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

23 AUGUST 2019

DAY 8

PROCEEDINGS HELD ON 23 AUGUST 2019

ADV TEMBEKA NGCUKAITOBI: Thank you, good morning, can we get started? We have the South African Optometric Association this morning. Maybe we should just start with the introductions, I see there are four gentlemen?

MR DOLLARS BOLOKA: Thank you Chairperson, good morning, my name is Dollars Boloka, I am the president of the SAOA.

ADV TEMBEKA NGCUKAITOBI: Just give me your surname again?

MR DOLLARS BOLOKA: Boloka, the national anthem. B-o-l-o-k-a.

ADV TEMBEKA NGCUKAITOBI: Alright, thank you. Will you be making the presentation?

MR DOLLARS BOLOKA: Yes.

ADV TEMBEKA NGCUKAITOBI: And the other gentlemen?

MR DOLLARS BOLOKA: With the two gentlemen.

MR DOLLARS BOLOKA: Yes.

ADV TEMBEKA NGCUKAITOBI: Alright. Can they introduce themselves please?

MR AUDIENCE MALULEKE: Thank you, good morning Chairperson, my name is Audience Maluleke, I am the immediate past president of the South African Optometric Association and the Chairperson of the Private Practice portfolio for the organisation.

MR HARRY ROSEN: Good morning Chair, panel, my name is Harry Rosen, I am what is referred to as the consulting Chief Executive Officer for the South African Optometric Association.

ADV TEMBEKA NGCUKAITOBI: Alright, so one person will be making the presentation?

MR HARRY ROSEN: No, it is all three of us.

ADV TEMBEKA NGCUKAITOBI: Alright, so can I take your oath then? Shall I start with you and then we will move that way? Will you take the oath or the affirmation?

MR HARRY ROSEN: Yes I will.

ADV TEMBEKA NGCUKAITOBI: Alright, so we will go for the oath then. Will you say after me, I, and your name.

MR HARRY ROSEN: I, Harry Rosen.

ADV TEMBEKA NGCUKAITOBI: Swear that the evidence I shall give.

MR HARRY ROSEN: Swear that the evidence I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

MR HARRY ROSEN: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

MR HARRY ROSEN: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing but the truth.

MR HARRY ROSEN: And nothing but the truth.

ADV TEMBEKA NGCUKAITOBI: Please raise your right hand and say so help me God.

MR HARRY ROSEN: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. Mr Boloka, will you also take the oath?

MR DOLLARS BOLOKA: Yes.

ADV TEMBEKA NGCUKAITOBI: Say after me I, and your name.

MR DOLLARS BOLOKA: I, Dollars Boloka.

ADV TEMBEKA NGCUKAITOBI: Swear that the evidence I shall give.

MR DOLLARS BOLOKA: Swear that the evidence I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

MR DOLLARS BOLOKA: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

MR DOLLARS BOLOKA: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing but the truth.

MR DOLLARS BOLOKA: And nothing but the truth.

ADV TEMBEKA NGCUKAITOBI: So raise your right hand and say so help me God.

MR DOLLARS BOLOKA: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you, and will you also say after me I, and your name.

MR AUDIENCE MALULEKE: I, Audience Maluleke.

ADV TEMBEKA NGCUKAITOBI: Swear that the evidence I shall give.

MR AUDIENCE MALULEKE: Swear that the evidence I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

MR AUDIENCE MALULEKE: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

MR AUDIENCE MALULEKE: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing but the truth.

MR AUDIENCE MALULEKE: And nothing but the truth.

ADV TEMBEKA NGCUKAITOBI: So raise your right hand and say so help me God.

MR AUDIENCE MALULEKE: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you, so gentlemen you may decide how you are going to structure your presentation and you may decide who will go fist.

MR DOLLARS BOLOKA: Thank you very much Chairperson, I am going to start with the broad over view of who we are, and present the salient point of our issues, and our consulting CEO, Mr Rosen will address some bit of legislative frameworks that deals with our issues. And Audience Maluleke is the Private Practice Chairperson who will be giving some bit of examples in terms of the issues that we will be talking about. Firstly the SAOA would like to thank the opportunity provided and we are appreciative of that. We view this process as quite very important and given the unfoldings of the year, as our presentation will come to show later on we feel that it has come at quite an opportune time for us. In our presentation you have got just a quick presentation about ourselves and that we are part of the eye-care team that is responsible and deals with the issue of eyesight. We are quite impressed that all the esteemed advocates are having their spectacles on and it shows that you do care about your eyesight, as we say they are the most delightful of our senses that we have. The background of the SAOA is that we are responsible for the profession of optometry and dispensing optitionary, we were found back then in 1924, we are a NPC, a non-profit company and we have both membership in private and public sector, but in the main, a lot of our footprint is in the private sector. There is about 2600, plus-minus practicing optometrists, and of that we have got about 1600 in our books,

both either of good standing and others not quite. We are proud to say Chairperson that optometry in South Africa is ranked among the finest in the world by the World Counsel of Optometry. This is just to show some area of what an optometric cada is, it is an autonomous profession that one has to go through education to achieve and it confines itself within the regulations as per the Health Professions Act. A definition of an optometrist shortly and sweetly is that he is a primary health care practitioner that deals with the eye and the visual system. That is just the definition of optometry as per the WCO, I will just skip past that. And in our country, the Republic optometrists in the main deal with the performance of our examinations, provision of spectacles, contact lenses, sunglasses, diagnostic procedures that assist in diagnosing certain eye diseases, and also address the therapeutic aspect of those particular diseases. As we have stated, Mr Chairperson and esteemed panel, that we have got both footprint in public and private sector, however quite deeply entrenched into the private sector, perhaps by design of the profession in the erstwhile, the past years. But as the SAOA we have quite a very strong position because we know that the fact that we are in private sector, always opens up the quite used words of FWA, the Fraud, Wastage and Abuse, and as an association we are quite very clear, unambiguous, unapologetic that we oppose fraud, wastage and abuse in any form, shape, type, size, we are extremely and exclusively against that. We oppose that, and our members, non-members, everyone in the profession knows that that is the position of the association, that anybody who does fraudulent wasteful or abusive tendencies, we will not support

them. So we just wanted to make that point very clear so that we, tomorrow, we are not being accused of trying to entrench FWA.

ADV TEMBEKA NGCUKAITOBI: Could you just tell me, I mean, it seems everyone accepts that fraud is rampant within the profession, what is the view of your association, I mean, is fraud rampant or, if you look at your own presentation, it starts off by accepting the problem that you know, fraud is a major problem. What is the actual evidence that fraud is perpetrated by practitioners?

MR DOLLARS BOLOKA: If we are to limit ourselves to optometry, we have got about 2.83 billion in terms of the entire health stake, in terms of claims and so forth. We would not say there is a lot of fraud happening in optometry. But as well, we will not say that there is no fraud happening at all, so we are saying that because we know that ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: What I am asking you is, if you look at your submission.

MR DOLLARS BOLOKA: Our submission yes.

ADV TEMBEKA NGCUKAITOBI: In the third page,

MR DOLLARS BOLOKA: Mm?

ADV TEMBEKA NGCUKAITOBI: Under the heading Fraud.

MR DOLLARS BOLOKA: Yes.

ADV TEMBEKA NGCUKAITOBI: You see, you start off by saying that it is acknowledged that incidents of fraud cross all healthcare disciplines has reached unacceptable proportions, so you yourselves accept that fraud has become unacceptable, or, my phrase was rampant. Are you

saying no, sorry, it is actually not? What is the basis for this in your profession?

MR DOLLARS BOLOKA: The basis of this statement is based on the quantification of fraud amount, that it is quite very high and we are saying in terms of the amount, the billions amount as per BHF, I think it is around 22 billion or so, that is the base of this statement to say if there is an estimation of 22 billion, in terms of fraud, wastage and abuse, in our view, that is quite unacceptable. So that is where the basis of the statement comes from as we extrapolate from the stats that have been shared in terms of fraud. So, but in particular, and insofar as optometry is concerned, we will not say that there is massive deeply entrenched fraud.

MR AUDIENCE MALULEKE: Alright, Chair, if I could add, to some extent, the whole FWA space it is so because of, at times, administrative errors in the form of coding, and I think given time, we may expand on what we mean with administrative errors and coding, that are so referred to as being fraudulent by, for an example, schemes and their forensic teams.

ADV TEMBEKA NGCUKAITOBI: That is what I was trying to understand, you see, because your presentation says fraud has reached unacceptable levels, I put to your representative, he says no, in the optometry we have no evidence, you are also saying actually, most of the time it is administrative errors that are then classified as fraud, that is what I was trying to understand, what is the basis for your claim that fraud has reached unacceptable levels. But I think you have answered it to say you

have got on independent information, you are relying on the general figure by BHF that says 22 billion rands every year that go into fraud.

MR DOLLARS BOLOKA: Thank you Chairperson. Insofar as the TOR's of this investigate panel, bordering as well around the issues of race, and as you have noticed with our submission, that as an association, we do not necessarily have a racial breakdown or trac of our members, and as submitted, our issue in terms of race has been that we accompany our members whenever they are given letters of this so-called meeting without prejudice by the schemes. So they would, some of them would contact us to say could you please accompany us and we go with them there, so that we want to make sure that their rights are fully reserved and protected. And in that particular view, and as in line with the TOR's of this particular investigative panel, we can confirm that in the past years and recent times, an overwhelming majority of those that come to us and we accompany, are actually blacks and Indians. We are not having established reasons why that particular trend is there, but we can confirm that those that we do accompany to schemes, they are in the main your blacks, and Indian and coloured practitioners.

ADV TEMBEKA NGCUKAITOBI: Just tell me again, I see this thing where you say in 2019 you accompanied eight practitioner to schemes who were subject to Section 59 investigations, and all of them were black? Can you see that in page 3, or the third page because these pages are not numbered?

MR HARRY ROSEN: Actually, if you look at the wording we said mostly, so you are quite right you said eight and you said mostly.

ADV TEMBEKA NGCUKAITOBI: That is what I am trying to understand. Because his presentation is that they were all black, your letter says that mostly, but I want to understand what the figures are and we need to know which schemes, which doctors, what the allegations were, what the investigation produced.

MR HARRY ROSEN: Okay, so if I understand your question correctly we accompanied eight optometrists who – which is often referred to as meetings without prejudice at medical schemes, one of which was a white practitioner. If you want me to elaborate on the type of cases I am happy to do so.

ADV TEMBEKA NGCUKAITOBI: Please.

MR HARRY ROSEN: Sure, okay. So I suppose it is really like a packet of liquorice all-sorts because there was no real commonality. The one case, to illustrate a point that we are wanting to make a little later on anyway, is that the practitioner had put the wrong dates for the, for claiming purposes. So what I mean by that is that she had seen patient, let us say on the 4th of August, I am using these dates just to illustrate a point, they are not actual dates. And she claimed maybe on the 6th of August, the claims indicated the consultation took place on the 6th of August. The medical scheme or the forensic unit of the scheme concerned, had regarded that as fraudulent. The scheme had not lost anything, the practitioner had not gained anything and the patient had benefitted as he or she would anyway.

ADV ADILA HASSIM: Which scheme is that Mr Rosen?

MR HARRY ROSEN: Medscheme, it is actually an administrator. Then there was a case of a practitioner who was visited by two probes, I think the term probe is well understood, I do not think I need to elaborate what is meant by probes, am I correct? So two probes visited this practitioner, they went under cover and had enticed the practitioner to, well when I say enticed, I think let me just change my terminology and say they had gone in with the intent of getting the practitioner to put through sunglasses as something else. The bottom line is that the particular practice had a promotion on at the time, a free pair of sunglasses with every new pair of spectacles, and in this particular case, one of the probes had said that she had a grandson who had visual impairment and they had an agreement that the probe would bring grandchild back to the practice. Under those circumstances the practitioner had allowed a free pair of sunglasses, unfortunately, the probe, when she had put forward her affidavit, had indicated that the practitioner actually had committed fraud. In our view, for what is worth, I mean, you are not actually asking for our opinion, you want facts, but I am just going to add that in now, it was probably a very unfair allegation under the circumstance. Do you want me to continue?

ADV TEMBEKA NGCUKAITOBI: Yes, it would be helpful if we understand what the nature of the allegations were and what scheme was involved.

MR HARRY ROSEN: Sure. So the last was Discovery Health, in both those cases the allegations were of a fraudulent nature. There was a …(intervenes).

ADV ADILA HASSIM: Sorry, it was Discovery that sent in the probes?

MR HARRY ROSEN: Yes. There were two probes. In fact, to be blunt if I may, for the purpose of this enquiry, any reference of probes is restricted to Discovery, we were not involved in any other, we were not involved with any other scheme or administrator that had made use of what is referred to as probes or undercover agents, for want of a better term.

ADV KELLY WILLIAMS: In relation to this case, can you just explain to us why you thought it was unfair, obviously Discovery will give their views on why they thought it was a fair allegation, why did you think it was unfair?

MR HARRY ROSEN: Well based on the evidences made available to us, including the record cards, you now, the practitioner had not bowed to the wishes of the probes. The probes had said they want sunglasses, the practitioner had said that they do not involve themselves with that kind of conduct, and that was made very clear to the probes. And what I mean by that, that they will not make available sunglasses to be put through as a professional service for claiming purposes. What did happen subsequently, is that the probes had agreed to undergo an eye exam, each of them. Which they did. Both of them were in need of spectacles, and in fact, what happened was that the probes actually walked out, he had tried to pursue them based on the story I had told you about the grandchild, but they had, they were of the view that their mission had been accomplished, that they had received sunglasses and that he was going to put through those sunglasses as a claim. The evidence is

available, in our view, for what it is worth, did not substantiate the allegation of fraud. What Discovery did do, despite the evidences made available to them, the discussion that took place, they cut off direct payment. We would like to, we obviously, as we go along during the course of this investigation, we are going to address some of these issues. Indirect payment is a form of punitive action you know, especially if a precedent had already been established, if a practitioner had enjoyed direct payment, until that point.

ADV ADILA HASSIM: Was this interaction videoed and recorded in any way?

MR HARRY ROSEN: No, it was not, but there are notes, there are notes of the meeting.

ADV ADILA HASSIM: Notes of which meeting?

MR HARRY ROSEN: Yes, the minutes taken of the proceedings and those are available.

ADV ADILA HASSIM: But was the incident regarding the probes, did the probes secretly record?

MR HARRY ROSEN: My apologies, yes. We were led to believe that it as, but we were also led to believe that it was of such a poor nature that it could not be used.

ADV ADILA HASSIM: Did the practitioner see the recording?

MR HARRY ROSEN: No.

ADV TEMBEKA NGCUKAITOBI: When you say we were led to believe, because that is very vague you see, what do you actually mean?

MR HARRY ROSEN: So, if I can be more specific, the evidence is put forward to Discovery and ourselves, clearly state – clearly demonstrated that the practitioner did not go out of his way, did not institute any form of fraudulent action at that point in time. I think the interaction between the probes and this particular practitioner had other dimensions to it, including an affidavit signed by one of the probes, which we felt was not true. Then some of the other cases had to do with frame mark-ups, it is also part of our presentation. All of a sudden out of the blue, one morning, it appears, somebody in Medscheme woke up and decided that a 65% mark-up in frames, you know, that really was the threshold beyond which practitioners cannot charges. So what happened there, to cut it short, is that Medscheme unilaterally decided, without any policy document, without any consultation and so forth, unilaterally decided that they were going do deduct the difference between the actual charge and the 65% mark-up from the claim, and this particular practice, I think it was R45 000,00 that was deducted from the claim. And *ja,* from our point of view, that is unacceptable. There have been subsequent, from Discovery point of view, they appeared to, they have fallen in line with a similar type approach, where they also had felt that their mark-ups are unacceptably high. In fairness to Discovery, I do not think they are quite sure what they regard as a reasonable mark-up or not, and to put it into perspective from a practical point of view, to have a percentage mark-up as a threshold, or not a guideline, as a criteria, is almost ridiculous because if you buy a pencil for one cent and you sell it for two cents, that is 100% mark-up. So there are many factors that are involved in the

costing of a frame. So there were two or three cases where practitioners were asked to attend these meeting without prejudice, the very sad part about this tale, and in most of those cases their claims were withheld, they were not paid, and it is another point we are going to make later on so, I know, I will take advantage to say from our point of view it is unacceptable, you know, to withhold payment is almost like a death sentence for some of these practitioners. They face financial ruin. In one of the cases the practitioner had gone overseas to purchase the frames in Dubai, as a matter of interest and the medical scheme Discovery, had asked for this meeting without prejudice, put all payments on hold and when, I was the one who accompanied him, when we got there Discovery made the allegation that he was charging 30 times the cost of the frame, which they found unacceptable. And it was pointed out in fact, to Discovery forensic unit that he was charged in Dollars, not in Rands, and they apologised. The bottom line is when we speak about unfairness and injustice, why would they simply, just having a look at a document, without looking at it thoroughly, which they are supposed to do, put his payments on hold. So those are some of the situations Chair, that we have been faced with over, this is with specific reference to 2019.

ADV TEMBEKA NGCUKAITOBI: Just explain something, I mean I know in your submission earlier you say well, we do not have racial statistics, but later on you say actually the doctors that were invited were mostly black, you have now given us the numbers, it is seven out of eight were black. So, do you have a sense of how it comes about that seven out of

the eight that have been investigated in the first, presumably, seven months of this year are black?

MR DOLLARS BOLOKA: Firstly to clarify on the question of us not having a racial breakdown, we are talking about the totality of our members. And that, which we speak with certainty, that out of the eight, seven were black. Because they came, we were accompanying them. As to what are the reasons, Mr Chairperson, we may not confidently be able to, ours is to respond, there are people who then decide that for whatever reason, if this, we are three of us, perhaps they might call the two of us, for whatever reason, we do not know. But we know that of the eight, seven were definitely black, Indian or coloured.

ADV KELLY WILLIAMS: And what are the numbers for you total practicing membership? How many black practitioners do you have and how many white practitioners do you have?

MR DOLLARS BOLOKA: That is the point that we are making that we do not have a racial breakdown in terms of our members, who is black, who is…(intervenes).

ADV KELLY WILLIAMS: Can you get it?

MR HARRY ROSEN: Yes, we can get it.

ADV KELLY WILLIAMS: And would you be able to get figures, both from this year 2019 going back to 2012? Both of your total membership as well as the investigations that you have accompanied?

MR HARRY ROSEN: We can try. Certainly the last two or three years we are confident that we can. Prior to that maybe a bit of a challenge, but we will pledge to try.

ADV TEMBEKA NGCUKAITOBI: So when you say the last two or three years, so 2016? 2015?

MR HARRY ROSEN: *Ja,* sorry, 2017, 2018, 2019.

ADV TEMBEKA NGCUKAITOBI: 2017, okay. And what will you give us, you will give us the numbers of all of your members who have been subjected to Section 59 investigations? You will break that down according to race.

MR HARRY ROSEN: Okay, alright, that is a very different question Chair. The question that was already asked by Advocate Williams was can we give a breakdown of our membership, so we responded accordingly.

ADV TEMBEKA NGCUKAITOBI: She wants both of them, she wants the breakdown of the membership and the breakdown of those subjected to Section 59 investigation.

MR HARRY ROSEN: So, I think we have responded to the first part of Section A of question 1. Section B of question 1, we will do our very best.

ADV KELLY WILLIAMS: Perhaps what we can do is we can send you a follow-up letter, and you can give it some thought.

MR HARRY ROSEN: Thank you.

ADV TEMBEKA NGCUKAITOBI: Alright, let us carry on, Mr Dollars.

MR DOLLARS BOLOKA: Thank you very much. So, *ja,* in short, and thank you for your questions, that in terms of the TOR's, in particular to the issue of racial profiling, that is what we can submit. And as per our return submission, we would however like to also enlighten the esteemed panel about the actual challenges the profession of optometry is facing,

and has been facing. And is, as we have said in the opening that we feel that this panel investigation could not have been better timed. And as you can see on the slide there, as part of the key issues we address ...(indistinct), under that we have got CMS, which coincidentally are hosting us today. And as a profession we have been consistent among ourselves and even externally that some of the major fundamental problems that the profession faces are actually housed in this particular building. We can go as far as our problems the sources of our problems could be solved in this particular building but for many years there has not been any forward movement towards even trying to solve those particular issues. We have got a slide break down in terms of how the structure in the optometry profession works, where you have an optometrist and then you will have Advocate Williams as a patient, and then she will have her own medical aid which can be administered by the administrator, or which can be administered by the so called managed care organisation. And either the manager care, the MCO, the administrator and the scheme, either of them can have some forensic company within that deals with issues of fraud and so forth, which, as a structure, we are not necessarily having big issues with. However, when we say our problems are housed at this particular building where we are today, some years ago, the accreditation committee of the CMS had decided that the managed care aspect of optometry, which is done by the so-called managed care organisation, no longer needed to be accredited, because in their view and I am sure they are far better informed that us, because they deal with those things, in their view they thought that the

managed care organisation that were involved in optometry, did not execute clear managed care protocols and therefore they took a decision that those guys no longer needs to be accredited. In doing that, as we will prove as the days go by, they then created a space in health sector, because, the principal of CMS is that anyone who works or who handles monies of members to pay services must be under the radar of the CMS. In this instance – by that decision, they made a process that the people who are in charge of paying optometry benefits, are not in the radar of CMS, that that decision justifies that. And...(intervenes).

ADV KELLY WILLIAMS: Sorry, who are these people who are in charge of paying optometry benefits that are not under the radar...(intervenes).

MR DOLLARS BOLOKA: I am coming to that, thanks. So, the MCO's as I have said, you have got optometrists, members, administrators and MCO's. MCO's we have got three big ones and other few small ones. The three big ones is PPN, Opticlear and Isoliso. I just want to make clear on the point that CMS then took addition that they no longer need to accredit these guys. For many years - I will start with PPN, which somehow it's always thought that the association has a problem with, that is actually not accurate because we view on it as the same regardless of what they do, there are differences in our view is the names. When CMS decided that optometry networks will not be no be accredited, you'll find instances where PPN for the past many years, we have said you've got about 2.6 or so practicing optometrists in the country. If, for every claim, PPN will take 150, every patient that we see it will be taken from your claim as what is referred to as a

settlement discount. If we are conservative, the profession is not as busy because there are more numbers in terms of practitioners but if we are very conservative, Mr Chairperson, to say that if every practice that was under PPN at that time would see 10 patients a month, which is a very, very conservative number. If you multiply everything, you are looking at an annual settlement discount to the value of just over R50 million that was taken from all optometrists annually and this happened for a very, very long time, many years. Could be eight ten years it's been very long. And then in 2018, December, PPN released a manual that said those 150s are now going to change to – they are going to be made in percentage which, when you quantify it, some of the discounts will go to SIS over R300, double of what was deducted. Furthermore, the manual spoke that optometrists were in the process of trying to fight this fraud, wastage and abuse and so forth and because, you see when – in our profession we see you, but then we must order your lenses, your frames and so forth so that they can then put into a proper spectacle device. In the manual they also advise that the optical lenses that we put on the frames should be ordered through certain labs. They went to your big established labs that have been there for a long time and they disregarded your small ...(indistinct) labs that are in the main black-owned. So when they did that, there was an uproar because there was also a payment arrangement that was made with these labs that the PPN, as an MCO, will pay on behalf of us as optometrists with the labs and settling with us whatever that is remaining. So optometrists stood up and said no, this is enough, we

are not going to stand for this and they resigned en masse. When they resigned en masse, they were what we could refer to as retaliatory tactics that were used. By the way before I move deeper into that. The 50 million settlement discounts as a conservative amount has been a surprise to us that we've – when we approached the CMS they were shocked that there were discounts because in their view capacitated contracts between schemes and networks is a financial arrangement of some sort to say that as a network I take the risks from you as a scheme, I will make sure that your optometry claims are within this limit. If optometrists claim more than that limit that you've agreed to the scheme, he knows there's a network, that's the nature of the business. If optometrists claim lesser, you win but they did not know that there were 150s that were taken as a side thing to an extent that even the actual schemes, we have visited Bestmed that was shocked when we told them that this is what is happening, Polmed was actually surprised as well and unfortunately – you know, I'm happy I saw their name at the register there. Bonitas, we wanted to put in the same thing and they kicked us out of their meeting to say that they are not involved, it is not their issue, it must be a matter between and optometrist and the networks and we had argued that you have appointed these people to take a risk off you, if we are not comfortable with them, who then do we complain at? But again, it comes back to say our problems are halved here because all these things we came back to complain here to say this is what happening and nothing has happened. So I will go back to the retaliatory tactics. Everybody – a

lot of people, almost 500 to 600 optometrists resigned from that particular network to say no, we are tired, it's enough. Then the network by virtue of resigning, they pull a clause from the contract to say for as long as you've not signed with them they are going to apply an indirect payment to you. So, in the main, if you are member with them until the 31 January, you resign on the 31 January, on the 1 February they have lost your banking details, you are no longer in their system. Dr Mabasa, he was saying he does not understand this interpretation of Section 59 that I'll go consult with Adv Ngcukaitobi and he will send an invoice to my insurance in his name but that invoice will be paid to me and schemes use Section 59 to say *ja,* we have a right to say that, we don't care whose invoice, whose name is on the invoice we can pay for the service. So they will then stop paying patients, stop paying providers and start paying patients because providers have all resigned. Now there were practical issues and problems that were then introduced into this particular system because firstly ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Sorry, can you just explain this I mean it is the first time I have heard from reading your submission that by removing your name from the network that can result in indirect payment. So where is this happening, what is the evidence?

MR DOLLARS BOLOKA: That's why, Mr Chairperson, we are saying our problems are rooted at this particular building. This dossier has been submitted in February to this particular building and it houses all the complaints. We just wanted to ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: No, sorry, we only share the building with CMS but ...(intervenes).

MR DOLLARS BOLOKA: *Ja,* no, no, no, definitely, we are aware, we are aware, we are aware. We are aware, we are aware.

ADV KELLY WILLIAMS: But, Mr Boloka, importantly, can you also explain to us how this falls within our terms of reference? That's also important.

MR DOLLARS BOLOKA: It may not necessarily confine itself directly to your terms of reference but we wanted to broadly show that what our – the issues because you would notice that as we say we have submitted this, we have knocked in many doors and even in our submission you can see that as much as we try to confine ourselves and I think even with other previous presenters, found pains to explain other things that were not directly in line with the terms and references of the panel. However, it is still the challenges that – day-to-day to challenges that practitioners faces out there and somewhere somehow there is always that bit of hope that people are looking to say who can we cry at because those that we have, have not shown anything. So we are joining that particular bus to say there's cries out there. So when they place you on indirect payment in the panel, they will then pay ...(intervenes).

ADV KELLY WILLIAMS: Sorry, Mr Boloka, you have also made allegations against the Council for Medical Schemes saying the problem is housed there.

MR DOLLARS BOLOKA: Yes, yes.

ADV KELLY WILLIAMS: But you haven't told us yet what is – I don't understand yet exactly what you mean by that, what the problems are.

MR DOLLARS BOLOKA: Alright, okay, I'm coming there.

ADV KELLY WILLIAMS: Why is this seen as the stumbling block for you?

MR DOLLARS BOLOKA: Alright.

ADV KELLY WILLIAMS: And also, there's some lack of clarity around PPN, ICLS and others what your concern is, whether they are accredited or not accredited or what your concern is because at one point you said there were networks which were not accredited, managed care organisations and then you indicated that they were. So I am also not following you.

MR DOLLARS BOLOKA: Alright. There will be interchange of the word managed care and network. For us it's the same thing in terms of how they define themselves.

ADV KELLY WILLIAMS: For us it's not.

MR DOLLARS BOLOKA: Okay.

ADV KELLY WILLIAMS: Because the regulations defines what managed healthcare is and who is required to be accredited. So you do need to be precise around this so we understand you.

MR DOLLARS BOLOKA: Okay. Previously, the managed care, as much as the regulation is clear what is a managed care, the regulation also says that the managed care must be accredited by CMS for it to be a managed care. So in terms of optometry, those accreditation would – they said there was no longer a need. I think that will also speak to

your question. The said there is no longer a need to accredit them and therefore, because there was no longer a need to accredit them, it then becomes very difficult to keep referring them to a managed care if they do not ...(intervenes).

ADV KELLY WILLIAMS: So there's no longer a need to accredit whom?

MR DOLLARS BOLOKA: The managed care, the managed care players within optometry, the PPN, the ICLS, the Opticare and the small others. So because they were not accredited, these problems that we are saying emanates from – because within accreditation it means there is no longer proper Regulation, there is no longer – yes, is that – alright. So to – because I just wanted to point on each of the networking.

ADV KELLY WILLIAMS: So your submission is they performing a managed healthcare function.

MR DOLLARS BOLOKA: Yes.

ADV KELLY WILLIAMS: And they should be accredited.

MR DOLLARS BOLOKA: Yes.

ADV KELLY WILLIAMS: Thank you.

MR DOLLARS BOLOKA: Yes, definitely, very clearly. Now when PPN pays your patient, the esteemed panel seems to be a little older, I've got a young man next to me. He could have joined a medical aid 30, 40 years ago. When he joined the scheme there's an account number that he will write to say when they want to reimburse him they can use that account number. In 2019 after en masse resignations, the young men no longer use that account, maybe it's 20, 30 years he's not been using

it. The scheme – the so-called managed care would pay into his account, that no longer works, so you would find that that normal 30 days period of payment and settlement of claims in practical no longer exists because money is left, the managed care, into his account and back into the managed care and the optometrists have not been paid, the patient has not been paid. So – and all of these things is because there is no proper oversight and you go to the other network, Isoleso, they have something called differential payment that they use which says if you belong to them you become their shareholder, you are entitled to higher fees which we are told it is allowable. However, we've been raising these issues with CMS to say somebody who has got experience, somebody who specialises in certain line in optometry can be paid lesser by a student who graduates today and opens a practice tomorrow because that student belongs to that particular network, is a shareholder of that particular network. And then you further have Opticare, all these things happened because there's no oversight. There is a definition of lenses in optometry, others are more specialised and more specialised means the person is in need more than your normal average other patient. Desktop designed software are meant to trace the norms. So those specialised cases where in terms of numbers is fewer people. Whenever claims are submitted you will be requested to motivate because it does not happen a lot but that is the person who needs assistance more than all these others that happens a lot comparatively and again, because there's no oversight, this thing has been allowed to happen for many years that the people who are in

the most needing are the ones that have to wait far longer. Furthermore, you have – I think Harry spoke about it, administrators. They can come and tell you after six months revoke Section 59 and tell that this was not supposed to be paid to you, we want you to pay us back and there's nothing you could do and these other ones are now regulated. But again, Advocate, are seeing – when we say we've got problems the same as 2017 – June 2017, we lodge a complaint here with CMS about the conduct of Medscheme where they just woke and said *ja,* today 60% free mark-up is sharp sharp anyone over, we'll deal with them, up until today.

ADV KELLY WILLIAMS: Can I perhaps pause you on that? Both yourself and Mr Rosen have given evidence on this question of the 65% mark-up of frames.

MR DOLLARS BOLOKA: Yes, yes.

ADV KELLY WILLIAMS: Could you just start by explaining to us basically how the optometry business works because certainly in my mind, I understand that you charge for services and there would be codes associated with optometry services.

MR DOLLARS BOLOKA: Yes.

ADV KELLY WILLIAMS: And of course there's the – you want to call them materials or consumables, whatever they are, the frames, and that would be a form of pass-through cost but there's a mark-up.

MR DOLLARS BOLOKA: Yes.

ADV KELLY WILLIAMS: Can you just explain how you bill for those two things and how you determine the prices for those two things in

order to be reimbursed? I think that's a good starting point.

MR AUDIENCE MALULEKE: Thank you. As you put it, for – we have services and materials that we bill for, so we have a comprehensive set of codes that we designed, that are used to bill for the procedures that we actually perform and those – a tariff will be set by an independent – a tariff guideline is set by independent person but we may not have a relationship with due to the ruling of competition that we shall not engage in that activity of setting out tariffs. That's the first. The second would be on materials, lenses, low vision devices, prosthetics, contact lenses and so forth. The same process takes place where these tariffs are set outside of our control and are circulated with schemes. You will appreciate that schemes also have their own set of requirements and they would, to a large degree, make out their own tariffs. With regard to frames, of course there would be limits to what is payable and what's not payable from that perspective. When a practitioner procures a frame from a supplier or wherever they get it, they will then put up an exit price looking into a number of variables that I think Harry spoke to, a little bit about that, then the price is set. So a combination of the three then makes up a bill. If then the patient requires of optical device to be made available.

ADV KELLY WILLIAMS: So what regulates the cost of frames?

MR AUDIENCE MALULEKE: No one regulates the costs of frames because the optometric association, as it is at this point, is prohibited from setting a guideline.

ADV KELLY WILLIAMS: So is it fair to say that the schemes through

their benefit options determine what proportion of a frame is paid for?

MR AUDIENCE MALULEKE: They would recommend what they are willing to pay as a limit – as a ceiling but what we have a problem with is the fact that the schemes would therefore say this frame procured at x amount you're only allowed to put so much percentage mark-up to come to an exit price that we are comfortable with as a third party funder.

ADV KELLY WILLIAMS: So what I'm trying to understand is if the benefit options are the way to regulate – or not regulate but are the way to manage costs associated with frames in this business from a schemes perspective, how is becoming a Section 59 issue?

MR AUDIENCE MALULEKE: Correct, it becomes that because thereafter – after you have built you are then called back to say in terms of Section 59 we are claiming back.

ADV KELLY WILLIAMS: So you are saying despite the benefit option, making the benefit available at the rate at which the claim was submitted there's a subsequent claw back?

MR AUDIENCE MALULEKE: Correct.

ADV TEMBEKA NGCUKAITOBI: And if you can go to your own submission, I think that's where you deal with it. I can't tell you the page because you didn't number your submission but under the heading of Frame Mark-up Determination by Schemes and Administrators and then the following page you summarise them in five bullet points and the last one is the Section 59 concern which is the deductions, is that correct? Is that correct?

MR AUDIENCE MALULEKE: Correct.

ADV TEMBEKA NGCUKAITOBI: Do you want to expend, Mr Rosen?

MR HARRY ROSEN: Yes, I do. Thank you. I think Advocate Williams have ask a pretty direct question towards the latter part of the discussion saying that there was a subsequent claw back. You see, as Audience Maluleke particularly put forward that there was a benefit structure in place which basically restricted the level of the price. So whether it was R1 000, R600, whatever it was, nobody has an argument with that because that's what the schemes do and that's accepted, the principle's accepted. The problem that we've highlighted actually is multi-factorial, the first of them is the fact that the medical schemes administrators concerned, unilaterally took a decision without any notice prior to the intervention, there was no policy discussion, there was no adoption or endorsement in terms of benefits designed by the CMS and I was a little bit sarcastic without apology a little bit earlier on, that somebody someday decided all of a sudden that 60% or 65% is the mark-up. None of the practitioners were aware of it and that on its own is very unfair practice to such a degree that some practitioners have been compromised significantly by having a claw back or putting payments on hold. Most importantly was the actual – one of the examples that I gave you where they deducted R45 000 from the one practice. So it's not just simply the principle because I take your point, Advocate Williams, you're speaking about a benefit design in some regulation from the medicals, we understand that. So it's not just the principle of the mark-up it was the way that it was implemented and

they way that it was – the intervention that was instituted without any prior warning, without any policy document, without any consultation. Practices had to ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Where there's a dispute about the mark-up at that point the scheme would suspend payment until that's resolved and then sometimes they would deduct.

MR HARRY ROSEN: With due respect, Chair, mark-up has never been an issue that's been raised in any negotiations, certainly as – he said I'm a young man, in my time, I've never ever known any negotiation has anything to do with mark-up at any time. So this was a new intervention that was suddenly introduced without warning. So all the – in the old days, prior to – as Audience Maluleke had suggested or had stated, you know, the competition laws have a major impact on the pricing just generally speaking. So prior to that, mark-up has never been negotiated, it's the actual price, so mark-up has never – *ja.*

ADV TEMBEKA NGCUKAITOBI: No, I understand. No, what I'm trying to understand is the – my colleague, Ms Williams, asks the question around how does this become a Section 59 issue? I understand at the end in relation to claw blacks it is a Section 59 issue.

MR HARRY ROSEN: Yes, sir.

ADV TEMBEKA NGCUKAITOBI: But I'm asking whether or not during the process whether is a dispute between the practitioner and the scheme about the mark-up what is the conduct of the scheme? Do they put a person on indirect payment or not?

MR AUDIENCE MALULEKE: *Ja,* you are put on hold. You are put on

hold, you are – *ja.*

ADV KELLY WILLIAMS: So just to be clear on this, so if you have marked up a pair of frames greater than 65% you put on hold?

MR HARRY ROSEN: That's what happens and that was a complaint that was lodged in July 2017. There has been an acknowledgement to say thank you so much for your complaint and that was the only form of communication that's taken place and hence Mr Boloka's comments – Advocate Hassim, regarding the building. I understand the relationship.

MR AUDIENCE MALULEKE: We do have to register that we always make follow-ups with regard to the complaints that we actually sent to CMS hence the expression that we think that our problems are not far from where we are.

ADV TEMBEKA NGCUKAITOBI: Alright, do you want to proceed with your presentation, Mr Boloka?

MR DOLLARS BOLOKA: Yes, yes, I just had I think two, three more lines to go. I think in a way as well it answers the question, Advocate, you just asked, Mr Chairperson. Whenever a practitioner written a letter as an indication whether an audit or this meeting without prejudice, if that's what it is, you are automatically presumed guilty until you prove yourself otherwise and indirect payment – or at other times withholding of claims that you've already serviced patients for and people have collected their spectacles and so forth and they've left. Others, maybe they fled the country and so forth, you will not be paid until you prove that you're innocent. So the principle – the legal

principle of the Republic of – you're innocent until proven otherwise is practiced in reverse when people are audited and so forth. I think on the last item on my presentation, it's an issue that – as well went to the networks that I see I just omitted. When – back to the PPN network, when everybody resigned. You would come to consult in my rooms at the time that I confirm a benefit, an SMS will come, I think it was the President of the HPCSA who spoke about the issue, an SMS will come to a patient to say that oh, by the way, were you about to consult you must know that person is an in-out, is an out of network provider, you can go elsewhere, here's a list and you'll be paid – your benefits have got 50% or 43% or whatever greater percentage on the other side and you'd be lucky for a patient to stick around if he's a new patient. And those that have been with you will still pose questions in terms of this, for the past 10, 15 years has never happened, why is it happening now? But again, the complication becomes that the risk for me as an out of network is that a patient can walk out but as well, the risk for him, as an in-network is that he's name is on the list of those that are in the network and in terms of the HPA and the ethical rules canvassing and touting is prohibited so he's canvassed for and touted for without even giving a head that do that against my colleagues. So we are compromised everywhere and hence we say, as I close and hand over to – that a lot of these things, as much as some may not fall directly into the Section 59, is frustrations that for many years practitioners have been going through. So thank you, and Harry will go on with other legislative issues.

MR HARRY ROSEN: Thank you, Chair.

ADV TEMBEKA NGCUKAITOBI: Please proceed.

MR HARRY ROSEN: Yes. *Ja,* thank you, Chair. We felt it was really important, you know, to highlight a number of principles to illustrate the environment and the context in which allegations and our concerns have been raised. The first point that we felt was of great significance is the relationship between the practitioner, the medical schemes, the networks, the administrators and so forth, and as you can see on my screen we've just simply termed it power asymmetry. There's just simply no contest and I'll give you an example. If an optometrist has a practice which is predominately has Bonitas patients and Bonitas entered into a contract with a particular network, the optometry concerned has no choice but to enter into a contract with either in the network or the medical scheme concerned and there are two reasons for that. The first was the fear of losing patients and of course linked to that the fear of loss of income. I mean we had a phone call from an optometrist who had been in practice for many years who was situated in a city surrounded by banking institutions. 90% of her practice were Bankmed patients, there were employees of the banks and therefore they were Bankmed patients. Bankmed had entered into a contract with one of the – as Dollar said, referred to as a network or a managed care organisation and she was faced with a dilemma. If she entered into a contract with this particular network she couldn't sustain her practice and if she didn't, she had the risk of losing patients. So it's all very well, as we'll come to it a little bit later on, for the medical scheme to

suggest or even indicate that when practitioners into contracts, they say that these practitioners are adult people who had entered knowingly into signing certain of these contracts. The point we wanted to make to you is that it's not as simple as that, they are really – the practitioners are forced into a situation where they have no choice purely to survive. So that's the first principle we wanted to draw to your attention. The second point is that, you know, you refer to Section 59. The problem that we have is that medical schemes and their forensic units wear a number of hats, all at the same time. They assume the role of police officer, prosecutor and judge and I think in any reasonable society anywhere in the world, that it cannot be an acceptable principle. So the practitioners go to these meetings without prejudice based on the request from the medical schemes and they are listened to and judgments are taken and they have to then adapt accordingly. Many of those practitioners – and to be a bit repetitive, we've accompanied many, signed acknowledgements of debt because they can't see a way out of it and just to put that in perspective, in many cases the payments are being withheld, all these indirect payments. So many practitioners can't survive because of that type of intervention which is punitive. If they don't sign an acknowledgement of debt they've then got to wait for the case to be heard by the HPCSA, as an example, or for other sort of protocols to be considered. They've got families to feed. So the principle of what we're trying to raise here, the asymmetry of power and the fact that the medical schemes and their forensic counterparts, some of them are part of the organisation

some are outsourced, assume those roles and we'd like to really raise that and draw that to your attention because we believe it's pivotal to the allegations and the concerns that we raise. I think Mr Boloka has covered a lot of ground regarding medical schemes. I'm going to go through these next few slides quite quickly. We've addressed the issue of the managed care organisations. I'll just pause here and again with your permission Chair, if that's okay. There's simply one way to make the point, if you have a look, and who am I asking you to look at a slide that you know well the role of the medical schemes so no disrespect intended. The reason why we've got that slide on the screen as it is is that the role of the medical scheme appears to be quite well defined within the Medical Schemes Act. And in our view some of these medical schemes and their forensic units go way outside those boundaries because in simple terms, there is a relationship and Mr Boloka had referred to it in a much more – well what's happening now is a little bit more complicated than it should be. You have the patient, the practitioner and the medical scheme and the medical scheme really should just honour the obligations of the patient for services received. So in our view they've gone way beyond that in times. The Council for Medical Schemes has come up and I know Advocate Hassim has raised the issue and asked the question about the role of the CMS from our point of view and our concerns. I can tell you and we can supply the information to you. We have ourselves as an association lodged- 1, 2, 3, 4, 5 complaints since 2017, none of them have been accommodated. There have been patients who've been – there's one in particular who

in 2016 already had been audited by GEMS. I think the total amount, I'll stand for correction, was R750. Payment was put on hold, she was suspended actually from the network and she's never ever been told why. So ... (intervenes).

ADV TEMBEKA NGCUKAITOBI: We need to get some detail about this because the imputation that since 2016 you've been raising complaints to CMS and none of them were attended to.

MR HARRY ROSEN: Yes.

ADV TEMBEKA NGCUKAITOBI: That appears to be unfair to CMS unless you give us some detail to work with.

MR HARRY ROSEN: Yes Chair.

ADV TEMBEKA NGCUKAITOBI: What exactly are you – I mean what did you complain when? I mean 2016 is a long time ... (intervenes).

MR HARRY ROSEN: Alright *ja*. No, it is.

ADV TEMBEKA NGCUKAITOBI: For CMS to do nothing about the complaints.

MR HARRY ROSEN: So in 2016, ja I think just in terms of being fair to the practitioners concern, we happy to furnish you with names. I wouldn't like to do it in a public platform like this but the one in 2016 had to do with a practitioner that I referred to who was investigated and Momentum was involved, it was GEMS patients. I think the total amount was R750. They've suspended her from the network and she's never ever been given the reasons why. So complaints were lodged, we supported her. I personally met with the legal department in this very building downstairs. We were given a reference number which

we'll furnish to you with pleasure – well maybe I should delete with pleasure. We will furnish you, *ja*. Mr Boloka also referred to a complaint that we lodged against GEMS by June 2017 we got in coding, that's never been addressed. In this very year 2019, we lodged two complaints in May. One against Bonitas and the other against BestMed, we've never even received an acknowledgement of receipt. So Chair, I think that just indicates some of the frustrations that we're sharing with you on this platform today.

ADV TEMBEKA NGCUKAITOBI: Just tell me – I mean so if just to talk about the 2016 complaint.

MR HARRY ROSEN: Yes.

ADV TEMBEKA NGCUKAITOBI: So you've got a member who is investigated for what appears to be a paltry sum of R750.

MR HARRY ROSEN: Yes.

ADV TEMBEKA NGCUKAITOBI: He's then suspended from the network.

MR HARRY ROSEN: Yes.

ADV TEMBEKA NGCUKAITOBI: A complaint is lodged by the CMS.

MR HARRY ROSEN: To the CMS.

ADV TEMBEKA NGCUKAITOBI: Yes sorry, to the CMS by your association.

MR HARRY ROSEN: Yes.

ADV TEMBEKA NGCUKAITOBI: Up until now, nothing has happened?

MR HARRY ROSEN: Nothing.

ADV TEMBEKA NGCUKAITOBI: And all you got was an

acknowledgment of the complaint and a reference number.

MR HARRY ROSEN: Yes. We will make the information available to you.

ADV TEMBEKA NGCUKAITOBI: And have you followed up with the CMS? I mean to ask ... (intervenes).

MR HARRY ROSEN: Yes.

ADV TEMBEKA NGCUKAITOBI: Why are you not attending to this, its start of your job to do it?

MR HARRY ROSEN: Yes. So as Mr Boloka had indicated, we do follow up to the best of our ability on fairly regular basis. But if I may repeat, I personally came to the CMS met with a member of the legal department and had assured me that it would be alleviated to a certain degree. So that assurance lost in a few minutes. It did not happen.

ADV KELLY WILLIAMS: I do not understand how it can be that a dispute around R750 has resulted in ... (intervenes).

MR HARRY ROSEN: Advocate Williams to tell you the truth, we share your sentiments and hence we're raising it.

ADV TEMBEKA NGCUKAITOBI: I mean I suppose the point is is there something else that we are not being told in the story because it just sounds mind boggling to use a phrase?

MR HARRY ROSEN: I can only repeat Chair that your choice of terminology is shared by ourselves and if I may repeat, that's why we thought it was important to bring it to your attention. And I have to go back, the practitioner concerned in some of these cases face financial ruin, it's not a joke. And that's why we were so keen to have this

opportunity to raise some of these issues. The dossier on my left is a comprehensive one which incorporates a lot of what we've been telling you today and these issues have not been resolved. Even if I may say so, even if there was another part to this story that's not been told, the mere fact that the complaint wasn't addressed the way it should have we – as Mr Boloka has said earlier on, our role really is to ensure that the rights of our members are respected, that's all. If somebody has done something wrong, so be it. But they have the right to reply, they have the right to know why certain things have been done. Why they face financial ruin because of something that's alleged that it been done. In this case the practitioner concerned has not been informed. As I said, I'm going to go race through some of these because I think they've been comprehensively addressed. Just to make the point again, that the designated service providers of optometry, we do refer to them as networks so they are synonyms of each other, preferred providers of managed care organisations. Just to make the point the Health Professions Council supports the concept- there are certain criteria that there should be no exclusivity and that the criteria should be based on their qualification. *Ja,* there were two aspects of the Medical Schemes Act that we felt was important that you, Advocate you would know well, that the group of providers who are selected to perform certain services should be accredited and for those organisations that provide managed care services are also are expected to be accredited. Now I think that's been addressed and for instance within optometry, none of them optometric networks are

accredited. *Ja* so, I'm going to skip most of these because we've done it, *ja*. And this is simply just as an example where a complaint was lodged against one particular network and the response from the clinical analyst of managed care organisations or the CMS simply have reference to the one particular network saying, this particular network is not an accredited managed care organisation, and it's also applicable to the others that Mr Boloka has mentioned. What's of concern to us, despite the fact that we've raised what we believe are to be violations of certain aspects of the law or activities or actions that we regard as ethically undesirable. The medical schemes who appointed the designated service providers who are not accredited have abdicated from all responsibility and this is an- so we've mentioned two cases where we actually instituted complaints, one against Bonitas the other against BestMed. Now if I may repeat, there was no response from the Council for Medical Schemes. Simply saying BestMed can unfortunately not get involved beyond this point and you take it further with the DSP. This is a reference from Sections 57 of the Medical Schemes Act. So from our point of view there is a breach of the law. The Council for Medical Schemes appear to be fairly impotent now in the way they addressed us and hence again one of the reasons why we raised it in this particular forum. We felt that the Board of Trustees of the Medical Schemes have a responsibility to ensure that their operations as administration as per the Medical Schemes Act to ensure that all of that is adhered to in terms of the legislation and to bring it to your attention. Just as a matter of interest, it was 2013, it

was 24th of March 2013 the Health Professions Council had sent out a notice to practitioners across the board to all registered health care practitioners and the heading of that particular document was, Concerns over the Exploitation of Healthcare Practitioners. And in that document they also referred to Section 59 and had made the point that if there are contracts where the practitioners feel that they are enticed or forced to enter which are ethically undesirable, they should then make this know to the Health Professions Council. So I'm only raising this and we're only raising this to let you know it's not simply that we've – as the Health Professions Council other regulatory authorities haven't been alerted to some of the actions and some of the injustices that have taken place, they have been. *Ja,* just as a matter of interest we felt it is also of some relevance. *Ja,* in terms of the intent of the medical scheme, that really we can't sort of qualify in any way but it's just interesting to note that when practitioners are audited – Mr Boloka had referred to random audits in particular. They receive a letter that simply says there's a paragraph or so that introduces the medical scheme and their responsibilities and that's followed by a paragraph that says; ''you have been selected to participate in a random audit program''. It's almost like giving you a medal to say, congratulations.

ADV KELLY WILLIAMS: Mr Rosen, can I just ask you a question.

MR HARRY ROSEN: Ja sure.

ADV KELLY WILLIAMS: Because this is the first time we hearing evidence in relation to random audits.

MR HARRY ROSEN: Yes.

ADV KELLY WILLIAMS: The evidence we've heard so far suggest that practices are flagged because they're an outlier and then they're subject to a form of audit and investigation. So which schemes or administrators are conducting random audits?

MR HARRY ROSEN: *Ja.* So this type of terminology is directly extracted from correspondence sent and that's Discovery and Medscheme. We can't speak on their behalf, we only really referring the matter to you and I'm bringing it to your attention. But the manner in which it's done is also problematic from our point of view to simply say, ''congratulations you're now part of our random audit''. And then two or three there's a paragraph that says, ''we trust we can resolve this matter within 7 days''. So I don't think I need to say more.

MR AUDIENCE MALULEKE: Chair, may add that in addition to the two PPN also engages in random audits.

MR HARRY ROSEN: I think one of the reasons that sometimes given ring to the reference to a random audit, is they refer to the practitioners as outliers. It's an unfortunate term because not everybody understands what an outlier is and thus causes some apprehension for those who receive such a letter. But, the bottom line they are random audits and the terminology is directly extracted as I said.

ADV KELLY WILLIAMS: I think if they are accompanied by that allegation, it seems that they're not random audits in the way that we would understand it. They're driven by the practitioner being an outlier so perhaps that clarifies the matter.

MR HARRY ROSEN: In those circumstances yes but not in all circumstances.

ADV KELLY WILLIAMS: So you are saying there a group where you are randomly audited because you're flagged as an outlier and there's a group where you're just randomly audited?

MR HARRY ROSEN: That appears to be the case, yes.

ADV KELLY WILLIAMS: Thank you.

MR HARRY ROSEN: *Ja,* we just wanted to make mention briefly but not to dilute the importance of this issue of access to record cards, there appears to be some contradiction from time to time in terms of legislation instituted by the various regulatory bodies ... (intervenes).

ADV KELLY WILLIAMS: Sorry Mr Rosen, before you move on then.

MR HARRY ROSEN: Yes sorry.

ADV KELLY WILLIAMS: What is your submission in relation to the random audits besides the fact that the way in which it's notified as in your view not completely appropriate? What are your further submissions in relation to the random audits?

MR HARRY ROSEN: No, I really thank you for asking that question. From our point of view, we regard such an audit as a fishing expedition.

MR AUDIENCE MALULEKE: As a result we actually do not have problems with mechanisms of trying to safeguard the members' benefits and so forth. If there is reason to believe that a specific claim that has been made is not appropriate, we've got no reason to object to targeted audit as it were. But, random audits, you just waking up in the morning you're going for fishing expedition hoping to catch a big one.

ADV TEMBEKA NGCUKAITOBI: Can I just put to you I suppose Mr Rosen, you can also look into this. I mean so from the schemes perspective right. So we process monthly, thousands and thousands of claims. We have to pay them within 30 days according to the Act. We settle them in good faith. Later on we go through these claims, we pick up anomalies. It's not really practical that before these payments are made, we can go through each and every claim in minute detail and discover claims are fraudulent or not. The only time this realistically can be done is post the payment.

MR HARRY ROSEN: That's right.

ADV TEMBEKA NGCUKAITOBI: And even when we do it post the payment, we can inspect each and every claim from each and every practitioner and we have to use a sampling methodology because that's the most practical methodology. So I hear that the practitioners are complaining about that but if you just put yourselves in the shoes of the schemes where they have a primary responsibility to members and protecting them against the perceived fraud, let's forget about use and abuse for a moment but let's talk about acts of deliberate fraud. What exactly do you expect the schemes to do?

MR HARRY ROSEN: Oh okay, I think there's one word I think that may answer your question to a degree. And we expect everybody to act reasonably and what I mean by that, if there's evidence that comes to light as Mr Maluleke has put that indicates something is not quite right, then of course one can go about that. Because even if you go outside the world of healthcare and there are different payment mechanisms

and things. You don't get the Police knocking at your door every morning just to see whether you've stolen anything. The bottom line is that practitioners, the vast majority in our view really work very hard. They render professional services to the benefit of the public. They are compromised right from the very beginning as we've said earlier on in terms of the power asymmetry. The medical schemes dictate the price and we understand that they have those rights. Then on top of it they've got to contend with these interventions some of which are not justified. So it's not just a matter of the audits – I repeat, Mr Maluleke I think had expressed as well, we have no problem with that but part of it as an example they withhold payment. So I gave you the example of the frame that was – sorry, the frames that were purchased in Dubai where they didn't see the dollar sign, they saw the rand sign and they put the practitioner on hold. He was overseas. I mean I left out a lot of detail. So he had locums working his practice and his practice was put on hold for two weeks whenever it was, it's not right. Oh yes, so the point I wanted to make about the record cards and I'm speaking about what appears to be contradiction sometimes and I suppose one could say that there are ways and means of dealing with it but it confusing for the practitioner … (intervenes).

ADV KELLY WILLIAMS: Sorry Mr Rosen, before you move on.

MR HARRY ROSEN: *Ja* sure.

ADV KELLY WILLIAMS: I'm just not finished understanding this- your answer … (intervenes).

MR HARRY ROSEN: Alright.

ADV KELLY WILLIAMS: That everyone must act reasonably.

MR HARRY ROSEN: Yes.

ADV KELLY WILLIAMS: Because the schemes would argue that it's perfectly reasonable if your practice is flagged as an outlier to investigate further and I can't see actually an issue with that.

MR HARRY ROSEN: Well, I think we addressed that part to say if there's evidence to suggest that there's something that needs to be done. You correctly said there were two groups, one where the word outlier forms part of the correspondence and there's another group that doesn't, so sorry.

ADV KELLY WILLIAMS: That's fine. Then let's talk about the group where there's no flagging and it's just purely a random audit.

MR HARRY ROSEN: Yes.

ADV KELLY WILLIAMS: I think we must get some detail on that, who the schemes are – administrators that do this and how it works.

MR HARRY ROSEN: Alright. So I think for the purpose now I'll give you one or two examples. Some of the contracts with the designated service provider's example - I'm going back to what we said earlier on about the power asymmetry so I'll leave that for now but I just wanted to raise it again. So some of the contracts give offices of those particular entities the right to enter into practices during working hours to have access to record cards so that was an example of and I can tell you that I mean just one the entities was PPN, it was referred to that they had done this. Whether they have stopped it or not, it's still a facet that … (intervenes).

ADV KELLY WILLIAMS: PPN is obviously difficult for us because they're neither a scheme nor an administrator as I understand it.

MR HARRY ROSEN: Well, that's the reason why we're raising this to your attention. They operate – they act on behalf of a medical scheme has appointed them. They provide managed care services.

ADV KELLY WILLIAMS: So your submission is in fact they are Bonitas in disguise?

MR HARRY ROSEN: Yes. *Ja,* what I meant to tell you not so much … (intervenes).

ADV KELLY WILLIAMS: Sorry, not to … (intervenes).

MR HARRY ROSEN: Yes.

ADV KELLY WILLIAMS: As I said, be disrespectful add humour to this but … (intervenes).

MR HARRY ROSEN: Yes.

ADV KELLY WILLIAMS: But seriously, what is the submission? Is it that they are Bonitas? They're acting on behalf of Bonitas?

MR HARRY ROSEN: They – because they're not accredited absolutely, they're acting- *ja,* I wouldn't say in disguise though because we all know who they're representing. Alright, may I Chair?

ADV TEMBEKA NGCUKAITOBI: Yes, you may proceed.

MR HARRY ROSEN: Thank you.

ADV TEMBEKA NGCUKAITOBI: I mean I don't know if you finished your answer on unpacking the concept of acting reasonably. What that might entail.

MR HARRY ROSEN: Okay. So maybe just to clarify a little bit further,

we simply saying, if there are evidences to suggest that a practice is in fact out acting outside certain defied boundaries, then we believe that schemes, forensic units whatever entities involved, has the right to investigate further. Our submission to you is that there are areas where that doesn't happen. In other words, there doesn't appear to be anything reasonable.

ADV TEMBEKA NGCUKAITOBI: I mean I take your point about the suspension prior to the conclusion of the investigation that might appear disproportionate to the practitioner.

MR HARRY ROSEN: Correct.

ADV TEMBEKA NGCUKAITOBI: But there's a counter argument to that that if there's an instance of suspected fraud, it's putting the members contributions at risk to continue paying that practitioner. And so you must stop as soon as possible.

MR HARRY ROSEN: Well, I would suggest there may be preferable intervention so sometimes the practitioners aren't even aware that their practice has either been suspended or their payments have been put on hold. So there should be a mechanisms or policies in place. Many of these schemes don't even have policies. I already mentioned the mark-up where does that come from? So I mean Mr Maluleke mentioned earlier on when you were interrogating the term fraud and the incidence of fraud. We basically referred to certain administered anomalies like coding anomalies. *Ja* so, when I say reasonable, ones got to identify the issue, get the information and act accordingly. It's very unfair if there's a coding anomaly and maybe one could argue, well the scheme

wouldn't know until they've met. But then it goes back to the slide I have earlier on police officer, prosecutor and judge. Some of these things have isolation, I think one could argue but if you look at the package in the context of the allegations that we've made and the concerns that we've raised, those are the reasons why we've raised them.

ADV KELLY WILLIAMS: And my last question on the random audits. Could you just explain to us how PPN is conducting these random audits so we have further information on that?

MR HARRY ROSEN: Sure *ja.* So I already mentioned now whether it's been stopped or not, I'm just taking a step back. We've raised it and if it wasn't for certain interventions it would continue but the one example would be based on a contractual clause that offices of this particular entity would have access to the record cards during working hours. So they would enter a practice and they would then have access to the cards and they would ask for a number 20 or 30 cards whatever it may be just to see that everything seems to be okay. So that would be a good example of a random audit.

MR DOLLARS BOLOKA: I think before we go on maybe just to add Chair on the reasonability. Practitioners versus schemes, then the point we are making, it's quite reasonable to say would the scheme not be risking member fees if they keep on paying somebody they had flagged. But I think as well an aspect that to be defined as an outlier, if you see more patients than those around you, you'll still be regarded as an outlier so you may be punished for being busy. And if we say

that the reasonability from the medical scheme is that once they suspect that there's a problem here, let us stop payment then that person who seeing more patients who's doing more good, is at a risk of not being paid if that is reasonable to look at. So that is why for us and our rule is to always look at the reasonability but in the main we are always biased towards the practitioners because we represent, we are the voices of the practitioners. And we are always advocating for systems that will be fair and I think he said reasonable. It will be fair and reasonable to say that, if I am very busy I am not compromised for being very busy. And you're told that your claims are this high compared to audience who- perhaps he's not even doing contact lenses and why do you do so many contact lenses, and therefore we'll put you on hold until we find out why do you do contact lenses. And the honour is on me to leave everything that I do, come to the scheme to say, I'm doing contact lenses. I am better in contact lenses. I specialise at contact lenses. And even if you say that, you must still provide further proof that you do those things. So being good can ultimately be bad for you in a way.

ADV TEMBEKA NGCUKAITOBI: Well, you would become an outlier won't you?

ADV ADILA HASSIM: Sorry, if I could just go back to the discussion about the fairness and reasonableness of the process and the submission that you make as an association that being placed on indirect payment means that practitioners face financial ruin. Why did you make that submission when it doesn't mean – being placed on

indirect payment, does not mean that you will not get paid. It simply means that the member will be paid and will need to pay the practitioner rather than the scheme directly paying the practitioner. It isn't a case where you no longer get paid for a service that is provided.

MR HARRY ROSEN: Okay I think if I may just make a brief comment and then Mr Boloka would elaborate a bit. I think on paper what you say is correct that the medical scheme chooses to pay the patient but there are many situations many circumstances where the practitioner doesn't get paid. So I'm talking about the indirect situation but I think let Mr Boloka if you don't mind comment.

MR DOLLARS BOLOKA: *Ja* because I think it's direct payment and withholding but in particular to indirect payment. I want- I'd given an example of the young man having joined the scheme long time ago. If they pay into an account that no longer exist for an example when we see patients for this month of August, our business running on August, it is depended on us that our overheads will be paid by the business that we do in the month of August. And if you are to be comfortable and say perhaps we might expect payment month end of September if we consider the 30 day principle and so forth. But by the mere fact that payments as much as schemes say yes within 17 days we've paid into Advocate Hassim's account which no longer exist. By the way they have got my account because they have been paying me directly previously. So they pay into Advocate Hassim because their reconciliation on paper takes long, it should, they might pick up if they pick up ever after two months that the money had gone back to them or

then it becomes the responsibility of the practice or the patient to follow up which most often than not falls way over the 30 days. So an indirect payment has got more direct line to practitioners not being paid or not being paid on time. There is a lot more- if you are paid, you are going to be paid late but most often than not most of us are not paid if we are on indirect payment.

MR AUDIENCE MALULEKE: Also to add to that and I think the point has been made here before by some of the other presenters previously that it also depends on who is your patient. For an example, because if you are practicing in a place where you are servicing your high LSL patients, that does not become an issue but if you are servicing your GEMS, your POLMED patients with no disrespect to our patients in those medical aids. You'll understand that the socio-economic situations are different and the majority of these patients that you're actually servicing barely have anything left by the 16th of the month by the 16th day of the month, it will actually cover for every other of their liabilities that once money goes into their account, they don't know that money is going to come into their account, they'll use it. And the onus rest on me to be a debt collector, I'm only a practitioner trying to do my work. And that actually again makes the relationship however old or however long that relationship has been with the patient a little bit awkward that I will be calling on them that I need my money. And because, obviously, as a practitioner I have my day set to see patients do what is best for the patients. I am going to have to channel additional resources which I do not have. To begin with. To get to

someone that is qualified to do debt collection. To do that. But then again on the practitioner to do his work.

ADV TEMBEKA NGCUKAITOBI: Well, I suppose the schemes also know this vulnerability and that is why it is easy to use this as a pressure point on the investigation that is put to an indirect – that puts the pressure to co-operate with the investigation. So there is an upside from the schemes perspective. That we want you to co-operate with the investigation. And what lever do we have, other than put you on indirect payment?

MR AUDIENCE MALULEKE: 100%. 100%. Failure for you to sign an AOD takes away the freedom for you to actually to continue to practice. The moment – and I think the point has been a number of times by other practitioner groups that the moment you sign an AOD then everything is hunky-dory. You can continue to practice. And this is exactly why we felt these points need to be made quite clear.

ADV ADILA HASSIM: Sorry. The medical schemes will say that it is not – you would not – you do not need to sign an AOD. If you co-operate with the investigation and the problem is resolved, then the problem goes away. It does not need to culminate in an AOD.

MR AUDIENCE MALULEKE: No.

ADV TEMBEKA NGCUKAITOBI: Just explain that.

MR AUDIENCE MALULEKE: Yes.

MR HARRY ROSEN: No.

MR AUDIENCE MALULEKE: Yes.

[laughs]

MR HARRY ROSEN: The co-operation with the investigation is not really the problem because certainly in our experience and our advise to our members has always been to co-operate. *Ja,* we never advise anybody not – the problem is with Audience Maluleke has just said is when it comes to the AOD. Because if you sign the AOD then everything is okay. If you do not sign the AOD then it is not always okay. And what I mean by that. If payments are being withheld, just as an example, and you refuse to sign an AOD, then the medical scheme will say to you: "Well, that is fine for us. You know. We will continue to withhold it. No, we cannot continue the relationship we had". You know. You need to then find other ways and means. If there is indirect payment – I can tell you. I am under oath. I know practitioners who have signed acknowledgments of debt because they were put in indirect payment. They could not sustain their practices even in late payments. So the co-operation part is not – if I understood your question correctly, Adv Hassim. The co-operation has never been problematic. I cannot think of one case where there has not been co-operation. Where information has been asked for and that has been made available. It comes to the point of AOD. The terminology is: You go your way. We go our way. And that is it. But if you do not. The indirect payment stays or they will withhold it or payments stays or the suspension stays until it is resolved from another point of view.

MR DOLLARS BOLOKA: I think maybe to add Advocate Hassim. As you have said. Once you have called you are presumed guilty. Once they call you, you are guilty. And therefore the solution – a co-

operation in the definition is an AOD. That is co-operation. If ...(intervenes).

ADV ADILA HASSIM: Sorry. You are saying that if you were to present information to the scheme that explains whatever they are concerned about in relation to the billing and would resolve it that they, nevertheless, insist on an AOD? So there is no way – in other words – provide information to satisfy that scheme or the administrator that there is not any waste abuse or fraud in relation to the billing?

MR HARRY ROSEN: Sorry. Advocate, may I...(intervenes)?

MR DOLLARS BOLOKA: Advocate ...(indistinct).

MR HARRY ROSEN: Yes. I think – *ja,* again, if I understood your question correctly. I think in fairness to the schemes. You know, those cases where they have – I gave you the example earlier on. Where they have misread the dollar sign. Said it was thirty times the amount of the costs and so forth. It was easily explained and there was no problem. Where there is an issue where there is a dispute. So, I said earlier on, you know, I know of cases and I do. Where the acknowledgment of debt has been signed, purely the practitioners cannot afford to be put on the indirect payment route. So, he disputed the allegations made by Discovery and Discovery were not happy with his explanations.

MR DOLLARS BOLOKA: Just to add. Harry and I have been to Discovery a number of times at which point it was quite clear that despite the evidence to substantiate the fact that there was no wrongdoing from the part of the practitioner, that the forensics would

say: "This is not possible to our probe, our cluster probe, would have continued to engage with you on that basis." So, from where we sit. Co-operation is quite different. It has a different meaning. It has a different meaning because we have had practitioners being co-operative. Providing information that disproves the fact that there was a wrongdoing. But, the forensics would continue to say: "It is not possible that our probe continued to engage with you on the basis that you are actually putting forward to us."

ADV TEMBEKA NGCUKAITOBI: Thank you. I mean, I think we get your gist of the complaint here, which is that, the investigation is not really used as an instrument to establish the facts. It is used as an instrument to put pressure to sign an AOD. Once the AOD is signed, the investigation disappears. That is your complaint in relation to the AOD's.

MR HARRY ROSEN: It is not really – *ja,* that is a fact.

ADV TEMBEKA NGCUKAITOBI: You say it is not a complaint. It is a fact.

MR HARRY ROSEN: (Indistinct) *Ja.* No.

ADV TEMBEKA NGCUKAITOBI: [laughs] Yes, I have to ...(indistinct) ...(intervenes).

MR HARRY ROSEN: But that is a concern. Absolutely.

ADV TEMBEKA NGCUKAITOBI: I have to record it as an allegation. I know that you have delivered to the fact.

MR HARRY ROSEN: Yes. Thank you.

ADV TEMBEKA NGCUKAITOBI: All right. You must continue with the

rest of your presentation. You have about fifteen minutes.

MR HARRY ROSEN: Yes, I know. I think I am going to stop my side with the exception of one point. Is that, we understand that there is legislation in place where, if there is evidence of fraud or allegations of fraud that exceeds a R100 000, there is an obligation of the parties concerned to report it to authorities and that is another concern, you know. If schemes are genuinely of the opinion that fraud has taken place and that the amount exceeds a R100 000, you know, that sort of principle of involving other parties, you know, falls away. So from a practitioner's point of view. It is really a line of these resistance to sign his acknowledgments of debt. It does not get referred to the HPCSA. It does not go to the police. Everybody lives as if nothing ever happened. So, I think let me stop there.

ADV TEMBEKA NGCUKAITOBI: We also understand that even on the HPCSA's side, the investigations take a long, long time. Similar investigations would go on for years. So that is also another factor, you know, the schemes, you know, one must take into account that, you know. To refer a practitioner to the HPCSA before you can terminate payment where you suspect fraud. It simply increases the risk.

MR HARRY ROSEN: Chair, that is a really important point you raised because I can tell you there are cases, in our view, where we have advised our members not to indulge in further negotiation, correct terminology with the scheme. Rather take their chances. Go to the Health Professions Council and let their peers then judge you accordingly. But, bases on what you have just said. Particularly in

those situations where punitive actions already been instituted, such as the withholding of funds or the indirect payment, the practitioner's concern, cannot afford to wait that long and therefore sign acknowledgements of debt.

MR AUDIENCE MALULEKE: *Ja,* if I may continue from where Harry has stopped? Chair, I need your – I need to indulge you in a video that we have ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: In a video?

MR AUDIENCE MALULEKE: Yes.

ADV TEMBEKA NGCUKAITOBI: Okay, this is going to be interesting. [laughs]

MR AUDIENCE MALULEKE: Chair, please note that there is no audio. This is a CCTV footage of the proceedings. As you can see four gentlemen entering ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: You may just start by telling us what exactly – where was this taken? I mean, was it authenticated? Who took it? Where was it taken? What was the date? What was the context? Before you tell us what is going on.

MR AUDIENCE MALULEKE: Okay. So this is a CCTV footage in a practice. I think the date does reflect there.

UNIDENTIFIED PERSON: (Indistinct) pause it while...

ADV TEMBEKA NGCUKAITOBI: I mean, you know. It is very difficult to say this. If somebody can probably just switch off the lights here?

UNIDENTIFIED PERSON: (Indistinct).

ADV TEMBEKA NGCUKAITOBI: *Ja,* if you can switch off these lights?

MR AUDIENCE MALULEKE: Maybe in the meantime, we can get to explain the video itself? Okay, Harry?

MR HARRY ROSEN: Okay. So this is, as Audience had suggested, is a security footage taken in a practice in Secunda on the 13th of February 2019. The practitioner and I think there were two staff members who were in the practice at that point in time. So four gentlemen had entered the practice, completely unannounced. As you can be able to look at the footage now. You can see four of them entering this practice. These four gentlemen represent the forensic unit of Medscheme. So I think – if I can stop there and for you just to allow you to see what took place and how this investigation was conducted. Now, I have to say again, if I may, that when I say unannounced. The practitioner had no idea of who these gentlemen were.

ADV ADILA HASSIM: Is this the practitioner?

MR HARRY ROSEN: The practitioner - yes, she is – *ja,* in the front.

MR AUDIENCE MALULEKE: *Ja,* behind the counter.

MR HARRY ROSEN: Yes. So, you cannot that clear. There is a gentleman directly in front and a gentleman to her left and there are two gentlemen sitting down.

MR AUDIENCE MALULEKE: So the point we are trying to highlight here, Chair. Is the way in which we are being handled. Unannounced. Without an opportunity – without given an opportunity to have representation. And I think at some or other – *ja,* some way within the video, you can see the body language. The body language, you know.

Which actually is quite intimidating. Just to say the least. And I think we have, of this video, we have two angles which we have made available for your indulgence. And to...(intervenes).

ADV ADILA HASSIM: So, these are not probes? These are actual investigators?

MR AUDIENCE MALULEKE: Yes, these are investigators.

ADV TEMBEKA NGCUKAITOBI: So what you are showing is that this is how the investigation is conducted?

MR AUDIENCE MALULEKE: Well, in this case. We can say it is how it is conducted. You will appreciate, Chair. That we do not have the insight to all the investigations but we report on what we actually have been intimately involved in.

ADV TEMBEKA NGCUKAITOBI: No, I am saying. This is how this one was conducted?

MR AUDIENCE MALULEKE: Correct.

ADV KELLY WILLIAMS: Do you know what they were investigating? Or at least, what they saying?

MR HARRY ROSEN: Yes. *Ja,* the practitioner concerned, as we have said earlier on. I mean, the information you may need, we will certainly provide. The practitioner concerned, is certainly willing to come forward at the appropriate time. But one of the allegations – and I think I have mentioned it earlier on – against her, was that she had been fraudulent in her claims, because the dates of the consultations did not correlate. And that is as a matter of interest, on this occasion, Medscheme had wanted – they wanted R300 000. Acknowledgement of

debt for R300 000. And part of it, as I have said, is because the dates of the consultations did not correlate. They were just a few days apart. So that was one of the allegations. And just as a matter of interest. Based on – well, I would just refer to it as a negotiation for the purpose of this – of today. That was dropped to R90 000. And I can tell you that this practitioner could not handle the stress anymore. You know, ...(indistinct) of these reasons has left her lot and ended up signing an acknowledgement of debt for R90 000. Although she believes that she has not really done anything that was deserved.

MR AUDIENCE MALULEKE: Which is just a thousand or a few rands below their threshold to evoke the services of law enforcement. It actually tells you – it does tell you something. I mean, and I think the point has been made here, Chair. That there might be a need to actually check how many of them – the people that have been put under investigations, have been reported for further investigation by law enforcement agencies as per the provision because – *ja,* you can understand. It dropped substantially from over R350 000 to R99 000. It actually now puts the point that says: "We are interested in a clawing back and not necessarily the justice of justice."

ADV ADILA HASSIM: Is this taken on the 13th of February 2019?

MR AUDIENCE MALULEKE: Yes.

ADV TEMBEKA NGCUKAITOBI: By who?

MR AUDIENCE MALULEKE: This is the CCTV footage.

ADV TEMBEKA NGCUKAITOBI: So it is the security ...(intervenes).

MR AUDIENCE MALULEKE: *Ja,* in the practice.

ADV TEMBEKA NGCUKAITOBI: In the practice. I see.

MR AUDIENCE MALULEKE: Yes. And as I have said. There are two angles to this video. The other video has been made available for your further indulgence.

ADV TEMBEKA NGCUKAITOBI: And there is no audio?

MR AUDIENCE MALULEKE: Well, it is a CCTV footage. So there is no audio unfortunately.

ADV TEMBEKA NGCUKAITOBI: All right. Anyway. Is there a statement from the practitioner, at the very least?

MR AUDIENCE MALULEKE: Well, I think Harry has mentioned that the practitioner concerned has given - *ja,* Harry if you ...?

MR HARRY ROSEN: Yes, we have the affidavit from the practitioner and the staff.

ADV TEMBEKA NGCUKAITOBI: All right. Thank you for the video. Is there another angle that you want to show us?

MR AUDIENCE MALULEKE: No, I think the other angle, we will just make it available for you for further indulgence. Not to show here. *Ja.* So that we are able to move forward. So, as it were. We can confirm that – and I think we have had conversations...(intervenes).

ADV TEMBEKA NGCUKAITOBI: I mean, why are you putting this video under intimidation? Did this practitioner say that she was intimidated? Because it is very difficult to see from the body language that there is intimidation. There are just four men. One of them speaks to her and the other one comes closer. And then she is talking and then using her hands. But, I mean, to look at that video and then

to infer intimidation, is probably unfair to Medscheme.

MR HARRY ROSEN: So, Chair. *Ja,* I think we would argue for the type of allegation that was put forward to have four big men entering a practice to address one practitioner, I think is a bit of an overkill. To be blunt, from our side. And to answer your question. Yes, she was intimidated based on her evidence.

ADV KELLY WILLIAMS: Would you say it is safe to say to send in big four men into a practice where there is a man proprietor versus a woman proprietor?

MR HARRY ROSEN: Well, I can only speak for myself. I can tell you. I would probably feel uncomfortable myself. Especially – I think you will appreciate. Especially – it is like a police officer comes to you and questions to you about a crime. Not that it has happened to me. I just have to – but nevertheless, the principle of somebody showing a badge of authority. You have got four men, senior men, walking into a practice with a badge of authority representing a forensic unit of a medical scheme. I can tell you again, based on our experience. I do not know of any case, no matter how serious or how severe the allegations are, the practitioners are not – really apprehensive. Mouths are dry. Do not sleep. It is a pretty traumatic experience. Full stop. So I repeat. In our view. For four men, in this case, we believe it is an overkill and by definition, intimidatory.

ADV TEMBEKA NGCUKAITOBI: So you would say that regardless of what was said, the entire atmosphere was an intimidating atmosphere, the way that they entered, their posture and the accusations put to her?

MR HARRY ROSEN: Yes.

ADV TEMBEKA NGCUKAITOBI: Just tell me? Was that acknowledgement of debt signed there and then?

MR HARRY ROSEN: No.

ADV TEMBEKA NGCUKAITOBI: It was signed at a later stage?

MR HARRY ROSEN: Yes. *Ja,* we were quite intimately involved in that particular case. *Ja,* we knew about the amounts of money that was involved in this particular case.

ADV TEMBEKA NGCUKAITOBI: Did Medscheme want it signed there and then with those four men? Was their proposal that: "We have got an AOD. You can sign to make the problem go away."

MR HARRY ROSEN: No. It did not happen. If I understood your question correctly. There were subsequent meetings. There were correspondence...(intervenes).

ADV TEMBEKA NGCUKAITOBI: I am saying, that apart from the fact that she came to report the men. If it was according to Medscheme, would they have wanted the AOD signed at that meeting?

MR HARRY ROSEN: No.

MR AUDIENCE MALULEKE: Okay. Again, just to illustrate the point. Harry is intimately involved. When you are in the cubicle in some of these forensic meetings, it has been in some instances where the forensic investigator or personnel would go to the extent of saying: "You are fraudulent!" You know, being the ...(indistinct). It has happened. People are intimidated. That is why we needed to make this point to you. And I think this point has – the one on withholding of

claims. I think I am just going to skip on it. But the aspect on cooperation, it comes out as a statement like the one that is displayed. But in actual sense, as we have articulated now, it does not – cooperation and cooperation is different. The claw backs on claims that have already been paid. We have examples of instances where a practitioner sees a patient. They are paid months after they are told that they need to payback to – and I will give you an example of a scheme, Fedhealth. And a victim, Chair, is none other than myself in this particular instance. Where on the 31st of January – is it 2017/2018? *Ja,* 2017/2018. I cannot remember the year but I have – we will provide all that. A patient is seen. Benefits are confirmed. Reference number given. Then we see the patient. Seven days or ten days later – after seven days the claim is paid. In April then you receive a letter that says: "Morning, Mr Maluleke. We need our R 495,00 for the examination that you actually did on this member because you are not entitled for it because 1) the patient has resigned from the medical scheme on the 31st of December." My question would naturally have been. If it was on the 31st of December that the patient came to me, one day later and you give me the assurance that this member has benefit. This member is covered. Because if I was not given that assurance I could have acted differently. I could have asked me to pay me then and there. But that did not happen because I was assured. And I think the point that has been made again by the president of the HPCSA that we are giving service. Thinking that we will be reimbursed and we actually get surprised at the time when we

actually reimbursements. I think the quote-very well. This particular clause. When they were corresponding with me. That we are evoking Section 59. And I would have argued that I was entitled to that money because I have provided a service. It is the scheme's administrative error. And I think if you were to read Section 59 with Regulation 6, the onus becomes on them to actually – I may be misinterpreting these things. As you would understand. I am a practitioner. The onus becomes on them to prove that I was not entitled for that amount as it were. So that has been then the issue. Indirect payment. We spoke about that a lot with this. We just pass the – in the interest of time. And I think the guilty until proven until innocent has been exhausted, Chair. I think this point was also...(intervenes).

ADV ADILA HASSIM: Mr Maluleke, before you move onto this. Can I actually just take you back because I see you are changing themes. To the point in your written submission that we have not properly covered yet. You have previously explained to us how tariff codes are set by an independent body. I just have a couple of more questions on that. Where do we find the codes that govern optometry in terms of what procedural codes should be used and associative tariffs? Which manual is applicable?

MR AUDIENCE MALULEKE: Okay. We would answer in this manner that the tariff codes – not the tariff codes. The codes for optometry are available on our website. We will make those available. Because of the fact that we have mentioned here that we are not involved in the tariffs. We do not have a file per se as the association to say that

these are the tariffs that can apply to this specific code. But it is safe insofar as to say that there is a number of guidelines that are available in the market that are done independently of ourselves. There is a file called Optical Assistant. It is done by a company called SB Media. But some schemes have applied codes. I mean, tariffs. To our same SAOA Codes that we actually speak to. Optel, its tariffs. Discovery has its tariffs and so forth and so forth. That we can make available.

ADV ADILA HASSIM: Thank you. And then just to go to your written submission. You say:

> "The reference to codes relates to allegations that medical aid schemes in question are refusing to pay certain tariff codes. Instead, these schemes are said to be advising practitioners to bill, using other codes, resulting in a situation where these practitioners are encourage or forced in committing fraudulent acts."

Again, I am sorry. I cannot give you the page number. But as I understand the submission. You have your own codes. There are other codes in the market and of pertinence here is that schemes at advising optometrists to use codes which you then consider to be codes which are incorrect and therefore, are suggesting that you are committing a fraudulent act. Can you give us or confirm that and give us specific examples, please?

MR AUDIENCE MALULEKE: Okay. There will be two examples to this. As it were. The codes that we actually have made available are quite comprehensive and specific to a product. So when we say that

Advocate Williams has consulted and we are going to prescribe for her a specific multi-focal or bi-focal lens with specific properties, there is a specific code for that. That is unique for that particular product. So there will be schemes and or administrators that will not want to use the codes that we are referring to that has direct implication into what exactly is the material that we are actually prescribing. At which point, you are going to use a category and then a sub-category which is not specific to the specific material that we are prescribing. Until recently, for example, Gems was not using in particular the new – the updated code structure that we have in the market. They continued to use the old codes that were ended in 2007. Sorry, 2017, May. As a result there would have been updates in September – September 2017, January 2018, May and September, so if and when you use the codes on an updated material, you do not have a code to actually use for that specific material that you have used because it is not on the list, it is not updated. As a result, you are going to use a nearest, a closest code or a non-specific code, which to us, does not necessarily represent the exact, so *ja.* So what is on the claim is not necessarily what is being provided for.

ADV KELLY WILLIAMS: Thank you, so I understand this relates all to multi-focal lenses and what codes are used for that? Or is that it?

MR DOLLARS BOLOKA: All lenses, I just made an example on multi-focal. All lens categories.

ADV KELLY WILLIAMS: I just want to be clear, just in relation to the example that you gave me, so I understand that applies to all lenses, there would be updates and you obviously have to use the updated code

in order to be accurate, and medical schemes may, in this case, GEMS may not have included the updated code in their particular reimbursement models, but just in relation to this specific example, so for multi-focal lenses, is it true that there was a code in 2017 that GEMS continued to use that then you could not use an accurate code for in 2018? I am looking or specifics that is what I am getting at. Because we run the risk of being too general and then therefore making factual mistakes.

MR DOLLARS BOLOKA: Because a particular, say multifocal lens from a particular, let us take a new entrance into the market.

ADV TEMBEKA NGCUKAITOBI: No, no, Mr Dollars, answer the question.

MR DOLLARS BOLOKA: No, I am giving...(intervenes).

ADV KELLY WILLIAMS: I just want one specific example and, as I understood you were giving me this specific example in relation to multifocal lenses, and the coding in relation to that?

MR DOLLARS BOLOKA: Yes, yes, it means then that the code that we will use it is not necessarily the exact code that you will have actually provided. But you would have then had to use a code for any other material, you know, any other material, it is not the material that we talk about.

ADV TEMBEKA NGCUKAITOBI: No, Mr Dollars, look, let us do this. You have said to us that GEMS was using an outdated code in 2017, which was inconsistent with 2018 claims, and as a consequence, were refusing to reimburse based on the new codes, is that true or not?

MR DOLLARS BOLOKA: We can argue it is true.

ADV KELLY WILLIAMS: In relation to what product and code?

MR DOLLARS BOLOKA: Any of the products that were not necessarily on the code listing, before the time of the implementation of the new codes.

ADV KELLY WILLIAMS: Would that include multifocal lenses?

MR DOLLARS BOLOKA: All lens categories.

ADV KELLY WILLIAMS: So is your answer yes?

MR DOLLARS BOLOKA: Yes.

ADV KELLY WILLIAMS: Thank you.

ADV TEMBEKA NGCUKAITOBI: You may proceed, assume that we are aware of the provisions of PRACA, we are aware of the provisions of the Prevention and Combating of corrupt Activities Act, you can assume that, so continue with your presentation.

MR AUDIENCE MALULEKE: : *Ja,* and I think, we have made that point. *Ja,* I think this point on AOD's was exhausted as well. The president will continue from here.

ADV TEMBEKA NGCUKAITOBI: Mr Dollars, is that you?

MR HARRY ROSEN: Sorry Chair, if I may just make a point.

ADV TEMBEKA NGCUKAITOBI: Oh, the other president.

MR HARRY ROSEN: A very quick one *ja.* Just to go back to the video, I obviously refer to the gender of men, from our point of the intimidation was the four employees, I just wanted to make that point, irrespective if it was between male or female, female, female only, I just mentioned men, I just wanted to make that point. Thank you.

MR DOLLARS BOLOKA: It was quite an important point to make. In actual fact, I am not continuing Chairperson, I am concluding.

ADV TEMBEKA NGCUKAITOBI: We still have a slide, what is the slide, advertising, touting, and canvassing?

MR DOLLARS BOLOKA: Oh, we did not speak to that. Alright, yes, I covered a little bit on the opening on the issue of touting and canvassing which is a violation of the ethical rule from the HPCSA. So, in the main it still speaks about the SMS that patient will receive at the moment you are sitting in my practice, I have called the scheme to confirm your benefits, you get an sms to say that, I have got one that unfortunately a patient of mine sent while he was seated in my practice, and he has been someone who had been consulting with me for about four, five years. So he was quite surprised that why is it now that when he is supposed to come and consult with me an sms comes in, it was him and the wife, an sms comes in to say that he is about to say that he is about to consult with an out-of-network provider, it is exactly that. A medical aid benefit enquiry has been made on your profile by an out-of-network provider. Your frame benefit is 43% more if you visit an in-network provider, click here to find a provider, and there is a link that is supplied on the message. And the link has got all those in-network providers. So in the main it means that those network providers who are on that link are being touted for and canvassed for, whether they have agreed on the touting and canvassing, is an irrelevant matter if it comes here, but we are quite aware because we have lodged a complaint with the HPCSA about this, and they are looking into the matter on that. So, but our point is, as a practitioner, if

you are outside, if you are out of the network you are compromised because your patient will receive those type of messages. If you are in-network, you are compromised because our regulator will come after you on that. So, in the main, that was the issue on touting and canvassing. And we want to take this opportunity to thank you for affording us and we do know that some of the issues might not be falling within the TOR's but as we have mentioned, we have got quite tremendous hope in the panel and we wish you all the best as you continue.

ADV TEMBEKA NGCUKAITOBI: Thank you, thank you to you, Mr President and to your association for the written submission and your oral presentations this morning. We will be sending you further requests for information on some of the items we have been discussing today, specifically on the specific instances of the practitioners and the way they related to the schemes and of course, we would be looking further into that video incident. But for now, thank you for your presentation. So, the enquiry will then adjourn until one o'clock when Advocate Trengrove will be presenting on the legal meaning of racial profiling.

INQUIRY ADJOURNS

INQUIRY RESUMES

ADV TEMBEKA NGCUKAITOBI: Advocate Wim Trengove SC who is an expert in many areas of the law and including the constitution itself. He is going to be taking us through the legal implications of what has been referred to as racial profiling. Mr Trengove, I see that you have been multiplied three times.

ADV WIM TRENGOVE: You want (indistinct – microphone not on).

ADV TEMBEKA NGCUKAITOBI: No, *ja,* I suppose ...(intervenes).

ADV KELLY WILLIAMS: You'll need to put your mic on, Mr Trengove.

ADV TEMBEKA NGCUKAITOBI: Alright, so you've been called as an expert so no point in swearing you in so just take us through your presentation.

ADV WIM TRENGOVE: Chair, may I hand up extracts from the constitution, the Equality Act and two cases to which I shall refer. And let me perhaps just frame what it is that I am going to address. To make it clear that it's a very limited topic, as I understand it. I will speak only about unfair discrimination on the grounds of race and then, in doing so, deal particularly with two sub-questions and the one is the difference between direct and indirect discrimination. And secondly, the relevance and role of intention in assessing discrimination. Now discrimination may be committed by a law or by conduct and I am not au fait with the intricacies of your enquiry but I will take the example of conduct because it might be of closer relevance to you. Let's call it a policy. Question is whether any particular policy constitutes unfair discrimination and the way in which I propose to approach it is firstly to look at the constitution, what it says about unfair race discrimination, then to look at two of the leading cases which have created the framework for the regulation of unfair race discrimination and then in the light of that background, the constitution and the cases, to look at the Equality Act to see how it addresses unfair race discrimination. So what I'll do is, to start then with the constitution. I gave you a copy of an extract from the constitution and I merely point to the following

provisions. A good starting point is perhaps Section 1B because it makes it clear that non-racialism is a founding value of our society and our constitution and it is in the light of that elevated importance of that value that the enquiry into unfair race discrimination should be approached. Then there is Section 8 which is of marginal relevance and particularly Section 8(2) which makes it clear that although the constitution generally applies to the state, some of its provisions may also apply to private individuals so that in the context of an inquiry such as this, the constitution may in certain circumstances apply directly to healthcare funders. We get then to the really important section, section 9, the equality section, and as I said, I am going to focus on unfair race discrimination and I am not going to deal with equality generally but it is of some relevance to start with the first and second sub-sections of Section 9 which deal with the right of equality.

1 says:

"Everyone is equal before the law and has the right to equal protection and benefit of the law."

2 says:

"Equality includes the full and equal enjoyment of all rights and freedoms, promote the achievement of equality, legislative and other measures designed to protect or advance persons or categories of persons, disadvantaged by unfair discrimination may be taken."

For our purposes the relevance of these equality provisions is that they make it clear that what the constitution guarantees is

substantive equality, not mere formal equality. So we look at substance, we look at reality, we look at impact and not mere words. There is then two provisions that prohibit unfair discrimination, 3 and 4. The first applies to the state and the second to everybody else. So we will be in the everybody else category, that's 4, but let me by way of background start with 3 and point out that it is a prohibition upon the state which says it may not unfairly discriminate directly or indirectly against anyone on one or more grounds including race. So let me – and then a number of other grounds are mentioned. So race is one of the specified grounds of discrimination which is prohibited and in this provision – but on this provision, the one that applies to the State, unfair discrimination is prohibited not only on the specified grounds but on – but also on the specified grounds, so it is not a closed category of prohibited grounds. You then get to the one that's directly relevant to us and that is sub 4. It applied to everybody including healthcare providers, it says:

"No person may unfairly discriminate directly or indirectly"

There I again that phrase which speaks directly to one of the questions of my brief.

"No person unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of sub-section 3. National legislation must be enacted to prevent or prohibit unfair discrimination."

So in this case this applies to everybody, not only against the state, the prohibition is also one of direct or indirect discrimination and

it is confined to the enumerated or the specified ground, no longer including, so it is a closed list of grounds upon which there may be no discrimination. And then last provision of Section 9 is (5) which is relevant to our enquiry and it says:

> "Discrimination on one or more of the grounds listed in subsection 3 in unfair unless it is established that the discrimination is fair."

In other words, once there is discrimination on a specified ground then the discrimination is presumed to be unfair unless the perpetrator discharges the onus of proving that it is not. So much then for the constitution. If I may then go to the two cases which I have said created the structure under which these provisions are applied. The first is Harksen's case, it's Harksen v Lane 1998(1) SA page 300, a judgment of the Constitutional Court in which it analysed the equality provisions in Section 8 of the interim constitution but you can accept that this case and what it said about equality under interim constitution are equally applicable to the final constitution for two reasons. The first is that the Constitutional Court has said so on a numerous of times, so we have it on the highest authority that this is still the authoritative analysis of the equality provision not only under the interim constitution but also under the final constitution. And the second is that you will see that the final constitution has in fact adopted its formulation with the Harksen structure in mind, reinforcing the Constitutional Court's finding that Harksen is still good law. And what Harksen did was to analyse the method by which one determines

whether in any particular case unfair discrimination has been committed. It does so from paragraph 43 but then after an exhaustive analysis summarises its conclusions in paragraph 54 and if I may just read a few of the crucial snatches of paragraph 54 because they are ultimately the structure that we're concerned with.

Paragraph 54 says the following:

"At the cost of repetition it may as well be to tabulate the stages of inquiry which become necessary where an attack is made on a provision in reliance on Section 8 of the interim constitution. They are:

1. Does the provision differentiate between people or categories of people? "

That's the first question and I'll come back to it. In (b).

"Does the differentiation amount to unfair discrimination? This requires a two stage analysis.

Firstly, does the differentiation amount to discrimination? If it is on a specified ground then discrimination will have been established."

And then sub 2:

"If the differentiation amounts to discrimination, does it amount to unfair discrimination? If it has been found to be on a specified ground then unfairness will be presumed. If it is on an unspecified ground..."

Well, I don't need to read the rest, we're dealing with race discrimination which is a specified ground. So this is actually a very

simple structure. If I may reduce it to its essential steps in an enquiry whether a policy constitutes unfair race discrimination, the first question is, does it differentiate against people? And to determine differentiation, one looks at its impact, not its language. The question is not merely is it on its face – does it on its face differentiate, you ask – because we're concerned with substance and not words – you ask yourself does it disproportionately impact on some people rather than others? So that's the first question, does it differentiate? If it does, the second question is, does it differentiate along the lines of race because that would then be differentiation on the grounds of race. You'll see where the line of differentiation lies and you ask yourself is a race. In other words, does it impact disproportionately on one race rather than the other? If the answer is then yes, then the third step comes in. The yes answer triggers two consequences. The first is that the differentiation is now classified as discrimination, there's no further enquiry, differentiation along the lines of race constitutes discrimination. But it doesn't yet constitute unfair discrimination. The second consequence of the conclusion that there is differentiation along racial lines is that it is presumed to be unfair but that presumption is not conclusive. In fact it is often really the beginning of the real substantive enquiry into the fairness of the differentiation. And let me give perhaps a trite example just to make the point that the enquiry often starts at the unfairness enquiry rather than end at the question of – ends at the presumption of unfairness. Take, for instance, the law that criminalises robbery and assume that 99% of

people caught and prosecuted and jailed for robbery are men, then you would have a differentiation on the grounds of gender, that's enumerated ground, and for that reason it constitutes discrimination and it's presumed to be unfair but the unfairness enquiry will immediately tell you this is an easy unfairness enquiry, there's nothing unfair about it, men commit robbery more often than women and it is not – it is not – because the law is biased, it is simply because as a social phenomenon men commit robbery more often than women. There are more difficult issues. One of the issues that have arisen in our law where I think the Constitutional Court might have gone wrong, is on question whether the criminal prohibition of sex work discriminates against women. The fact of the matter is that the people who are arrested and prosecuted and jailed for sex work are more often than not women rather than men. The Constitutional Court said that that was for other reasons than gender and for that reason did not find it to be unfair. So I think what I'm saying is that in our enquiry, is there differentiation? Is it on the grounds of race? If so, it is – it constitutes discrimination and the remaining enquiry is one into fairness. Then it seems to me that in your case the analysis is a pretty easy one, up to the point where you get to the fairness enquiry. So I don't profess to know anything about the practice of healthcare providers but on my limited understanding, for instance, they employ an algorithm to identify suspect service providers. If that algorithm disproportionately points a finger at black doctors rather than white doctors then that would be differentiation on the grounds of race which constitutes

discrimination and which opens the unfairness enquiry and in that enquiry, the people who implement and practice that policy would bear the onus of proving fairness and let me just say then as far as fairness is concerned, that's the most difficult part of the enquiry. What the Constitutional Court said in Harksen, you'll see there in their paragraph 54(b)(2) the last sentence, it says:

> "The test of unfairness focuses primarily on the impact of the discrimination on the complainant and others in his or her situation."

So the focus of the unfairness inquiry is to look at the adverse impact on the victim and to ask yourself in all the circumstances is that disproportionate impact unfair? The Constitutional Court elaborated on the unfairness enquiry in paragraph 52, so you can put a cross-reference there at sub 2 to paragraph 52 and I'm not going to go there but you'll see it remains, at the end of the day, a very difficult enquiry in many cases because the Constitutional Court does no better than to tell us that there is a range of factors that one takes into account but it does remain at the end of the day a value judgment that you need to make in which you way up justification, the purpose of the policy against the impact on the victims, you ask yourself isn't there a better way of doing it to avoid the impact and if the impact can't be avoided you say well, is it fair that the victims of this differentiation of the discrimination should bear that unfair impact. The second case to which I'd like to refer because it addresses the two specific questions you've asked me to look at, is the case of Pretoria City Council v

Walker 1998(2) SA 363 Constitutional Court. And it was an interesting case because what happened there was that Mr Walker, a white inhabitant of Pretoria complained that the municipality discriminated against him in favour of the black Pretoria citizens. What the council had did was to – the City Council had a diverse water provision policy mostly born of our history. In white Pretoria, people were individually billed and if they didn't pay they were generally prosecuted for not paying. In Mamelodi and Attridgeville, two of the traditional townships in Pretoria, a different policy was followed. The policy there was to charge everybody a flat rate and Mr Walker complained that that flat rate was cheaper than the price at which – the rate at which he was billed. And secondly, the municipality generally didn't prosecute people who didn't pay. So Mr Walker complained – when Mr Walker was sued for his –for not paying his bills he said but the system is unconstitutional and therefore he shouldn't be prosecuted. The Constitutional Court then entered into the first enquiry and that is, is there discrimination on the grounds of race? And that gave rise to two different questions. The first is, the fact that the policy of the City Council said nothing about race, it spoke, if I may paraphrase it, it spoke of old Pretoria and it spoke of Attridgeville and Mamelodi, there was not mention of race in the policy the applied but the Constitutional Court said that that is irrelevant because we look at impact not language. The question is not whether the law is racially discriminatory on its face, the question is whether it impacts disproportionately and if you would go in the Walker extract at paragraph 31, you'll see that that

is where they deal with this question. The court said in paragraph 31:

> "The inclusion of both direct and indirect discrimination within the ambit of prohibition imposed by Section 8(2) evinces a concern for the consequences rather than the form of conduct. It recognises that conduct which may appear to be neutral and non-discriminatory may nonetheless result in discrimination and, if it does, that it falls within the purview of Section 8(2)."

And then in paragraph 32, if I could skip to the middle, to a sentence that starts right on the right hand side with the word "the".

> "The fact that differential treatment was made applicable to geographical areas rather than to persons of a particular race may mean that the discrimination was not direct but it does not, in my view, alter the fact that the circumstances of the present case it constitutes discrimination albeit indirect on the grounds of race."

Reinforcing the point again that we look at substance, not form and you ask – and particularly when you ask about differentiation, you look at impact rather than language and a policy may be – may differentiate on the grounds of race either because it does so expressly or because it does so in its – or because it has a differential impact even if it doesn't do so expressly, or thirdly, because it might in its application, in its administration be differentially applied to people of different races. So that you really get three forms of differentiation. The one would be explicit, when it's on its face, differentiates. The second would be where it differentiates in its impact, the policy itself,

differentiates in its impact. The third is where the application of – the policy might be sound but if it is applied in a manner which impacts adversely on one group and not another, then that would also constitute discrimination.

ADV TEMBEKA NGCUKAITOBI: Mr Trengove, can I ask you about intention? So we have had submissions which say we have no intention to discriminate. Is intention relevant? If so, what is the relevance of intention?

ADV WIM TRENGOVE: Let me say this, Chair, intention is irrelevant to the determination of whether there is race discrimination, discrimination on the grounds of race. Intention may become relevant at two levels. The first is in the fairness enquiry. It may sometimes be relevant to say that my purpose with this policy is x, it is not intended to discriminate and I accept that it is an incident of the policy that there is discrimination but that's not my purpose. It doesn't remove the policy from the category of race discrimination but it may sometimes be relevant to fairness. For instance, if there is no other way of doing it and if the adverse impact is slight, but it's merely a factor that goes into the fairness assessment, it doesn't absolve the perpetrator at all. Fairness may also – and remember, fairness may secondly be relevant at a different level and that is this. Remember that once you have concluded that somebody commits unfair race discrimination then it is not yet a crime in itself, it just means that that conduct is unlawful, unconstitutional and may open the perpetrator to the remedies, the penalties provided for under the Equality Act. In the determination of

the remedy, i.e. the penalty to be imposed, intention may again be a relevant factor because it is obviously – there is obviously greater culpability where race discrimination is perpetrated intentionally than there would be if it is unintentional so – and on that ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Can I also ask another question related to the issue of intention. Let us assume that the outcomes that are produced by the application of a policy, disproportionately negatively affect blacks as a fact, assume that as a fact.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: But you, as the administrator that policy, are essentially reckless or you do not care, are negligent about that outcome.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: What does the Section 9 say should happen in those instances? I mean, would that be evidence of discrimination and if so, which type, direct or indirect?

ADV WIM TRENGOVE: Well, again the analysis would be there is differentiation on the grounds of race, it triggers a conclusion that it is discrimination, it opens the inquiry into fairness and in that inquiry, if the perpetrator has to discharge the onus of proving fairness, I find it very hard to imagine any circumstances in which it will succeed in discharging that onus if the adverse impact is a product of its own recklessness or its own negligence. You know, it seems to me almost a foregone conclusion that where the disproportionate impact is the product of the perpetrator's negligence or recklessness then the

conclusion would be that it's unfair.

ADV KELLY WILLIAMS: And that would be based on an objective standard.

ADV WIM TRENGOVE: Oh, yes.

ADV KELLY WILLIAMS: Objective test.

ADV WIM TRENGOVE: Oh yes, absolutely.

ADV KELLY WILLIAMS: It doesn't matter what the subjective intention of the perpetrator.

ADV WIM TRENGOVE: *Ja,* well you may conclude that the perpetrator was subjectively negligent or reckless and for that reason you would conclude that the conduct in question is not fair because although it might not have intended to discriminate on the grounds of race, the discrimination was caused by its recklessness or its disregard of that risk and then you would almost inevitably conclude that it is not fair. Could I take you to two paragraphs of the same Walker judgment on the question of intention? The first is at paragraph 39 where the court said the following:

> "With regard to the question whether intention has any relevance in the determination of unfairness it is to be noted that in none of the four judgments was it suggested that intention to discriminate is an essential element of unfair discrimination."

In other words, it's not a requirement – intention is not required in order to render the discrimination unfair. People can inadvertently perpetrate discrimination which is unfair despite the fact

that they didn't intend to do so. And then at paragraph 43, if I can pick it up just after footnote 40.

> "In many cases particularly those in which indirect discrimination is alleged, the protective purpose would be defeated if the person's complaining of discrimination had to prove not only that they were unfairly discriminated against but also that the unfair discrimination was intended."

This problem would be particularly acute in cases of indirect discrimination where there is almost always some purpose other than the discriminately purpose involved in the conduct or action to which objection is taken. There is nothing on the language of Section 82 which necessarily calls for the section to be interpreted as requiring proof of intention to discriminate as a threshold requirement for either direct or indirect discrimination. Consistent with a purpose of approach that this Court has adopted to the interpretation of provisions of the Bill of Rights I would hold that proof for such an intention is not required in order to establish that the conduct complained of infringes Section 8(2). Both elements at discrimination and unfairness must be determined objectively in the light of the facts of each particular case. So, intention is not a requirement. The absence of intention may be a factor, but it is not a requirement for. So, if I could then go lastly to the equality act of which I've also annexed an extract to – the papers I have handed up to you. It seems to me that the provision relevant to our discussion is firstly the definition of discrimination in section 1 it says;

"Discrimination means any act or omission including a policy, that's our policy we're talking about, a policy, law, rule, practice, condition or situation which directly or indirectly- there's again the directly or indirectly phrase, imposes burdens, obligations or disadvantages or withholds benefits opportunities or advantages from any person on one or more of the prohibited grounds. "

So, you'll see that it's direct or indirect and there's no requirement of intention. It doesn't say that it is done with the intention to discriminate. The prohibited grounds are again define domain include race. And then section 6 and 7 prohibit unfair race discrimination. Section 6 is a general prohibition of all unfair discrimination but then you'll see that there are certain forms of discrimination which have been afforded special treatment, the big three as it were and they are race, gender and disability. The specific prohibition of race discrimination is in section 7 subject to section 6. No person may unfairly discriminate against any person on the ground of race. That would trigger again the Harksen analysis, is there differentiation, is it on the grounds of race? If so, it is discrimination. The last question is, is it unfair where the burden is born by the perpetrator. In section 13 there's regulation of the burden of proof in a manner which I would suggest to you is consistent with the Harksen analysis. Section 16 starts off by saying,

1. If the complainant makes out a prima facie case of discrimination – remember now this is discrimination as

> defined and that is differentiation on a specified ground. A prima facie case of discrimination not proof, the respondent must proof of the facts before the Court that the discrimination did not take place as alleged or the respondent must proof that the conduct is not based on one or more of the prohibited grounds.

So, what it does is it goes to Harksen, you'll remember the first two questions under Harksen is, is there differentiation? Secondly, is it on prohibited ground? Now what this provision does is to provide us a leg-up to the complainant to the victim in that the victim merely needs to prove those two. The victim merely needs to answer those two questions on a *prima faci* basis, prima facie evidence that there is differentiation and *prima faci* evidence that it is on the grounds of race. Once that is- so that is what the victim needs to do in order to get a foot in the door. What then happens is described in subsection 2;

If the discrimination did take place on a ground in paragraph A of the definition of prohibited grounds, then it is unfair unless the respondent proves the discrimination is fair. So, under the first leg the onus is on the respondent to prove that there is no differentiation or it's not on the grounds of race. If the respondent fails, in other words, if there is differentiation and it is on the grounds of race then the respondent bares the onus which it has under Harksen of proving that it is not unfair. It is presumed to be unfair unless it is proven not to be so. And Section 14 then goes on to say how the enquiry into unfairness must be undertaken. What the relevant factors are when one assesses

unfairness and again they're interesting and they're helpful but there's no point in my reading them out to you. They will ultimately assist in any assessment but they will almost never provide a mechanical answer. It is always a value judgement that you have to make in the end of the day and the big question in that value judgment is what is the function of this policy? What is the purpose and the function of it? The legitimate purpose and function of it and does it justify the adverse impact on its victims? The emphasis at the end of the day is- the question at the end of the day is, is the adverse impact on the victims, is it fair or not? So, Chair, that's the outline as I see it of the law on unfair discrimination on the grounds of race and I have nothing further to add to it.

ADV KELLY WILLIAMS: Mr Trengove, my I just ask on the meaning of section 14 and I suppose the determination of fairness or unfairness. One of the factors listed there is whether the discrimination is systemic in nature … (intervenes).

ADV WIM TRENGOVE: *Ja.*

ADV KELLY WILLIAMS: Which seems advised to this enquiry.

ADV WIM TRENGOVE: Yes.

ADV KELLY WILLIAMS: And I was wondering if you could comment on that and the importance of that?

ADV WIM TRENGOVE: Oh yes because and I don't think there's any magic to it but what it suggests is that systemic discrimination is a far more serious issue than incidental discrimination because systemic discrimination by its very nature discriminates day in and day out

against all the members of the disadvantaged class and therefore requires – is therefore a more serious form of discrimination than incidental discrimination and requires more serious remedy. So, it is an important factor but like all factors not decisive in itself.

ADV TEMBEKA NGCUKAITOBI: Can I ask you about your reference to the- I think it was the Walker decision, the impact on geography? So, assuming that you have a neutral policy *ex faci* neutral ... (intervenes).

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: But on application it disproportionally impacts people residing within a particular area. So, both the policy is neutral and the impact is geographic rather than explicitly racial. How should we deal with that scenario?

ADV WIM TRENGOVE: If the impact is geographic and nothing more, in other words, it impacts on Houghton and not on Westcliffe and there's no other in other words there's no hidden enumerated differentiation in that differentiation. Then it is not differentiation on an enumerated ground and also not on an analogous ground because it doesn't impair the dignity of anybody. But I'll assume – well it's very important to my answer, is that I assume that there is for instance no race difference between those two geographic areas. If the one is Alexandra and the other one is Houghton then it is race discrimination by another name.

ADV TEMBEKA NGCUKAITOBI: So, if the impact is – I mean people have been using various codes, one of them is socio-economic status.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: If the impact is felt disproportionately in let us say medical practitioners practicing in townships and in outlying areas that could constitute racial discrimination?

ADV WIM TRENGOVE: Oh *ja*. Oh yes, no absolutely. I mean that comes very closely to Walker's case. Different rules apply to Waterkloof and to Attridgeville, there's no mention of race but if you come from Pretoria as I do, then you know that that's code for race, Waterkloof is white and Attridgeville is black.

ADV ADILA HASSIM: And that's an example where geography and race intersect.

ADV WIM TRENGOVE: Yes.

ADV ADILA HASSIM: But socio-economic status and race could intersect as well.

ADV WIM TRENGOVE: Yes, very much so.

ADV ADILA HASSIM: So, if it falls more heavily the policy on new entrants to the profession medical profession and poorer … (intervenes).

ADV WIM TRENGOVE: *Ja.*

ADV ADILA HASSIM: Smaller practices, would that … (intervenes)

ADV WIM TRENGOVE: Advocate Hassim, let me just make it quite clear. I have only- I have confined myself to race discrimination but of course race is not the only enumerated ground. There are whole long lists of enumerated grounds and socio-economic status is one of them so that may in itself constitute unlawful discrimination, not on the grounds of race but socio-economic status. Sometimes discrimination

on the grounds of socio-economic status may also be discrimination on the grounds of race etcetera.

ADV TEMBEKA NGCUKAITOBI: I mean I'm also interested in this issue because of intersectionality. I mean assuming your enquiry like ours is focussed only on race. The question I suppose is whether or not socio-economic status can be a proxy for race?

ADV WIM TRENGOVE: Yes, I'm sure it often is. I mean you – if you look at crime statistics, I don't know what the crime statistics say but assuming in our society they say that more crimes are committed, a disproportionate number of crimes are committed by black people rather than white. Then my suggestion would be that it's a function of a socio-economic differentiation that crimes are generally committed or a lot of crimes are often committed by poor people and not crimes are committed by poor people of any race but if you have a great of a portion of black people who are poor then they will also be disproportionally represented in that population.

ADV TEMBEKA NGCUKAITOBI: Can I ask you also a general question Sir Trengove on this issue because you see let us assume and not to get too much into the facts of what we're dealing with here. Let us assume that you have a general population of medical doctors so that's your 100%, 60% of whom are white and 40% of whom are black and let us assume that black includes Indians and Coloureds. But in practice when you come to investigations under Section 59, 70% of those investigated are blacks and less than 10% of those investigated are whites. Now you see there's an inverse between your potential target

group and your actually investigated group. I mean is that evidence of *prima faci* race discrimination or how should we approach that issue?

ADV WIM TRENGOVE: Well, let me go back to Harksen. There is differentiation because it differentiates in its impact, there's greater differentiation on some than others. Second question that line of differentiation runs along the lines of race. So, having concluded that there is differentiation along the lines of race, the third step is triggered which means the differentiation constitutes discrimination on the grounds of race. The only remaining question then is, is it unfair? And in that enquiry if you want to formulate it accurately, the real question is, has it been shown not to be unfair because it is the perpetrator who bares the onus of proving fairness. So yes, the hypothetical facts you raised will give rise to a presumption of unlawful race discrimination unless the schemes satisfy you that the differentiation is not unfair.

ADV ADILA HASSIM: Mr Trengove … (intervenes).

ADV WIM TRENGOVE: Let me also just say that it like in my robbery crime, there isn't necessarily a suggestion of unfairness but there's a question of unfairness and the onus of proof is on the perpetrator.

ADV ADILA HASSIM: I was going to ask you a very similar question to the Chair and on the basis of a slide that is before you but I want to say the following; that we have not heard from the schemes or the funders administrators yet. We've only heard from the complainants thus far and certain representative associations. But we are getting evidence from those associations about a disproportionate impact so

this slide is not- I'm not making any – we're not suggesting that this is a matter of fact the figures in this slide. But if you look at this slide which refers to psychiatrists and it's based on members of this organisation of psychiatrists. And if you look at the first row it tells you how many members they have and how that's broken down by race, 64 black, 6 coloured, 66 Indian, 147 white ... (intervenes).

ADV WIM TRENGOVE: 147 yes, that's the population ...(intervenes).

ADV ADILA HASSIM: That's the population.

ADV WIM TRENGOVE: By race.

ADV ADILA HASSIM: That's right. And at the very last line- well, actually not the very last line, let's start at the third. The number of members investigated or even the second, number of investigations per race category we start to see that there's a greater proportion of black psychiatrists than white and we see that reflected in the percentage in the last line. So 35.9% black versus 17 – well, black if you take all three categories it's even greater if you put them together versus white. So this is an example of what we've just been discussing with you now, which would need to then be put to the funders to this proof ... (intervenes).

ADV WIM TRENGOVE: *Ja.*

ADV ADILA HASSIM: That this is unfair discrimination.

ADV WIM TRENGOVE: *Ja.* Taking these figures as hypothetical on their face they clearly say two things. Firstly there's disproportionate impact and that the line of that disproportion runs along the lines of race. It means that it constitutes discrimination and it raises the

fairness question where the funders would then have to satisfy you where the onus of proving that the discrimination is not unfair.

ADV KELLY WILLIAMS: Mr Trengove, I have one further question. In Harksen and in Pretoria City Council versus Walker, you had one complainant. In enquiries such as these there are many and there are many potential complainants. Is the test designed to cater for both situations?

ADV WIM TRENGOVE: Yes because remember Mr Walker was typical of his kind there so he was also just the personification of a very large class who if he had a complaint would have had a complaint too. So the Walker test would still apply and one would then simply allow for the fact that the impact of the discrimination is felt by many and not by one alone. But it seems to me that that is a relevant factor whether the party before you is Mr Walker on his own or Mr Walker and the rest of white Pretoria. The question still is, is it unfair to white Pretoria to have the policy that they adopted regardless of who the person is that raised the complaint before you. So I don't think that the number of complaints in the forum makes any difference. You ask yourself how many people are victims whether they're here or not?

ADV TEMBEKA NGCUKAITOBI: Trengove, just interest in the earlier question in relation to just making sure that there's clarity when you say, those figures do give rise to inference of discrimination ... (intervenes).

ADV WIM TRENGOVE: Yes.

ADV TEMBEKA NGCUKAITOBI: That that is not unlawful per se

because it is only unlawful if it is unfair.

ADV WIM TRENGOVE: *Ja.* Remember you quite right and the language you use is right as well. The prohibition is a prohibition of unfair discrimination. Questions one and two leads to a conclusion of discrimination presumed to be unfair but not yet shown to be unfair or shown to be fair.

ADV TEMBEKA NGCUKAITOBI: Now I just want to go back to this issue so we've spoken about intention and we've spoken about the possibility of recklessness but just to make sure that I mean I understand the correct legal position. So you have a neutral methodology for conduction investigation that constantly over time produces racially skewed results and that as I say that the matter is neutral but the results are racially skewed and that you do nothing about it. Can you draw an inference of discrimination from the failure to do something about racially biased outcomes produced by the application of apparently neutral methodologies?

ADV WIM TRENGOVE: The answer is yes but it's I think the answer is actually easier than the question suggests because remember if you go back to the rule that it is for the perpetrator to satisfy you that the discrimination is fair, then you will simply not credit the explanation if it is the product of inadequate regulation or there may also be in such an enquiry a difference between the forward looking enquiry and the backward looking enquiry and I'm now going to speak hypothetically again because I really don't know the circumstances of your investigation. But assume that there is a perpetrator who's policy is

shown to impact disproportionately on black people so there's an enquiry into and the conclusion is its discrimination. The enquiry is one of fairness and the perpetrator has to proof. Now the perpetrator say, my goodness I'm so sorry, I never realised that my policy had that effect. That's not a complete answer but it might persuade you together with all the other factors and the slight impact that it has and so on. It might persuade you that the assessment of that policy on the looking back on the historical assessment is not unfair. But Mr Perpetrator now knows that that is the impact of the policy so going forward Mr Perpetrator would not have the excuse of ignorance of the impact of its policy. So it would be quite rational for you in such a case to conclude, I conclude that your historical conduct has not been unfair but now that the racially discriminatory impact of your policy has been shown to you, it would be- it would constitute with unfair discrimination for you to continue to apply this policy as you have done in the past because it is a flawed policy.

ADV ADILA HASSIM: Can I challenge you on that to say, that wouldn't it be more appropriate to say that it's relevant to remedy rather than whether they – rather than fairness. So the response that says, I had no idea, wouldn't change anything as far as the unfairness or fairness leg of the enquiry goes. It really is only relevant with regard to remedies.

ADV WIM TRENGOVE: You are quite right in saying that it is not decisive. In other words, ignorance is not an excuse in itself but ignorance is also not irrelevant. If the perpetrator genuinely didn't

know and couldn't have known and if there is no suggestion that he should have investigated the matter, in other words, that you can't say to him, that he should have known. Then ignorance may well persuade you that his past conduct was not unfair. So I do think that ignorance is relevant to the fairness enquiry not decisive by any means. It's not an excuse but it is a relevant factor looking back. Looking forward of course there's no longer any ignorance.

ADV TEMBEKA NGCUKAITOBI: But you see let's just take this one step- this enquiry with my colleague now. So let's take medical scheme X, the hypothetical medical scheme X.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: It conducts Section 59 investigations in 2016.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: They show by far that disproportionally the impact is on black doctors as opposed to white doctors despite its population size.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: In 2017, they do nothing about it they continue.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: In 2018, they do nothing they continue.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Until this investigation. So there are

both previous in the future conduct.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Is that conduct relevant to remedy only or is it also relevant to – I think that's the point that Ms Hassim is trying to enquire.

ADV WIM TRENGOVE: *Ja* but the fact you postulate is someone who is not ignorant. They knew that their policy impacted disproportionately on black people and did nothing about it.

ADV TEMBEKA NGCUKAITOBI: *Ja.*

ADV WIM TRENGOVE: Intention is relevant to fairness and in the same way as I said, an innocent mind is not an excuse but it's a relevant factor. A guilty mind is by the same token also a relevant factor, it increases the burden of proving fairness and it's very hard to imagine that knowing a deliberate discrimination can never be justified as fair.

ADV KELLY WILLIAMS: May I ask a related but slightly different question? Just hypothetically in relation to the claim of ignorance at not knowing for example the disproportionate impact on black people. How can that be credible when you can see that people are black or white, where race is visible to the eye?

ADV WIM TRENGOVE: You must forgive me for not knowing the facts of your case. I'm talking about a hypothetical ... (intervenes).

ADV TEMBEKA NGCUKAITOBI: It's the facts of our enquiry Mr Trengove.

ADV WIM TRENGOVE: *Ja,* I appreciate that but I'm talking about a

hypothetical perpetrator who does not realise the implications of its policy. If you tell me that in a policy that you looking at people do know what the implications of their policy are, then of course that is a different matter. But that's a question of fact not a question of law.

ADV TEMBEKA NGCUKAITOBI: Yes. I suppose what you are suggesting to us is that the enquiry is actually a simpler enquiry and we may be over complicating it ... (intervenes).

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Because we have to look at whether the outcomes are disproportionate to a population group.

ADV WIM TRENGOVE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Once we are there, discrimination is established what is presumed is the question of fairness which then requires justification by the perpetrator.

ADV WIM TRENGOVE: *Ja* and it means that if you are left not unable to determine whether it's fair, then the perpetrator loses because it bears the onus.

ADV TEMBEKA NGCUKAITOBI: Thank you Mr Trengove. We are very grateful that you've taken the time to prepare and to come and present.

ADV WIM TRENGOVE: It's been a pleasure, thank you very much.

ADV TEMBEKA NGCUKAITOBI: Alright, so the enquiry will be adjourned until- I think we have one more presentation I think until 15:00, until 15:00

INQUIRY ADJOURNS

INQUIRY RESUMES

ADV TEMBEKA NGCUKAITOBI: Good afternoon. We are continuing with the inquiry. I just want to see who the next presenter is from. It is the Dental Health Professional Association. So, sorry. Are you the presenter?

DR THABO TWALA: Yes, Chair.

ADV TEMBEKA NGCUKAITOBI: Okay, what is your name?

MR THABO TWALA My name is Thabo Twala. I am the Chairman of the Dental Health Professional Association.

ADV TEMBEKA NGCUKAITOBI: Thabo Twala?

DR THABO TWALA: Yes.

ADV TEMBEKA NGCUKAITOBI: Is it Mr Twala or Dr Twala?

DR THABO TWALA: Yes.

ADV TEMBEKA NGCUKAITOBI: All right. Dr Twala, I need to administer your oath. Will you say after me, I and your full names?

DR THABO TWALA: I, Thabo Twala...

ADV TEMBEKA NGCUKAITOBI: Hereby swear.

DR THABO TWALA: Hereby swear.

ADV TEMBEKA NGCUKAITOBI: That the evidence I will give.

DR THABO TWALA: That the evidence I will give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR THABO TWALA: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

DR THABO TWALA: The whole truth

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

DR THABO TWALA: And nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: Raise your right hand and say, so help me God.

DR THABO TWALA: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. So, the floor is yours. I see that you have just handed us a document called Survey Results. But take us through how you want to structure your presentation.

DR THABO TWALA: Thank you, Chair and the other Commissioners. From the Dental Health Professional Association, commonly known as the DPA, we are really grateful for being afforded this opportunity to come and present to the Commission. As practitioners in this particular space, the issues that are being ventilated in this Commission are actually very close to us and it affects a lot of our members greatly and I hope by making a presentation, you know, I will be able to assist the Commission in its investigations. Chair, I think I should start first by giving an introduction about the Dental Health Professional Association and I will therefore follow on, on the issues that relates to the scope of this Commission as regards Section 59 in its application by medical schemes. Right. Thank you, Chair. Just by way of introduction. The Dental Professional Association is an association of dental professionals in the main dentists but we also have dental therapists in our association and oral hygienists. Our membership is predominantly the black dental professionals. Our association was formed in 1992 and it has been existing up until now. However, safe to say that I can just mention that roundabout 1998 we went into a merger with the South African Dental Association, which measure unravelled about six

years ago. Mainly – part of the reasons why the measure unravelled was precisely because we felt that the South African Dental Association was not really protecting the interest of the members. In particular the black dentists. That is where the decision was then taken. You know, to move out of the dental association and once again become an independent association. Mr Chair, I have provided a survey because as you will appreciate, we have members coming to the association complaining about being harassed and being made to enter into settlements with a variety of medical schemes. However, it is very difficult to collate the data as regard that because those kind of issues come as and when and you know, they – I may just say that, you know, given our – the way that we want to spend our resources, you know, we do not usually spend as much on this particular issues. However, they are very important to the livelihoods of our members. And as well, I think this will also give you an indication of the kind of association that the Dental Professional Association is. So if we go into the survey results for instance, you will see that the people who responded to the survey, they were dentists, dental specialists, dental therapists. And as you can see there, that about 60% of the people who responded were dentists. And in our association a majority of our members are female, as it is reflected in the question number 3. Most of our members are full time private practice. About eighty percent. I will just quickly go through some of the things that are important. The way our members are allocated. The vast majority are in Gauteng, followed by North West and in Limpopo. However, the Dental Professional

Association is a national association and we have got members across the country. A very important issue that I think I should mention. It relates to Q7. Exactly where our members are practicing. So according to this survey, for instance. You will realise that forty-three percent of our members practice in the city centres. Forty percent practice in the townships and...(intervenes).

ADV TEMBEKA NGCUKAITOBI: It is Q7?

DR THABO TWALA: It is Q7 on the survey.

ADV TEMBEKA NGCUKAITOBI: No, but I do not have a Q7. I have got – it moves from Q6 to Q8 and then to Q9.

DR THABO TWALA: I am not to sure why you do not – I hope the other Commissioners do.

ADV TEMBEKA NGCUKAITOBI: Do you have?

ADV KELLY WILLIAMS: No.

ADV ADILA HASSIM: No.

ADV TEMBEKA NGCUKAITOBI: No.

DR THABO TWALA: Okay. But in any case. From my sheet, it is not really much. I think we can get it even afterwards the issues relating to Q7.

ADV ADILA HASSIM: You will provide us with the missing page?

DR THABO TWALA: Yes, for sure. Most definitely.

ADV TEMBEKA NGCUKAITOBI: Continue.

DR THABO TWALA: Okay. So, forty-three percent of our members practice in the city centres. 40% in the townships. About eig18% in the rural areas and another 18% will practice in what we can call the

suburban areas. So that will the suburbs and so on. *Ja,* alright, Q9 – I do hope you have Q9 there. Okay, Q8 relates to the remuneration. So about 68, safe to say, 70% of our practices depend mainly on medical aid for reimbursement and about 28% is a combination of both medical aid and cash. So indeed, medical aid is for us is a very important source of funding for the services that we provide. Q9, I think that is very important because an impression can easily be created that dentists and doctors are actually making a lot of money from medical schemes and so on. But as we can from the results of the survey, close to 60% of our members practices actually have a turnover of less than a R100 000 per month. About 18% have a turnover of less than R200 000 per month. So, I mean these are professionals who have spent many years studying. They have invested a lot of money to set up a dental practice. I mean, a dental practice is not cheap to set up. And yet these are the financial outcomes. This is not earnings. This is turnover. That members are generating in their practices.

ADV TEMBEKA NGCUKAITOBI: Does that not change with experience?

DR TABO TWALA: No, no. Absolutely not. I mean – absolutely not. So a dentist who enters in practice yesterday will earn exactly the same as the dentist who entered in practice 20 years ago.

ADV TEMBEKA NGCUKAITOBI: No, what I mean is. So, I mean, it is less than 100 000 a month. So one can say – can accept that for new entrance, but over time, you know, as you gain more experience, more exposure and more patients, the income would increase. Or are you

saying it would not increase?

DR THABO TWALA: I think as I make the presentation it will show that it is actually possible to – for somebody who has been practicing for twenty-years will still be earning 100 000. Okay, if we then go to – I would like to present Q11 which I think...(intervenes),

ADV KELLY WILLIAMS: Just a quick question before you go there.

DR THABO TWALA: Yes.

ADV KELLY WILLIAMS: I might have missed it. But what is your total membership?

DR THABO TWALA: It is slightly below five hundred.

ADV KELLY WILLIAMS: Just below 500. So what was your response rate on the survey?

DR THABO TWALA: Our response rate was 118 people responded.

ADV KELLY WILLIAMS: So, 118 out of 500?

DR THABO TWALA: Yes. All right. The question that is being said to the terms of reference of this Commission is actually Q11, where we have asked people if their practices have been audited by medical schemes. And 56% said, indeed they have been audited by medical schemes. Q12 – just excuse me. I just need to – Q12 relates to the financial settlements that members have made as a result of, you know, either the investigations or negotiations or whatever you can call them. That will...(intervenes).

ADV ADILA HASSIM: Sorry. Can you read out what the question was in Q12? Because that seems to be cut-off and Q14 seems to deal with financial settlements.

DR THABO TWALA: Yes, just one moment. I just need to get it on my iPad.

ADV TEMBEKA NGCUKAITOBI: When did you do the survey?

DR THABO TWALA: The survey was done in July. I think just after the announcement.

ADV TEMBEKA NGCUKAITOBI: So it was done in preparation of this inquiry?

DR THABO TWALA: Yes, Chair. I just need to get all the data. However, because my papers are also cut-off at that and I am struggling with my technology here. Or maybe I could have another... The questions is not very clear. However, the issues were that those people who have been investigated by medial schemes, did they, you know, made any form of financial settlements to the medical schemes. That is more or less what the question was relating to. And about 56% who had been investigated said that they have made financial settlements with medical schemes.

ADV KELLY WILLIAMS: Sorry. Mr Twala, can I just also ask you a question about the survey and how we should give it meaning. It seems to me that it is not representative of your membership if you only have 118 responses out of 500. Would that be correct?

DR THABO TWALA: I do think that is representative. In the sense that our members are both from the public and the private sectors. So, and for – in my view - 118 is actually a very reasonable sample. I would say.

ADV KELLY WILLIAMS: If it was a random sample, I think it would be

– I am certainly not a statistician. But I wonder if it was a random sample, it seem to be very representative. But if it is self-selecting and that is people actually responded. Is there not an argument that there are approximately 380 people who might give completely different answers and then skew the results?

DR THABO TWALA: Yes, but – I take the point what you are making. However, you have to appreciate the fact that, like I have said, some of our members are in the public sector and they may not necessarily have had an interest in this specific survey.

ADV TEMBEKA NGCUKAITOBI: How many?

DR THABO TWALA: I will not be able to – I think about two-thirds of our membership is in the private sector and about a third is in the public sector.

ADV TEMBEKA NGCUKAITOBI: So you would say this is representative of the two-thirds?

DR THABO TWALA: I would say so, yes.

ADV TEMBEKA NGCUKAITOBI: Yes, please proceed.

DR THABO TWALA: Thank you. Okay, and then, *ja,* I think the last point would be that if they have ever experienced spying in the practices and about almost half of the people who responded said that they have experienced some sort of spying in their practice. We did not go into the details of what that entailed. All right. So, I think that is the issue. I would just park there. The survey results for now. And I think I have managed to also give the Commissioners an indication of the membership profile of the DPA. All right. Getting to the issues. In

preparation for this commission, I had a look at the data from the Council for Medical Schemes regarding the reimbursements of dentists. My calculations were that in 1992, the total share of dentists in the medical scheme funding pool was about 9.7%. Around 2000 when the regulations on managed health care were introduced, the reimbursement to dentists was 6.1% and then in 2017 it was less than 2%. That is the calculations I made in preparation for this.

So, as we can see, over time the remuneration to dentists has been declining. I might say, at an alarming rate. However, for me the decline is mainly related to one thing and one thing only and that is manage care. So you will know that when manage care was introduced around 2000, in the main, it was meant to provide low cost options or rather possibilities for people who could not afford medical schemes. You know, your low costs options were great and so that they can easily afford them. And then those low cost options, managed care rules were introduced. Now managed care rules basically, they design a set of rules and protocols according to which all members of the scheme should be treated. And, you know, various ways are made to get members to adhere to that. One of the ways is by making them join what is called a providers network. I think in certain instances it is called DSP's and so on. But us in dentistry, we understand it better as providers networks. To join the providers networks, amongst other things, is that the provider must agree to abide by the managed care protocols that have been given. Number one. And number 2, is that, you need to comply to the tariff that is being provided. And the

incentives of de-incentives, you know, about joining or not joining, you know, but I think mainly I think it is the de-incentives. Because even if you do not join the managed care network, the medical scheme, what they do is that they pay you less for the services that you provide compared to somebody who is not on the network. They can also exclude you completely from reimbursement. Now what has happened actually, is that, managed care has over time been creeping. So from low costs options a managed care in most medical schemes and especially those medical schemes where the majority of the members are black people. You know, managed health care has actually moved from becoming – I mean, moved from low cost options to all the options that are there. So all options now are under managed care. And what managed care actually does, is that, it actually reduces the basket of services that providers are able to, you know, to provide to their patients. I mean, they get these hundred of services of treatments that a dentist is able to offer, but however, what managed care does, is that it reduces that basket of services to about four or five services that would be reimbursed, ultimately. So, effectively what it does is that – especially in the case of dentists, you know, it reduces them to – and I mean no disrespect. But it reduces them to become dental therapists or oral hygienists. And it is almost impossible to actually serve your patients to the best of your skill if ever you are treating them under managed care protocols. So for us, managed care has actually been very detrimental, you know. To the services that we are able to provide. To the development of dentistry as a profession and most

definitely financially. So, just back to the question that you asked earlier on. What has been happening over time, is that, because of the introduction of managed care and the reduction of in the basket of services, those practitioners who have been in practice for a long time, will actually experience a decline in reimbursement, as a result of the issues that I have aligned. So, ultimately, there is only a few – in the industry there are certain codes, procedure codes that we normally use to claim for the treatment that we give. Ultimately, what happens is that, there is only a few codes that can be reimbursed and it is not very difficult to see why practitioners will then use those specific codes more than any others because those are the ones that will be reimbursed. However, the system needs a lot of policing as well. So medical schemes and managed care companies, you know, they have developed what they call algorithm and so on. You know, so - but algorithms are basically, in our understanding, they are just almost like speed traps. So if you look at the algorithm you will be able to see that: "Look, man. There is probably something not right with the claiming pattern here." Right. Or you do not even need an algorithm. You just need somebody who is a dentist or has experience to see that there is a problem here. And I do think that medical schemes do identify those kinds of anomalies but what they do not know is that they do not call out the practitioner when they pick up a problem. They let it go on and on and on. Then two or three years later, then they call them in and then they throw the practitioner with a bill of about a million rands and whatever have you not. You know that they are being

accused of doing. So that is one way that ultimately medical schemes will deal with providers. However, there is another way. I mean, they also send investigators into practices of practitioners. I believe they also have installed spy cameras in other people's practices and so on. So, in other words, they send police to come and police the system and intelligence agents and so on. You know, to do that kind of work. Now having found whatever evidence that they would have found, then they call in the person and then they prosecute themselves. The individual, you know, who has been accused. I mean, they themselves prosecute this person and they themselves pass judgment on this particular person.

ADV ADILA HASSIM: But, Dr Twala, do you have evidence of these submissions that you are making? Does your association assists your members in these investigations and do you have records to substantiate your submissions?

DR TABO TWALA: What I would say is that I know for a fact that – you see what happens is that the medical schemes call our practitioners in private to go and discuss these things. The settlements that they reach with them are in private. We have certainly represented certain practitioners, but I do not think all the practitioners, they would have been able to represent. You know, reflect the true picture of the practitioners that have been dealt with by medical schemes. I hope I am answering your question.

ADV TEMBEKA NGCUKAITOBI: No. Yes, you are. I mean, the question, I suppose, you see, you are saying here that people have spy

cameras installed. Where is the evidence of that? You see. So are you saying – you identified the problem. You do not fix it now. You wait three years down the line and then you try to claw back. Where is the evidence of that? So, if you have got specific examples that you can give to us? Also, which schemes are installing cameras at your members' practices? So it is that sort of detail that we are looking for. Or are you just basing it on anecdotes or do you actually have got examples?

DR TABO TWALA: Yes, it is anecdotal. However, if you follow what I said. I said believe that even cameras are being installed. In terms of spying, for instance, our survey results says that members have said: "Yes, we have been spied upon." But I also said that I believe that cameras have been installed. You know, what I know is that certain members in the association and other associations, individually they have made submissions to the Commission. And that those who do have evidence, I would really hope that they have submitted that particular evidence.

ADV TEMBEKA NGCUKAITOBI: Yes. No, but you see. They have in relation to their practices and in relation to their occupations. You are here for the dentists that are members of your association. The question is, whether or not the dentists who are members of your association also have similar experiences? And if they do, where is the hard evidence?

DR TABO TWALA: In relation to the cameras, Chair.

ADV TEMBEKA NGCUKAITOBI: Do not limit it to cameras. I mean,

the complaints you have been outlining, you know.

DR TABO TWALA: Yes.

ADV TEMBEKA NGCUKAITOBI: Do you have anything to substantiate them?

DR TABO TWALA: Okay. I will say that as a dental practitioner myself, I made a submission individually. Separated from the submissions that have been made. And in the submission that I made, I detailed my own experiences. Not in relation to spying but in relation to the investigations that have been conducted against my practice. So, in my specific case, I have submitted that evidence.

ADV TEMBEKA NGCUKAITOBI: What is the evidence? What happened?

DR TABO TWALA: All right. So, in the submission I made, I say that the modus operandi of medical schemes, is that, whenever they suspect that there is something wrong, the first thing that they do is that they suspend payments to the practice. When they suspend payments to your practice, they put you in a very desperate position because, you know, all practices they need cash-flow in order to function. When that happens, they would then want all manner of records. You know, your clinical records, for instance. They would want...(intervenes),

ADV ADILA HASSIM: Have you been describing what happened to you?

DR TABO TWALA: Yes.

ADV ADILA HASSIM: So you were placed on suspension?

DR TABO TWALA: Yes, several times.

ADV ADILA HASSIM: When and by which schemes and for what reason?

DR TABO TWALA: I have been placed on suspension by all manner of schemes, starting with GEMS, Polmed – *ja*. So what happens is that, in the industry there are medical schemes administrators. So you will find, for instance, Medscheme. Medscheme have several medical schemes. So when they stop payment to your practice, they actually stop payments from all the schemes that they administer, right, so, at any one point in time if medical scheme suspends you from payment, you know, you will not get paid from Polmed, you will not get paid from SABC or Bonitas or whoever else is being managed by Medscheme. I mean, at this point in time, I think if you, if the record that I have sent to the commission, is available, you know, I am dealing, had the very same issue with Medscheme, but it is not Medscheme. If my memory serves me well, around 2008, I had a similar problem with Hosmed, however at that time I was probably naïve and so on, so I refused to make any kind of submission to the medical schemes, because I was angry about the manner in which I was being treated, they stopped payments to my practice, I went to court on the issue and I lost the court case. Unfortunately now, the lesson that I learned from that was that when the medical scheme, and subsequent to that I never got reimbursement again from Hosmed, but the lesson that I learned was that, if the medical scheme wants records, in as much as it may make you upset or angry, in order to maintain the financial viability of your practice, the easiest thing to do is to submit the records. And over time I have received those

requests and I have submitted it and I suppose that was the end of the story. But it is never ending. It comes all the time.

ADV ADILA HASSIM: You made, you said something about Medscheme, Medscheme represents several different, Medscheme is an administrator for several different schemes.

DR THABO TWALA: Yes.

ADV ADILA HASSIM: If you have found, if you have been found to have billed irregularly or whatever the example might be in relation to one scheme, Medscheme suspends payment on behalf of all the schemes that it administers, is that what you are saying?

DR THABO TWALA: That is correct yes.

ADV TEMBEKA NGCUKAITOBI: Where is the evidence of this, Doctor Twala, I mean, this is part of the problem now, we are trying to understand. You see, if you make an allegation that you are wrong on Bonitas and then you are cancelled on five other schemes, even though there is no irregularity in relation to those schemes, where is the evidence?

DR THABO TWALA: Chair, in my view, if you, I will really ask you to look at the submission that I made as an individual, because in that submission for instance, it may have been around 2016 when I had a similar problem and then at the time I approached the Dental Protection Society. They provide professional indemnity for healthcare professionals, and I wanted assistance, and they very kindly found, I think Webber Wentzel attorneys to represent me. And the opinion of Webber Wentzel Attorneys, I think I did include it in my individual

submission, and this was precisely the issues that we, I was most unhappy about, that Medscheme is suspending payments, you know, to all medical schemes that they administer. Safe to say that ultimately I abandoned the court case, and the reason I abandoned was for only one reason. At the time, Medscheme was administering, at least when I am practicing, fewer medical schemes, you know, SABC and a few others, which were not significant to my practice. So, I was prepared to go, you know, all the way to fight this issue. However, when Medscheme took over administration of Polmed, now Polmed is a big medical scheme where I am practising, and they stopped payments to my practice from Polmed, you know, I had no choice but to abandon the legal challenge, because now I was under significant financial pressure, you know, to toe the line as it were, safe to say that I did submit the records that they were looking for and, you know, payments to my practice were unlocked. But that evidence, in the individual submission that I made, it is there.

ADV TEMBEKA NGCUKAITOBI: Thank you.

DR THABO TWALA: Okay, thank you Chair, so I think that is basically the issues that I wanted to say. One other issue that we made mention of in our affidavit is that it is our view that there is always a perverse incentive, or a perverse relationship that exists between you know, managed care companies, and medical scheme administrators and to the companies that will be doing the forensics audits. For instance, the audits of Medscheme are done by I think, Afrocentric Forensics, something like that, and everybody knows that Afrocentric is a major shareholder in Medscheme. So, a subsidiary of Afrocentric is actually

doing this particular work, and it is also possible you know, that there is some financial rewards, you know, that arise due to the perverse relationship that exits, both to medical scheme administrators and the companies that do the investigations. Now, I have been able to show you that dentists for instance by mere chance are the biggest drivers of costs in health care. The real drivers of costs are well known and it is hospitals, specialists, pharmaceuticals and administration services. I really wonder if, you know, some of the actions that are being taken against providers, similarly are being directed at the people who are actually responsible for, you know, for the rising cost of healthcare. And in conclusion Chair, I would just like to say that a figure is banded about a lot of the times that, they call it fraud, waste and abuse that is taking place in the industry is costing the industry about R25 billion per annum and so on, it may or not be true. However, in my view, you know, this figure falls into insignificance if we look at you know, the losses that practitioners are incurring as a result of medical schemes. This refers for instance to non-payment of legitimate services. I mean...(intervenes).

ADV ADILA HASSIM: And what is that figure?

DR THABO TWALA: I do not have the figure.

ADV ADILA HASSIM: Do you calculate the loss to the...(intervenes).

DR THABO TWALA: No, I have not taken the time to calculate it, but I know for instance, I mean in my practice, the loss, I mean we lose about, we have a bad debt due to non-payments or short payments of between 10-20% of whatever is billed, and it is, each and every practitioner will tell you the same story, that they are incurring losses. So, equally, we

are experiencing significant financial losses as a result of the action of medical schemes, and finally, the fact that people had been locked into network agreements and so on, and receiving below inflation tariff increases, over time, has actually resulted in massive losses to us as professionals and as dentists and health care practitioners. *Ja.* That will be my submission.

ADV TEMBEKA NGCUKAITOBI: The complaint in paragraph 10 in your submission, that the counsel for medical schemes has generally been reluctant to deal with complaints for our members and association against medical schemes. I mean, what is the basis for that complaint?

DR THABO TWALA: Chair, personally as the Chairman of the DPA, on several occasions, I have tried to engage with counsel officials, not only on the issue of issues relating to members but on issues relating to the industry in general, in particular managed care. Because I wanted to raise specific issues regarding managed care, I did not even get the benefit of a response. Before I personally went to ask the dental protection for assistance legally, individually I tried to engage with the counsel of medical schemes and there was no response. I know for a fact that the other practitioners who had similar problems regarding investigations by medical schemes, they have tried to go to the counsel of medical schemes and they did not find any joy.

ADV TEMBEKA NGCUKAITOBI: Where are those examples, I mean, you see, if you have made a sort of serious allegation that says the CMS is reluctant to deal with complaints lodged by your members and by your

association, but I do not know what is the value of that in the absence of the actual complaints and the responses by the CMS.

DR THABO TWALA: I take your point Chair, I take your point. If , I do not know, if it is possible to provide, because on this particular issue, I have got no doubt that myself an many of our other members has got the same experience, which can show that CMS is absolutely not interested in dealing with these issues.

ADV TEMBEKA NGCUKAITOBI: Will you furnish it to the secretariat?

DR THABO TWALA: Absolutely.

ADV TEMBEKA NGCUKAITOBI: Thank you, do you have anything else to say?

DR THABO TWALA: Yes, I think that completes my submission Chair.

ADV TEMBEKA NGCUKAITOBI: Alright, thank you Doctor Twala, thank you for your association's time and effort in preparing the written submission and in coming to present here. We will be in contact for further information should it become necessary.

DR THABO TWALA: Thank you so much for the opportunity.

ADV TEMBEKA NGCUKAITOBI: The enquiry will adjourn until the 29th of August at 10:00.

INQUIRY ADJOURNS TO 29 AUGUST 2019

TRANSCRIBERS CERTIFICATE

FOR 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

DATE HELD	: 2019-08-23
DAY:	: 08
TRANSCRIBERS	: D BONTHUYS; V FAASEN; B DODD; Y KLIEM

Audio's are typed verbatim, as far as audible/possible

Accura Africa Group

Your Forward-Thinking Partner