th January. Yet, from January until the end of June, I was not paid. So this is their level of vindictiveness. They’re not, because you chose to challenge them, you got to pay a price. And
20 the price is at every level they will try to destroy you. Anyway. After the Sechaba case they started paying me as from the 1st January 2017. Prior to that I had contracts. This, so-called Designated Service Provider contracts, we’re already signed up with most of these medical aids. So they continued to pay me and then they used
25 the DSP as a means of the last vengeance against me. As from

March 2018 they cancelled all my contracts. Now, the question against was, again was asked, is there fairness in a Designated Service Provider's contract? There's no fairness.

If you are non-designated, you get paid far less than the
5 designated service provider. Number one. Number two, if you are not contracted you get far less visits. They, a lot, X number of visits, that the full medical aid visit, that they're allowed to because you are not contracted to them. So, again putting the squeeze on your business. This is how they operate. They main intent is to destroy
10 you because you chose to defend yourself. The one question that was asked earlier, of interest the HPCSA knew about this extortion racket in 2010. When they provided, when they gave an article stating what doctors, what, how medical aids are behaving, so this is not new. It is something that the HPCSA knows about. Comes the
15 last question. Did I go, come to the CMS? Yes. I came to the CMS for help. It was my first line of help.

I met an attorney by that, by the name of, I mean Dambusa. I had communications with him and Medscheme across. Nothing transpired. Nothing was beneficial for me. I then telephonically, I
20 couldn't run up and down. At that time it was in Hatfield, so telephonically I then communicated with another attorney, Steven Martley, also of the CMS. Again nothing was done. The person, unfortunately the Rule 52, 59.2 has been a thorn in everyone's flesh. It, the keepers of the law is the CMS. And they themselves did not
25 understand the law. They didn't understand the law. Because if they

did, they would probably get Medscheme to pay me.

The other question that needs to be asked, at what level do you classify as, a service provider as having committed fraud? At what level is fraud committed? Is, I, do you, when you get the letter, 5 are you now a fraudulent? Or are you fraudulent after going to court. At what juncture are you regarded as fraudulent? We haven't classified that. So when you ask, when we talk about fraud, we're talking about how medical aids think. We talk about from the day they sent you the letter and withheld your payment, it just carries on. 10 The question is, even if you've proved that you did not commit any fraud, their actions remain the same. They persecute you. They punish you. And this is how they intend operating. Okay. The last thing I'd like to say, you had asked earlier about on what paragraph is the 59.2. The [intervenes]

15 CHAIRPERSON: What paragraph of Sechaba.

DR VALLEY: Of the Sechaba case. It's actually paragraph 25. Sorry, I just found this now. Just to highlight something. And I think this is important. In the Sechaba case they talk about the Rule 26(1)(b). And this Act says that the scheme 20 assumes liability and payment of which it must guarantee. The paragraph is 25, when we talk about the High Court thought that the effect of 59.2 was to give the medical aid scheme a choice between paying the amount of the benefit to the member or paying it to the service provider. But if the benefit is owing to the service provider, 25 which the section says, I fail to see on what basis it can be paid to

the medical aid scheme, you know. It needs to be paid to the service provider.

To my mind, this is in accordance with the relationship between the member and the medical scheme. Scheme members
5 are not primarily expecting to receive a sum of money from the scheme as a result of them having sought medical treatment. They become members in the expectation that the scheme will pay their medical bills to the extent of the benefits for which they contract. Right? And then 59.3, again 59.3 we talk about fraud. And my
10 question against it, at what juncture do we say we're holding X amount on the basis of fraud. At what juncture? Is it on the assumption of fraud? Or is it on the knowledge that fraud was committed. That is I think very important. So 59.3 loosely applied would mean, at any juncture. But if applied correctly, it would mean
15 when a fraud act has been committed. I thank you for having listened to me.

CHAIRPERSON: Thank you Dr Valley. Can we get copies of the documents that you were reading from? I know some of them are included in the submission by SAMA, but I think there are some
20 that are not included. So maybe if copies can be made and given to the secretariat.

DR VALLEY: Not a problem.

CHAIRPERSON: Thank you. Gentlemen and ladies, do you have further submissions from SAMA's side? Alright. There's
25 still, okay, there's still. Alright. Dr Mzukwa.

DR MZUKWA: Thank you so much, Chair. I must thank you, the investigating team for giving SAMA an opportunity to make submissions. Mine would be very short because it's just a conclusion and summary of what has been said already. But our, SAMA would
5 like to affirm our support and trust in the process led by you and your esteemed team. Chair, I'm not saying this because, only because I read your well-researched book, The Land is Ours, but because of other excellent work you have done in other areas.

CHAIRPERSON: One person has read it.

10 DR MZUKWA: As a representative organisation of both specialist and journalist, SAMA has received complaints from both. Specialists have complained about abusive power of medical aids and how they got paralysed financially by the said abuse. Some of our specialists are now requesting cash up front and then they give
15 invoice to patients who must then claim from their medical aids because they are exhausted by the fights between them and the medical aids. So they want to exclude the third party. So that's how complicated the matters have been. But I want to highlight the issue of the referee. We, as healthcare provider, or professionals, I always
20 try and avoid this thing of being service providers as if we are commodifying this thing. But as healthcare professionals we feel that there's no referee between healthcare professionals and medical aids when there's a dispute.

Because if you, recently when we approach the Council for
25 Medical Schemes, they said they don't have a mandate to be

dealing with healthcare professionals and medical schemes. They only have a mandate between patients and medical schemes. So I think that's one of the things that we are looking for. And also this direct payment to medical aid members. I want to submit to this
5 investigating team that is a violation of the doctor/patient relationship. Where a doctor must now act as a debt collector instead of focussing on disease management. And this places unnecessary administrative burden on healthcare professionals. We're already doing lots of, should I say, charity work, for medical
10 schemes because we, in most cases we don't get paid for that administrative work which I sometimes think is charity work.

The investigation, the investigation and withholding of healthcare claims money is the biggest elephant in the room. We are particularly worried about the legality of the process. We are worried
15 about the legality of the process. I think even in the summit that we had earlier this year, we all agreed that we don't want any fraudulent practitioners, you know, to continue doing fraudulent work. We don't like it. SAMA doesn't like it. Every other association as far as I know, they don't like it. But what we are questioning is how the process is
20 being conducted. We feel that the process needs be managed effectively. South-Africa, as you know, has a functional in the highly esteemed judiciary. And we feel it must not be replaced by what we could term rogue units by administrators.

There's also the element of the, you know, the element of the
25 remunerated work outside the public service called, ARWYP. Now,

we have, some of our colleagues are having their claims withheld because the doctor did not have any contract between the Department of Health and the doctor. And we know that in that policy ARWYP says in that policy, if after 30-days of making an application,
5 there is no response, you take it as you are granted permission. But now, when you don't have that contract, medical aids they withhold payment. They say but you, you're also doing sessions in government. But the challenge is that, it's that I would expect from a healthcare professional that, you know, medical, it would be,
10 government would say, you've made money out using my time. Give me that money, but it's not the government that is doing that. It's medical aids.

So, I think there's a problem with that. So, I think in conclusion we would welcome, you know, a very fair process of you
15 know, listening to both funders and healthcare providers and you know, iron out all this problems. Especially also, you know, this relocation of patients, you know, to other service providers regardless of a long relationship that exist between healthcare professionals and that particular patient. So, we believe that this
20 process would assist in managing, you know, this deteriorating relationship between us and the schemes. Thank you so much Chair and the team.

CHAIRPERSON: Thank you very much. It remains of me then to thank SAMA for being present today and making your
25 presentation and thank you Dr Valley. You say you are 62, but it's

not your birthday. But thank you for your impassioned and thoughtful presentation this morning. It will enrich the work that we will do. We will adjourn. I think the next, the next submission is from the Independent Practitioners Association Foundation. They should have
5 started at half past 11. Someone else ate their time. So, two and a half hours. Okay. Ja, well, alright. That’s fine. So you made two and a half hours. Anyway. So let’s take an adjournment for 15 minutes and then come back to listen to IPAF. Thank you.

PROCEEDINGS ADJOURN

10 **END OF AUDIO**