SECTION 59 INVESTIGATION

DATE: 2019-08-02

HELD IN: IMBIZO BOARDROOM,

COUNCIL FOR MEDICAL SCHEMES OFFICES, CENTURION

PANEL: ADV TEMBEKA NGCUKAITOBI, CHAIRPERSON

ADV ADILA HASSIM, PANEL MEMBER

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PRESENT FOR NATIONAL DEPARTMENT OF HEALTH:

MR B CABUKO

DR ANBAN PILLAY

<u>CERTIFICATE OF VERACITY</u>

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

Section 59 Investigation

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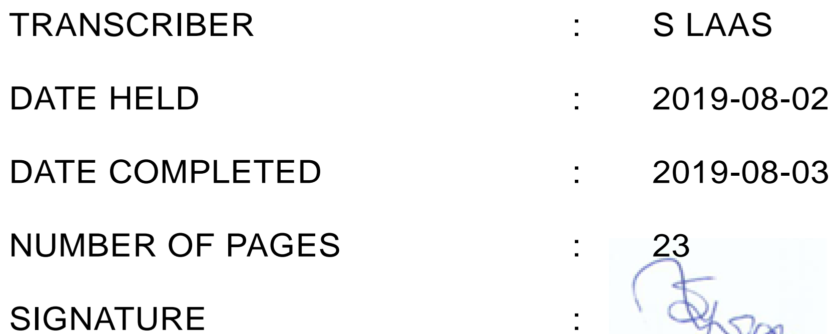
SIGNATURE	:	

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1. This is a verbatim transcription and transcribed without the benefit of any documentation for the verification of spelling of names and places.
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PROCEEDINGS CONTINUE ON 2 AUGUST 2019

CHAIRPERSON: Thank you. We are continuing the Section 59 investigation. We have the Department of Health to make a presentation. Can we just get introductions to see who is
5 present?

DR PILLAY: Good day. My name is Anban Pillay. I am the Deputy Director General in the National Department of Health and Mbelelo Cabuko.

MR CABUKO: Good day. My name is Mbulelo Cabuko.
10 I am the Director Health Information Systems.

CHAIRPERSON: Alright. So, it's Dr Pillay or Mr Pillay?

DR PILLAY: Dr Pillay.

CHAIRPERSON: Dr Pillay. And Mr Cabuko or Dr Cabuko?

MR CABUKO: Mister.

15 CHAIRPERSON: Mr Cabuko. Alright. Thank you. How are we going to do this? Dr Pillay, are you going to take the oath or the affirmation?

DR PILLAY: Yes, I have no problem doing so.

CHAIRPERSON: Alright. Thank you. Let's do that. Will
20 you just say then after me I and your name?

DR PILLAY: I, Anban Pillay.

CHAIRPERSON: Swear that the evidence that I shall give.

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

CHAIRPERSON: Shall be the truth.

25 DR PILLAY: Shall be the truth.

CHAIRPERSON: The whole truth.

DR PILLAY: The whole truth.

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

5 DR PILLAY: So help me God.

CHAIRPERSON: Mr Cabuko, are you also going to be speaking?

MR CABUKO: I will be supporting Dr Anban Pillay.

CHAIRPERSON: Alright. So maybe let me take your oath

10 as well then. So will you say after me I and your name?

MR CABUKO: I Mbulelo Cabuko.

CHAIRPERSON: Swear that the evidence that I shall give.

MR CABUKO: Swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

15 MR CABUKO: Shall be the truth.

CHAIRPERSON: The whole truth.

MR CABUKO: The whole truth.

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

20 MR CABUKO: So help me God.

CHAIRPERSON: Thank you. Alright, Dr Pillay the floor is yours. We have not received a written submission from the Department but I presume you will take us through what you have to say.

DR PILLAY: Thank you Chair. Chair, we, we, we received the invitation or I, I received one yesterday and so I didn't have an opportunity to put together any presentation at this stage. I understand there were two matters that you wanted to discuss with
5 us, one relates to procedure codes and the other relating to the National Health reference price list history [intervenes]

CHAIRPERSON: Let, let's just clarify this. You say you received the invitation yesterday?

DR PILLAY: Yes, I, myself, yes.

10 CHAIRPERSON: Yes because the invitations were sent a couple of weeks ago. So it's unclear why you then re-, received it yesterday.

DR PILLAY: Yes. I, I'm not talking on behalf of my department, I'm talking about for myself. So I'm saying I received it
15 yesterday.

CHAIRPERSON: So it went to the Department but it didn't come to you?

DR PILLAY: Yes, that's what I'm saying.

CHAIRPERSON: Alright. Alright, thank you. So, alright.
20 So, what have you prepared?

DR PILLAY: So, I, I, it wasn't clear to me exactly what you were looking for in terms of these two areas. I would be able to speak to you about the reference price list and Mr Cabuko would be able to talk to you about the ICD10 codes, but we don't have a

presentation as such. We were hoping that you would have some questions for us which we can then respond to.

CHAIRPERSON: Yes, no, we will do that. Look, I mean, I think that the fact that we sent an invitation a couple of weeks ago
5 and that it seems to have been lost in the system, and for you to arrive today with no presentation and also with no clarity about what the Commission is looking for in circumstances where we announced more than two months ago and in circumstances where everybody else who has come before the Department has come
10 with a written presentation and has come with a clear sense of what they would like to do with the Commission. That is something that will have to be taken up with the Department. Do you know how the invitation got lost in the system?

DR PILLAY: No, I can't speculate on that.

15 CHAIRPERSON: Alright, thank you. Perhaps then let's use the time meaningfully. You have things to say, then we will ask questions in due course. Thank you.

DR PILLAY: Maybe I can start by talking about the reference price list. So, the reference pricelist had been
20 established several years ago. In around 1994 there was a process for establishing a price list through the RAMS process. And that eventually led to a reference price list which the Council for Medical Schemes administered. The process basically involved a costing exercise of what it cost to deliver services and a list was then put up
25 for each type of service and what the price is linked to that. We in

the Department then came up with regulations to formalise this process because the process had largely been ad hoc prior to that.

So we defined the way costs should be calculated, who should calculate and how those costs should be, should be

5 presented. And we undertook an exercise to verify costs. We embarked on that exercise after finalising regulations and at the end of that, that exercise we came up with prices for a range of services. The, the providers of healthcare were, were not very happy with the draft prices that were produced and then decided to

10 take the matter to court after initially participating with us in the process. And their arguments in the, in the, in the court was that the regulations were not appropriately established because the regulations were established in terms of the National Health Act and required concurrence with the National Health Council.

15 ADV HASSIM: Is this the case that was brought by the Hospital Association of South Africa?

DR PILLAY: That's right. It wasn't just the Hospital Association, it was everybody actually including, including the doctor groups etcetera who joined the case. And so the, the

20 regulations were struck down and there was then no, no reference price list which also affected the coding, which is the other area I think you are interested in. Because the prices are obviously linked to procedures which are then effectively summarised into a code and so they kind of go hand in glove. In the absence of a reference

25 price list, we then engaged the industry to, to deal with this *lacuna*

through some sort of a voluntary process where the industry be willing to share information about costs and we'd be willing to then up to a reference price list and if that went well we would redraft regulations.

5 There were many sectors of the industry that were not willing to co-operate with us in terms of the Act and indicated the, the Competition Act prevent them from participating. The Minister of Health at the time convened a meeting with the Competition Commission and gave the assurance to stakeholders that they 10 would not be found foul of the Competition Act given that the Department is convening this, despite that the co-operation from this sector was, was poor, and so we were unable to proceed. We then, given, given this, this *lacuna* in the system and many lpayers are arguing thereafter that actually there is a need for a price list, 15 some of those same players that struck down the previous list.

We then approached the Health Market Inquiry or, or approached the Competition Commission that established the Health Market Inquiry, indicating that we have this, this problem and we think that it would be appropriate that some investigation is done 20 to, to set in place a structure that would come up with prices, codes etcetera. And that gave birth to the HMI which is now in place and I think the Health Market Inquiry probably would finish its work soon. Our intention was to then take on board the recommendations of the HMI in, in the amendments of the Medical Schemes Act and 25 [intervenes]

CHAIRPERSON: Can you just explain so that we, we understand the concept. One of the major complaints we've had this week is that there is confusion around coding and that leads to doctors being unfairly investigated by schemes because they just
5 happen to get the codes wrong. And one person I think then says well we need a regulated coded system. But what you started with is a reference pricing system. So can you explain what the relationship is between the reference pricing system and the coding system?

10 DR PILLAY: So, the reference pricing system includes the coding system. So, the reference price system will have a code, it will have a description of a code which include the procedure and then it will end up with a price for that particular procedure. So, if you have a code but you don't have prices linked to it it's a bit
15 difficult to then deal with that. There, there are, there are some, some challenges with the way the coding system has been used. So in our submission to the Health Market Inquiry, we provided evidence of a number of areas where there were, there was what we call "up coding" because in the Medical Schemes Act the
20 scheme has to pay in full for prescribed minimum benefits and the obligation for those conditions that are not PMB's are different.

And, it was very clear that when providers were aware of what all the PMB codes were, they would prefer to, to bill on a PMB code rather than non-PMB code and the epidemiology of the

country would suggest that the incidents of that particular condition is not as significant as the, the claims data would suggest.

CHAIRPERSON: Alright, okay.

ADV HASSIM: So, and ICD10 codes are-, have a price
5 attached to them?

DR PILLAY: Yes, in the reference price list but the-, my, my, my colleague deals with the ICD10 codes which the public sector uses as well but it is obviously not for the purposes of pricing but for the purposes of health information planning and monitoring
10 it.

ADV WILLIAMS: We heard evidence the day before yesterday I think that there's a link between the ICD10 codes and the reference price list coding. Would that be a correct submission?

DR PILLAY: You want to answer?

15 MR CABUKO: Yes, there is a relationship but I-, let me just clarify. In terms of the, the ICD10 code, the ICD10 coding it's mainly for coding of, of, of diagnosis. So, in terms of the, the coding is international statistical classification of disease, which is owned by the [indistinct-00:11:25]. But in terms of implementation in the
20 country, then the National Department of Health then co-ordi-, co-ordinate-, co-ordinates that, that implementation working with the various stakeholders such as Council for Medical Schemes, the-, all the medical schemes, the medical aid administrators.

And also in terms of then the implementation, the
25 implementation of the ICD10 coding was then implemented in

conjunction with the Council for Medical Schemes, which then regulated its implementation. And in terms of then the, the, the codes, you find that then the-, at the end of the, the consultation, then the doctor, once they have determined the, the, the diagnosis,
5 they have to then put a code so that then the medical aid scheme can then, can be able then to prepare in accordance with, with the, with the code for, for the diagnosis. So it's a very important standard for, for coding for diagnosis.

ADV WILLIAMS: A follow-up question Mr Cabuko just to
10 understand this correctly. My understanding from what we've heard so far is that the procedural code in the reference price list is what is used to determine reimbursement whereas the ICD10 code is used to determine what the diagnosis is, but there is some mirroring between the two. So you might be able to match a ICD10 code with
15 a procedural code in the reference price list, but the main codes that determines whether you are reimbursed as a doctor, is the procedural code. Is my understanding correct?

MR CABUKO: Yes, your understanding is, is correct but obviously the procedure that is undertaken has got a direct
20 relationship to the, to the diagnosis of the, of the condition.

DR PILLAY: Can I maybe add? I, on a regular basis get calls from practitioners asking me, what code should I use? And, and I-, my response is I don't really know, I am not sitting with you so it is difficult for me to help you with that. So clearly there is a
25 problem in the industry about how codes are determined, but very

often the person that's asking me the question is not a clinical person, it's the, the administrative person who has submit the bill. And so, he or she just wants to know what is the code that will get reimbursement, because we are having this problem and we
5 thought that you may be able to give us the answer, I think so, it's, it's a problem in terms of the way people understand and interpret it.

CHAIRPERSON: But I mean, isn't there something a lot deeper than this? Because you see, the problem with this coding is that if you are dealing with a Section 59 implementation regime, we
10 don't know, because the medical schemes haven't given us the data, how much of those claims that fall under Section 59 are because of innocent coding errors or they are as a consequence of deliberate fraudulent conduct. If the majority is innocent coding errors, the absence of a clear regulatory framework impacts on
15 people's lives and practices being shut down and unfair amputations of fraud against them.

Now, when they say-, when they phone you, the administrative assistant phones you and say well Dr Pillay what code should I use and the answer is you don't-, I don't know. That
20 cascades across the industry, no one knows what the code should be and this is part of the concern of at least this panel that the, the gap in the coding enables abuse.

DR PILLAY: We would agree with you that, that the, the issue of coding is, is a huge problem in the industry. I think the
25 Health Market Inquiry as well, in their interim report, flagged this as

a problem. We ourselves have in our submission flagged coding as a, as a huge problem. Coding, however, must go hand in hand with the, with a panel that would appropriately approve the codes because it is also about the, the clinical skill to, to appropriate craft
5 the codes. The coding is also the subject of a lot of commercial interest and so we, we've, we've had great challenges in trying to implement a coding system in the private sector because of those, those, those challenges.

ADV HASSIM: You said that the, the reference price list
10 is linked to the diagnosis code, what's the status of the reference price list as far as it is in relation to cost? You haven't been able to undertake a costing exercise, so how, how do you come up with that, that figure? And then how does that then play into what the medical schemes reimburse?

15 DR PILLAY: So, at the time when the reference price list was, was utilised or, or a, or a document that was, that was used by the industry formerly, the process was a bottom up costing which included an understanding of what are the operating costs of, of a practice, the time that the clinician spent etcetera, etcetera. And
20 that came together in a particular price that was used. After the, the reference price list regulations were struck down, we did not publish a price list after that. However, our understanding is that many medical schemes continue to use the, the price list with an inflator from what has historically been published as the basis for their

calculations. But we are-, we have not published since the regulations have been struck down, any price list.

ADV HASSIM: And how would the price list and the costing reflect the difference between practitioners who have
5 practices in Sandton where the operating costs are higher and those who have practices in, in Giyani?

DR PILLAY: Yes, so, one of the things we, we often debated when we were doing the reference price list is, do you provide a single price or do you provide a price range. And we had
10 opted to provide a range so that you can have a sense of what is the range, what will be the lowest possible price and what could be the highest possible price that could be charged. What's interesting though is that the, the contribution of many of those types of operating costs such as rental etcetera, are marginal relative to
15 some of the other costs that, that may be attributed such as labour. Labour costs are a significant contributor to the overall price for a particular procedure.

And, and so understanding that is important in, in coming up with a price but our plan was or we had indicated at the time of
20 publication of the last reference price list provide a range so that people understand, or schemes understand what would be that potential range.

CHAIRPERSON: Just tell me when-, I mean, I just want to come back to the example you make that you usually get calls from
25 administrative assistants, I mean that is a good example because it

provides precisely the basis of why people are complaining. So when they say what code should I use, I mean the schemes will say well you know what code it is because we've given you the code. Now, why are they still unable to know what code to use because
5 the scheme says it is obvious what the code is?

DR PILLAY: Yes, it is a bit of a circular argument so I would say to them well what, what's the problem, why are the scheme saying to you they wouldn't pay on that code. Well, they don't quite understand what the reason is or they don't appreciate
10 the reason and they believe somehow we know what code it is that the scheme can never refuse to pay, I suppose is what I'm saying. Because they said the practitioner is, is, is upset that he is not being paid and can you just give me a code so we can get this account paid.

15 And so that's, that's I think the difficulty that practitioners have and schemes on the other side engage with those practitioners about being very clear about how they actually intend paying accounts, because that's really the problem.

CHAIRPERSON: But I mean, what codes are the schemes
20 using? If, if the Department doesn't know the codes, who knows this codes?

DR PILLAY: No, it's not that we don't know the codes. People do not know which code to use for that particular condition so [intervenes]

25 CHAIRPERSON: Yes.

DR PILLAY: *Ja*.

CHAIRPERSON: But let's take that example as a narrow one. But if you yourself don't know and the doctor doesn't know and the scheme also doesn't know [intervenes]

5 DR PILLAY: I don't think the scheme doesn't know, I think the scheme's question is that the, the codes do not add up to the procedures that you are billing us for and so that's where this-, because the schemes have in-bill systems that flag for them that this code doesn't match with what you are claiming for so

10 something is not right. And so, but they are not telling that to the practitioner to say, well choose one of this because it is either you have this condition or that condition or if they have both, then maybe you must fix the codes or whatever. But they don't, they don't counsel practitioners about how they should provide a proper

15 submission so they simply say this is rejected and then that's, that's [intervenes]

ADV HASSIM: Why can't that same person who calls you, call the scheme and get the scheme to answer that question?

DR PILLAY: That's exactly what I ask and they, and

20 they say well the, the scheme basically tells us this code is wrong, they are not going to pay it and then it's not their job to help us get the right code. So, we thought maybe you can help us.

CHAIRPERSON: Thank you. You can continue.

DR PILLAY: Chair on, on the specific issue relating to

25 the, to the investigation I suppose any information I could, I could

share with you that may be useful is that prior to this investigation myself and the department who usually we deal with matters relating to medical schemes and policy etcetera had never, never received any, any complaints of the nature as it is presented now. I
5 have received complaints that medical schemes refuse to pay, pay suppliers and there are always disputes between suppliers and schemes as well as patients and schemes about what should be reimbursed and what is not being reimbursed.

The, the matter as it's presented now, we've never received
10 a formal complaint. The first time I understood this matter was a few months ago when, when this matter was in the media and the former Minister of Health convened a meeting where we understood from doctors that were affected about what actually happened, which I think raise the flag that may be in our amendments to the
15 Medical Schemes Act we need to review the way various sections are structured to deal with this matter more effectively. And so we, we would be hoping to do that in the revision of the Medical Schemes Act.

CHAIRPERSON: Just tell me about the reference pricing.
20 You say that because the regulations was struck down, I mean that striking down happened more than 10 years ago and what has been the actual problem with getting the system back on track?

DR PILLAY: Well, I suppose that the point, when the regulations were struck down the Department was faced with two
25 options. The one option was to redo the regulations complying with

the legal requirements of the matter being served before the National Health Council and thereafter proceeding in a, in a manner that would then put the reference price list up again. The alternative is to do something different and the Minister of Health
5 was of the view at the time that this reference price list is always going to be in dispute but because actually the issue was not whether we follow the procedure of the regulations and table them before the National Health Council.

The reality was that practitioners saw what tariffs they were
10 going to get and they said they don't like it, that if these tariffs continue then they will go to court and they would have those, struck down. So, the Minister's view was that well look, if you are going to go back and do this why do you think you'll get a different answer because all you are doing is, is having the same fight again.
15 So, should we not deal with this matter more decisively? And, some off the problems that the reference price list process had would need to be fixed in order for us to do that. So, one of the problems we had was that we had asked practitioners to, to provide us with the costing of their practices, so to provide information about their
20 operating costs, labour costs etcetera.

We would then with the defined methodology then come up with a, with a tariff or a price. And, clearly when we receive the information about the costs, just based on our own information it was clear that these were, were costs that are much higher than
25 what we would have anticipated the market is. We then appointed

an auditing company to, to go in and check as to why is it that these costs are so much higher than what we anticipated. And that company then found that these costs were inflated, largely because I suppose part of our fault is we had structurally said that the, the,
5 the various disciplines will appoint a, a consultant or, or an expert who would bring the costs together for that discipline.

So surgeons would get a, a consultant would collect the costs for different surgeons, put it together and submit it to us. And those individuals did not necessarily visit the facilities and basically
10 saw getting as higher price for that particular group as their objection. And so when we did the, the, the verification or the audit it became clear that the costs were much lower and that's when the disputes started and similarly in the case of hospitals we had some disputes about the methodology and based on that, that's how the,
15 the reference price list issue broke down. So the Minister's view was that to deal with this matter more decisively, we would need to have powers to go in and get this information ourselves.

Historically we've never been able to get this information from practitioners, they've, they've been unwilling to supply
20 information in a manner that would allow us to come up with what we call a fair price. And so in order to do that, the view was that we need to have an inquiry that would get to the heart of the matters and make sure the entire system is dealt with collectively. Because there is also the issue about billing and what we call "a free for
25 service" model which causes some of these problems as well.

ADV WILLIAMS: Dr Pillay, may I ask, we have received-, certain allegations have been made which suggest that the schemes flagged practitioners on a number of bases, but one of the bases is that they are an outlier in relation to the price that they
5 charge. So what I'm trying to understand is what would the scheme legitimately have reference to in determining that this price that has been charged is not not an outlier but is, is not an appropriate price, bearing in mind what you are saying, that there is no reference prices or price in the market.

10 CHAIRPERSON: In fact you might add to that question a much more simpler one, who decides the tariff?

DR PILLAY: The tariff is decided by the practitioner because practitioners on their own have their right to set their own tariff. The scheme has its tariff, what it's prepared to reimburse for
15 that service and so when a, a member of a scheme visits a practitioner he or she is faced with, with the, with the possibility that the scheme is not going to pay the full tariff. So many practitioners actually are not interested whether you have medical scheme or not. They are simply expecting to be paid in cash and you claim
20 from your medical scheme and whatever the scheme pays you is what you are entitled to and you can deal with all of the issues linked to that. So, the practitioner has the right to come up with a tariff, yes.

CHAIRPERSON: I suppose that's then where the question
25 by Ms Williams comes in. If, if a practitioner is entitled to decide

their own tariff, what right does a scheme have to tell them that you are an outlier in relation to price?

DR PILLAY: Well, I'm, I'm not sure. I suppose schemes would be in the best position to answer that. But I would
5 have thought that they would have to understand why it is that the tariff is so high from that practitioner and that there would be an inquiry to the practitioner [indistinct-0:29:37].

ADV HASSIM: Wouldn't the scheme just say we will reimburse up to the level that we've, we've, we've determined and
10 the rest is balance billing basically. So, the member then bears the, the cost of the balance?

DR PILLAY: So, so, so many, as I said, many practitioners would take your, your, your medical scheme information but not bill and ask you to pay upfront and then give you
15 the, the, the procedures and you claim from your scheme what you've paid and the scheme may pay you less than that. Obviously the balance is then for your own account. Some, some practitioners would ask you if you have a medical scheme and also ask you if you have got gap cover and so they would make sure that they, they
20 extract the balance from the, from the gap cover.

ADV HASSIM: The question is, what interest does the scheme have in saying to a practitioner that you charge too much if they are not going to pay that amount in any event?

DR PILLAY: Yes, I am not sure why they would do
25 that. I've, I've never engaged schemes to understand the detail

about why they would that, I didn't understand that they were actually flagging practitioners. My understanding was, or the complaints that I've ever heard was that they were of the view that practitioners were, were in the business of over-servicing patients,
5 which is a different matter as opposed to charging a tariff beyond what they would be willing to pay.

ADV WILLIAMS: May I ask my question again because I, I still would be interested to hear your view on it as, from the Department? If a scheme flags a practice for having effectively
10 charged a price that was too high, over a number of years or claims, they then, they flag that practice and the intention is to claw back that money from the, from the practice, what would they legitimately have reference to in determining what is too high?

DR PILLAY: I think a number of practitioners have,
15 have understood I don't know they would have engaged the scheme on this but accepted this is a tariff that the scheme would be willing to accept and so, in terms of that there would be practitioners that would have achieved a full payment from schemes and those would be the practitioners that would not have any queries linked to their
20 tariffs. I am not sure how they divide that currently, whether it is through the IPA's etcetera, they have information about exactly what the scheme will actually pay for a particular service.

ADV WILLIAMS: Is it possible that there's nothing?

DR PILLAY: It is possible that there is nothing, yes. I'm, I'm not aware exactly, I'm just speculating about what it could be.

ADV HASSIM: Dr Pillay, would the Department be able to provide us with some statistical information regarding the number and distribution of private practitioners and having that broken down by race and location and type of practice?

DR PILLAY: I would, I don't have this information myself but I could investigate whether we could provide that and at what level of detail. What I do know is that our, our information comes from two sources, the Health Professions Council where the practitioners are registered with that Council, and the second source would be the practice code numbering system. And, depending on the level of detail about each practitioner, we would be able to provide that information in that context.

ADV WILLIAMS: The Department doesn't keep its own statistics?

DR PILLAY: No, it doesn't. We were only collecting the statistics of [indistinct-0:33:29] in terms of our planning for the National Health Insurance. So, we, we ordinarily never kept statistics of practitioners and where they were and that kind of thing. There is no licensing system for practitioners currently. It's only, the only sector that has licensing in the private sector is private pharmacies.

CHAIRPERSON: Your practice code numbering system, does that make reference to race?

DR PILLAY: I, I, as far as I know it doesn't.

ADV HASSIM: Is that the BHF's PCN's?

5 DR PILLAY: That's right yes. So, the Council for Medical schemes had, had contracted the BHF to, to perform that service on their behalf. So, so they have given us the information relating to the PCN's.

CHAIRPERSON: Thank you. If you are satisfied that

10 you've told us everything you planned to, you can let us know otherwise we-, this would be the end of your presentation.

DR PILLAY: The only other matter I want to just clarify is, in terms of the submissions that you require from us, will we receive some communication about what exactly you would like

15 us to-, what information you like us to share with so we can do that.

CHAIRPERSON: Okay, thank you. That will be done. Thank you, that will be the end of the Department of Health's con-, presentation. It remains of me to thank Dr Pillay for the submissions that have been made. We will be in communication. I

20 am slightly unsettled that correspondence was sent to your Department but it came to your attention only a day before you came. So that is something that your Department needs to attend to but we will make sure that it goes to the right person. We will take the-, I sup-, oh no, there is no adjournment because there's no-

25 one else coming. So this will be the end of the proceedings for this

week and for today. I think the next session is the 20th of August. Well, it will be announced publically in due course. We, we are adjourned.

PROCEEDINGS ADJOURN

5 **END OF AUDIO**