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 INDEPENDENT PRACTITIONERS FOUNDATION ASSOCIATION:

DR ELIJAH NKOSI

MR HENRU KRÛGER

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	:	40
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 1 AUGUST 2019

CHAIRPERSON: Good afternoon. So, we are continuing the Council for Medical Schemes Section 50 Inquiry. It, I-, we now are going to be hearing from the Independent Practitioners Association Foundation. There are two gentlemen upfront. Could you please introduce yourselves?

DR NKOSI: I'm, I'm Dr Elijah Nkosi. I am the Chief Executive Officer of the IPA Foundation of SA.

MR KRÛGER: I am Henru Krûger. I am Chief Operations Officer for ASAIPA, which is the Alliance of South African Independent Practitioners Association. It is also a member of the IPA Foundation.

CHAIRPERSON: Thank you very much. Dr Nkosi, will you be speaking on behalf of IPAF?

DR NKOSI: Yes, I will be.

CHAIRPERSON: Alright. Do you prefer taking the oath or the affirmation?

DR NKOSI: Taking the oath.

CHAIRPERSON: Alright. Will you say after me, me and your name?

DR NKOSI: I, Elijah Nkosi.

CHAIRPERSON: Swear that the evidence that I shall give.

DR NKOSI: Swear that the evidence that I will give.

CHAIRPERSON: Shall be the truth.

DR NKOSI: Shall be the truth.

CHAIRPERSON: The whole truth.

DR NKOSI: The whole truth.

CHAIRPERSON: And, so help me God,

DR NKOSI: And, so help me God.

CHAIRPERSON: And Mr Kruger, will you be speaking?

MR KRÛGER: Yes. I'm, I think our submission is made up of three parts. The first part is basically complaints received from members which Nkosi will handle. Then there's a second part which just refers to the legal aspects that I will be speaking on. And then the last part is just recommendations that we've proposed and I think, you know, the panel is more than competent to, to actually work through that.

CHAIRPERSON: But you will be dealing legal submissions, not evidence?

MR KRÛGER: Ja, that also is my question from my side. Are we supposed to just present today or are we going to actually be delivering substantive evidence because we haven't really, I haven't prepared substantive evidence as such for today?

CHAIRPERSON: Alright.

MR KRÛGER: I will just be speaking from my personal knowledge, so if that is sufficient, you know, I am willing to do an affirmation and to basically [intervenes]

CHAIRPERSON: Yes.

MR KRÛGER: … state that under oath.

CHAIRPERSON: That will be sufficient. We do expect that we will be sending out queries of items that are not clear and if you wish to supplement anything you say today, you would be more than welcome to do that.

MR KRÛGER: That's, that's my understanding, that's it.

CHAIRPERSON: Thank you. Okay. So you will take the affirmation?

MR KRÛGER: Yes.

CHAIRPERSON: And then will you say then after me, me and your name.

MR KRÛGER: I, Henru Krûger.

CHAIRPERSON: Solemnly affirm that the evidence.

MR KRÛGER: Solemnly affirm that the evidence.

CHAIRPERSON: That I shall give.

MR KRÛGER: That I shall give.

CHAIRPERSON: Shall be the whole truth.

MR KRÛGER: Shall be the whole truth.

CHAIRPERSON: And nothing but the truth.

MR KRÛGER: And nothing but the truth.

CHAIRPERSON: Thank you. Dr Nkosi.

DR NKOSI: Yes. I'll start first by introducing our organisation, the Independent Practitioner Association of SA. This is a national network that comprises of a number of organisations. It has SMTP provider network, which is called SPNet. It has ASAIPA, it has Nimpa Healthcare and it has SMCC. SMCC is

national, SMT-, SPNet is national, so is ASAIPA and so also is the NHC. So in terms of representation, it's right across the colour line. We have more than 5 000 members who are part of the organisation. We were found in 2005 and there were an NPC.

So, there-, there's, like he's explained, part of the submission would be the complaints and we'll also want to talk about peer view in that we are the only organisation in the country that is currently doing peer review on behalf of some schemes and administrators. I'll just talk more about that when it comes to that aspect. I'll just start by coming with the kind of complaints that we've submitted in our submission and which hopefully you do have a copy thereof. This comes in lieu of the complaints that we get from our members. The first complaint is that of entrapment, where in this particular case probes are sent to practices where they adduce some of their members to do something that is unethical and then come back and then charge them.

And said, look this is the kind of practice, that's happening in this practice, but I will get more into that once we are going to the substance of, of our submissions. And, and this leads to withhold of payment. We know, I mean certainly that the withhold of payment will affect the cash flow of the practitioner and it has led to instances where doctors have lost their practices simply because they could not afford to pay their debts, home loans and even their children's school fees due to that withhold of payment. Lastly, Henru will talk about the Setjhaba judgment. The summary thereof is that when,

when that judgment was made [indistinct-00:06:24] with Section 5-, 59.2 and the summary of the charge then was when a member utilises medical services and arranges for the provider to submit a claim to the scheme, they are in effect authorising the scheme to pay the doctor directly and not the member.

But we do have, I mean, cases where our members have not been paid directly and the schemes has paid patients. The fourth point it's, it's a situation where doctors are coerced into signing an NOD, an I-, an AOD. How this happens is that in some instances the scheme or the admin-, or, or the forensic unit would come to a practice and come in with allegations of a fraudulent activity. In this instance, the doctor is not given an opportunity or has not been given an opportunity to test the allegation, I mean in that one. And secondly, he is on his own and has no representation.

And, and this AOD's are then made a repayment plan where they would say based on the evidence that has not been tested but the scheme has, they will then say you owe us so much money based on the percentage where… [background talking] based on, on the percentage that the attribute has been gained fraudulently. So if one also consider that in these instances, you know a doctor hasn't had, like I said an opportunity to test the allegation, he hasn't had an opportunity to review everything that has been said and is threatened with being reported to the HPCSA if he doesn't accept what the scheme is saying or even being reported to the SAPS for a fraudulent behaviour.

And then this becomes a repayment plan. And what also worries us is that an administrator would then say, we administer the following 10 schemes, we've picked up fraudulent behaviour in this one scheme and then we'll assume that this has been going on for the past 3 or 4 years and now looking at the other schemes that we are administering would then say this behaviour has been prevalent and you've exercised it in all the schemes. And then they would come in with a figure as to what that doctor is owed. And they can, in some instances they've asked for down payment in that situation or maybe a repayment plan that would go over 3 years or 4 years where they clawing back the money that they feel has been claimed erroneously. Ja, but I think for now I'll pass it on to Henru.

ADV WILLIAMS: Apologies, before you hand over, Dr Nkosi, may I ask you just a couple of questions?

DR NKOSI: Ja.

ADV WILLIAMS: I understand that some-, one of your members is a network [intervenes]

DR NKOSI: Ja.

ADV WILLIAMS: So, it, it makes me wonder if you have any information about network arrangements. So, we've been trying to understand how doctors may or not be contracted with schemes. So, we understand that doctors might be contracted by way of DSP arrangements [intervenes]

DR NKOSI: Ja.

ADV WILLIAMS: And there may be other forms by which doctor's contract. So, do you have any information on that?

DR NKOSI: There are contracts that we have with some of the schemes. In these contracts in actual fact, we provide the least of the doctors that are part of the network that have agreed to become a DSP for that particular scheme. So we do have our own network that we contract out to schemes and, and the schemes would then use, I mean, those particular doctors. So in effect, that becomes a DSP.

ADV WILLIAMS: So you are say-, are you saying doctors have created their own networks and then enter into contractual arrangements to provide services to schemes at agreed rates?

DR NKOSI: Ja, yes. We do have contracts like that with schemes but the other schemes in actual fact it would be a doctor who is willing to sign a contract that comes from th-, from that particular schemes. These are schemes that we don't have contracts with but would then advise our members if you look at the contract to see if it does, I mean, follow or whether it's legal in terms of it is framed and whether it, it's compromising the-, compromising them as doctors or whether it compromises patient care. That's where we come in, I mean in terms of reviewing the contracts that are on the market.

And, and based on the contract, we are able to then say to our members, this is a good contract. But we are not forcing them to sign any contract or not to sign a contract. The choice is theirs.

The only thing we can do, I mean, is really to advise them regards the various contracts that come to the market.

ADV WILLIAMS: And you refer to these contracts as DSP arrangements [intervenes]

DR NKOSI: Ja.

ADV WILLIAMS: Is it correct that they are only limited to prescribed minimum benefits or do they go-, services beyond those listed as prescribed minimum benefits?

DR NKOSI: They, they go-, they go beyond-, beyond PMB's, I mean in that the, the doctor would service, I mean, those patients who belong to that particular scheme and not only limited to chronic illness because PMB's mostly are around chronic illnesses. So they will treat even acute illnesses and almost anything that their patient complains of.

ADV WILLIAMS: And then my other question relates to your function which you perform, or not, I think it's meant to be the NHC performs the peer review function and peer monitoring function, is that right?

DR NKOSI: Ja, yes, we do peer reviews and peer mentoring.

ADV WILLIAMS: So what does that involve?

DR NKOSI: We've got a contract whereby we do peer review with schemes, we've got a contract, may I'll just name the schemes because it's something that's above board, it's something that is public knowledge. We have a contract with Med-,

with Discovery where we do peer review for Discovery. We've got a contract with Medshield, we've got a contract with Bestmed, with Medihelp where we do, I mean, peer review for those schemes. And we also do peer review for Medscheme, but Medscheme has their own profiling system. The schemes and Discovery has their own profiling system but now for the other schemes that I've referred to, there's an actuarial company which is called Insight and Insight does their profiling.

And once they've done the profiling they would send the data to our central peer review committee that is based in Durban. And then what then happens, the profiling will in actual fact come in with categories. Like there's three categories, category 1, 2 and 3. The category 1 would be a doctor who performs exceptionally well in terms of [intervenes]

ADV WILLIAMS: Can I just ask you to slow down a bit.

DR NKOSI: Okay, okay, Ja, Ja. So, so [intervenes]

ADV WILLIAMS: So perhaps explain how your peer review mechanism works with the schemes you've described, if it works the same for all of them or differently for some of them? And you are welcome to start at whichever is convenient.

DR NKOSI: Ja. I, I, I think the peer review is really based on profiling and it is a standardised process. What happens in this case [intervenes]

CHAIRPERSON: You don't mean racial profiling?

DR NKOSI: No, no, no, that, it, it profiles doctors' data that they've submitted and this data is risk rated for age, gender and disease bearing or [indistinct-00:16:26]. And then looking at that data, it would then be able to show who are the outliers. So what we are looking at, we are looking at costs and we also are looking at quality. So, a doctor who might be cost effective but has poor quality and bad outcomes, in that particular instant would be flagged, he would not probably be category 1 because we then say, look clinically you are not performing up to the standard that is expected based on how your peers nationally and geographically perform.

ADV WILLIAMS: Dr Nkosi, am I understanding you correctly when you say that the risk profiling is done by another company [intervenes]

DR NKOSI: Exactly.

ADV WILLIAMS: Insight, being one of them, this company called Insight [intervenes]

DR NKOSI: That's correct.

ADV WILLIAMS: And then Discovery has their own risk profiling program [intervenes]

DR NKOSI: That's correct.

ADV WILLIAMS: And Medscheme has their own risk profiling [intervenes]

DR NKOSI: That's correct.

ADV WILLIAMS: And then you, once the profiling has been done [intervenes]

DR NKOSI: Ja.

ADV WILLIAMS: By these different entities, you then check the red flags and do a peer review from that, is that right?

DR NKOSI: Ja, maybe to explain it better is that we'll get to their entire data, it's aggregated data for a doctor, it might even be based on stats over a period of a year or something like that. And then, we'll then be able to then see, I mean based on the entire data, that how the various doctors have performed. They will then be categorised into category 1, category 2 [intervenes]

ADV WILLIAMS: You do the categorisation?

DR NKOSI: … category 3. No the categorisation is done by the actuarial companies. It will be done by Insight, it would be done via [indistinct-00:18:30] at Medscheme and Discovery would use the John Hopkins method that they use for profiling. So once they've been profiled, they would then be categorised, like I said into 1, 2 and 3. Category 1 [intervenes]

ADV WILLIAMS: Apologies for interrupting [intervenes]

DR NKOSI: Okay.

ADV WILLIAMS: I don't want to break the chain, but did you say the John Hopkins methodology?

DR NKOSI: Discovery uses that system, Ja.

ADV WILLIAMS: Thanks.

CHAIRPERSON: What's the point of this, this profiling and categorisation?

DR NKOSI: It's, it's to promote good behaviour, I mean in that a doctor who is category 1 would be paid a higher incentive, I mean in one of the contracts with one scheme, maybe I should say, with Gems, a category 1 patient would get R50.00 more for every consult that it does for Gems members who are in their higher options. And the category 2 might not get any money or get very little money. And then the category 3 would not get any money. In actual fact, that would be the category that would be liable for peer review in that the process of peer review in this case is to then help this doctor understand what might be wrong with his costs, what might be wrong with his quality with the view of helping them to can then improve in that we are looking patient outcomes.

CHAIRPERSON: What, what do you do with your own categorisation? So you've now done this a, b-, 1, 2, 3 [intervenes]

DR NKOSI: Ja.

CHAIRPERSON: And you've got an actual document, what happens to that document?

DR NKOSI: What then happens, the category 3 doctors would get a call from a peer review. What we have, I mean in the peer review office that we have in Durban, we've got a list of doctors who have been trained in doing peer review and they get regular refresher courses and things like that. They are also trained in how they should engage with a colleague in that the entire

process really process of peer review it's a collegial process where one is hoping to help a colleague see how they can improve in terms of delivering healthcare. So, what then happens, I mean in that we do peer review for various schemes, the office has the list of peer reviewers, and if a doctor is not doing well, let's say Medscheme is not doing well in-, or Bestmed or Medshield in that all of those schemes are flagging that particular doctor.

He would have one doctor who is looking after him and would then help in terms of mentoring him, talking to him or her and saying, look if you want to improve your category, this is what you should do, these are the tests that you need to do. It will also look at costs where you'll find a doctor who is dispensing ethical drugs when there are generics that can do that. So part of the advice would be saying to reduce costs just look at the medication that you script or dispense. If it's a doctor who is doing excessive sonar's or ultrasonographies are able to pick that up and say look, if you look at the area where you are, and your, your colleagues they do, let's say maybe 5% of their patients have sonar's, in your case it's 40 or 50%, can you give the reason why. I mean, if it is based on the demographic of the area, you are an outlier.

ADV WILLIAMS: So, just so I understand your evidence correctly. It sounds like the peer review mechanism is not entirely aimed at the, let's say the quality of the service or how to be a better doctor, it sounds like it is aimed at how to, let's say be better

in terms of being reimbursed by the scheme. Is that a fair, fair or unfair summary?

DR NKOSI: It's an unfair summary.

ADV WILLIAMS: Okay, good. Could you explain it to me?

DR NKOSI: I mean, in that we've got-, we look at costs and we look at quality and that's why earlier I said you might find a doctor who is very cheap, if I had to put it like that, in terms of his costs compared to the peers but you find that there are worse outcomes, I mean in that, I'll give an example, his diabetics are not well-controlled, his hypertensives end up being hospitalised, or something like that. So, the main driver is the quality of care. So a doctor who does well will be category 1 and will then be reimbursed based on that. So, so primarily we're not really looking at costs but we also are saying look, I mean patients have limited benefits.

If you look at maybe patients who don't have a chronic illness, he will come for an acute consultation. But to then ensure that, I mean all who has a medical savings account which has limited funds, that you need to then also be considerate of the costs and not only dispense expensive medication when there are suitable alternatives. But primarily peer review is to improve the quality of care and get better outcomes for patients. It's patient centric and it's not cost centric.

ADV WILLIAMS: So just so I understand, so you contract with the various schemes and administrators to do this?

DR NKOSI: Ja.

ADV WILLIAMS: And you are doing this on their behalf to improve outcomes, clinical outcomes?

DR NKOSI: Ja.

ADV WILLIAMS: So [intervenes]

CHAIRPERSON: Well it's what I wanted to understand, what happens to that document. Does that document go to the schemes?

DR NKOSI: We would give a report to the scheme.

MR KRÛGER: Ja.

DR NKOSI: Ja, that report would then outline that look these are the doctors who have been peer reviewed and then this is our finding. In some instance, you will find that if, let's say it's an instance where there are high costs and the doctor is able to justify and say, look the area I am in these are the prevailing factors. Then we are able to tell the scheme that look in this particular case this is the situation or if a doctor has an extra qualification despite being a GP and does work beyond GP work, we are then able to say no this doctor is qualified to do these various procedures based on his qualification that's beyond GP practice.

ADV WILLIAMS: Dr Nkosi, do the doctors know that you are contracted with the medical schemes when you offer them your peer review services to them?

DR NKOSI: Ja, yes they know, they know, I mean all our members know and part of the undertaking that they sign when

they join network is then that they will be available for peer review or they will avail themselves for peer review.

ADV WILLIAMS: And is the peer review that you do part of the investigation process of the administrators and the schemes? So, do they take your information and use it to assist in a particular investigation of a doctor?

DR NKOSI: No, peer review is not used for that purpose.

ADV WILLIAMS: As far as you know.

DR NKOSI: Ja, yes, but in the peer review process at times you can pick up somewhere where you see that if one looks at these costs, these costs are way out and it might be that there's something wrong that the doctor is doing. So in this particular instance we are able to then now talk to the doctor and say, look based on your data that we're getting from the administrators, this is the situation and then be able to then talk the doctor out of whatever that might just be, that might be wrong in their practice in that we want to provide a network that is ethical and that is cost efficient and that's through quality driven. Basically those are the key factors that we look at.

CHAIRPERSON: Thank you.

ADV WILLIAMS Last question. So do doctors who are part of the, is it the NHC network… no, let's just call it [intervenes]

DR NKOSI: Let's say IPIF because [intervenes]

ADV WILLIAMS: IPIF network?

DR NKOSI: Ja, but not NHCPA, they are not part of our network. So the NHC in this case is Nimpa Healthcare. They've got a building in Bryanston, there's one around Centurion, there's one around-, it's a huge group practice which belongs to an an IP called Nimpa. So NHC stands, in this case, for Nimpa Healthcare. So, it's a mixed group, right across the colour line you find practitioners in those practices. It's a group practice kind of undertaking.

ADV WILLIAMS: So what I'm trying to understand is whether doctors who are part of that network and have the benefit of the peer review process which [intervenes]

DR NKOSI: Ja.

ADV WILLIAMS: … seems to give both clinical and cost control input.

DR NKOSI: That's right.

ADV WILLIAMS: Do they still get audited by the schemes or is it, is it a mechanism to avoid audits?

DR NKOSI: Come with the question again, I didn't get it.

ADV WILLIAMS: Perhaps you haven't had the benefit of some of the evidence that's been led previously but we understand that the schemes audits practices and flag outliers and so it seems that you are getting some information which may be similar. The doctors are categorised and they may be outliers in relation to

various things, but it does seem that there's a parallel process because your doctors also appear to be audited, is that correct?

DR NKOSI: In our case we are looking at, at clinical outcomes. So, in a way you can't really parallel what we do with what the forensic units do. I mean the forensic units are out there, they are looking for fraud. What we are looking out for is better clinical outcomes and to provide a network that would be patient centric and then sure, I mean, they are looking after the patient's interest. So in actual fact we are able in some of the instances defend our members where we think they are being unfairly treated by schemes and administrators in that we have this process.

CHAIRPERSON: Thank you. I think, is it Dr Kruger or Mr Kruger?

MR KRÛGER: Ja. I maybe can just clarify that, I am not a doctor so you've heard now from a doctor and it's quite confusing. I really sympathy with doctors in the environment that they are practising in. I am not a doctor, I am head of operations at ASAIPA. I do have background in the medical funding industry. I have previously worked for a medical scheme and maybe specifically I can say in internal audit at the medical scheme. So, just maybe to clarify before I start a few misconceptions. I think the main thing to differentiate between is a preferred provider network and then a designated service provider network because there's huge differences between the two.

So if I should describe the network that's existing within IPAF I would say it's a preferred provider network. The members that belong to the different IPA's do so voluntarily but part of that application process where they join as members, they actually agree to good quality and cost-effective healthcare and in that process they also consent to being peer reviewed. So that's basically the pillars on which these IPA's function. And the main reason why the IPA Foundation was founded is as a sort of a defence mechanism against managed care because managed care is mainly focused on costs.

It's driving down costs and from the IPA movement the need was actually recognised to drive quality. So it's-, I can actually say it's in direct opposition to each other. So, a designated service provider network is basically as I understand it, set up in the Medical Schemes Act to curb costs involved with prescribed minimum benefits. So, again if we can differentiate, there are some schemes with which IPAF have agreements. Those are not all the schemes and those are really primarily schemes that don't have the necessary funds to actually get a big administrator a managed care company to actually run this network on their behalf.

So that is where the IPA Foundation comes into the play because it's cost effective. We are not a big organisation. Like you can see today, we're only two people here today. So, it's very lean, it's a non-profit company. The organisation that I work for is a non-profit organisation. It is a voluntary association of members.

There's not much money going around. So it's basically focussed on assisting our members, practitioners in practice, to help them to actually practice better. So, if you look at the peer review process, it's based on profiles that are extrapolated from ICD10 claims data. It's not clinical data and that is a big problem.

So you can't ICD10 code everything, it's impossible. So, the profiling that is done, and I'm first just going to focus on the contracts that we do have with schemes and that is where we utilise and we work together with Insight Actuaries and they actually do these profiles from ICD10 claims data. So we try to put in some clinical indicators. So for instance, if I can give an example is when you do a *pap smear*, so if you claim an ICD10 that's indicative of the fact that you've done a *pap smear*. It's still not a real clinical quality indicator but it's at least indicative that you are doing this sort of preventative, sort of practising medicine.

So, the profiles that we get through Insight Actuaries is actually vetted by medical practitioners and it does entail some clinical indicators. And those are the ones where you get a profile on a practice and it's not in time, it's not real time, it's spanning over a period of 3 months, you get peer reviewed for 3 months in arrears. And then you peer reviewed on that profile for the 3 months and then you get afforded the chance to better on that profile. So the next 3 months you'll again get audited or peer reviewed on that sort of profile that you have. So that's the one process. Then in the

schemes, Ja, the schemes where we don't have contracts, they actually use their own profiling systems.

Like for instance, Dr Nkosi referring now to a John Hopkins sort of a model and I know Medscheme I think also is utilising that. So, those sort of profiling should also be indicative of, of, of quality measurements and clinical indicators. We, we trust, you know, that. So we're not involved in that profiling system at all. So where we get involved, because medical schemes and, and funders they not supposed to really be judge, jury and, you know, in their own case and Health Professions Council's ethical guidelines also dictate that practitioners should do peer review. I mean it's a peer mentoring exercise.

So you can't have a desk clerk actually peer reviewing, you know, a medical practitioner. So, some of those schemes or administrators, like Medscheme and for instance Discovery, then utilise the IPA Foundation not in contractor or really as an organisation, but they utilise the IPA Foundation's peer reviewers which is trained medical practitioners that are trained to do peer review. They know how to interpret the profile. They can see where the outlying areas are in that practice and they know to engage with the practitioner to get them actually rectify, you know, some of, of, of the instances where they are an outlier. So those are two different also sort of processes and it gets confusing [intervenes]

CHAIRPERSON: Can you just explain how this actually works in practice? I mean, we've heard evidence now for 3 days

from individual practitioners who say, look you get identified as an outlier, an investigator comes, sometimes one, sometimes four and those are not medically qualified. And that is one of the major complaints from doctors is that we are being judged by people who have no idea what we do. Now, at what point will your organisation come into that equation?

MR KRÛGER: Okay, so this is where it's really confusing. So, that's not part of our process at all. So if I can explain it like this, preferred provider network, DSP networks, then you get peer review and then you get forensic investigation. This sort of process that I've explained now is the peer review process. That is a profile constituted over 3 months, 6 months, 9 months. It's based on clinical indicators. It's done by an actuarial firm. Okay. Let's move on to a forensic investigation. And this [intervenes]

CHAIRPERSON: My understanding is that even part you've described is not clinical, it's also cost based.

MR KRÛGER: Well, you can't look at quality in a, in a, in a vacuum, you have to look at cost because you know you can be the best doctor that there is and you only use the most expensive sort of equipment and medicine and whatever, that doesn't make you a bad doctor. But that, you know, your ethical guidelines say, you must in the [indistinct-00:39:02] of what the patient can afford and affordability you have to practice. So it is a ethical consideration as well to, to take costs into consideration but the peer review process is not mainly focussed on costs.

CHAIRPERSON: I understanding that. I think Dr Nkosi mentioned that. But, if it is also cost based and you are judged for being an outlier and you have collected the data and given it to the schemes, the schemes will know for a fact, do you use that information especially cost related information to decide who should be forensically investigated. But that's why I want to understand where you feature in that decision-making by the schemes. Do you just give them the data and you have no control of what they do over it or what?

MR KRÛGER: Maybe I can just quickly, just practically tell the following incident. We went and engaged with Medscheme, the forensic investigation, a unit. And we, we specifically took a member of ours, a ASAIPA member that was busy undergoing a forensic investigation and we immediately pulled his peer review profile because we have access to that. We asked, as an IPA group we can get hold of that profile, like you are rightly saying. So we got his profile on, on the Medscheme sort of schemes, and he was a category 1 doctor. He was really performing well under peer review.

We took that profile to forensics and they said but we are not interested in that profile, we don't look at that at all. We don't even engage or speak to the peer review department, we are a forensic investigation unit, we use a whole different system. We use like sort of a banking system which is real time and we pick these sort of outliers or not outliers it's, I don't know, it's an indicator that

something is not right here. If you use your credit card and you usually don't pay an American based company and all of a sudden use your credit card there, they will phone you and say, we've noticed this on your credit card, what is going on here?

That's how I understand the forensic investigation system. So they said to us, they are not interested in this doctor's profile, they actually just look at this sort of indicators and it's not clear what exactly they look at or what they are after and they not very willing to share that. We actually went to offer our assistance to say, you know, can we help you, can we do something preventative? If our members are sighted, what can we do to speed up the process? And they were not very willing to engage because they follow a process and I understand, you know, it's a forensic process, it's a whole different process.

So, just to answer your question in that regard, it's got nothing to do with the peer review. You can utilise it like Dr Nkosi has said to say, you know, we did pick on-, up on his peer review profile that he is doing a lot of sonar's and this was the instance, the problem in this instance was there's a high amount of sonar's being done in the practice. So, from the peer review exercise, we had a discussion with the doctor, he was based in Polokwane. There wasn't any facilities in the area. Everybody was referring into this practice to actually deliver this service. So we could explain it but from forensics side, they come in with a whole different process and say, we want the following evidence to be delivered to us because

we are, you know, suspecting something is wrong in this practice and, you know, then you have to deliver your qualifications, what sort of experience do you have, you have to give calibration on your machine and you have to provide that evidence. From our engagement with the practice we knew that this practice was doing this service because of this demographic area where they were situated.

CHAIRPERSON: Now that's very interesting because you are saying that the forensic investigators were not interested in information that would have helped to improve behaviour. They wanted to prove guilt.

MR KRÛGER: Ja, and for, for us that-, that, is the problem and that's also part of our submission here, is that, you know, and from my experience in a medical scheme, in internal audit we were measured on the amount of audits we did, the recommendations that we did and how many of our recommendations were accepted. And according to that we got performance bonuses, we got increases. On the forensic side it was how many cases they did, how many money was regrouped and on basis of that their performance bonus and their increases were determined.

So for me that's a problem and I think that should be fixed. I am not saying this is within my personal knowledge, as far as I know, I am not saying it's happening in all schemes or in all the administrators but it is a question that I want to ask, you know, is

that, the, the case and if that's the case it is problematic and it should be looked at.

CHAIRPERSON: So you are saying that the incentives on the forensic investigators may encourage imposition of wrong techniques and sometimes extraction of money in circumstances where there is no clear proof. You are saying the incentives are bad.

MR KRÛGER: Well, you know, if it's a deduction that can be made I'm not going to say, you know, that, that is the only deduction that can be made, but it certainly is and the answer that we got was that you are looking as a medical practitioner in treating a patient. And we are not saying that you are not allowed to do whatever you have to do to treat that patient, but from an administrator and a funding side we have to make a funding decision to say, we are not paying for that. So the focus is just completely different and that is also a problem.

ADV WILLIAMS: Do the forensic investigators make assessments or judgments about clinical decisions that are taken by the doctors?

MR KRÛGER: Well, I can mention another case that I was involved in. And this was after we, we actually met with Medscheme and I got to meet the clinical advisor at Medscheme's forensic unit. They actually have a medical advisor in their employ. So we had a practice in Standerton that's open after hours. It is also a catchment area because there's not a lot of towns in that, in

that area. So after hours that's basically the only practice that's open and so this practice got sighted, and, and this is also for me problematic, you would get a, a certain spike in forensic investigations and because we are national we can see this sort of trend.

So all of a sudden you get an ICD code of 146, 0146 and 0145 which is after hours consults, you'll get a sudden spike in forensic investigations just pertaining to those sort of ICD10 codes. And so this specific practice got sighted because they had too many of these consults. But again, from a peer review side, we can explain that because this practice is the only practice that's open. And so one instance they clawed back from the practice to say this is not an after hour consult. When I engage with the practice they said to me, this patient actually passed away on his or her way to hospital because it was a bleeding ulcer that actually raptured. And this was clawed back.

But I must say that the positive of, of this was, I sent through this case to the medical advisor at Medscheme and he said to me, this is a mistake, he will rectify this. But coming back to the question, does these forensic investigators who do these forensic investigations [intervenes]

CHAIRPERSON: Was it rectified in fact?

MR KRÛGER: Sorry, was is it [intervenes]

CHAIRPERSON: Was it actually rectified? I mean, you know, the example you're giving is, is, is a harrowing example for

the family especially someone dying when they shouldn't have died because the medical scheme has taken the wrong decision.

MR KRÛGER: Well, the positive was they said that they would rectify it. The negative is, I engaged again with the practice and they said they actually on some of the other clawbacks as well, they engaged with the patient to say, did it go off your medical aid account? Yes, it went out. So, it got clawed back from the practice. So the practice manager was asking me where is the money now, can they actually get it back now from the patient. The patient said but I paid. And the practitioner said but I got, you know, I got clawed back. Where did that money go?

And that's also a question that I want to ask today, you know, is there an explanation for, for this, where does the money go to? Does it go back, you know, to, to the member or it does go into a central fund, you know, if it's a day-to-day it should go back to the member, if it is out of risk it should go back to the risk pool.

ADV WILLIAMS: May I just ask a further question? So you've given us an example of the Standerton case with the after hour consult codes that were alleged to be misused and that was resolved successfully. I mean there wasn't, okay, perhaps tell us if it was or wasn't resolved successfully.

MR KRÛGER: Well, [intervenes]

ADV WILLIAMS: Sorry Mr Krûger, do you have the evidence to support this example that you could provide to us?

MR KRÛGER: Ja, that's why I said I haven't prepared substantive evidence but I have this on e-mail. So I will have-, I can go back and, and find that e-mail and I have the e-mail trail. So that's, that's something that I can provide the, the panel with. The only thing that I want to say is, you know, doctors are quite, I would say, scared in a way to have their, you know, their practice number and their names and, and this, you know, made known to the schemes because you know they are afraid that the scheme will now target them and go after them and so on. So, I am just referring to cases as well, I am not mentioning names or practices specifically but I can do that in confidence with the panel afterwards.

ADV WILLIAMS: Mr Krûger, to reiterate, it is important for you to know that you can provide information confidentially to the panel [intervenes]

MR KRÛGER: Thank you.

ADV WILLIAMS: For the purposes of the investigation.

MR KRÛGER: Thank you.

DR NKOSI: Maybe just to add, we have our position that we circulate to schemes and administrators, our position regards the forensic units. I think it's part of the presentation that we submitted. I just quickly, I am reading it, we say we accept the fact that members funds have to be protected and the scheme said administrators have to ensure that fraud is eliminated in the industry. However, in terms of the South African law, any person is

presumed innocent until proven guilty therefore, when investigating fraud this right has to be recognised and respected at all times.

What has been brought to our attention as IPAF is the disregard for the law and due process when investigating fraud. There are not set operational standard by which these units operate. There seems to be no standard of minimum qualification or accreditation of their officers in these units. HPCSA has repeatedly requested that any doctor found to have behaved unethically or guilty of any fraudulent behaviour that brings the profession into disrepute should be reported to them to take disciplinary action. These units do not do this, rather they suggest non-disclosure and use that as leverage to coerce the doctor into signing an NOD.

Our position is that they need to be properly regulated so that they operate within the law or within, I mean, our understanding so that we can in actual fact advise our members accordingly, and that doctors who break the law should be reported to SAP-, to SAPS as well as to the Health Professional Council and charged accordingly rather than being embarrassed into signing AOD's in return for continuation of guaranteed payment by the funders. So, we have circulated to most of the administrators, Ja, yes, we are worried about what's happening in the forensic unit. It is not clear to us how they operate.

We all have cases that we can refer to where there's been entrapment, entrapment it's where a doctor is coerced to doing

something wrong and then is then found to be unethical and clawback and things like that, it's, it's all, I mean that we are saying should not happen.

CHAIRPERSON: Can you just explain, I mean we've got your examples here on the, what you call them, misuses of Section 59 [intervenes]

DR NKOSI: Ja.

CHAIRPERSON: … on the procedural side. But this is neutral in the sense that it can happen to anyone. Now the second side to what we are required to do is racial profiling. What is your experience about racial profiling?

DR NKOSI: It's, it's, it's, it's a difficult one because it's, it's not something that is quite clear. I mean, schemes have said they, they using peer numbers, certainly they do use peer numbers to do profiling. And equally, Insight, the company that we've employed to do our profiling, they use that, that data and not race but it can happen. I mean that if one looks at where the practice is or the practices are geographically, you can in a way target an area. And then profile doctors in that particular area. So, it's something in our case that, that's really difficult to prove but is probable, it can happen.

ADV WILLIAMS: But at the second level of their audits, of the investigation, it's not anymore the system that's at work but actual humans that are at work so the forensic investigators would know what the race of the, of their subjects are, isn't it?

DR NKOSI: Yes, Ja, they would, they would. They would also, you know, based on the geography, I mean if you go to Soweto you'd hardly find a black doctor-, *ai* a white doctor and equally if you go to Tembisa, you would, you'd not find a white doctor. But there was one instance where doctors in Tembisa were uncomfortable because it was this one particular forensic unit that was doing round around there and, and getting into their practices and sort of harassing them.

ADV WILLIAMS: Will you provide us with evidence of that?

DR NKOSI: It's a difficult one. I mean, they seem anecdotal, I mean in that we can't give you evidence because doctors are not willing to can then expose themselves to them. Ja. But I can see if I can find a doctor who is willing to be able to give us something and then I can send it through.

CHAIRPERSON: I mean there's another side to racial profiling which is on the outcome side. I mean, if you look at those people who've actually been investigated under Section 59, which you've categorised here as misuses of Section 59, are they white or black?

MR KRÛGER: For us it's a national organisation and we are made of, of different ethnic groups. From my personal knowledge, you know, it's 3 to 1 where I've, the matters that I've treated, there's mainly Indian and Black because I don't know why. Maybe it's more practitioners in our organisation but again I want to,

you know, agree with Dr Nkosi, it's, the main problems that we have is the outlying areas, it's the Towandas, it's the Standertons, it's the Dundees. It's a place where the socio-economic circumstances, you know, doesn't that afford you to fit the profile really, if I can put it that way.

You see more than 30 patients a day and they would say it's impossible, but I tell you, you make it possible when you are in an area where there is dire need. And I think really there should be a relaxation or realisation of the, the, the circumstances under which these practices actually practice. And you know one shouldn't be taking, sort of a sit back in your chair and have a look at these practices and you know, pull them over a barrel and, you know, try to close them down. Because this is what happens when somebody claws back 600 000 from your practice, you close down.

I had a doctor that phoned me on a Friday afternoon, the 30th of the month, telling me that he can't pay his salaries. I said to him, doctor what must I do? I can phone the principal officer, I can phone the scheme manager, but you are not going to pay the salaries today. And that's a practice that's located in Dundee, it's been sighted numerous times by different schemes and you the other problem that we have a peer review, you can be a category 1 doctor with one scheme but you can be a category 3 doctor with another scheme. How is that possible? And that's what the doctors ask me on a daily basis. Henru, I've been practising for 30 years, I

do the same medicine, how can I be a category 3 today, I've never changed anything in my behaviour.

I'm saying there is something seriously wrong with the way that the profiling is done and there should be a standard, it should be accepted by all and the time has come to fix it now because the patients in these areas are the ones that are suffering.

ADV WILLIAMS: Did that doctor close his practice, the one who called you?

MR KRÛGER: No, he's, he's, he's lost a few partners but he is still there. I haven't spoken to him recently but it is a struggle because, you know, every other, every other time it's, it's a different matter and it's a different forensic unit. I can maybe mention the first one that I engaged with was Metropolitan Health Risk Managers. They were actually not that bad because the forensic investigator's contact details was on the, the letter that was sent. I could engage with that forensic auditor because you know that auditor is sitting in Cape Town, you know, and it's far away from Dundee.

Immediately I asked the auditor, have you visited Dundee, were you in the practice? No, I haven't been there, it's a desktop audit and that's, that's also the problem. We've done a desktop audit and provisionally we are having a problem with your practice. What I would suggest and you know, I know that maybe there's, there's cost constraints and resource constraints but get into your car, make, you know, like the South African Police Service, visit the

crime scene, go and look at the crime scene and start compiling your docket from there. The, the, the problem is you, you, you use a banking system or whatever predictive system, you do a desktop audit and from there you try to extrapolate evidence from a practice.

Now, the doctor has to actually stop practicing because, you know, in certain instances it's 4 years of evidence that they want from you. You have to pull all your resources and I'm talking about practices that's got a single practitioner with somebody that does the reception. You know, now they must get into files. And you know in this country, there's no electronic health records and it's hand files, patient lists are write-, written up in, in handwriting and signed, you know. So now that practice must stop everything to get this evidence. Do this prove a forensic unit? All the while the Medical Schemes Act says if a medical scheme has a problem with an account, it's up to them to prove it and you have to do that within 90 days, you know.

And then, if you follow the process, the doctor should have the opportunity to correct if he's done something wrong. How do you correct something 4 years running? And that's what I've argued with forensic units, saying to them, but do this going forward from today, you've caught out the practice now to say that you've been claiming something that's not right in terms of scheme rules, because we are also dealing with scheme rules. Certain scheme rules still say that the scheme has the option to pay the patient or

the doctor, it is in the scheme rules. It is written in there, not only in the Medical Schemes Act.

So, in terms of schemes' rules you've done something wrong and remember we are sitting with so many different schemes, the poor doctor or the medical practitioner, he has to cope with all this admin and all these different requirements and all these different sort of DSP contracts. Because what we've done and tried in IPAF is to standardise the contract that we've drafted to say, please implement this in your scheme. And now the, the, the trend is to cancel the IPAF contracts to put in a scheme contract, you know, according to scheme rules and to, to cost considerations and to what that scheme wants.

And that makes it difficult because now you've got one DSP arrangement, you've got another one, our members are all over the place, they don't know what to do. And then, I mean now you have to prove yourself innocent and you don't get the opportunity to correct your account, now they say they are going to clawback. We've made a sort of a analysis and if you've done this in this instance our deduction is that you've done this for the last 4 years or whatever and they come to an amount and then they let you sign an acknowledgment of debt. For me, I want to ask and you know, ask that if, if you are caught out in something that is not correct, going forward, fix it.

Don't claw back 4 years and ask the doctor now to pay in because of a mistake. If it's a true mistake you know, you should

have notified that doctor within the terms and the time period in, in, in the Medical Schemes Act and then that doctor could have corrected it.

CHAIRPERSON: One of the testimonies was that the perception or the feeling of practitioners is that CMS, which is the body that is meant to regulate schemes, is toothless. What is your view on this?

DR NKOSI: It's, it's, it's a difficult one to judge, I mean in the sense that I think what they are looking after it's much more schemes interests and the viability of, of the entire industry. But in terms of Section 59, I mean which is the reason why we are here, we just hope that now schemes that are abusing Section 59, CMS would be able to regulate appropriately. But right now, I mean especially the forensic units, we believe that they certainly are a law onto themselves, they do as they please, they harass doctors. And that's also unfortunate is that if you, if one scheme, if one administrator now sights you because they share information, it means you are now going to be red-carded throughout the entire industry.

You might then be visited by another administrator who can then come with an allegation and, and stop payment. So that, that's where the challenge is. We just hope, I mean, Regulation 9 will be tightened.

CHAIRPERSON: Thank you Dr Nkosi. Thank you Mr Krûger. We are very much interested in the, I know that a lot of

it is confidential, we will treat it as confidential. We might have to share it with schemes but with adjustments into what can be disclosed and what cannot be disclosed because we want answers from the schemes and they will say to us, where is the information that we should answer from. So, although we will treat it confidentially, you should expect that some of it may have to be disclosed to the schemes for their answers.

MR KRÛGER: I've got no problem with that. I've also got another matter in Bloemfontein that occurred that I would also like to send through to the panel. It was actually a doctor that was targeted by a forensic unit, they sent in probes in the end into his practice. Because of the reason that we got involved he was summonsed to attend a informal discussion because that's what they say it is, it isn't a forensic investigation or anything, it's just a informal discussion. And on that basis I actually said to the doctor don't attend because it's informal, it's up to you to attend or not.

And, you know, I got a letter back, it was very derogatory. It was saying that I gave legal advice, which I wasn't allowed to do, it was really bad and the next thing they send in a probe and they actually reported the matter to the Health Professions Council, we got an attorney involved and he was exonerated of all complaints. So I would love to have that specific administrator answering on that case but again, that doctor has already been targeted, I don't want to put him through any more strain because he took immense strain.

He had to close down his practice, fly into OR Tambo to attend that Health Professions Council hearing.

But I would really love to, to present that case in confidence to, to, to the panel and then also the, the other matter that we actually to, to Medscheme to discuss. I would also love to send that through and Ja. I mean the, the, the administrators are more than willing to, to, to answer to that and to engage because we have to fix this in the end, it affords nobody any benefit to keep on fighting like this. We have to actually work together and fix this.

CHAIRPERSON: Thank you. Sorry, it remains of me to thank you for coming and making your presentation and we will be continuing in bilateral discussions with you. You might be called back for more evidence but you might also be required to provide some evidence in writing. So, today's session will then adjourn. We will reconvene tomorrow at 10 with the Health Funders Association. The session is adjourned.

PROCEEDINGS ADJOURN

END OF AUDIO