THE COUNCIL FOR MEDICAL SCHEMES [CMS]

INQUIRY UNDER SECTION 59 OF THE MEDICAL SCHEMES ACT

HELD AT

BLOCK A, ECO GLADES 2, OFFICE PARK, CENTURION

20 AUGUST 2019

DAY 6

PROCEEDINGS HELD ON 20 AUGUST 2019

ADV TEMBEKA NGCUKATOBI: We are continuing the hearings into Section 59 of the Medical Schemes Act. This morning we will be hearing a presentation from the South African Practitioners Forum. Who is here for the SAPF? You are? Alright, can we get your details?

DR ADRI KOK: I am Doctor Adri Kok, I am a specialist physician in a private practice.

ADV TEMBEKA NGCUKATOBI: How do you spell your surname?

DR ADRI KOK: K-o-k.

ADV TEMBEKA NGCUKATOBI: K-o-k. Okay, alright, will you be making the presentation?

DR ADRI KOK: Yes sir.

ADV TEMBEKA NGCUKATOBI: Alright, let me just take your oath, are you happy with an oath?

DR ADRI KOK: I think.

ADV TEMBEKA NGCUKATOBI: Say after me I.

DR ADRI KOK: I.

ADV TEMBEKA NGCUKATOBI: And your full name?

DR ADRI KOK: Johanna Adrianna Kok

ADV TEMBEKA NGCUKATOBI: Do hereby swear.

DR ADRI KOK: Do hereby swear.

ADV TEMBEKA NGCUKATOBI: That the evidence that I will give.

DR ADRI KOK: That the evidence that I will give.

ADV TEMBEKA NGCUKATOBI: Shall be the truth.

DR ADRI KOK: Shall be the truth.

ADV TEMBEKA NGCUKATOBI: The whole truth.

DR ADRI KOK: The whole truth.

ADV TEMBEKA NGCUKATOBI: And nothing else but the truth.

DR ADRI KOK: And nothing else but the truth.

ADV TEMBEKA NGCUKATOBI: Now raise your right hand and say so help me God.

DR ADRI KOK: Now raise your right hand and say so help me God.

ADV TEMBEKA NGCUKATOBI: Thank you. We received a one-page submission dated the 19th of July, but I have been informed that you have a PowerPoint presentation.

DR ADRI KOK: That is correct.

ADV TEMBEKA NGCUKATOBI: Alright thank you, you can take us through your presentation.

DR ADRI KOK: Thank you very much for the opportunity. So the Faculty of Consulting Physicians of South Africa represent the consulting disciplines and we are a sub-group of the South African Private Practitioners Forum.

We represent multiple societies and we have logistical support from a group called HealthMan, who do all the logistical support of all our societies. So I will be speaking mainly on behalf of the Physicians Association and specifically just excluding the cardiologists, because they are a separate group from us.

So we include from general physicians, pulmonologists, endocrinologists, rheumatologists, gastroenterologists, neurologists, and intensivists and I think I have remembered all the ologists and

nephrologists as well, so – except cardiology.

So we represent the – especially specifically private practice members, but we also have some public sector doctors as part of our society. So there are three main definitions that we need to look at, first of all fraud, where there is a wilful misrepresentation of what is actually given to the medical scheme, I do not know, can you see the slides?

ADV TEMBEKA NGCUKATOBI: Someone should have put them here on our screens but apparently no-one has done that but carry on.

DR ADRI KOK: Okay, secondly if there is waste, where there is useless expenditure or consumption, and thirdly where there is abuse, where it is inconsistent with sound medical and business practice. And these are the definitions applied then when we assess what happen with our members.

So I think there are a few discussion points and I will try to go through these and I think we can either have questions as we go or if anything is unclear, please just stop me and we can go through those. So, coding I think has been a problem, and these would be particularly coding, looking at our – when we see a patient and you perform a procedure, there has to be a code to describe what you have done, and with that code you then present it to the medical aid with your invoice and that would then say what have you done, how much time did it take and so on.

So there has been a problem after 2006 because the coding done through a combined discussion on codes stopped happening because of the Competition Commission Investigation that thought this was not conducive to fair practice, and from that time it has been a

problem.

So may procedures that have been developed over time there are the codes that have had to be adjusted to have not been accepted by some of the funders, some funders have accepted it. There is a lot of obsolete and old definitions and descriptors, there is new technology, there is new procedures that have not had adequate representation and so for many of the funders, and it is difficult to name particular funders, they use the reference process of 2006 for their forensic investigations. So we are not really up to date with 2019 where we should be.

There is sometimes also differences in opinion and interpretation of the codes and so the coding is not perfect, so I think that is the starting point also from our side. The coding manual devised by the South African Medical Association has always been the sort of blueprint that everybody has used, but again some of these codes have not been accepted.

And I am not going belabour that because I think the HealthMan and SAPAF presentation would focus on those more specifically. From the physician's point of view, I will go through some of the ones that particularly affect us, and just to show you in bold, the main ones, let me just see, the main ones that are pertaining to physicians.

So, if you deviate from the norm, so the way the medical aids assess this, they have a profile of all the physicians in the country, they have around 624 physicians – general physicians in the country, and then the various smaller groupings, for example neurology, I think there is 39 neurologists in private practice, intensivists, I think there is 11,

rheumatologists, I think there is about 48 of them, gastroenterologists have a few more but they have recently been part of FCPSA so we do not have that much information on their side.

But all the groups are ...(intervenes).

ADV ADILA HASSIM: Sorry, these are in the private sector, these numbers you are referring to?

DR ADRI KOK: Yes*, ja.* The 624 include the public sector, so in private sector there is about 450 general physicians. Of these, we have about 250 that are members of our society, not everybody is a member, which is also a problem.

So they way that they have evaluated is they have taken a view of all physicians in the country and then they would compare the individual doctor against that sort of general number, and then they say you do not fall into the norm. What we have discussed with the funders, on various circumstances where for example, if you have a doctor working in Vryburg in the Northern Cape, there is only one physician, almost in a 200-kilometre radius.

So, of course that doctor will deviate from the norm because of their geographic position. In some centres for example, in an urban setting there is many more physicians, so there it is much easier to actually compare the groups or the person against the doctors in that group and we are trying to ...(intervenes).

ADV KELLY WILLIAMS: Doctor Kok, can I just ask a question about your example that you gave, about the doctor in Vryburg, who would obviously deviate from the norm, can you tell us how that doctor would

obviously deviate from the norm?

DR ADRI KOK: So because he is the only person in that area, they would receive all the patients from that more or less 200 kilometre radius, some would go through to Cape Town if there is need for more intensive investigations or management that is not possible in his immediate hospital, but he would have many more admissions to hospital, merely because of his position.

And oftentimes they, the doctors in these peripheral areas are inundated with patients because there just are not, there is nobody else to see the patient, so they often get admitted to hospital. So if you look at admissions to hospital, they would appear to be an outlier because of their geographic location rather than that they are abusing the system.

And this has been again a situation where we have had to try and explain those outlier situations, because sometimes they did not have the geographic location of the doctor to be able to interpret why they look like an outlier. The second point that developed is that they often do not know if a doctor specialises in a certain group, for example, they may be 180 practice number as a general physician, but they may have an interest in cardiology for example.

Or they may have more gastroenterology interest, so they would appear to be an outlier, but it is actually in keeping with their training and with their particular interest. But they are not a gastroenterologist. So, the coding does not fit with the doctor's practice number, but their practice number as a general physician is how they are then picked up as an outlier because they are being compared to other physicians. So we

try to …(intervenes).

ADV ADILA HASSIM: Sorry, just to follow up on that, so those are reasonable explanations for why a physician would appear to be an outlier?

DR ADRI KOK: Yes.

ADV ADILA HASSIM: In the context of an investigation, the doctor would inform the funder that or the administrator that this is the reason for the number of admissions?

DR ADRI KOK: Exactly.

ADV ADILA HASSIM: Or I am responsible for, and then would that not resolve the problem?

DR ADRI KOK: So, what unfortunately happens is that sometimes they are already sanctioned without an explanation. So there has also been some situations where unfortunately, the doctors have not responded to the investigation or the letter to say look, we have picked you up as an outlier, please explain.

So that has been a problem and we have tried to ensure that our members understand you have to respond. We have asked them please to respond through HealthMan because we have a whole group of people that help to support that kind of investigation because we know that their would be reasonable explanations in many cases.

And I will get to some examples where there is not reasonable explanation and where the doctor was found to be guilty. So, I think it is just that we have, over time, as the funders have become more robust in their investigations and they have been able with their IT systems to

determine these outliers they pick up on just the practice data ...(intervenes).

ADV NGCUKAITOBI: Let me just tell you this Doctor Kok, so you are talking about someone deviating from the norm, what is the norm?

DR ADRI KOK: So as I said, that they would take everybody in the country, pick up sort of a bell curve and say your practice falls completely outside of this bell curve. And then they would say that this is an outlier practice.

But then they have not looked at the two points, what is the geographic area? How many doctors are there in his area or her area? Are their any support services? So for example, if you are sitting in a peripheral area do you have a cardiologist available to refer to, or do you have to see everybody that comes? Do you have a neurologist? Do you even have a scan that you can do scans on patients that present with a stroke, for example?

So in many of the peripheral areas, these doctors work in isolation, under extreme pressure and they may look like an outlier on paper but they are not, because of their situation and where they actually practice.

ADV NGCUKAITOBI: Now how do we know that they look at the national average? I mean that you say, so they look at each and every doctor in the country?

DR ADRI KOK: Yes.

ADV NGCUKAITOBI: So how do we know that?

DR ADRI KOK: They do it under the physician number, the practice

number, 180, and they then draw up a, I can call it, standard and then they compare the doctor against that. So we – this is particularly from Discovery Health, and I think they have had the most advanced IT evaluation of where we practice, what we do, what is our performance, of all the funders.

And they have given us some feedback on an annual basis since 2016 of how you as an individual compare to your peers in the country. So they have really helped us to understand what the issues are and they have given us the opportunity to then, if they do pick up an outlier to discuss that particular doctor's situation and to understand better why they showed up as an outlier.

And they have been very good with engaging with us, not in all cases, but in many cases to understand better what – why that doctor would show up as an outlier.

ADV NGCUKAITOBI: And, so you have got this national average which, if you are a doctor in Vryheid, you have no idea how it is compiled. And then you get identified as an outlier or a potential outlier, but all of this is a desktop exercise, somebody is sitting in Sandton, looking through a computer?

DR ADRI KOK: *Ja.*

ADV NGCUKAITOBI: Now, from your experience especially with the larger schemes, at what point do you as a doctor then get terminated and the scheme says we are no longer referring patients to you and we are no longer honouring the accounts that you submit?

DR ADRI KOK: So what we have experienced and this has been at the –

can I may call it, the insistence form our side, because we may only know once the doctor has received the letter that there is an issue. So it is one of our problems that we, I do not have a clue what the guy in Vryburg is doing, I am in Alberton.

I do not - you know, I do not personally know the guy in Vryburg, so I am absolutely reliant on the scheme to come to say to me look, you are the president of your association, we have picked up this pattern of behaviour of this doctor, do you agree or do you not agree, how do we manage it? So we have implored them, please discuss with us so that we can investigate with the doctor, understand their circumstances, and then if there is a true abuse, we would discuss it with that doctor and we can do a peer-to-peer discussion and say to them, look we have picked up this issue, what was causing it, is there an explanation.

It has been a problem that not every physician as I say, belongs to our association, but if there has been some circumstance, and I will show you some examples, where they have come to us, we have been able to resolve many of the issues that have come up, because there was a reasonable explanation for their supposed outlier status, according to the funder.

ADV NGCUKAITOBI: Yes. You see what I am trying to understand is, so there are two stages at which the doctor is told by the scheme that claims from you will not be honoured. The first is where the scheme picks up that there is something wrong with you.

DR ADRI KOK: Correct.

ADV NGCUKAITOBI: You are an outlier. And they say look, we are

about to start an investigation and before we do that, we are putting you on what they call direct payment, so we will pay your patients directly.

DR ADRI KOK: Yes.

ADV NGCUKAITOBI: The other stage is where they conduct an investigation and the doctor does not co-operate.

DR ADRI KOK: Yes.

ADV NGCUKAITOBI: And they say well, we are not going to tolerate your non-cooperation, we are going to put you on direct payment.

DR ADRI KOK: *Ja.*

ADV NGCUKAITOBI: What is your experience about these two stages of termination?

DR ADRI KOK: So we really have mainly Discovery to go on because some of the other funders, GEMS have had some investigations but they were quite advanced by the time they involved us. And this has been the situation with Discovery that they have really gone through several iterations of a letter advising the doctor that they have picked up that there is an outlier behaviour, that they have wanted to investigate and I think many of these do not even come to our attention because it is resolved, as I understand.

They would not stop payment or do direct payment unless there has been complete non-compliance from the doctor's side or absolutely no response to letters and I do know that the personally do go and visit the doctors.

So if it is a representative in the area or an area manager that would physically go to the doctor's practice to visit them. There are

circumstances where the doctor's refused to see these representatives, specifically from Discovery because I know that that has been a issue, and again you know, in that situation it is very difficult to help the doctor if they do not give an opportunity to evaluate what is actually happening with their practice to understand better.

So that has happened in some cases, unfortunately, because I think the more you can open your books, show what you are doing and there is transparency, obviously you can defend what you have done. So we have tried to ensure that our members understand that it is absolutely crucial if you feel that you have done correctly you must be able to defend it, I do not think there should be an issue with that.

So if the funders have picked up a problem, we have asked our members to please be in contact with us so we can help you through the process, understand better what the issues are and then see where there has been a problem, that occurred.

For example, in some instances, especially with young doctors going into practice, they have had very bad advice on coding and so there has been abnormal coding practices for example, where they do not understand in intensive care, what the particular code should be, they may have added codes where it was not appropriate, or they have applied a certain code that was not applicable in that situation and so many of those we have actually been able to resolve because it was a pure misunderstanding, and the doctor going into practice new, and not having the information at hand to know exactly how to do their billing correctly.

ADV NGCUKAITOBI: Yes, so I just want to understand something, just

also based on your own experience, so you told us earlier that what you find is that typically it is the doctors in the outlying areas, you made the example of Vryheid, I hope no one is from Vryheid here today?

ADV KELLY WILLIAMS: Vryburg.

ADV NGCUKAITOBI: Vryburg, oh, it is even worse. But, what is your experience of the class of doctors that are affected. I mean, you know that this enquiry also partly looks at racial profiling.

DR ADRI KOK: Yes.

ADV NGCUKAITOBI: Have you found that the bulk of those that are affected are whites, black, mixed?

DR ADRI KOK: Can I go onto a further slide then I can show you the exact details?

ADV NGCUKAITOBI: Oh, okay, thank you.

DR ADRI KOK: Okay. And I just – the one other thing, because we are consulting physicians, the hours that you spend and the after hours consultations, that also cause some problems. So there is some additional codes, 0145, 46, 47. 47 is away from your practice after hours, an emergency code.

So if they pick up that every single patient that you see is an emergency code, you would also be seen to be an outlier. But in some circumstances every patient you see is after hours. So it is again, it is a situation, even in Secunda, Vryburg is an extreme example, but there has been one doctor in Secunda for years, he has now got a second person helping him.

In Port Elizabeth, for example, there were eight physicians, four

have retired, so suddenly you have half the physicians. So the practice is just a practical thing that the physician are the people that really are the backbone of the hospital. And also, if you are stuck with a patient, you consult a physician, you know, you need to know, where do you go with this patient.

So oftentimes the physician would be your final step of asking advice, getting support, trying to understand what the situation is with a particular patient. So you would – I mean in my hospital for example, I have got about 48 GP's that refer to me, but I have got in my hospital, we are six physicians, so there is a spread, so I will not come up as an outlier easily because there are other physicians seeing patients. But if I am the only person in Secunda and I have got 48 GP's referring to me, of course the profile of my practice would be completely different, and it has taken the funders some time to understand that.

I think you know what triggers the investigations, so I will just go through this quickly. So just to show you, this is our physician membership, so we have 250 physicians on our books and that is the distribution also with the geographic distribution.

And the fact, for example in the Free State, that you see there, there is one – and can I just mention that we do not have actual racial registration at our society, anybody comes, these have been absolutely inferred from the patient's surname, and so I apologise if that is racial profiling, that is the only way that we have to do it. I also do not have a male female distribution, but I can tell you that the majority are male.

ADV ADILA HASSIM: What is brown?

DR ADRI KOK: Exactly. I did not draw up the slide, so I do – and other as well, that is a person who did not want to be classified as anything, so I do apologise, that should obviously not be brown.

ADV NGCUKAITOBI: Well certainly that is not white?

DR ADRI KOK: Yes. So, I mean, our crazy country hey? And, for example, as you can see like Kwazulu Natal that the focus of the Indian doctors, etcetera. So it just gives you a bit of a spread of the focus of the doctors in the various areas. So does that answer your question just to give you an idea? So just to, so part of our problem is ...(intervenes).

ADV NGCUKAITOBI: Something further, I mean that is your pool.

DR ADRI KOK: *Ja.*

ADV NGCUKAITOBI: I want to know out of that pool, what the rate of investigations per category?

DR ADRI KOK: *Ja,* so there they are, just to show you the members per race category and that gives you the percentages. So, of the African doctors that are members, 35 of them, three were investigated, which makes up 8.6%. Of the coloured doctors there was really very few, if none. Indian doctors, there was 14.3% and white 4.7%, so that is the total that have been investigated. Does that answer your question?

ADV NGCUKAITOBI: Yes, and if you add the 14 plus the 8.6% if you classify all those as black, then you are at 21.something % versus only the 4.7% of white, yes it does, thank you.

DR ADRI KOK: Then in summary, just to look at the audits, so of the 22 physicians that have been approached by our group, FCPSA, Faculty of Consulting Physicians, 18 of these had to refund the medical schemes to

some degree. 14 of these were anomalies found as as I said these were mainly due to abnormal coding practices where they misunderstood codes and we do not know what the recovery amounts were because it was not discussed with us. But the doctors agree that there was a coding abnormality and we could account for those. In four audits …(intervenes).

ADV ADILA HASSIM: Doctor if it was of a coding anomaly, why would a refund be necessary?

DR ADRI KOK: *Ja,* I do not know if there was even a refund negotiated, I just know that there were anomalies found and when I say they had to refund the scheme, I actually do not know the detail of what happened, but can I call it there was an agreement with the doctor.

So there was not non-payment and there was not a complete, you know, like a direct payment to the patient that we know of. In four situations there was – no anomalies were found, so even though the doctors were cited to be an outlier, it was never confirmed and in four audits there was a significant refund to the scheme. R 2 600 000,00 over the six-yearperiod that was assessed.

So we try to ensure that our physicians understand why audits happen, that they understand coding and especially that their staff understand coding because often the doctor does not do the coding themselves, they can see – they have seen a patient and it was nine o'clock at night in casualty, there is a certain code.

And the staff need to capture that and submit it to the funder. So, there are situations where some of the young doctors especially have

had outside agencies to do the coding for them and there was up-coding we found that.

So we have advised them that they have to make sure in their individual practice, they are responsible to understand that their coding is done correctly by their staff. We have given when we have our annual congress, and also smaller congresses where we have weekend meetings, we have tried to put coding and coding issues as a topic for discussion and also an opportunity to have like a workshop where people could ask questions if they did not understand it.

To try and mitigate against this. So I think recently in the last, I would say, three four years, the funding industry has had better IT assessments of what happens in practices, they have approved their evaluation and I think that is why there has been such a focus on coding and also why these outlier sort of, can I callit behaviours, have been picked up better than ever before.

I think previously the IT systems just were not able to detect these individual cases as much as it does now. The difficulty is that we as a physician association do not always have insight into how these IT systems, as you said, it may be a person sitting with a computer interpreting what happens in a practice without really understanding the circumstances of that practice.

So we hope that in the future, especially after this investigation, there would be better cooperation on that side. Because the whole idea is to try and really we cannot afford fraud, we cannot afford to have people that abuse the system, I do not care where they work or who they

work with. And it is important for us to make sure that the practice must be beyond reproach, because I think that protects our patients best.

Sometimes we have also picked up issues where the auditors, because some of these are auditors that do the investigations or that develop the programs that then evaluate what happens in a particular situation and we have often asked that their should be a South African, can I call it development, to assess the South African situation, we cannot use a Johns Hopkins model in South Africa, we need to have a South African assessment.

You know, if we look at some of the hospitals in America, a hospital would have 3 000 doctors, you know, we have like 3 500 specialists across the country. So it is important that we have a South African evaluation of what happens in our circumstance, understanding the demographics and also the challenges with just the numbers of patients that doctors have to see, physicians specifically.

And the volume of work that we have, to give you an idea, my practice, since April, I have had a full book until December. Because you simply cannot see more people in a day, and you try to accommodate but it is not always easy to do that, so it is really important that that is understood as well, that there is a huge pressure on time and effort to be able to manage these patients.

We also have ...(intervenes).

ADV ADILA HASSIM: Doctor Kok, before you go on, can I just pause you, and I am going to take your back to your data when you are finished I think but just to ask you about your critique of using the John Hopkins

model. Could you explain to us two things, one, which schemes use that, and what part of their FWA detection system uses it, and then just take us slowly through your concerns about using this in the South African context, if you would.

DR ADRI KOK: I think it is developed in a very different context to South Africa and I think if you take an outside measurement and you impose on a different system ...(intervenes).

ADV KERRY WILLIAMS: Perhaps start with who is using it.

DR ADRI KOK: Okay, so the only people I know that is using that I know of specifically is Discovery Health and it is difficult to – I cannot give you the detail, I mean I have just looked at what they come up with results and how do we – how we have helped them to refine it over time as they understood better what our concerns were.

And again, from where we started to really have discussions and interact with them to better understand what happens and how to evaluate the South African doctors and the physicians specifically that consult in the specialist fields that I have mentioned and they could not for example pick up a person with a 180 practice number that is doing nephrology or gastroenterology that have a focus on that rather than just general physician work.

In some instances physicians do a lot of intensive care work, that again depends on where you work and where your support team sits. If you have a physician in your unit that is an intensivist, they would see more of the ICU work for example.

In my hospital we do all the ICU work. In KZN, for example,

the anaesthetist would see most of the ICU work. So if you compare a physician in KZN to a physician in Gauteng, for example, it would appear different.

So you need to understand the complexities of our situation to be able to understand what the data shows.

At the same time some of the outliers have been ramped outliers and those people have really been fraudulent, there is no question about it.

I can tell you that the one Medscheme investigation on one doctor was to the amount of 2.5 million that I was involved with and he asked us to assist with his investigation and there was no question that this doctor had abused coding for procedures that were not actually done. No question about it.

He could not defend it, he could not show us the data, he could not confirm – you have got to say, for example, I say I have interpreted in the ECG, I have got to have the ECG in the file.

If I do not have the ECG in the file I did not do it. If I say I have done an echocardiogram, I need to actually know that I can do an echocardiogram. So the one doctor, for example, that was investigated on that side ...(intervenes)

ADV KERRY WILLIAMS: So Dr Kok, is that – would you make that determination based on assessment of their clinical notes?

DR ADRI KOK: Yes, so these were - again the scheme that asked us, they had picked up this particular doctor and they asked us just to look at their interpretation of the data, did we agree with it. Looking

through I and then asking the doctor to be able to supply us with their interpretation of what they had done.

They could not do that and, you know, on one scheme 2.5 million is a huge amount. So there was no question and again it was a situation where this doctor was working in a smaller community and there was no support around to evaluate what was happening, so there is no – there is no checks and balances and that is part of the problem, that often times people are in areas where they do not have anybody – not looking over their shoulder but just having a team to be able to say look, you know, I see you are doing this, is that acceptable standard of care? No, it is not or it is.

And that is often where we hope that with our annual meetings we get people to come to the meeting, have an opportunity to discuss these issues and again have a collegiate approach to what we are doing as doctors.

ADV KERRY WILLIAMS: And would the sharing of clinical notes be a violation of your code of ethics?

DR ADRI KOK: I do not think so because again when the doctor has become a member of the association they have agreed that they would like to be part of a group that can evaluate and give support to one another. So it is part of our association's ethical rules, that we would – I would like to know that I can submit my practice to scrutiny, if I can put it that way.

This has become important over time, as you look at how private practice and the funding industry developed, there was no

checks and balances in place. So, you know, if you are in your practice you just carried on regardless and maybe the first time somebody would ask a question is if you have a person taking you to the HPCSA, for example.

So there is never been a system - like if you have a public sector hospital, you have a head of unit, you have got the registrars, you have got the junior staff, you have got a team of people that monitor one another automatically. In private practices, a physician, that is it, you are it.

You decide what you need to do, you need to decide to do investigations and we have tried to put a – almost like a guideline for people to practice so that a young doctor coming into practice understand what they need to do, how do you monitor yourself?

I could do a stress test on every single patient, but it is not correct but who decides that? Actually, I do. And unless I am picked up now by a funder as an outlier, I could have stress ECG's till it comes out my ears. That is the problem, we have had to try and almost – the horse has bolted in a way and we have had to try and put that horse back in the stable.

Now again, the majority, 99%, if you look at the numbers of people actually do practice within the ethical guidelines. It is the 1% that unfortunately sullies our profession and that is where we have to try and mitigate against that because if you look at the volume and how quickly a person can cause harm from a financial point of view it is a lot and that is what we have tried to actually just try and maintain a –

not that you can police it at all, you cannot.

We are absolutely dependent on the funders giving us details. If they pick up an issue can we discuss it with that person and it could be something really innocent or it could be a real wilful abuse of the system. There is no question that there are two sides to it. And that I can say from a physician's side, we have not picked up a racial – you know, that there is one race that has more than the other, maybe because our physician group is more spread.

ADV TEMBEKA NGCUKATOBI: If I could just follow-up with this question from my colleague. So I suppose there would be two instances. So there would be one where your own peer or your colleague says give me your clinical notes and what they will do with those, I mean, they could support you, tell you where you went wrong and so that they can put you back on track, so that is a more supportive function.

DR ADRI KOK: Yes.

ADV TEMBEKA NGCUKATOBI: Which is what you are talking about. But there is another where a scheme is investigating you in order to decide whether you have committed misconduct.

DR ADRI KOK: Yes.

ADV TEMBEKA NGCUKATOBI: That would justify them putting you on direct payment.

DR ADRI KOK: Yes.

ADV TEMBEKA NGCUKATOBI: So if you are not dealing with the second category, would you agree that the sharing of the clinical notes

in the second context would infringe the National Health Act because it has a provision that says a doctor must maintain client/doctor – patient/doctor confidentiality.

DR ADRI KOK: Yes, so what for example Discovery has done, they would have a patient – a doctor A, doctor B, doctor C. So we do not have the detail of who the doctor is, they just show us the profile and then we would say yes, we agree or do not agree and then if we agree that there is a – it looks like it is not in keeping with the standard, then we would – they would then approach that doctor and see – and it is only been a few times where we have actually physically spoken to the doctor at the doctor's request, not at the fund's request because again trying to maintain that doctor's privacy, so – and I must say this is again difficult because some funders have gone ahead without consulting us at all, so I must say that this is limited to again, as I say – mainly Discovery has developed this can I call it a support system with the association to try and ensure that it would rather be a positive support of the doctor rather than a sanction, to try and avoid the sanction whereas in some circumstances I know that from a physician's side as far as I know not any of the physician's have had their payments stopped. I know it is happened in other groups ad that would be again discussed by the other groups that will present specifically HealthMan.

So as far as I know, nobody in a physician's space has had their payment suspended. Some doctors have definitely had direct payment imposed and again in some circumstances and the one that I

have got on here is a Dr J R.

He is an elderly doctor, he had been in practice more than 30 years and they suddenly said to him but he cannot do echoes and he had to then present them with what he had done as a physician specialising in echocardiography, so he is not a cardiologist, so they said he could not do it because he is not a cardiologist and again it just shows he is had the courses, he is done it, he is worked at Oxford.

Again, we could assist him because we could send all of these details through and it was accepted by the fund. So it is this individual type of case – I did not have 20 million of them, I mean, it is just to show you some of the issues that I have come across that we could defend a person who happens to be white.

ADV KERRY WILLIAMS: To ask you a question on Dr J R, it obviously goes to illustrating your point that the scheme systems were not – had not evolved at that stage to distinguish between a 180 practice number performing let us say a specialist service and being legitimately able to perform that specialist service.

DR ADRI KOK: That is right.

ADV KERRY WILLIAMS: So now has those – well, it was Discovery in this case, has Discovery changed its system to now allow for this subtlety to ...(intervenes).

DR ADRI KOK: This was not Discovery.

ADV KERRY WILLIAMS: This was not Discovery.

DR ADRI KOK: *Ja,* sorry. *Ja,* this was not Discovery. So there is sometimes where it seems as if there is a, can I call it a mining of a

code, where a code is then thought, okay, let us look at this code and see if it is abused and then there is a series of investigations.

So we have had to really try and just inform the particular funder when we have become aware of it. So this doctor did approach us, which is why we could defend his situation. I cannot remember which fund this was. It was Medscheme. His payment was stopped until this investigation was completed which of course can sink your practice.

ADV KERRY WILLIAMS: And just ask the question in relation to Discovery. Post your engagement with them around this subtlety of some code PCNS numbers 180 being able to perform other types of services, has the system changed?

DR ADRI KOK: Yes, so from my point of view. So - as far as we know, so just looking at some of the referrals that we have had or people that have come to us for help, it is definitely been – it is improved. I cannot say it is ever perfect, we keep working at it and we have just encouraged them if there is an issue and especially if a doctor has not been open to discuss with them to discuss with us and see if we can at least reach that person, you know, see if we can help them through the process rather than wait until there is a sanction, rather than be proactive than wait until the problem occurs and then try and sort of dial back.

ADV KERRY WILLIAMS: Thanks. You said that Discovery has developed a relationship with the association to try to assist.

DR ADRI KOK: Yes.

ADV KERRY WILLIAMS: Have any of the other administrators or schemes done that?

DR ADRI KOK: So Medscheme and GEMS have to a degree. Medscheme, for example, has asked us to help with assessing their guiding principles for different disease categories and we have helped them to develop those to understand admissions to hospital.

There have been times where they have opportunities to discuss with us. For example, they wanted to impose a limitation of days on certain admission diagnosis like, for example, pneumonia and we have had an opportunity to give feedback to them and say we cannot have a one day admission, you have got to have at least two days to get the cultures back, for example, and they have been willing to discuss with us.

Their data and practice evaluations, we have not seen any major feedback from them at all. The one case at Medscheme was a fraud investigation where they brought us the detail. The doctor had asked for our support and this was the 2.5 million that I spoke about.

There was one other doctor that was also an abuse situation and the doctor agreed that they had wrongly used codes and there was use of codes that were not appropriate for the physician to use, for example ultrasound investigations that was actually done by the hospital radiology department, not by the doctor, that the doctor had coded for.

There were some, for example, in intensive care where there was some double coding where the doctor did not understand the

descriptor of the code and then had the wrong code. But those were very easily resolved and these were often – we found new doctors in private practice that simply did not know the correct coding and this was again across the board, it was not a specific – I know this is more on the racial issue but it was not a specific racial group that was affected.

And interesting enough, more men because there are just more men that are physicians than females so there is definitely a discrepancy, male-female distribution.

ADV TEMBEKA NGCUKATOBI: I do want you to take us back to your slides because we started asking you questions and that took you away from your plan.

DR ADRI KOK: Sure. So we – I think what is important for us, we are actually dependent on the funder who have oversight in a physician space to be able to understand where issues come up because then when you have identified you can discuss, you know, we can have it as a lecture when we have kind of CME meetings or continuing professional development meetings, we can discuss it and manage it.

We try to – we have brought in the last two years coding into any kind of meeting that we have, we try to have at least an hour or two hours of coding issues, how do you code correctly, make sure that your staff understand it and there is also updates for staff to understand it then how coding works, how to apply the correct ICD 10 codes, for example.

So again the disease description has to match the procedure

so those have also been a learning process as people have become better but we are absolutely dependent on the funders for the data. We – you know, the difficulty in South Africa, and this is again coming back to the Johns Hopkins' question ...(intervenes).

ADV TEMBEKA NGCUKATOBI: Sorry, just help me with something. The funds have given us submissions in writing.

DR ADRI KOK: Yes.

ADV TEMBEKA NGCUKATOBI: And BHF and HFA have told us there is no way we can know who is being investigated because nobody keeps racial data as such, no one knows because everyone follows a practice number.

DR ADRI KOK: Yes.

ADV TEMBEKA NGCUKATOBI: But you have been able to tell us without any difficulty what the racial breakdown is of those doctors that are investigated.

DR ADRI KOK: Yes.

ADV TEMBEKA NGCUKATOBI: So how is – or difficult is it for the funders to know what the racial profiling is of the doctors they are investigating?

DR ADRI KOK: They should be able to do it, I cannot understand that they say they cannot because they do have your name attached to the practice number and they do have your geographic location. So I must say I do not think that that is an argument that they can use. I cannot see that.

What I was saying about the – I was just thinking now what, I

forgot my train of thought – about the Johns Hopkins' – if you look at the physician space, again to try and apply the data in the South African context, when you have for example a Cleveland Clinic, that is like a city, you know, you hear of Cleveland Clinic, it is multiple disciplines in one area and loads of doctors.

So, for example, if you then have a person who falls outside the norm or they do not practice according to the ethical standard that you want, you get rid of them and the next guy comes and in South Africa we do not have that ability because we simply do not have people to replace a person that is not, if I can call it, behaving in an ethical way.

We also have evaluations where we try to ensure on the Netcare Ethics Committee, for example, and the Clinical Practice Committee. So if we pick up an issue with a physician specifically, that case is then discussed with a doctor present with a Netcare management group to see if there is a situation where can support the doctor.

So it may be an older doctor that is not practicing according to their ability anymore or a doctor where there is clear questions about their clinical expertise. So we try to ensure that we are part of that decision-making and trying to evaluate really what the approach would be to try and ensure that that situation is resolved because at the end of that doctor is a patient and we have got to make sure that the patients are safe.

What I was trying to think of about the Johns Hopkins' model,

if you look at the Americans, they have got the American Medical Association, they have the American College of Physicians, they have an entire board just employed by the American College of Physicians doing this kind of support system for their doctors.

We have to practice – this morning I started my ward round at five to be in time here. You do it whilst you are practicing medicine. My whole exco are all practicing physicians, none of us are only doing the association and that is part of the problem that often times we have had to try and fit in to try and have these meetings with funders, it is often after hours, to try and ensure that we have a system in place to protect our doctors at the same time as protecting the patients and the health system in general.

And I think that is again where these, can I call it profiling mechanisms, may not be able to really accommodate that kind of distinction and to be able to really understand the South African context of what we deal with.

ADV ADILA HASSIM: Is the not HPCSA supposed to be performing that function, those board functions. I mean, there are disciplinary boards within the HPCSA, so is that not the role that you are talking about, is it not appropriate for the HPCSA – in fact, not appropriate, is it not in fact a statutory obligation to do so?

DR ADRI KOK: *Ja,* I think it would be. I think there is only as far as I know two clinical people on the HPCSA, I do not know if that is changed. And again, to really understand practice, you have got to have people that are living in that space to understand what the

doctors are dealing with.

You know, the – I always laugh when I go to overseas conferences, then you hear the guys talking, you know, they are so busy, they have got four patients in hospital. If I have four patients in hospital I am stressing because, you know, where has all my patients gone to?

So it is – the volume of people that physicians have to deal with, there is no understanding of the hours that physicians work and sometimes even the pressure, because, as I said, the buck stops with you, there is no more senior person that the physician to make a decision on a patient and there is a lot of that pressure that is not really understood and I do not care what racial group you are, this affects absolutely everybody and in some circumstances people are in situations where they do not have, for example, a neurologist that they can consult or a nephrologist or a cardiologist, they have to do all of it and it puts immense pressure on that doctor, he cannot just refer to the next place, you know, where do you go to?

So like Kimberly goes to Bloemfontein, that is two hours away. Upington has to go to Kimberly to go to Bloemfontein. You know what I mean? That again, that context of where the person is working absolutely influences what – so often times they would rather admit the patient where they can physically observe them and monitor them rather than take a chance and sending a patient home.

So I think it is always – it is an HPCSA function but I think the clinical context is sometimes not available to the HPCSA and 100%

HPCSA and not again the processes at HPCSA has been quite slow to actually anticipate these changes.

I mean, Tully Medicine, for example, there is no rules in South Africa to govern Tully Medicine, yet my patient sent me Whatsapps, they sent me their sugar profiles on email. I do not charge for that time because there is no code to describe it but I spend time with my patient, respond to them, but that, according to HPCSA rules actually is not allowed, they want you to have a face-to-face with the patient and that is simply not always possible.

So it is a difficult one, there is no – I think the HPCSA, the clinical aspect again is not always sort of borne in mind.

ADV TEMBEKA NGCUKATOBI: So if I understand you, we have a coding system that is not in tune with the clinical context of South Africa.

DR ADRI KOK: *Ja.*

ADV TEMBEKA NGCUKATOBI: But the clinical context itself takes into account the social disparities of South Africa.

DR ADRI KOK: *Ja.*

ADV TEMBEKA NGCUKATOBI: We just do not have enough doctors.

DR ADRI KOK: *Ja.*

ADV TEMBEKA NGCUKATOBI: And we have a lot of poverty in South Africa and so it ...(intervenes).

DR ADRI KOK: But it is not just poverty, you know, it is the burden of disease.

ADV TEMBEKA NGCUKATOBI: Yes.

DR ADRI KOK: I mean, if you look at the chronic diseases, the non-communicable diseases explosion in South Africa, it just scary. I mean we – I was at the Department of Health the other day discussing the NCD's and how do we manage the burden of what we face and, you know, in the past, for example, it was said that black patients do not get heart disease.

Recently I had at least five young black men die of cardiac infarcts. So we have to change our thinking and again we - again, the same group that do these evaluations, that practice – we are also the people doing research and sometimes we cannot actually report back on what we see because we simply do not have time to do so but it is this kind of – so we are trying to also with the guys in the academic world to try and bring these issues in a physician space to the fore because there is a changing dynamic on that side.

HIV used to be number one killer, that is number five now. Cardiovascular disease is number one, diabetes is number two and yet in some provinces, for example in many provinces in the public sector there is no glucologist at the clinics and we try to help the academic sector from private practice to try and ensure that we have a standard of care to prevent complications in the future.

Now this is nothing to do with racial profiling, it is just the burden of disease in our country and to understand if there is a change in how these diseased occur, where can we interact? I mean, why are we doing so well with HIV?

Because, first of all, the drugs became more affordable.

Secondly, we have understood that there was a problem. Thirdly, we had a better approach, there was a standard across the country. Everybody does the same thing and whether you are in public or private you have got a standard of care and that is why we could get on top of it. The same thing is possible for the other diseases as well and the physicians are the people that need to drive this.

ADV ADILA HASSIM: You say the burden of disease does not have anything to do with race but would it not be correct to say that the burden of disease would be related to socioeconomic status?

DR ADRI KOK: No, I would not. We really see these non-communicable diseases across groups. Interesting enough, the NHS data from 2012, the South African NHS data, there were 30% of our Indian population are diabetic, 30%. 12% of our coloured population. 8% of black and white are diabetic and of the black population, interesting enough, at that evaluation the urban blacks actually had a lower diabetic risk.

So it does not hold - you know, we sometimes we have a feeling it should be, that showed it did not. So again – and that was across the demographic groups, it was not a socioeconomic groups. So we see a spectrum of disease in everybody. I mean, we have often – this is one of our gripes with the medical aids is that they have plans, plan types. I have got a standard of care, now the patient comes with say diabetes, for example. If you are on this big executive plan and you can have a big basket of care, you can get this. Now you are on the lower plan, you can get this, the problem being, the patient that I

see have diabetes, I do not know what plan they are on, they may belong to medical aid A.

So I have to treat them according to the standard of care of treatment for diabetes, I do not know what plan the patient's on and that is often where our problems come from, is to try and ensure that that patient gets a fair management of their disease – and I understand that there are limitations to what can be afforded, but again you are preventing complications in the long run.

So that is part of our other work as physicians, where we try and interact on how these protocols and treatment algorithms are developed and to ensure that the patients often in the lower plans are often the sickest patients, does not mean that the guys on the higher plans or less sick or more sick, it is just the disease is there and we have got to manage the disease as best we can.

So often the plan types does affect how well we can treat the patients. I know this is nothing to do with the demographics but it is just some of the issues that one comes across.

ADV TEMBEKA NGCUKATOBI: Yes, you may proceed.

DR ADRI KOK: I do not think there was – I think maybe just my – my request is, as we go forward that again that there is better mentorship and we can only mentor if we have data and for us to have a – you know, I do not know how many schemes are present in our society today. I think it is over 70.

It is difficult to meet with all of them but if you can have principles and the principles are applied then it is much easier then to

be able to interact with different groups. I am on an advisory group for Universal Health, for example, and again they have – I think they have got 13 schemes that they work with and even though we have had initial meetings, again it is been important there to look at, for example, you talk about waste, that we have tried to put principles of, for example, antibiotics stewardship.

So this would be how to use antibiotics through the country, to limit, first of all, resistance. But secondly, to use antibiotics prudently. Stroke management, what would be the principles of care on stroke management?

Now to give you an idea through a hospital is way back wherever, have some of the best data on stroke management because the principles are applied. So the fact that you are in a rural setting does not mean that you do not have to practice good medicine.

We do advanced acute communicare, for example, again there is determinants, what should be given to the patient. It does not matter where you are, whether you arrive at any hospital, whether it be public or private.

So we try to, with the academic sector have these management principles again across the country and so that wherever you are, whether you are low socioeconomic person, high, does not matter, and that the treatment is equitable and that you do not waste in the management of that patient.

So the money that you do spend is spent well and the patient has a better outcome in the long run. So that is one of the – where the

data really makes a big difference for us and if you do not know the date you cannot actually act, you do not know where you stand because you do not know what the details are.

It is just really, we think that there should be an independent body that could better evaluate the coding that can better evaluate what happens in practices and where there has to be a universal terms of reference for South Africa that you can better establish an understanding of what should happen.

Then to understand what causes outlier behaviour and to address the very few doctors that abuse the system as thus seem to happen in some circumstances and to address those individuals. For me where I sit from a physician point of view, it is really a physician issue and that it is no race, can I say predilection for issues.

It just depends again where the doctor works, what is their circumstances, what is their support team and again what are the pressures on that doctor where they practice. So, I hope that that has given you some insight in the physician space.

ADV TEMBEKA NGCUKATOBI: Thank you. Can I just ask you about your figures because my … (intervenes)?

ADV ADILA HASSIM: Can we go back to that slide, please?

ADV TEMBEKA NGCUKATOBI: Yes.

DR ADRI KOK: Of the doctors or the investigations, this one?

ADV TEMBEKA NGCUKATOBI: The investigations.

ADV ADILA HASSIM: Demographics.

ADV TEMBEKA NGCUKATOBI: Yes. If you can*, ja.* If you look at that I

mean so we have got 35 African doctors ... (intervenes).

DR ADRI KOK: *Ja.*

ADV TEMBEKA NGCUKATOBI: And 6 are investigated.

DR ADRI KOK: *Ja.*

ADV TEMBEKA NGCUKATOBI: And that but 148 whites and only 7 are subject to an investigation.

DR ADRI KOK: *Ja.*

ADV TEMBEKA NGCUKATOBI: Now that gives you I mean the 4.7% versus the 8.6%, now that number, you know, looks surprising because it seems to suggest that there is a focussed investigation on Africans compared to whites and if you look at it without analysis that might be a sign that there is racial profiling.

DR ADRI KOK: I hear you*, ja.*

ADV TEMBEKA NGCUKATOBI: And if the same thing with Indian doctors, look at the fact that you have 63 of them, 9 investigations and that takes you to 14.3%.

DR ADRI KOK: Yes.

ADV TEMBEKA NGCUKATOBI: Again, so it looks here that there is a bias against black doctors, coloureds, Africans and Indians compared to whites who are sitting at 4.7%. So maybe there is an explanation to it so there could be various explanations. One could be well that is because there are higher instances of fraud among blacks and one say well that is an unfair imputation. The other is that schemes deliberately target black doctors for investigation.

DR ADRI KOK: *Ja.* So, we have not seen that and I know they have

come up more in numbers but when we look at again the data that was presented as mainly the Discovery data as I have said. It is really been all the doctors across the country. So, if somebody, Dr A or B came up as an outlier we had no idea what race group that person was. But these were numbers that came up when we evaluated the cases that were investigated.

ADV KERRY WILLIAMS: What time period is this over?

DR ADRI KOK: From 2016 so I would say about the last four or five years has been sort of a development of this evaluation.

ADV KERRY WILLIAMS: And at which … (intervenes).

DR ADRI KOK: We thought that it was not really done.

ADV ADILA HASSIM: And this is investigation by any scheme?

DR ADRI KOK: No, this is I would say the majority of being Discovery and Medscheme, the majority. Interestingly enough, just with my interaction with Universal Health for example, when you look at the data that we have seen at Discovery where for example there was some outlier behaviour for example in say KZN. The same can I call it focus could be seen in the Universal Health data as well. So, it was not limited to one scheme and the same thing was seen in the Medscheme data. So, it is seen across those three groups that I could say particularly that the same behaviour pattern was seen in the same areas, this was more geographic areas.

ADV TEMBEKA NGCUKATOBI: Yes, I understand but you see what I am trying to understand I mean you do not have to comment on this but I am just grappling with it. So, if you are talking about a new trial set of rules

that are applied uniformly without regard to race, why is that producing racially biased outcomes?

DR ADRI KOK: So, I think part of my and this is my personal interpretation if I can put it that way, is if you look at where some of our black doctors are working. They may be more isolated, and they may be in some of the rural areas I have spoken about. And that may be where they are working that this comes up as an outlier behaviour and as I say we have not had enough insight into the detail of what is determined to be, you know in these situations to be able to say whether that is true or not. Again, I do not know exactly where each person that is a member of my association is working. We have geographic areas, but we do not know a town or a whether it is an area where they have other support or not. So, it is more difficult. We just do not have the insight into exactly what their circumstances are and what – because often times they also they may work in public sector as well as private, so they actually try to get a service in the public sector hospital in that town as well. So, it is difficult for us to be able to comment on that. My impression from the data that was given to us, that it is applied across the group of physicians and these were the outliers that were determined. But as I say that I had no idea that there was a particular race group that was specifically targeted, not to my knowledge.

ADV KERRY WILLIAMS: Just another point of clarity on this slide. Why is there a difference between those first sorry – the second and third rows number of investigations per race category and number of members investigated. So, you will see for the Indian and whites it is the same but

for African it is different, can you just explain that?

DR ADRI KOK: I think certain doctors, Casper has just helped me from HealthMan, have multiple investigations and that is why they have – it might be more than one investigation in an individual.

ADV TEMBEKA NGCUKATOBI: So, if we come back to what I am trying to grapple with which is why do we have an apparent and neutral application of rules given us racially biased outcomes. So, one of you explanations, I am not tying you to this but I am trying to understand it. One of your explanations is it is because of their geographic location.

DR ADRI KOK: It could be.

ADV TEMBEKA NGCUKATOBI: Yes.

DR ADRI KOK: *Ja.* So I think one needs to – that needs to be evaluated better to understand again the circumstances and when I talk about the support, are there other physician specialists groupings available to support that doctor where they are as a general physician or are they it, you know do they see everything that comes? So, from patients with strokes to patients who need dialysis for example to people you need to ventilate in ICU. Where in certain areas there is an Intensivist that do the ICU care, there is a Nephrologist that do the dialysis, there is a neurologist that manage the stroke and the general physician really is just the support person. So then there is a very big difference in those two practices when you evaluate them on paper and that is sometimes where I think some of the funders do not have the – I do not know, it is my impression because we do not see data that give us – that really can go into that kind of detail to understand better why that person shows up

as an outlier.

ADV KERRY WILLIAMS: And another explanation as I understood you was that it seems that black doctors are more likely to work in both public and private practice, is that right?

DR ADRI KOK: No, there is really in especially in the rural areas a lot of doctors that also do some work in the public sector just as a support for the hospitals. So often the general practitioners would ask their support and they do it because they in a town where they are the main person to go to for advice and that happens in the urban areas as well. So many of the private doctors do sessions or do teaching or do some academic sessions in the academic hospitals.

ADV TEMBEKA NGCUKATOBI: I mean I suppose the geography might still not be enough of an explanation because you still need to look at what model is applied that is geographically biased because it looks like the way of identifying an outlier in a sense disadvantages people in rural areas and in the outlying areas. Almost look it is automatic that if you have got a model that will identify people practicing in outlying areas and those people are black, it seems obvious that the outcome will be primarily black doctors will be apparently targeted for investigation even if there is no intention to target them.

ADV TEMBEKA NGCUKATOBI: Yes, and I think it is again the nature of our country and how there is a distribution of doctors. And again, I did not show you the detail of the individual doctors because we have their names but these were doctors that interacted with us and these, I think if I say correctly all of them were urban – every single was in an urban

area. So again, these actually did not land up in the rural areas. And again, in the urban area it should not happen and that is where the fraud showed up absolutely 100%. So that is a refund of that 4% that we spoke about or that four doctors that had to refund was absolutely proven.

ADV ADILA HASSIM: So just to make sure I have understood correctly, this slide you are saying that the potential explanation for the racially biased outcome here would not be the geographic area.

DR ADRI KOK: *Ja.*

ADV ADILA HASSIM: Because in these investigations all took place in cities?

DR ADRI KOK: No, I am just saying that the people that then showed up as the – that were then – if I can just go back to that one – this one. That all of these were urban doctors so again that there was not a focus to say okay, you know let us look at all the people that looked like they have a black surname. So, I cannot say – I really have not come across that so I really do not think that that is true. It can be that more people who are black showed up in the profile but that is not that it was targeted if I can put it that way.

ADV ADILA HASSIM: *Ja,* that was fine. My question was more that you just saying that that is like … (intervenes).

DR ADRI KOK: It just happened … (intervenes).

ADV ADILA HASSIM: All investigations were not in – in urban areas.

DR ADRI KOK: No, they were all over the country it just happens that the people that were urban.

ADV TEMBEKA NGCUKATOBI: Yes, I mean it all depends on what model

you are using to initiate an investigation.

DR ADRI KOK: Sure.

ADV TEMBEKA NGCUKATOBI: If that model ultimately disadvantages people in the so-called outlying areas then black doctors who are in those areas will show up.

DR ADRI KOK: *Ja* but it did not you see; I think that was the interesting part of it. And again, we have really had to develop the understanding with the funders specifically in this situation the majority of the interaction is being with Discovery. For them to understand the distribution, the challenges, the time pressures, the support systems, all of that that could play a role in when they send their data because they sitting with a computer program and this shows a person A doing this. For example, right at the start they showed up a doctor and we then when we understood the profile could tell them that that person is actually a Nephrologist still practicing under 180 practice number. That was initially when we started to really sort of understand the data that they were presenting to us and it is been a progress to really come to an understanding. And as they do pick up issues, this is again why it is absolutely crucial that there needs to be a better cooperation between the funders and the doctors so that it does not become this them and us story. At the end of all of this are that we are defending, and we are really trying to protect the patients as much as possible. So, the standard of care must be above reproach and the application of meds and must be appropriate and the invoicing and charges need to be appropriate according to what is the standard that is acceptable. And that is what we

are trying to encourage and ensure especially as young doctors come through, that they practice with that same ethic.

ADV KERRY WILLIAMS: So, a final question on this on the data. So, you obviously presented it to us data from the fact of consulting physicians.

DR ADRI KOK: Yes.

ADV KERRY WILLIAMS: But SAPPF represents far more specialists than that.

DR ADRI KOK: Yes.

ADV KERRY WILLIAMS: Is there data available for the larger group?

DR ADRI KOK: Yes, I think that will be presented tomorrow. *Ja,* we wanted to really bring – because each group have unique issues. For example, we do not have equipment. You have got your basic equipment like a lung function and a stress ECG and that is it whereas some specialists groups like Ophthalmology would have loads of equipment so there is a huge difference in what your exposure might be from that point of view. So, the different specialist groupings definitely have unique issues. And we hope that at least with us to present the physicians part of it we would give you some insight into what we see as some of the solutions as well as we go forward.

ADV TEMBEKA NGCUKATOBI: Another slide here where you said these schemes have the data, but they are refusing to share it.

DR ADRI KOK: *Ja.*

ADV TEMBEKA NGCUKATOBI: Now what kind of data do you have in mind that they have but they are refusing to share it?

DR ADRI KOK: I think just the general data and understanding what if they do have this evaluation of physicians across the country and they pick up issues for example, if they see a code is wrongly used. Instead of sanctioning the doctor, why do they not approach the association and say, look we have picked up that a 100 of your members are using this code incorrectly? So, we could communicate with the members and say, do you know that this is the correct description of the code.

This is where it should be applied. And I can promise you that 100 doctors would comply. So instead of them saying – for example, I had one funder come to my offices because they said I charged for ECG's regularly.

I would charge for ECG's regularly; I am a physician and I had to actually pull my files and show them the ECG's. That is fine because I could show them the ECG's, so it is kind of – again I mean some funders did not even 100% understand what a physician does as a general physician.

Our description as a general physician was not something that they really understood what is our function in our rooms for example, what is our function in a hospital setting. And I happen to be the president of the International Society of Internal Medicine.

Across the world now we have got 78 countries that is members, we are trying to have a standard of that physicians across the world whether you be in a first world setting, third world whatever, what would be the standard of care as general physician?

Because in many countries that is exactly the problem that in

some countries, they have these subspecialists, we always joke about a big toe specialist. The point is that what should a general physician, what is the standard of care that a general physician, what is the standard of teaching to make sure that you are actually able to do the work that a general physician needs to do.

And this is again a focus to try and ensure that we have these principles of treatment which applies in all communities and in all socio-economic groups. It is a disease that you managing and you need to do it in a way that is equitable but also that will help the patient to be well in the future, it needs to avoid complications.

ADV ADILA HASSIM: And when you say the funders – you refer to funders as an M of this group. I would like to know what you mean when you say the funders approach you for example and enquire why there are so many ECG's that are conducted in your practice.

DR ADRI KOK: *Ja.*

ADV ADILA HASSIM: Who actually is the person who approaches you?

DR ADRI KOK: Well this was just a sort of a management person, it is not a doctor and this particular lady came to my practice, we drew the files, it happened to be Transmed. And she had to – she looked at the files to physically see the patient's details.

Now again, first of all there is no privacy for my patient but they say the funder have the right to do that because they are the funder and if the patient is a member of that fund then they have to give permission to do it. So it is a difficult thing.

I cannot refuse to her to see the files because then they say I

am being obstructive so, you know we could show them the ECG's and she was happy with that. But again, it just to me illustrated the almost a disconnect to understand what a physician does.

Clearly, I will do lots of ECG's, it is part of my work, almost every single patient will have an ECG otherwise I am not doing my job properly. But again, the management person at the front or the – I do not even know what her description was, she is not a doctor and that is often now another problem is that the interpretation of what is happening is not done by a peer, it may be a general practitioner who may also not understand the physicians space.

But that again is where we can come in where we could explain it, I do not think that there is a – can I call it a resistance to understand it but it is just to get to the point where this can be dealt with in a way that you can actually come to a solution without it being an obstructive situation.

It is not a – you know the whole idea is that the system must work again to the benefit of the patient for me.

ADV KERRY WILLIAMS: Dr Kok on that point, I think it was the Health Funders Association that made the submission that it was appropriate for a GP to let us say engage with a specialist in relation to the type of services that were provided in this audit process. What would your comment on that be?

DR ADRI KOK: I think I am not saying that the GP do not have the ability to evaluate but at the same time I do think for example if there are clinical issues that the best solution for me would be that another

specialist need to evaluate that because I do not think that in some circumstances that a General Practitioner would be able to make a clinical judgement on the patient and this is often a problem where certain investigations or an approach to treatment has to be made on the basis of seeing the patient and making a clinical decision. And this is a problem … (intervenes).

ADV KERRY WILLIAMS: Doctors, can you give a specific example where clinical expertise would be required?

DR ADRI KOK: Like for example, I have got a patient this morning where the patient is actually has c/o prostate and I need a bone scan and then I am told he is not registered on an oncology benefit so they cannot do the bone scan. So now you have to phone and explain you need a bone scan, the patient has got a lytic lesion in his vertebrae, I need to see if there is other bone lesion so that we can treat him. So, you are sitting with a funder making a decision on a funding principle and I have seen the patient. And so, you spend another day in hospital arguing your point …(intervenes).

ADV KERRY WILLIAMS: But in this instance were you speaking to a GP? I am trying to understand this point clearly.

DR ADRI KOK: That was actually not even a GP, it is just a person at the front who makes a decision on that patient's investigation …(intervenes).

ADV TEMBEKA NGCUKATOBI: No, I think the – I mean I suppose there are two questions. The one is where it is a non-medically qualified person so we are not dealing with that scenario, but we are dealing with someone medically qualified and remembering that the schemes are

saying A, this is impractical because we cannot have experts evaluating this clinical laws. And secondly, they say at rate a GP has basic medical training and they would be able to make sense of these clinical notes, so it is in that context that the question arises.

DR ADRI KOK: *Ja.* And again it depends on the circumstance whether that is valid or not so this is not really from a funding point of view as far as coding and so on go but for example chronic medication is one of our favourite situations is there again is a guideline management of a patient so we have the South African Diabetes Guidelines.

And then the funder, there is a medical advisor at the funder who is a GP, then sits with the funding rules and no matter that our South African Guideline says different, that is the funding rule and the patient cannot access what they actually should have to prevent complications in the future. So there again I mean that is a General Practitioner making a decision on the funding rule rather than on the clinical management of the patient. I do not know if that answers your question.

ADV KERRY WILLIAMS: Not quite. Let me just maybe give my example and you can comment on that.

DR ADRI KOK: Okay.

ADV KERRY WILLIAMS: So, if you are accused of fraud waste and abuse because you have over serviced.

DR ADRI KOK: *Ja.*

ADV KERRY WILLIAMS: And there is a GP at the scheme that is let us say, doing this analysis.

DR ADRI KOK: *Ja.*

ADV KERRY WILLIAMS: Would you be satisfied that the GP is able to do this analysis in relation to a specialist practice?

DR ADRI KOK: I think the initial management, the initial evaluation, I would be happy if they pick up a problem but then I think it needs to be discussed again at an association level so that one can really interrogate it properly because I do not think that with the best one in the world that they really specialist in all these fields.

So, they may have a funding principle rather than a clinical management of a patient and I do think there is a disconnect so I must say that I think there needs to be a next step. So, they may be able to determine that there is an issue but then we need to evaluate that issue and I think that is where we dependent on the data from them.

I hope that answer – I think the initial picking up that there is an issue, 100%. But then they need to evaluate it with somebody that work in that area whatever the specialist field might be, I think would be appropriate.

ADV TEMBEKA NGCUKATOBI: There is also another area that has arisen which is recoupment in relation to whether it is over serviced or it is fraudulently claimed. What is your associations experience on the practices followed by skills to recoup funds from members?

DR ADRI KOK: *Ja.* So, we have had some issued for example, that doctor that I mentioned whose payment was summarily suspended. And again, if you look at some of the investigations in that situation, it can take a few months and if especially if it is a fund that represents a big part of that doctor's practice, that could really put them out of business.

So, I really think that there needs to be a – can I call it a sequence of evaluation before such a drastic measure should be employed.

And for me that would be again, show the data to the association where there are peers that can evaluate it, they have picked up the issue no problem. Then see what the circumstances are, what is that doctor's situation, what is their support service, where are they situated and are the allegations valid or not and then what can take the next step.

But I think to summarily suspend a person's pay and even sometimes there is direct payment to patients although I understand that it is in the scheme Medical Scheme Act that they can do that. It is very problematic because I can promise you that the patient sees money in their account and they spend it immediately.

So, the doctor will never recoup that and to try and get money that is actually your income from a patient is extremely difficult. So, I think that kind of sanction to me is very negative and I think we could avoid it if we had a better system to the point where we can manage that.

If the doctor then completely does not comply there is the HPCSA is available.

ADV TEMBEKA NGCUKATOBI: Yes.

DR ADRI KOK: And although I know their process is slow and it does take time again, that may be a way to expedite it is to develop a better system at HPCSA level where these doctors are properly sanctioned. And again it must not be a slap on the wrist, you know we cannot afford fraud in South Africa, we really cannot.

ADV TEMBEKA NGCUKATOBI: Yes.

DR ADRI KOK: And I think if one or two people are properly sanctioned, it may give a message that this kind of behaviour is not going to be tolerated.

ADV TEMBEKA NGCUKATOBI: Yes. I mean I suppose there are two types of recoupment. So, there is one, the ability of the doctor to recover from the patient who has received direct payment.

DR ADRI KOK: *Ja.*

ADV TEMBEKA NGCUKATOBI: Because many patients are going to go to Pick 'n Pay rather than paying a doctor. But there is another recoupment which is how a scheme gets its money from a doctor they claim have fraudulently benefitted from.

DR ADRI KOK: Yes.

ADV TEMBEKA NGCUKATOBI: And so there apparently there is evidence that shows that the schemes will force doctors to sign acknowledgement of debts.

DR ADRI KOK: *Ja.*

ADV TEMBEKA NGCUKATOBI: And there is a complaint that that practice of forcing doctors to sign acknowledgement of debts it itself firstly it is rampant, it is racially biased, but it is also illegal. What is your experience on that conduct by schemes, recovering funds from doctors?

DR ADRI KOK: So, I have not had any personal experience where it is happened to our physician members but just generally speaking, I think you have a huge development to that point. You do not today understand that I have messed up for three years, there must be a pattern that you

have picked up and surely you could interact before it gets to the point where that kind of sanction is applied.

So, to me to get to that point, unless the doctor absolutely does not cooperate and completely does not interact with the scheme, there is a huge path that you could walk before you get there. I mean you not – if you do not pay your car at the bank for example, you do not pay today and now suddenly they going to come and take your house.

There is a pattern and there is progress and there is interaction way before that kind of rule should apply. So, to me it is become a very negative and if – as I say I do not have experience of that happening in the physician association members but again it may be happening to physicians that are not members.

But I think there is a – really there is a lot that can be done to avoid that kind of situation. I do not think that that should be necessary, you know the next step, there is a huge amount that could be done to avoid that from happening.

And again, as I say I think the more recent experience with funders, they have become more, can I call it aware of issues, they have been able to identify. They have been able to identify issues better and that is why I think we seen this explosion of recouping funds as you have said.

But to me again, if you picked up an issue there must be a way to interact with a doctor before it gets to the point where you have to take such a drastic action.

ADV ADILA HASSIM: There was this slide that you presented on

recovery of monies from doctors by the schemes. Can you go back to that slide please?

DR ADRI KOK: Let me just see if it is to the front. I do apologise, I cannot remember where it was. It might be further down. Sorry, I apologise it might be further down. I am not sure which one. Sorry, I do not think I am finding it but I think maybe HealthMan and SAPPF would take it further but just can you refer to it again? What was your question?

ADV ADILA HASSIM: I wanted to go back to the slide because I thought that I saw on that slide that there were agreements that had been reached by – between the doctors and the schemes to pay back.

DR ADRI KOK: Oh, I see which one it was. At the bottom*, ja* this one.

ADV ADILA HASSIM: Yes.

DR ADRI KOK: *Ja.* Again, that is data given to me by HealthMan so I would not know the detail of those and I am not sure what kind of agreement and the recovery amounts or like you said that there would even be an acknowledgement of debt if you can call it that. I am not sure what the detail is there.

ADV ADILA HASSIM: But HealthMan will be able to assist us?

DR ADRI KOK: Yes, and I am sure they will give you better details. Sorry, that I do not know that of that at hand.

ADV TEMBEKA NGCUKATOBI: Thank you. Will that be – do you have any more slides, or will that be all?

DR ADRI KOK: That is all, thank you sir.

ADV TEMBEKA NGCUKATOBI: Alright, I do not think any of my

colleagues have further questions. We would like to extend our thanks to your association and for your presentation. You may receive further correspondence from us requesting further information and you may also be invited again but for now, thank you very much for your presentation we appreciate it a lot.

DR ADRI KOK: Thank you very much.

ADV TEMBEKA NGCUKATOBI: So, we shall adjourn until 2 o'clock, I think that is when the next presentation is.

INQUIRY ADJOURNS

INQUIRY RESUMES

MR KGABO KOMAPE: The evidence I am about to give.

ADV TEMBEKA NGCUKATOBI: Shall be the truth.

MR KGABO KOMAPE: Shall be the truth.

ADV TEMBEKA NGCUKATOBI: The whole truth.

MR KGABO KOMAPE: The whole truth.

ADV TEMBEKA NGCUKATOBI: And nothing else but the truth.

MR KGABO KOMAPE: And nothing else but the truth.

ADV TEMBEKA NGCUKATOBI: Will you raise your right hand and say, so help me God?

MR KGABO KOMAPE: So help me God.

ADV TEMBEKA NGCUKATOBI: Thank you. We have received a written submission from your association. Thank you very much. It has – it goes up to 19 pages, signed by your chairman, your deputy chair and the CEO.

MR KGABO KOMAPE: That is correct, Chairperson.

ADV TEMBEKA NGCUKATOBI: But I presume you are fully briefed to

speak on the contents of that presentation?

MR KGABO KOMAPE: Yes, that is correct, Chairperson.

ADV TEMBEKA NGCUKATOBI: All right. Thank you. But I also see, there is something else that has been given to us. It is a PowerPoint presentation.

MR KGABO KOMAPE: Yes, at the time of submission there are other matters that were not submitted into the office. So I thought that it may be fit for me to present them orally.

ADV TEMBEKA NGCUKATOBI: All right.

MR KGABO KOMAPE: Those are the additional ...(intervenes).

ADV TEMBEKA NGCUKATOBI: All right. So what are you going to do? We are going to follow your PowerPoint presentation?

MR KGABO KOMAPE: Yes, Chairperson.

ADV TEMBEKA NGCUKATOBI: All right. Thank you. You may continue.

MR KGABO KOMAPE: Thank you, Chairperson. Thank you for the opportunity. I want to extend my sincere gratitude to the Commission and to also give thanks to those that have already presented before the ICPA. At this moment, Chairperson, I just have a small preamble to quickly go through, so I can then go to my presentation.

ADV TEMBEKA NGCUKATOBI: Yes, sure. Carry on.

MR KGABO KOMAPE: "It gives me great comfort that at last we are able to present before a well-structured Commission, matters that have been skewed against the professional pharmacists for more than two decades. Section 59 which is a well-meaning piece of legislation ignited(?) to

bring amicable just and reasonable solutions of mediation to any possible disputes or errors that might arise in the course of dispensation of patient care. It has now become... It has now been perverted by schemes into a tomb of oppression, where professionals, particularly in this case pharmacists, are being dehumanised and they are being bullied into submission and they are reduced into crooks, thieves and dishonest people, deserving of more respect from society. This leads to the marginalisation from the health economy and they are further sentenced to depression and in some cases and in some instances, even to death. It is true that skills have become the law unto themselves with no one to really straighten them out or keep them in check. That being to firmly regulate them e.g. investment of values that were found against the schemes. We as the ICPA believe that the ...(indistinct) courts that are being held at the scheme offices exist only to stop funds from professionals. Particularly, pharmacists in this case, through AOD's that are being done outside of the confines of the law and do not necessarily seek to resolve the irregularities and the errors that might be – that might have arose. The status quo, Chairperson cannot be allowed to continue 25 years into our democracy. An atmosphere of terror, fear, intimidation

> and discrimination has been cultivated by the schemes through the forensic units, who have to justify their existence by excluding funds from the unsuspecting service providers like pharmacies and therefore, unrelating the independent pharmacies and other health care providers into the periphery of the economy. The audits that are being done by the schemes are also being done by unqualified people that we believe are not really knowledgeable about the intricacies of our profession of pharmacy. The intricacies involving the medication, the generics and all the things that are related to practice of pharmacy, but those are the people are being said to be auditing. We are very keen to find out the qualifications of those auditors or their credentials thereof."

I will try to be quick, Chairperson on the – in as far as this presentation is concerned. We have just taken a few examples of some of the cases. We have not compiled everything that we have come across as unfair practises against the pharmacists.

ICPA, if I may introduce it, is a non-profit organisation, acting in the interest of independent pharmacy owners. It represents 1100 pharmacy owners, 2500 pharmacies, 20 000 support and health care personnel.

The ICPA membership represents arguable the largest pool of professional services in the health care sector in South Africa. With a substantial reach into both urban and rural South Africa. ICPA scheme's

imperative is; the right to a quality health care service for every citizen.

If I may introduce the board quickly, Chairperson. The ICPA board of directors, that is the composition from the far left is Mr Mehboob Ali Cassim and we have followed by Mr Mogologolo Phasha. Followed by Simone Eksteen and followed therefore by Pauline Randels. Followed also by Mr Rakesh Daya and myself, Kgabo and our chairperson, Mr Sham Moodley.

ICPA's geo-spread is across the whole – all the nine provinces of our country. We are represented in all the provinces. The special arrangements of our pharmacies are such that we believe that we reach almost every community that is existing in this country. All the major cities and towns are covered, the suburbs and the semi-suburbs and the deep rural, we are existing there.

We have got long operating hours open seven days a week and we do also home delivery services. Pharmacists are invested in the communities that they are serving through employment that they create in these particular spaces. We are often the first point of call for the primary health care services in those communities.

The ICPA's objective is to assist and support its members, in securing a sustainable and successful future as independent owner managed pharmacies. In addition to this, the ICPA has try to foster an understanding of the role of that independent pharmacies can and do play in delivering important health care services to the communities that they serve. ICPA members are committed to high quality pharmaceutical care and the restoration and maintenance of the health and wellbeing of the

consumers.

The non-compliant patient behaviour ...(indistinct) in CB. The discussions on the CB generally fall into two groups. The medication non-compliance and the disease specific non-compliance, e.g. asthma and diabetes and can usually be attributed to a failure of communication or a lack of comprehension on behalf of the patient.

Despite the balance of clinical effective prescription medicine for the treatment of chronic diseases, achieving optimal clinical goals remains elusive. There are clinical and socio-economic consequences of NCB. In addition to the increased bearing of care that is placed on the health care system, family members and other support structures.

The need for forensic audits:

We are alive to the ...(indistinct) fraud, waste and abuse amongst healthcare professionals and it is noted and is condemned in the strongest possible terms and ICPA maintains a zero tolerance towards that.

Forensic audits needed, however, they needed to be fair. That they should be transparent. That they should be unbiased. The relationship between the pharmacies and funders, however, is not an equal one and it seems common cause that pharmacies and other health care professionals have been at the receiving end of some unacceptable conduct and abuse by certain medical schemes and the administrators. Unacceptable reporting.

To quote Paul Ndlani, the head of Forensic at Medscheme:

"Independent pharmacies where there is no corporate

oversight of the books or the auditing of stocks is the source of great deal of fraud..."

And that was emphasised. Ndlani says:

"They also tends to be under pressure as the big chains steal away their customers and similarly to dabble in fraud..."

That is an article that we took from the Business Insider of 23 March 2018. Forensic auditors identify pharmacies that they flagged as outliers. Meaning, they seems to be beheading outside of the norm. When pharmacies are profiled using their sophisticated analytical tools. Whilst this admonished that this is an unreasonable starting point for an investigation, outline pharmacies ...(intervenes).

ADV TEMBEKA NGCUKATOBI: (Indistinct) unreasonable starting point.

MR KGABO KOMAPE: Yes. Chairperson?

ADV TEMBEKA NGCUKATOBI: I say that your presentation does not say "this is an unreasonable". This says, "this is not an unreasonable starting point".

MR KGABO KOMAPE: This is not an unreasonable starting point. Sorry, Chairperson. For an investigation, it is okay. Outlier pharmacy payments are withheld even before an investigation has begun, purely on suspicion of alleged fraud or irregular claims. What the auditors mostly fail to conduct is a preliminary investigation by engaging with the pharmacist to understand the prevalent business model utilised by that particular pharmacy.

Visiting the pharmacy to understand the geo special positioning

of that particular pharmacy and the impact of this on the practice profile. Understanding the demographics of the population in the LSM diversity of the clientele that patronise that pharmacy. ICPA conducted a snap survey, obviously, in the light of the allegation of racial bias. The ICPA conducted a snap survey in June 2019.

Pharmacies that are listed on the ICPA Whatsapp group were asked to respond to the following question. "Has your pharmacy undergone a forensic audit in the last 18 months or is currently undergoing a forensic audit by a medical scheme or administrator?" The results of that snap survey indicated on the screen there ...(intervenes).

ADV TEMBEKA NGCUKATOBI: I did not see the absolute numbers on this. I just saw the percentages in your presentation. Do you have the actual numbers of those who responded to your survey?

MR KGABO KOMAPE: I will avail any extra information that the panel requires afterwards, Chairperson. If you allow?

ADV TEMBEKA NGCUKATOBI: (No audible answer).

MR KGABO KOMAPE: The percentage of pharmacies audited by Medscheme, particularly in this case, the black owned pharmacies were 18% and the white owned pharmacies were 82%.

Percent of pharmacy ownership by race:

The black owned pharmacies account for 35% and the white owned pharmacies account for 65%. Ownership of independent pharmacies in South Africa split by race based on a sample of 1100 independent pharmacies which is our sample. 65% of the independent pharmacies sampled are owned by white pharmacies, yet only 18% have

been or are being audited. As opposed to 35% black pharmacy ownership attracting 82% of the audits.

These numbers clearly points to a bias against black owned pharmacies, particularly by Medscheme. ICPA has not extended the survey to other administrators and medical schemes but anecdotal experience related by independent pharmacies reflects similar trends. Some of the complaints that we received that we compiled together, were also coming from other schemes like Discovery. So, I will say we have got Medscheme and Discovery as the most highest in terms of complaints of audits.

ADV ADILA HASSIM: Mr Komape, could you also provide us with the total number of members on your Whatsapp group as well as their breakdown of the racial demography of that group?

MR KGABO KOMAPE: (No audible answer).

ADV ADILA HASSIM: Thank you.

ADV TEMBEKA NGCUKATOBI: I mean, if you look at page 5 of your presentation, that is why I am trying to get the absolute numbers.

MR KGABO KOMAPE: Yes, Chair?

ADV TEMBEKA NGCUKATOBI: In the second paragraph.

> "So figure to above illustrates the ownership of independent pharmacies in South Africa, split by race, based on a sample of 1100 independent pharmacies."
>
> I do not know what that means.

MR KGABO KOMAPE: Our membership is about 1100 independent pharmacies.

ADV TEMBEKA NGCUKATOBI: So what is the sample?

MR KGABO KOMAPE: The sample that they took, it is not the total number of those pharmacies. However ...(intervenes).

ADV TEMBEKA NGCUKATOBI: It is a sample out of 1100 ...(intervenes).

MR KGABO KOMAPE: Out of 1100 pharmacies. That was – it was not easily feasible for us to reach all of them in terms of the survey. Although, we sent the survey, we noted the response that it was not full 1100 that responded.

ADV TEMBEKA NGCUKATOBI: The sample of what?

MR KGABO KOMAPE: We sent to the whole 1100 the question.

ADV TEMBEKA NGCUKATOBI: *Ja*?

MR KGABO KOMAPE: But the response that returned, it was not all the pharmacies that responded.

ADV TEMBEKA NGCUKATOBI: But how many responded?

MR KGABO KOMAPE: I will provide that information to the panel, Chairperson. If you allow?

ADV TEMBEKA NGCUKATOBI: Alright.

MR KGABO KOMAPE: We took one example of one of the group of pharmacies within our portfolio, the Medicare Group of Pharmacies, which is a white owned group comprising of 47 independent pharmacies, located in various provinces in South Africa. Each pharmacy trades under a unique name and it is not also apparent from the pharmacy name that it belongs to the Medicare Group or that the pharmacy is not white owned. Eight of the 12 audits that were – and are being conducted on pharmacies, have African names. Tsusanang Pharmacy and Bhopelomed

Pharmacy were audited more than once in the same year albeit by different administrators.

Most of the pharmacies from this group that are targeted are in Limpopo. It is a noteworthy that the ownership of pharmacies in Limpopo between blacks and whites are roughly split 50-50. This chart in – we tried to collate the results of the complaints that arose from the Medicare auditing patterns. All the pharmacies that were carrying African names and they were in different provinces were all audited and all the pharmacies that were carrying a white or Afrikaans name were not audited, except for one.

So that was to us an indication that there is bias towards the African named pharmacies, where they believed that they are probably owned by black owners or black pharmacies. The forensic units or the schemes sometimes use phrases such as "fraud hotspots" which they say are areas that they have identified as most likely going to be doing some form of fraud or some form of irregularities.

So the forensic unit has stated that they are what they termed "fraud hotspots" in the country, naming and Limpopo in Kwazulu Natal as prime. Interestingly, the Medicare Group has seven pharmacies in Limpopo. Four ...(intervenes).

ADV ADILA HASSIM: Mr Komape, sorry to interrupt. But can you tell us just how you make the submission when you say that the forensic units have stated that there are what they term "fraud hotspots" in the country? Which forensic units? When was this heard? Could you give us some more detail?

MR KGABO KOMAPE: On behalf of our members, when we receive complaints of auditing and forensic units harassing them, we sometimes engage directly with the schemes and in the course of those engagements, certain information starts to come out and they indicate that – when we ask: "How are you using...? How are you conducting these forensic units? And how do you actually choose which areas you go to?" They indicate sometimes to say, for example I will give you Limpopo is a hotspot. We note that.

If they say Kwazulu Natal is a hotspot for fraud, we note that. Therefore, when we then collect our notes(?), we are able to say these provinces that are being named as hotspots, we therefore need to go and look at our members in those areas and see exactly what is going on, so that we can be able to reach deeper than what are actually being alleged.

So in this particular example. It is interesting that Medicare Group has seven pharmacies in Limpopo as a hotspot and four of those pharmacies are African – are bearing African names and three of them are bearing non-African names. All of those pharmacies trading with African names were audited and only one non-African named pharmacy was audited.

Our believe is that because Limpopo is a hotspot, all those seven pharmacies should have received an audit and not the predominantly African bearing pharmacy names.

ADV TEMBEKA NGCUKATOBI: And where are they located? I mean, we had evidence earlier that sometimes there is an overlap between geography and what they call an outlier. So, I mean – so the one

explanation could be, I do not know what the explanation is, it could be that this was an outcome of geographic identification of outliers and that the fact that they had African names was an accident. So apart from the fact that these are pharmacists bearing African names. What else do we know about them?

MR KGABO KOMAPE: The other information that we know about these pharmacies is that they are following the same module. A model of trade as other pharmacies that are falling within the group of Medicare. So we believe that if all those other pharmacies that are in urban areas and in cities and towns are not being audited but they all follow the same pattern of claiming in terms of modalities and the order and the module of ...(intervenes).

ADV TEMBEKA NGCUKATOBI: Sorry. Sorry, Mr Komape. You see, if you have two pharmacies in one street in the middle of Polokwane. Pharmacy A is audited and pharmacy B is not audited and pharmacy A has an African name and pharmacy B does not. So, I can understand your points there. But if you have pharmacy A in Polokwane and pharmacy B in Lebowakgomo and the pharmacy in Lebowakgomo is investigated and not the one in Polokwane.

So the one explanation could be. Because you are geographically located in a village or in a small town, the patterns of claims are not going to match those that you find in the city. And so the reason why they are investigating those is because they are an outlier.

We now have the sense of how that is determined. So that is why I am trying to press you to give us more details, rather than saying,

look at the names and therefore conclude that there is racial profiling.

MR KGABO KOMAPE: Thank you, Chairperson. I think I should go back and explain maybe for the lack of a better word. We have used an outlier there. Not necessarily meaning the pharmacy that is staying outside or in the furthest part of the town. An outlier in terms of the claiming patterns within pharmacies across the country. So let us say for example. There are tools of analyses. I am informing them that an average pharmacy claimed so and so and so number of medications of this particular type in these particular times, these are the average amounts. If you then go maybe beyond – let us say if it is 50 ...(indistinct) 70, as an example. You are termed an outlier in terms of you are outside of the parameters.

ADV TEMBEKA NGCUKATOBI: No, no. I accept that. I am not disagreeing with you there. But I am just trying to look at this. You have given us seven examples, right?

MR KGABO KOMAPE: Yes.

ADV TEMBEKA NGCUKATOBI: And you say that the four that had African names were investigated and the three without – with non-African names were not, right. So I just want to know. Out of the four that had African names. What else do we know about them? Where are they located? What are their claim patterns? I mean, the things that ordinarily that would give rise to an investigation, so that we can make sense of your presentation about whether this is about race or it is about other factors.

MR KGABO KOMAPE: Thank you, Chair. I will just give examples. For example, those pharmacies that are in African names, they are in

Polokwane which is the city and some are in Tzaneen which is a town and they are all bearing African names. Those that are not bearing African names are also within those areas of Polokwane and Tzaneen. So we believe that if auditing was being done fairly or totally within the hotspot which is Limpopo, all these pharmacies should have all been audited.

ADV TEMBEKA NGCUKATOBI: Sorry. Which ones are in your presentation? Is it the one at page 6 or the one at page 8?

MR KGABO KOMAPE: (No audible answer).

ADV TEMBEKA NGCUKATOBI: So, I have got 6 and 7. Tell me, I mean, if you look at 6. Sort of three are highlighted there. There is Modjadji but that is in Duiwelskloof and Motakola(?) that is in Thohoyandou. Tsusanang that is in Burgersfort. And you go to the following page. Bhopelomed, that is in Lebowakgomo. So these all seem to be in the outlying – outskirts of Limpopo.

MR KGABO KOMAPE: I will accept that Chairperson.

ADV TEMBEKA NGCUKATOBI: H'm?

MR KGABO KOMAPE: I will give further elaboration with the next examples that will clarify this – what we are alleging in this case.

ADV TEMBEKA NGCUKATOBI: Alright. That is fine.

MR KGABO KOMAPE: The fine imposed on Jagalo(?) Pharmacy for entering the incorrect doctor's name on the claim is a rather weak finding. Such instances are often the results of data capturing errors and not a deliberate attempt to defraud the scheme as it is being alleged. Which means the prescription is in front of a pharmacist. Instead of putting the right doctor's name, the pharmacist puts a different doctor's name but

gave the right medication to the client. According to the scheme, if such an error is made it is not something that they take to say it is an error that should be corrected, but rather it gets classified straight away as fraudulent activities.

Groblersdal Pharmacy:

The pharmacist found that the audit finding was far too resource(?) in turns to challenge and resigned to accept that fine imposed on the pharmacy. Simply to get this unpleasant saga behind them, so that they get on with the business of caring for their patients. The audits that are being done, if I may bring context there, Chairperson. They would ask for information that dates as far as back as three years.

And in an average pharmacy three years of records, it is not something that one can just peruse over ten days. Now if you submit all the invoices or to the best of your ability but there is a still a small discrepancy still showing, you are also going to be classified under – as a fraudulent practice. And therefore, they would impose a penalty upon on you and these penalties, they range between 15 000 to about a million, depending on how much they believe there were irregularities.

Horizon Pharmacy:

This pharmacy was found guilty of pre-dispensing. This is not an uncommon practice in pharmacies when dispensing higher cost items such as biological medicine that costs thousands of rands to acquire. Pharmacies do not normally keep these items in stock but order them based on need. How this practice is deemed irregular or fraudulent boggles the mind.

Pharmacy Direct(?), as an example, is a Medscheme sister company and the sole designated service provider for many Medscheme administered schemes. It pre-dispenses and yet Medscheme's forensic found no fault with that practice.

ADV ADILA HASSIM: Can you just explain to what pre-dispensing means?

MR KGABO KOMAPE: Pre-dispensing means. I know that so and so person will be coming to my pharmacy for their normal routine collection of their chronic medicines. Maybe I have set a routine reminder. I know that on the 25th they must come in and collect that medicine. I will put in a claim on that – on the day before they actually due for collection.

And he will note that at the time that I am putting in a claim, the patient is not in the pharmacy. However, it is an arrangement that many pharmacies enter into with their clients to expedite matters like these kind of items that are expensive.

Pharmacies are in a financial position that does not allow them to keep certain medicine in stock while waiting for the clients. What they would do is that they would time the period closer to that time. They will put an order and that order will be delivered coincidentally when we know that the claims went through. Because if you order it and put it on the shelve and you put a claim in on that day or on the day that the patient is in the pharmacy and the claim is rejected, this – some of these biologicals, you will not be allowed to return them to the supplier of – to the wholesaler, for example.

So we are going to get stuck(?) with those kind of medicine that

the client's medical aid is no longer paying or funds are exhausted and the client is no longer paying by cash because they just do not have it. In these kind of scenarios, the pharmacies will try to increase sufficiency by claiming prior which is pre-dispensing and then order afterwards. When the client arrives they will then get their medication ready.

I will explain it further with another slide coming. The selection of this pharmacy for investigation and auditing is an interesting case. The pharmacy was in the Cape Gate shopping mall when it was audited. It was audited by the same time that Dischem had applied for a pharmacy licence to establish a pharmacy in the same mall. Dischem is the preferred partner of Discovery Health. Discovery audited Durbell, Cape Gate Pharmacy sending probes to entrap the pharmacist.

Durbell's lease was at the same time terminated by the mall owners. What we are asking and which we do not want to allege is that – was there any commission between the landlord, Dischem and the National Department of Health in this scenario?

Another example is Brooklyn Pharmacy in the KZN. This pharmacy was bought by the new owner who is a black female pharmacist. And she experienced an audit. She bought the pharmacy in January 2019.

She received a notice of audit in March 2019 from Medscheme and immediately the payments were withheld is that where we asked. Supplied purchase invoices from January – she has applied purchases of invoices from January to February 2019 which were in her possession as the new owner.

The new owner is not in possession of the rest of the invoices prior to the purchase date of the pharmacy. The pharmacist who requested that payments be released as she had complied with the audit request and Medscheme had not made any findings on that part of an audit which is the three months.

The email sent to forensic unit on the 12th March stating that the pharmacy is under new ownership and the invoices that the new owner is accountable for have therefore been supplied. There was no reply or acknowledgement of the email from Medscheme until 04 July 2019, when the pharmacist received a call to advise that payments had been suspended as I had not sent through the requested documents which is the invoices.

On the 12th of July 2019 the pharmacist received an email stating that after consideration of my email 12/03/2019 we will still be liable for documents prior to the purchase of the pharmacy in January 2019.

She declared that I also requested that as there was no communication between 12/03/2019 to 04/07/2019 that payments please be resumed until we could find an amicable solution. On the 17/07/2019 …(indistinct) replied that I must comply but ignored my request to resume the outstanding payments from June 2019.

I proceeded to provide all invoices in my possession which is the same small period of around three months. She wrote and said please may I request that your audit book conducted with the invoices that I have further that and I am happy to address any short comings on them, as I

firmly believe that I have been honest and transparent in disclosing my view …(indistinct).

May I also humbly request that payments outstanding from June 2019 please be released in the interim as this is adding a heavy financial burden in payments to my suppliers and staffing. The reply from Paul was that; "good morning Shuham(?) please confirm if you have asked the seller Mr Naidoo to provide you with all the invoices your require."

The pharmacist's response was here is initial email 12/03/2019 was forwarded to Mr Chris Naidoo, he contacted me to advise that the documents were removed from the premises by the previous staff and the RP, which is the Responsible Pharmacist of the pharmacy, and is unable to provide much assistance as he is not able to contact those people.

I alerted him to emails and communication as of July 2019 with Medscheme and he again offered the same response. I have opened new accounts with suppliers so I am not privy to previous history of his purchases, which means if you – if she was going to be able to ask from the suppliers that Mr Naidoo was using she could then do so and ask for those suppliers to give assistance in terms of the invoices.

Please be assured that should you reach any further review of services provided as of 01/01/2019 I am in full capacity to assist. The reply came from Paul Ncladi(?), she said, he said;

> "Thanks Shuham so how do you suggest we proceed with the audit of 2018 claims? The law requires proper records to be kept for example how are you going to declare the tax for the business. Mr Naidoo should have

made you aware that he – you could be contentionally liable to law if he said the business – if he sold the business under – the business under misrepresentations. Please engage with him again and insist on his full cooperation or alternatively please provide solution as to how we can proceed with our audit. If there were instead of four streams the practice would remain liable so it remains imperative that we receive proof that the medicine claimed for was indeed purchased."

Our question in this case is that why is it the new owners responsibility to track the previous owner and request to – the purchase invoices. We believe that the previous invoices and the previous purchases should have been requested timeously that the previous owner was still in charge of the pharmacy, he would have been in a position to supply those invoices.

Failure in which if there is any findings that were made the new owner would have bought the pharmacy with the full knowledge that this pharmacy has got issues with the medical scheme on so on and so on, then she would have exercised her prerogative to either continue the transaction or not.

So she asked why are payments withheld when there are no adverse findings with the new owner practice audit which is the three months that she supplied? We believe that this is a blatant bullying and abuse of power by Medscheme, our advice to the new owner was she needed to engage amicably with the scheme and explain that she only

took over now but we will try to assist to get the previous owner, but to make the scheme aware that she is not the one to be actually held responsible for all the previous activities of the pharmacy.

The penalties imposed on pharmacies:

Medical schemes and administrators impose AOD which is Acknowledgement of Debts on pharmacists, the values range from over R1 million – from R15 000, if I put it that way, to even over R1 million.

When pharmacists who arrange the audit findings that the forensic unit …(indistinct), the forensic unit will reassess the audit and invariably the figure sometimes may reduce. The forensic agents badger the pharmacists into submission by obviously bringing them to the offices and showing them the consequences that are going to arise if they do not exceed to the AOD's.

ADV ADILA HASSIM: Sorry Mr Komape is there underlying evidence for these statements of the amounts, the values of the AOD's and the badgering of the pharmacists by the forensic agents?

MR KGABO KOMAPE: I would answer and say yes and no, yes because when the pharmacists are …(indistinct) to the office of ICPA regarding all these activities. We always advise them not to sign the Acknowledgement of Debts, but when you dig deeper you will find that the pharmacists are now – they were in a position of weakness and they actually entered into what we told them not to enter in to.

Now they do not always disclose and bring forth every other evidence that they have already entered into, but I believe the office has got a few where the Acknowledgement of Debts had been fined, which will

be supplied to the panel.

ADV TEMBEKA NGCUKATOBI: Can I ask you something about the – what you said earlier, I do not know if there is evidence of any collusion between Department of Health and Dischem and the owner of the mall which lead to the removal of one of your members from the mall.

What I want to ask you whether or not it is part of your submission that the ownership of Discovery – of Dischem results in a particular form of bias against independent pharmacies in favour of Discovery's financial interest via its ownership of Dischem?

So the reason I ask you is because I do not know what you want us to make about the statement about collusion whether or not your suggestion is that – your belief is that Discover favours Dischem because it owns Dischem to the prejudice of independent pharmacies.

MR KGABO KOMAPE: Our submission – thank you Chairperson, our submission on that matter is a – we deliberately stand away from making an allegation which we have not really researched but when you have noted the coincidence of the – and the order of how things occurred I that particular instance, we believe that because we know of the long standing relationship to Dischem and Discovery, it is Discovery's favour to have Dischem enter that particular mall at the expense of the independent pharmacy.

Because there is belief – a general belief that independence are not to be trusted, I believe that it was going to be a better scenario for Dischem – rather for Discovery to have a pharmacy like Dischem there rather than a n independent, which might be susceptible to fraudulent

activities in terms of their line of thinking.

ADV TEMBEKA NGCUKATOBI: You see it was not Discovery that sad that independence are not to be trusted it was Medscheme, Head of Forensics, who said – or it did not say that they are not to be trusted but he said there is likely to be a higher incidence of fraud among independence and the reason for that is because independence are financially compressed and their space is being squeezed by the larger trade pharmacies. So Dischem being one of the examples.

So I will still go back to the issue, I mean what exactly are you trying to make us – why – what are you – what is the point you are making about – are you saying that there is a potential, I am not saying that is what happened, there is a potential that because of the proximity between Discovery and Dischem that could operate in turn to the detriment of independent pharmacies?

MR KGABO KOMAPE: That is correct Chairperson.

ADV TEMBEKA NGCUKATOBI: Yes, now in so far as the view that is expressed by Paul – is this Medleni(?) or Mdlane(?)

MR KGABO KOMAPE: Mdlane.

ADV TEMBEKA NGCUKATOBI: Alright, so in relation to the view expressed by Paul Mdlane you know who says that – I mean unfortunately you have only given us one sentence, we do not know the full context in which he made that statement, we will have to read the full context.

But if we just take the narrow statement that you have extrapolated his view is there is likely to be a higher incident of fraud in independent pharmacies because – or they are facing more stringent

financial pressures than trade pharmacies. I mean that sounds emanate reasonable that that is their position, I am not saying – I think the fact that they are susceptible to financial pressures must be accepted.

The question whether or not they would result to fraud in order to counter those financial pressures that is a different issue which might require evidence. So what is your gripe with that statement?

MR KGABO KOMAPE: Our submission in that statement Chairperson is that we believe this is the kind of prejudice that the independent pharmacy always suffers. The predeterminate thoughts of certain people in high positions within medical aid schemes view independent pharmacies as already – as onus already being susceptible to fraud and actually being sort of presented as the ones that are rightly to be fraudulent.

We have not seen any evidence or – of audits of the Corporate Pharmacies, we are not privy to that we believe – based if that can be unravelled and we are able to see what kind of audits are being done on that side of the corporates perhaps it can be able to alleviate to say the audits are being done fairly and across to everyone and the current juncture we believe that we are already prejudice by virtue of just being an independent because we are being seen to be vulnerable to financial constraints.

ADV TEMBEKA NGCUKATOBI: But that is the thing I wanted to just explore following from the – from what exactly you want to make about the statement that independent – I think as a matter of economic sense it must be true that independent pharmacies are going to struggle in our

economy.

But it is not – it does not follow that they will result to fraud, but in order for us to get where you are we need to get some data about the investigation patterns of schemes for instance as against Dischem or as against some of the larger pharmacies.

I will know nothing about that because what you have come to present is only skewed from the point of view of the independent pharmacies. But we do not have a comparator so where can we get the comparator from?

MR KGABO KOMAPE: It is a good question Chairperson because we as the independent pharmacies are not proving to any investigations that would happen to – in to corporates or other chains because if you send the Medical Aid Scheme and us, how many audits have you done at a corporate or at a chain pharmacies?

The answer is that you are not in a position to receive confidential information of the scheme which belongs between the scheme and those that they are dealing with in terms of provision of service. So you overextending your request – you are ...(indistinct) in terms of request to want to find out what could be the statistics on that side. I believe the Commission perhaps can unravel it a little bit deeper and assist to have to see how the audits are being conducted on the chains. I was still on the penalties that are being posed on pharmacies ...(intervenes).

ADV TEMBEKA NGCUKATOBI: Sorry I just want to come back to this thing so that I make sure that I understand it. So you could have

potentially three kinds of complaints. So the one complaint is that there is an uncomfortable close relationship between Discovery and Dischem, that is a distinct complaint. The other could be that in the industry there is a bias against independent pharmacies which favours what you call corporates – what I call chain pharmacies and the – that is – those two still do not give rise to racial profiling, there could be a third complaint that where independent pharmacies are the subject of investigation the bloods turn to get a higher proportion of focus.

But I do not know if that is the – one of the complaints that you are making because you have given us 1100 independent pharmacies, I do not know out of that how many are black and how many are white and whether from that pool it is easy to discern whether there are practices that are racially biased.

MR KGABO KOMAPE: If I may just sample from one of the previous slides, we are sitting at 68 – around 65% white owned and 35% black owned, but when we looked on the audits we realize that the 35% which is already a smaller number, it is the one that is being audited the most at 82% versus the 18% of the 65% which is the white owned pharmacies. I do not know if it clarifies.

ADV ADILA HASSIM: It goes to the further information that I was asking for as well, so just to make sure we are clear. The 1100 pharmacists, is that the WhatsApp Group Membership, on which the survey was conducted?

MR KGABO KOMAPE: Yes, yes that is all of them.

ADV ADILA HASSIM: And – okay.

MR KGABO KOMAPE: So our composition is 65-35, 65 being white, 35 being black. Our belief is that when you audit you should find that a larger number of the 65% is the one that is receiving audits, but instead we find that here it is the other way around. The 35% is receiving 82% of audits versus that one. So ...(indistinct) point of the pharmacies that are being subjected to extremely honorus audits with unreasonable time demands, the standard one is three years of paper work and claim history and purchase history and it is required within ten days by the audit in the forensic units of the schemes.

We believe that is unreasonable, further since ...(indistinct) eventually submit to the administrators just so that they can get their funds released and so that they can get on with their work and their lives. That is one of the examples that we give under Medicare, because of looking at the cumbersome work that needs to be done to disprove the allegation, they just gave in so that they can continue with their lives and continue trading because we do not have special people that are in the office waiting to do the – to collect information from manual invoices and collate it so that the scheme can be satisfied.

It is the same people that render services on a daily basis to the incoming customers that must also do that work. The audits put tremendous strain on pharmacists in guiding on their health and their well-being.

The audit process short comings:

Pharmacy audits by schemes and administrators are honorus and ...(indistinct) intensive procedures, forensic audit units demand three to

four year to prove purchases of a list of medicines that they have been claimed for within ten working days. Auditors list the names of medicines but they do not state what strains, pack size or NAPPI code that is required.

So we just have to collect each and everything that is having that particular name, irrespective of strains or pack size or the NAPPI code. An example is that a Ecotrin which is a blood thinning product, it exist in 50's as well as in 100's.

The number of strength and dosage forms is 1 and the number of lines, which means the invoices that are required for a Ecotrin will be 2 per that line item. If it is ...(indistinct) it will be 4 lines per that particular item because of 4 strains of the molecule. If it is Panamor you are looking at 22 lines which means all the Panamor strains you need them to go and dig up three years or to two years within ten days and submit that information, otherwise payments will immediately be withheld.

Reasonable request:

Is it a reasonable request? Pharmacies purchase stock via several channels, some from ...(indistinct) every day at least twice a day, pharmacy buying groups are also ...(indistinct) a way of buying and also borrowings, you will enter into pharmacy borrowings is also a phenomenon that is there is pharmacies, as well as they buy at several manufacturers directly.

A typical small to medium sized pharmacy will handle thousands of invoices each month. That is a very conservative estimate of about 2000 invoices per month, a pharmacy would have therefore amass 70 000

invoices in a three year period.

That is what – which will be required to be sifted through manually to bring out the invoices that are required for auditing purposes.

The key points of contention:

The racial profiling of pharmacies and the trading of black owned pharmacies and pharmacies operating in predominantly black locations, that is our ...(indistinct). Pharmacies payment withheld for several months whilst the audit is in progress purely on suspicion of alleged fraud or irregular claims.

For us it would have been normal to continue servicing until you reach a conclusive that indeed there is problem, but in the meantime there is no need to strain that pharmacy because pharmacies are not – they are small medium enterprises, that do not have big budgets to carry on in business even if they are not earning.

They have to earn so that they can sustain. A typical pharmacy if you sustained ...(indistinct) for more than three months they will inevitably – possibly close. Unreasonable and non-transparent auditing processes and practices aimed at frustrating independent pharmacies.

If you do not comply with those audit processes and you do not supply the necessary invoices as required you are going to be either blocked from practicing in terms of that particular scheme which means even if you try to make a claim off that particular scheme it will just not go through, so the practice will be blocked and if that was forming chunk of your customers for the sustains of that business, it simply means you can consider closing because the remainder of the business that remains

if it is cash patients or it is other schemes therefore it means you are no longer going to be able to break even.

So pharmacies are not deep pocketed that they can be able to sustain themselves even when they are undergoing these processes and not earning. That alone monies that might be required to engage lawyers where necessary, so pharmacies resort not to go to lawyers they just go and engage the scheme in their offices and they most usually sign up for things that are not correct simply that they can just come out of this thing and continue with their normal trajectory of earning from the schemes.

ADV TEMBEKA NGCUKATOBI: Yes what we would also need – so you gave us examples of pharmacies at the beginning where you said the outcomes were unfair one way or the other. So we would need those specific files of those out – pharmacies. Now what you have just said now is also important we – you are saying that someone is unfairly subjected to an investigation in order for them to make sure that they can continue their business they then sign up and they confirm that we will pay the scheme.

But from an evidential point of view it is pointless because we have nothing to work on other than what you have just said. We do not know which pharmacy, who decided when, how much, which scheme. Now do you have actual examples of pharmacists that have come to you to complain as your members that I was unfairly targeted, I signed an Acknowledgement of Liability but I should not have signed it because I was actually innocent?

MR KGABO KOMAPE: That is correct Chairperson, what we will do on

our side in terms – as the ICPA is indeed to – because we have tried to cause such information but because there is also a shame related with this matters, pharmacists and pharmacy owners do not necessarily want to come out and explain and actually put there that this is the Acknowledgement of Debt that I have signed because this is also one of the things that proves their reputations at stake.

So at times they even resort to keeping it away from those that would be able to help them like the ICPA, so we get a complaint, we acknowledge the complaint, when you go further and you ask are you willing, for example, to appear before a formal structure so that we can test this thing further so that we can prove to, example Commissions that this is what happened.

It is where you start to see a little bit of a pull back, I believe that is the work that us ICPA needs to go and find ways of collating that information and bringing in tangible to the Commission. But the truth of the matter is that it is not a simple straight forward, we will sign the AOD – give me AOD, there is a lot of factors that they consider.

Also they look at sale, is this AOD I release it to the ICPA and the ICPA that contesting the medical scheme with that AOD it simply means I can also immediately be closed up from the ...(indistinct) of trading again.

Because then I have now disclosed what was supposed to be a private deal between the scheme and the pharmacy owner, so there is reluctance to bring forth all these things so that we can be able to test them as the Chairperson is asking.

So that is the area that I said we need to do a little bit of more work so that we can get those things.

ADV ADILA HASSIM: So how do you – how can you make a statement that the pharmacies capitulate because they have no choice? You do not have evidence of that.

MR KGABO KOMAPE: When you are a pharmacy you are just a complain to the ICPA for example, we ...(indistinct) request the timeline of how things began, how things went, what, what, what, what, what and as you come through that evidence you – because these are the people that we work with.

Some of them are real colleagues that you know, so there is no benefit in trying to accuse for no particular reason. You will be aware for example as the director of the office holder of the ICPA that this person it is so and so.

There is no reason or doubt in my mind that you would just want to allege something that is not costing you business because sometimes as we meet and talk or engage you will note that this pharmacy is about to close and then you ask and then you find that some of the things is things that happened a long time ago but the pharmacist was not really forthcoming because of his stigmas and shame and all those kind of things.

So there is a tendency to hide certain things even when they are happening, I do not know if it is the fear to – from the schemes that they have or it is mainly the issue of shame where you are going to be looked at as a fraudulent provider or a fraudulent practitioner.

Because there is that touch also of saying – so actually there is a little bit of truth that you would actually do something that is wrong and that impugns on the dignity and the status of that particular pharmacy owner.

So you – so it is an area that we try to tread carefully in sourcing that information.

ADV TEMBEKA NGCUKATOBI: Yes no that is fine, I – we understand that you say that they will not be willing to come publicly because there is stigma and also there is the likely retaliation by schemed. We have got a secretariat, they can supply their information to the secretariat.

So the problem that is being put to you is really the following, if you are a pharmacy and you sign an Acknowledgement of Debt. There are likely to be two reasons why you are signing it. The first one is that I just want to get the scheme off my back because I want to carry on with my business and I am not interested in whether I am guilty or not, I just want to get them off my back.

The other could be that you are in fact acknowledging that you are guilty and that you are simply trying to find a practical way of repaying the money. Now the schemes also have rights in this Commission, are being accused, we will have to put to them that one of the accusations against you is that you are extracting money from independent pharmacies who have no recourse against you, but they will say where is the evidence and we cannot say that Mr Kumape told us through hearsay and that is the only point we asking for this material.

If the only problem is that they do not want to bring it publicly

that is fine we will take it privately and we will engage with the schemes in relation to that so we can get their version on it.

MR KGABO KOMAPE: Indeed Chairperson.

ADV TEMBEKA NGCUKATOBI: But if it does not exist then there is no point in making the allegation in a public platform like this.

MR KGABO KOMAPE: I am in agreement. I was still on that point of the fraud auditing processes and findings that allude to poorly trained forensic agents who have poor understanding of retail pharmacy and business in general, the other complaint is that the auditing people are. and the complaint is that the auditing people are not really clued up with many things.

Some of the pharmacy owners will have to repeat or sort of explain by almost training that particular person that no, no – yes, this is the generic of that and this is this and that and this means the same thing. So there is some educative part that the pharmacy owner must also deliver to ensure that the discrepancies that are being pulled must not disfavour them.

So we believe that the auditors are not really up to standard. We would be interested to see what qualifications they hold.

The bullying and the intimidation by forensic agents, the truth is that in practice the schemes, when they come for auditing, it is not a friendly conversation where we are just trying to find out what happened and establish the facts from what looks like irregularities.

The truth is that it comes with a high-handedness where you indeed, as a practitioner, believe that it means you are already guilty of

whatever that has become an allegation against you. I would not go too much into this section, it is 35(3)(h) of the Bill of Rights which guarantees rights and so on but I will just read through it, Chairperson, for the sake of the slide.

> "Section 35(3)(h) of the Bill of Rights guarantees for everyone the right to a fair trial which includes the right to be presumed innocent at that trial."

Schemes and administrators play judge and jury with pharmacies by finding them guilty and bullying them into submission. This is common practice, Chairperson, where you are being called into an office, you are shown an error which you either you accept and you understand where the error occurred.

Let us say there is an error that cost the scheme R20 out of R100 claim, what you would expect is that because I have got an error of R20 and I have genuinely seen it and I acknowledge it, can I be given an opportunity to correct that R20 error?

It is where the forensic agents will tell you that it does not work that way. R20 of a R100 is 20% which therefore gets extrapolated to say if R20 of R100 you have collected it unfairly or illegally or irregularly or wrongly, therefore, when we look at three years or since the inception of your claiming into our scheme, we are reasonable and to believe that 20% of all your claims are therefore payable back to us. That is not a negotiation, it is a statement that will be put to a pharmacy owner.

If you want to continue dealing with us that we continue trading and we do not close off your practice number from practicing, from

helping our clients, therefore we agree that 20% we extrapolated back, we calculate. If it reaches a million, that is what you owe. We would then talk about how you pay it but we need to agree that 20% of all your claims are therefore irregular.

We believe that it incorrect and it unfair. We believe the right way of doing it will be to bring each and every of those particular claims and their details that the pharmacies can acknowledge and see that indeed here they have claimed for a bigger bottle but unfortunately it is a small bottle that a client actually got.

Those are some of the errors that can occur where a 200 ml claim, patient received a 100 ml claim. The patient can query it or the scheme can query it but it is something that can actually usually be corrected within the pharmacy before even the client leaves.

But because this one it does not happen from the client, that is a genuine client, it is an entrapment client. There is an entrapment agent who goes around and actually entices a pharmacy personnel – he will not go to the owner of the responsible pharmacist, he will go to the real(?) guys in terms of seniority in the pharmacy and ask for something that he knows very well that it should not be done like that.

So those ones, if they fall into those things and they actually help that person, they collect those goods, go to the scheme and then submit that this was claimed and this was actually given because I asked. Then when you investigate deeper you would then fine out that the pharmacy, lower personnel was actually enticed into engaging into something like that so that there can be evidence that will be provided to

the pharmacy owner when he gets called to the offices of the schemes.

Our belief is that if there is an error like that there several ways of correction before we can even talk about extrapolation of costs going backwards. We believe that it could be a genuine error unless if you say to me I have corrected you, 1, 2, 3, 4, you came back 5, 6, 7, 8. Not the first.

We believe that there should be an opportunity for somebody to look and say my staff is actually engaging in certain things that might put the business into risk and start finding ways of actually putting more SOP's or more layers to block those kind of things but in this scenario you will not have that opportunity to correct anything because just that one incident you are in and therefore you have to sign AOD or you will be excluded from the scheme's transactions.

ADV TEMBEKA NGCUKATOBI: On the ...(indistinct) issue, I mean my – you see, my understanding was that it is not as if they will take one claim and say there you have overcharged by whatever amount. What they will do is that they will do a sample of claims and then based on that sample they will do the average and going backwards but your evidence now is that they will take one claim and then average based on that one claim. I mean, that is not how I understood the practice to be.

MR KGAGO TSHEPO KOMAPE: That is correct, Chairperson, here I am talking in instances indeed where it is one claim. One claim that had an error constitutes extrapolation backwards. This one is not the sampling method where they have sampled and they have collected that, they have got reasonable belief that because here and there in different days of

different times you have committed the same thing therefore it looks like a norm rather than a mistake where here we are talking about where it is a single error that you are admitting to but that is now going to cost you a backward payment through an AOD.

We further submit that the audit add additional cost to pharmacies which many can ill-afford. The additional costs that are incurred, include additional staff, time, travel, logistics and diluted staff levels in the pharmacy to try and continue to provide services to their clients. Invitation to the forensic unit to visit the pharmacy and conduct an on-site audit is being declined by auditors. You are requested to appear at their offices.

Convicted cases:

ICBO calls on the investigative panel to determine how many pharmacies that have been found guilty of fraudulent behaviour and how many of these have been followed up through the normal course of the law either through the NPA and successfully prosecuted through the courts.

The forensic units are legally compelled to report this fraud to the authorities but in our experience they prefer to bully small practitioners and extract money from them to justify their existence and then allow the alleged offender to continue to service their members but also paying the AOD.

Here I am trying to submit that the existence of those forensic units, sometimes some of them are outsourced. So when an outsourced company is doing a work like forensic, they have to really find evidence

because otherwise if you keep on coming and saying clean audit, clean audit, clean audit, you are not justifying you are existent in this chain of business.

So it puts them in a corner where they have to find something and it is in the quest to find something that the practitioners are just simply being bullied and harassed and we believe that that cannot be right. Thank you, Chairperson, and the panellists.

ADV TEMBEKA NGCUKATOBI: Thank you, I believe that there are no further questions from the panel. If that will be the end of the submission, we may – I believe you have given the secretariat your Powerpoint presentation?

MR KGAGO TSHEPO KOMAPE: I did so, Chair.

ADV TEMBEKA NGCUKATOBI: Yes, we will be writing to you for further information especially the underlying data of what you have been talking about. I think you have noted some of the questions we were asking.

MR KGAGO TSHEPO KOMAPE: Yes.

ADV TEMBEKA NGCUKATOBI: But we will follow them up with a formal request for information.

MR KGAGO TSHEPO KOMAPE: Thank you, Chairperson.

ADV TEMBEKA NGCUKATOBI: If you could look into that in due course. It remains then of me to thank you on behalf of the ICPA for your attendance and presentation.

We will adjourn for the day and continue tomorrow at 10:00 with EKA, Elsabe Klincke and Associates and HealthMan at 13:00 and South African Medical and Dental Practitioners at 15:00.

The hearing is adjourned.

INQUIRY ADJOURNS TO 21 AUGUST 2019

THE COUNCIL FOR MEDICAL SCHEMES [CMS]

INQUIRY UNDER SECTION 59 OF THE MEDICAL SCHEMES ACT

HELD AT

JOHANNESBURG

	DATE HELD	: 2019-08-20
	DAY:	: 6
10	TRANSCRIBERS	: D BONTH; V FAASEN; B DODD; Y KLIEM

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