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

29 AUGUST 2019

DAY 9

PROCEEDINGS HELD ON 29 AUGUST 2019

ADV TEMBEKA NGCUKAITOBI: Good afternoon, firstly we should apologise for starting late, the reason was entirely mine, I had a commitment this morning. Nevertheless, we are continuing with the Section 59 Investigation. So today we have NHC Medical Centre, who is here on their behalf? Alright, I am corrected, it is SASOP that is going first, the South African Society of Psychiatrists. So who is here on behalf of SASOP?

DR MVUYISO TALATALA: Thanks Chair, my name is Doctor Vuyiso Talatala who is the past president of the South African Society of Psychiatrists.

ADV TEMBEKA NGCUKAITOBI: I just want to make sure that I get your surname correct.

DR MVUYISO TALATALA: It is Talatala, T-a-l-a-t-a-l-a.

ADV TEMBEKA NGCUKAITOBI: And is it doctor or mister?

DR MVUYISO TALATALA: Doctor, Vuyiso.

ADV TEMBEKA NGCUKAITOBI: Thank you and I see you have a colleague?

DR SIBULELO SEAPE: Yes thank you Chair, I am Doctor Sibulelo Seape.

ADV TEMBEKA NGCUKAITOBI: Seape?

DR SIBULELO SEAPE: S-e-a-p-e.

ADV TEMBEKA NGCUKAITOBI: And Doctor Seape. Alright. Dr Talatala do you want to take us through what you are going to do or who wants to speak?

DR MVUYISO TALATALA: Thank you, thank you Chair, advocates, I will do the presentation and Dr Seape will assist me with answering any questions.

ADV TEMBEKA NGCUKAITOBI: I would have to take your oath then, will you just say after me, are you happy with an oath or affirmation?

DR MVUYISO TALATALA: An oath is okay.

ADV TEMBEKA NGCUKAITOBI: Oath is fine, alright. Say after me, I, and your name.

DR MVUYISO TALATALA: I, Vuyiso Talatala.

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

DR MVUYISO TALATALA: Swear that the evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR MVUYISO TALATALA: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

DR MVUYISO TALATALA: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing but the truth.

DR MVUYISO TALATALA: And nothing but the truth.

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

DR MVUYISO TALATALA: So help me God.

ADV TEMBEKA NGCUKAITOBI: And Doctor Seape, will you also be giving evidence, yes alright, then I shall take your oath. Say after me I, and your full name.

DR SIBULELO SEAPE: I, Doctor Sibulelo Seape.

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

DR SIBULELO SEAPE: Swear that the evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR SIBULELO SEAPE: Shall be the truth.

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DR SIBULELO SEAPE: And nothing but the truth.

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

DR SIBULELO SEAPE: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you, Doctor Talatala.

DR MVUYISO TALATALA: Yes, thanks Chair. We shall be using the slides to assist our presentation.

ADV TEMBEKA NGCUKAITOBI: Yes, we do have the slides.

DR MVUYISO TALATALA: And we would like to thank the panel for giving us the opportunity to present and for accommodating our change in dates, since we were not available last week. The people were supposed to present, those are the four people I would like to introduce us and the colleagues that we are supposed to present with, it is myself Vuysio Talatala, I am a psychiatrist, I am previously Director of PsychMG, I am in the Senior Leadership of the South African Society of Psychiatrists since 2010. In terms of work I am in private practice, Doctor Sibulelo Seape is the President elect of the South African Society of Psychiatrists and she

is also the Chair of PsychMG, and I will explain the relationship between the two organisations. Professor Bonginkosi Chiliza is the current President of the South African Society of Psychiatrists and she is a signatory to the submission. And Dr Eugene Ellis is the past president of the South African Society of Psychiatrists and also the past Chair of the PsychMG. The South African Society of Psychiatrists represent about 700 members, mostly psychiatrists, about 600 psychiatrists and other members include medical officers and doctors who are in training to be psychiatrists. The South African Society of Psychiatrists is an Overall – is an Umbrella Body and psychiatrists are divided into two, we call them vocational bodies, whose who work in private practice and those who work in public practice. Those who work in private practice, their affairs are managed by a board call Psychiatry Management Group which his PsychMG, and those who work in the public sector are represented by a committee called Public Sector Vocational Group. So the PsychMG manages the affairs of the private psychiatrist which is probably what we are here about and does report to SASOP, but SASOP takes the overall direction in terms of the profession. There are 284 PsychMG members. Today I want to take you first to the objective, why we are here, but before I go through that I would like to give you a bit of the…(intervenes).

ADV TEMBEKA NGCUKAITOBI: Can we just get these numbers, what is that 700 that you mentioned?

DR MVUYISO TALATALA: Okay, the total number of members of SASOP is about 700.

ADV TEMBEKA NGCUKAITOBI: That is the 772?

DR MVUYISO TALATALA: It fluctuates it must be 772 but the actual figure should be about 772.

ADV TEMBEKA NGCUKAITOBI: Yes, that is what I have got.

DR MVUYISO TALATALA: Yes.

ADV TEMBEKA NGCUKAITOBI: And then the 284?

DR MVUYISO TALATALA: Is the members of the private psychiatrists who are members of the Psychiatry...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Private.

DR MVUYISO TALATALA: Yes.

ADV TEMBEKA NGCUKAITOBI: And the 772 includes public?

DR MVUYISO TALATALA: It includes public, it also includes doctors who are training to be psychiatrists, we call them registrars, it also includes medical officers who have an interest in psychiatry and who are working in psychiatry hospitals, and a few members who may not – who are honorary members like maybe a president of a society that we have a good relationship with.

ADV TEMBEKA NGCUKAITOBI: Okay, so the 284 practice in psychiatry?

DR MVUYISO TALATALA: Private practice.

ADV TEMBEKA NGCUKAITOBI: Okay.

DR MVUYISO TALATALA: So, I wanted to take you, if you will allow me firstly to explain why we are here. The South African Society of Psychiatrists is of the view that the forensics investigations that the schemes have an authoritarian, they have been unfair and they lack transparency. And this is by design. The way the system is designed is designed to be unfair. And an unfair – a system that lack of transparency

in our view that – is the hallmark of a system that is discriminatory and that happens throughout the world, and we have got examples of such systems in our country, from colonisation to apartheid and we have got European examples including Nazi Germany. The system itself is designed to be unfair so that those who are practising it, or even those who are victims of it may at times not even realise that they are practising an unfair system because it automatically works the way it is designed. That is our view, so I mean, under apartheid, the police, the prosecutions, the judges, the executives, there was no differentiation and as a right the adjudication of cases would be unfair, that is the system we have when it comes to forensic investigations of the schemes. And therefore our objective and our main submission is that the system needs to be overhauled in full, such that we have an independent transparent and a fair system that includes all stakeholders. So, what are our submissions to substantiate this proposal? Our data shows that there is a racial bias against black and Indian psychiatrists. Whether this is racism or is the system designed but we will show throughout our data that there is a bias towards black and Indian psychiatrists. Psychiatry as a discipline is unfairly targeted compared to other disciplines and we think that that is due to stigma against mental health care and stigma against people living with mental illness, and that could be by design or that could be due to financial pressures or it could just be due to prejudice. The process followed by the schemes who are investigating is unethical and we will show what they have done to us, what makes us to think they are unethical. And lastly ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: One of the presentations said that the difference with psychiatry and other occupations is that from the perspective of the schemes it is easy to investigate because it's all times based; you look at all the time spent.

DR MVUYISO TALATALA: If you are biased against a discipline you will find it easy. My view is that the costs of mental health care is escalating, the utilisation is escalating and therefore, to contain the costs of mental health care you need to deal with the practitioners so that either they under charge, under code, or it is a funny way really to reduce the utilisation of services or the cost of mental health care. I think that is what is underlying; I do not see why would it not be easy to find problems in other disciplines. And secondly, if that was the case, then cases should be, if it was just time based, is the only reason, then we know that doctors work 10-12 hours a day. Then the cases we should be dealing with, for instance the investigations should be those who are spending more than 12 hours a day, and therefore we should not have all the unethical things they do, we should just call a psychiatrist, I mean the scheme should just call a psychiatrist and say you work 18 hours a day, there should be no debate, there should be no calling or notes, all that I am going to show you, to justify that. If time is just the time, so psychiatry, we should say psychiatry can only work 12 hours, then it ends there. But when they do the investigations they go much beyond, way deeper than time. They also investigate psychiatrists who do not spend more than 12 hours.

ADV TEMBEKA NGCUKAITOBI: The investigations are not only focused on time, they also focus on other aspects, but just tell me something else, on the issue of – you say the cost of mental healthcare has been escalating and that is what you think is the reason behind the targeting of your occupation?

DR MVUYISO TALATALA: I think that is one of the reasons that the cost has been escalating, not because the fees are increasing but because the doctors are charging more, the increase in fees charged by psychiatrists has been increasing according to our past index for many, many years. But what is happening in the space of mental health care the utilisation, more people are coming out and presenting with bipolar disorder or schizophrenia or depression, and because of the increased utilisation, the budget spent by the schemes, or even government for that matter, is increasing for healthcare. And that is not a psychiatrists' problem, it is a good thing that people are presenting, but it is a problem the country should deal with in terms of budgeting.

ADV ADILA HASSIM: Is that – more people coming out, is that a shift or a change in the disease burden? Or is it just that their, those patients are becoming more aware of their ability to seek mental health services?

DR MVUYISO TALATALA: I think, the biggest, that is my opinion, the biggest contribution is people getting aware of the services. I work in Soweto in a black population, I am busy all day around because of and over the years, numbers have been increasing and I am busy because of people becoming aware of the illness. Obviously South Africa has got other problems that make mental illness more prevalent, we are talking

about violence or financial problems and all that. But I think people are becoming aware of the resources available to them. And also, the more we train psychiatrists, then the easer is the access and then more people will then seek help. When there were no psychiatrists in Soweto or there were no psychiatrists, then people would get tired of waiting for the psychiatrists, but if there are, the five psychiatrists as we have now, then people would present themselves.

ADV TEMBEKA NGCUKAITOBI: Yes, Dr Seape?

DR SIBULELO SEAPE: Yes, thank you Chair. I was just adding on the question of that you said that they said it is just time based. But it is beyond time. I think psychiatry and the mental health care user is the more vulnerable group so they present themselves as an easy target. They are not a vocal vociferous group that will put up a march, write a petition, you know, if they are not getting the services that they deserve. So in that manner, they are easier to lodge against. And even beyond time, generally in psychiatry practice we use very, very few codes, I think averagely about 13 codes are used over time, if not less, unlike if you look at a surgeon or a physician, there are millions of codes, so it should actually be easier to follow what the psychiatrists is doing because we have very few codes.

ADV TEMBEKA NGCUKAITOBI: Thank you, just tell me when you say, look, the escalation in usage is obviously driving the cost up and there may be other underlying reasons why the usage is escalating, where do you get this from, what is the data, what is the information, I mean, or is it just your own speculation or is there something tangible?

DR MVUYISO TALATALA: We do not have the data ourselves but one can see in practices, in our own experience, but the schemes themselves have shown in their meetings, they have shown the increase in utilisation. In fact, the schemes would be able to provide that data.

DR SIBULELO SEAPE: Can I add Chair, that also, that information should be easily available, because if you look five years ago, 10 years ago, there was a very small number of psychiatric beds and now they have over tripled, so that – and I am talking about just in patients, and so that is the – and they are always full, it is not unusual that you should wait for an admission bed when you are unwell.

ADV TEMBEKA NGCUKAITOBI: Thank you.

DR MVUYISO TALATALA: Thanks, thanks advocate. So we – let me just get myself so we said there is a racial bias that's how we submit that and we submit that psychiatrists are unfairly discriminated compared to other schemes, the process followed during the investigation is unethical and we will show that and then there is bullying. Once we say al – we put all the submission, we want them to be taken in context, that this is based on experience with these investigations by schemes and we are not inviting the schemes to investigate our white psychiatrists or to investigate other disciplines but that they put them on par with the vulnerable or discriminated people. And we are not in denial of the fraud, in fact we do accept that health is vulnerable to fraud, mental health is vulnerable to fraud. And we would want fraud to be singled out and to be dealt with and we would do, that is why we want the overhaul of the system. I will be going to now substantiate why I think there is racial bias and we are

going to use the data of our members. As I have said earlier on that SASOP and PsychMG have been involved with these forensic investigations for a long time, I think the first experience, real experience of an actual psychiatrist that was investigated was actually in 2008, Dr Eugene Ellars was involved at the time and I think I started getting involved around 2010, 2011 as a Chair of PsychMG at the time, and I have been involved over the years, Dr Seape has also been involved of course, because we are doing this after hours it is difficult to be involved consistently all the time when there is other challenges. I want to take you firstly in terms of the demographic data of our members. You do not have to pay attention to the provinces, but if you look at the top row, there is black, coloured, Indians and whites and total. At the bottom is the total, so we have got 64 blacks, 7 coloured, 66 Indians and 147 psychiatrists, we are just talking about the full private practice psychiatrists. So total number, we have got 284 psychiatrists. So if you put blacks, coloureds and Indians together we have got about 137 black, coloured, Indian psychiatrists and 147 white psychiatrists.

ADV KELLY WILLIAMS: Dr Talatala, just to ask a factual question, do you know how many psychiatrists there are in private practice in the whole of South Africa in other words, who may not be a member of your, of PsychMG?

DR SIBULELO SEAPE: I think there is about another 100 that are not members.

DR MVUYISO TALATALA: Yes, yes. But we can – we do have the – I just omitted to think about that when preparing, but we can submit the

exact number of the total number of psychiatrists who are in private practice. The extra 100 does not mean they are all in full time private practice, who can submit, they are private practice, maybe they are nor full time, retired, so we can submit that data that shows who is in full time private practice, whether they are full time part time, whether they are PsychMG members of not PsychMG members.

ADV KELLY WILLIAMS: That will be very helpful. Thank you.

DR MVUYISO TALATALA: Yes. So in terms of the PsychMG members, therefore we have got 52% white psychiatrists and 48% black, Indian coloured psychiatrists. In this slide, we are then dealing with a number of investigations per race, this is not the number of people, this is the number of the actual investigation, whether the investigation has taken place, but there are psychiatrists who have been investigated five times, one person who have been investigated five times and nothing ever found, so that is the total number of investigations. So black investigations it is 45, coloured 1, Indian 40 and white psychiatrists 34. So the total number of investigations that we have had is 120. That is looking at – I am going to then analyse that data further. The – so I look at membership versus the forensic investigations.

ADV TEMBEKA NGCUKAITOBI: Over what period is this?

DR MVUYISO TALATALA: Since when we started, since 2008.

ADV TEMBEKA NGCUKAITOBI: For the last eight years?

DR MVUYISO TALATALA: Since 2008. But of course the number has been increasing over the years, there have been more over the years.

We may have had one in 2008 and had nothing for a couple of years and then they increased over the years.

ADV KELLY WILLIAMS: Sorry, just to be clear, eight years takes us to 2011.

DR MVUYISO TALATALA: Since 2008.

ADV KELLY WILLIAMS: Okay, so you have 11 years' worth of data?

DR MVUYISO TALATALA: Yes, yes.

ADV KELLY WILLIAMS: Thank you.

ADV TEMBEKA NGCUKAITOBI: Now if you look at page 2 of your submissions, it says that SASOP has been aware of forensic investigations, audits, reviews of psychiatrists by medical schemes since 2008.

DR MVUYISO TALATALA: Yes.

ADV TEMBEKA NGCUKAITOBI: And then when you deal with the data, you say over the last 8 years there has been 120 audit cases, it must have been from psychiatrists requesting assistance form PsychMG, it is that data, 2.1.

DR MVUYISO TALATALA: I think we should look at the eight years, I suspect that before – beyond that we did not have capacity to capture it correctly. There were not many cases but we did not have – what changed in the society is that at some stage we then hired a company to actually assist us to keep data and so, I think when we were preparing the document...(intervenes).

ADV TEMBEKA NGCUKAITOBI: That is not a problem I think the only issue is just to get clarity whether this data is from 2011 or from 2008.

DR MVUYISO TALATALA: I think it is probably from 2011 and we can further just verify that so that is sorted, I think it is the past eight years, it has been experienced since 2008 but we began capturing the data in the past eight years. So in this slide we look at the demographics of the investigations, they said there are 45 black investigations, 1 coloured investigations, 40 Indian investigations and 34 white investigations leading us to 120 investigations. If we then drill down in the data, the number of members per race category, I am taking you back so that we have everything in one slide, we said we got 64 black psychiatrists, PsychMG 6 coloured psychiatrists, 66 Indian psychiatrists and 147 white psychiatrists which gives us 284 psychiatrists. The number of investigations per race, so out of the 64 black psychiatrists there have been 45 investigations. And out of the 6 coloured psychiatrists there has been 1 investigation and out of the 66 Indian psychiatrists there have been 40 investigations and out of the 147 white psychiatrists there has been 34 investigations. If we look at the members that actually got investigated because I said those are just the number of investigations that could be duplicate or even people investigated five times. Out of the 64 black psychiatrists there has been 23 psychiatrists investigated. Out of the 6 coloured psychiatrists there has been 1 coloured psychiatrist investigated. And out of the 66 Indian psychiatrists there has been 25 investigated and out of the 147 white psychiatrists there has been 25 psychiatrists, and that brings us to 74 psychiatrists, the actual psychiatrists investigated. From that slide it shows that the white psychiatrists are more than double the number of Indian psychiatrists for

instance, the Indians and whites have had the same number of psychiatrists investigated. And the black number is almost equal. The percentage of members per race, I am just going back to the first number, we are 22.5% black psychiatrists, 2.1% coloured psychiatrists, 23.2% Indian and we are 51.8 white psychiatrists, but if you look at the number of investigations, the investigation ...(indistinct) us that there are 37.5% investigations amongst that are taken by blacks on behalf of psychiatry, there is 0.8% taken by coloureds on behalf of psychiatry, 33% taken by Indians on behalf of psychiatry and 38% taken by whites on behalf of psychiatry. And if you look at the individual members, the actual psychiatrists then this also shows that there is almost equal number of psychiatrists investigated across black, Indian and white psychiatrists. The last line, we analysed the percentage, what is the percentage of psychiatrists investigated per race, like what is the impact of investigation per race. So there are 35.9% black psychiatrists investigates as a group, so if you are a black psychiatrist you have got a third of a chance to be, 1 out of 3 psychiatrists will be investigated. If you look at Indian psychiatrists, we have got 8.9% which is 38% over the number of Indian psychiatrists in the country have been investigated. But if you look at the white psychiatrists it is 17%. Despite the fact that white psychiatrists are a bigger pool, 50% of – over 50% of psychiatrists. So I am just iterating that, so the total burden of investigations that has been taken by black, Indian and coloured psychiatrists is 72% and the total burden taken by white psychiatrists has been 38%, that is despite the fact that the two groups, if I had to separate white psychiatry as a group, are

almost equal percentage in terms of membership. So, we further submit if I may move on that the stigma and discretion of psychiatry and mental health, 120 investigations, not psychiatrists, 120 investigations to psychiatry which represent 42% of psychiatrists. If we were to compare ourselves to other disciplines, that is the list we got from our management, the company that manages our burden at PsychMG and SASOP but also manages other disciplines. I am going to take you to the surgeons, the surgical, the PSCPSA which is the physicians and the Gynaecologists, GMG and even the paediatricians, if you look, all those disciplines, each discipline has more numbers than psychiatrists. I mean if we had less physicians than psychiatrists the county will have a – there will be a disaster. But if you look at the numbers investigated for the gynaecologists, it has been 46, for the physicians it has been 22, the total number. For the paediatricians 9, and obviously I am not inviting that they must be investigated but I am just showing that for psychiatry even the second specialist discipline has had 46 and psychiatry has had 120 investigations.

ADV ADILA HASSIM: Dr Talatala do we know the numbers of the membership of each – the total number of membership of each of the disciplines?

DR MVUYISO TALATALA: That was error on our side, we did not put it but we can submit it as well, but it is definitely more than psychiatrists, if we had less than 600 physicians in the country or 600 paediatricians or 600 surgeons, that will be a disaster, they are definitely more than psychiatrists.

ADV ADILA HASSIM: If you could get the numbers that will help us to compare.

DR MVUYISO TALATALA: Yes. So in terms of the outcomes of the investigations we can summarise that there has been 24 audit cases, where anomalies were found and the doctors had to refund the medical schemes, which is about 28.3%, there has been 66 audit cases which is 55% of all total cases where no anomalies were found and medical actually got feedback and explanations form the doctor. That is a very important figure in my view because it shows that the schemes have a fishing expedition in psychiatry. The psychiatrists are not practising expecting for a long time, we have not trained them to practice at defensive, a practise of psychiatrists that anticipates they will be audited. Because we don't have auditing of psychotherapy so they're just practicing as usual. So if they were able to prove that no anomaly has happened in 5% of them to me that says that there has been – there was a fishing expedition by the schemes. I remember that even the ones who accepted, it is not certain that they've done anything wrong because when the investigation is carried out, if the doctor does not cooperate then the payment stops and obviously the financial dynamics between the doctor and the scheme. The scheme stops paying and we don't have many schemes. It's not that if one scheme stops you are losing 10% of your income. No, if a scheme stops you probably losing 50% or 40% of your income. So it's very difficult for psychiatrist for any doctor if they are being investigated by the scheme to not agree to sign and pay whatever

money they have asked for, for your sake as a practitioner and for you patient.

ADV TEMBEKA NGCUKAITOBI: Tell me of that 55%, I mean we've seen the slide before, I think it came with Klinck or something but one of the professional bodies. The question I asked them is out of that 55% which was cleared after the investigation. How many do we know had payments suspended during the investigation?

DR MVUYISO TALATALA: We wouldn't know – I wouldn't know at this time. We can look for it as well. I wouldn't know when or how many actually got suspended. It's a threat that gets put and if you don't cooperate then they would suspend but if you cooperate they wouldn't. But at some stage, there was a time where some of the schemes and I didn't bring that – they would suspend even before they tell you that they are investigating you. And then once you – then you'll stay suspended until the matter is resolved but we did not look at that. I'm not sure if we actually have kept that kind of data.

ADV TEMBEKA NGCUKAITOBI: Okay.

ADV ADILA HASSIM: And in relation to the 28.33% where no anomalies were found – I mean, sorry, where anomalies were found? What type of anomalies were those? Was it fraud, waste or abuse or something completely different?

DR MVUYISO TALATALA: I'm just thinking off my head now what psychiatry – schemes have found. Psychiatrists would accept or even if they don't accept would sign an agreement to that they'll pay where they

have been accused of spending less time with a patient. I think that's the main thing.

DR SEBOLELO SEAPE: *Ja* it was at the time when the schemes said the time was not enough and I think that was the main thing. And then the codes because you see the time and the codes – the code depends on the time. So the scheme will then work out that, no, this couldn't have happened in that- you couldn't have seen this patient in this time and what then happens is that they extrapolate and he'll try – he'll talk about it later. Let's say for example that they find 5 patients then they say therefore that means that this percentage of your practice is not keeping up to the right time. So they extrapolate from a small number to include the whole practice and then they sanction you on the whole practice.

DR MVUYISO TALATALA: In fact, you are reminding me, the dispute will be – actually it's not even time. The dispute will be about the code. How the psychiatrist interprets the code and how the scheme interpret the code and how the society interprets the code, that's where the dispute starts.

And in all settlements, we'll settle with the scheme's interpretation of the code and therefore because of the schemes interpretation of the code, which differs with the psychiatrists and the code is time based then the psychiatrist then will be made to pay back but we'll still further explain that.

ADV KELLY WILLIAMS: In relation to this information of the 66 audit cases where there 55% of total cases, no anomalies are found. Those effectively false positives as I understand. The schemes evidence would

be, there are system flags, a practice for audit and then they investigate and then they get a result. But you are presenting to us is that system is producing 55% of false positives, am I correct?

DR MVUYISO TALATALA: Yes of course.

ADV KELLY WILLIAMS: So do you know the break-up of the schemes in question here? Who is responsible here, which schemes or administrators are responsible for producing this false positive?

DR MVUYISO TALATALA: I think there – it might – we actually do have the data as well, unfortunately I didn't bring that as the breakdown of the schemes. But with from my experience all the schemes that investigate will have the false positive.

ADV KELLY WILLIAMS: Perhaps you can just get that information.

DR MVUYISO TALATALA: Yes, we can get that.

ADV KELLY WILLIAMS: Thank you.

DR MVUYISO TALATALA: So for us – if I may continue Advocate?

ADV TEMBEKA NGCUKAITOBI: Yes.

DR MVUYISO TALATALA: Yeah. For us we believe that there's humans behind the numbers. Maybe for the actuaries and the designers of the systems, the numbers are more – in fact even to the economies and people run big business or even government, the numbers are more important than the human beings. But for us the human beings are more important and who are those human beings? I'm talking about the psychiatrist, the patient and their family. And I want to show this. When the scheme – when there's a dispute between the scheme and the psychiatrist and the psychiatrist does not accept the methodology of the

investigation and the scheme stops paying the psychiatrist, immediately the patients cannot afford the psychiatrist. A huge number of patients would not afford to see a psychiatrist unless they're on a scheme. When they then stop paying the psychiatrist, the psychiatrist which it's difficult to even see the patients for free for the time because it won't be just a 10% or a 5%, it will be 40 or 50% of their actual practice. What then happens to those patients is that they will not have access to medications. Some of them, the illness itself made them not to trust the psychiatrist in the first place so there'll be breakdown with the therapeutic relationship between the psychiatrist and the patient. Most of them are working, working for the bank, working for different industries. If the patient was in hospital last week, the bank wants the sick leave note, they want a report why the – in fact, remember the patient is already discriminated by the work environment. So if the employer, I'm sorry to pick on the banks but the employers almost all of them are like that. The employer is already not believing that you're in hospital as a mental ill person and therefore they want evidence, probably they'll even want an affidavit but they don't. But they'll want solid evidence that you're in hospital. You cannot come and tell them a story that my psychiatrist is not seeing us now and therefore I cannot produce the report that you want. And if that patient then moves to the next psychiatrist or to the public sector to a clinic, the public sector clinic the psychiatrist at the public sector clinic will not be able to account for that time and therefore this effect the patients in the workplace. Obviously, I won't take you – waste your time Advocate with the impact of this

financials with the patient and financial to the family to the community even to that employer who's distressed because they don't know how to accommodate this person. Maybe they have insurance to cover the time the person was away at work but they cannot claim for the insurance, they cannot hire a new person so it affects the system. These investigations in stopping of payment affect all of us and we're of the view that ... (intervenes)

ADV ADILA HASSIM: Sorry, just to clarify. By stopping of the payment, do you mean being put on indirect payment? So that the patient would have to pay you upfront and get reimbursed by the medical scheme, is that right?

DR MVUYISO TALATALA: Some of the schemes will put you on indirect payment where the patient can pay and then get an invoice and go and claim. Other schemes would stop payment, they say you mustn't see that – they don't tell the patient that they mustn't see you but the patient they can't, they won't refund you if you saw that psychiatrist that they are not paying. But even the indirect payment, even if you have to say the psychiatrist – sorry, the scheme is going to choose to stop the indirect payment. That is still destructive because most of the low-income families will not afford to pay the psychiatrist upfront. In fact, actually I can say almost 90% of psychiatry patients rely on the medical of mental ill – probably living with mental illness, rely on the schemes to get their treatment. They do very few patients, very few people who live with mental illness will afford to pay cash for mental healthcare. And I know this because actually most psychiatrists most – 90% of psychiatrists are

in arrangement with – they take up almost 90%, they take up fee arrangements with the schemes. They take them up even before they're recommended because there's pressure from the patients who cannot afford to pay cash for mental healthcare. So we believe that stopping the payment is insensitive, is reckless and it really does affect the care of the medical care users. Now I'm going to show the stigma – further evidence of stigma against psychiatry by the schemes. When people have a mental illness and they get put on treatment it is well known that they'll have weight gain from the medications but also the illness itself puts at risk of other illnesses that may result in weight gain for instance as an example. But a lot of schemes will not fund dieticians if dieticians are treating there for instance in a hospital, a patient admitted with a mental illness. If you refer, the dieticians won't be paid and yet that is key treatment for mental – for at least the adverse effects or the side effects of the medications used. Most schemes have stopped paying for physiotherapy, they will not pay – some of the schemes will not pay for physiotherapy even if the first 3 days you were in the medical ward and you were dealt mostly with a medical illness that needs physiotherapy and you then get transferred to a psychiatry ward because the psychiatry illness is weighing heavier than the medical illness but you still need physio for your lung problem. When you get to the psychiatry ward the physiotherapy stops. Obviously, a lot of schemes have stopped paying for physiotherapy when it's required for mental illness. For instance, you've got depression which is known to cause pain scientifically and the pain of depression you cannot treat it with pain killers because the

patients would get addicted to the pain killers because it doesn't go away. So the pain of depression needs physiotherapy. But if you ask the scheme to pay even for a condition for Bipolar Disorder or depression, something one prescribe on annual benefit. Schemes a lot of schemes not all of them, a lot of schemes will not pay for physiotherapy in whatever form and which is further discrimination. At times, this is not always, when you got – if I admit a patient in the psychiatry ward for depression and the blood sugar is not stable it's going up which is common in mental illness and the blood pressure and you ask for a physician to come and see, physicians refuse because physicians don't get paid. So probably you have to discharge the patient to go the patient go and see the physician and then the patient comes back. So I think finances have influenced the medical aids to lose the sincerity and appropriateness when it comes to treating mental illness. I am moving on to submit that the process itself that's followed by the schemes is unethical and I think that is due to stigma and lack of care. Schemes believe that they can follow an unethical process because the mentally ill people will not complain anyway or it doesn't matter – I don't know their reasons why they will not follow the ethical processes and I'll show this. Firstly, I'll start with the process. The schemes they make the rules regarding the investigations unilaterally. They determine who should be investigated. They carry out the investigation themselves. They employ their own methodology but remember these are the people that are supposed to be – they're almost like an insurance that should be paying. They do not share the data to verify the healthcare – that the healthcare

professional is an outlier. If they say you are seeing too many of this code versus your peers. You don't know the psychiatrists don't know who his peers are. In fact, if you had shared that data upfront, then probably the psychiatrist would have noticed that in my hospital I do too many CT scans of the brain. Why am I doing more scans than other people? They would have noticed that themselves and learned from it. But the schemes won't tell you that you're an outlier … (intervenes).

ADV TEMBEKA NGCUKAITOBI: Let me just – tell me, have you ever seen a case, I mean how is a case actually resolved you see because you start an investigation and you're talking here about finding someone guilty but there's no third-party that is going to impose a verdict of guilt. And there's not third-party that will impose a sanction for being guilty. My understanding is that there are really two ways in which a case is concluded. One is they find that there is no evidence. They're satisfied with your explanation. The other is that you sign a settlement agreement. There's just no other way of concluding a case. What is your experience?

DR MVUYISO TALATALA: It's not a settlement agreement. I've said with psychiatrists it's called … (intervenes).

ADV TEMBEKA NGCUKAITOBI: It's called an AOD but yes.

DR MVUYISO TALATALA: Yes, maybe that's how it's concluded. But why we saying there's guilt is that when there's a hearing, they'll call the psychiatrist and they will put the allegation that you've done this there and that and the psychiatrist would explain that they've done it differently. But that wouldn't matter. Then they will then make a finding

that you are wrong and therefore sign the settlement so a settlement that we are agreeing that we don't want to take this thing further.

ADV TEMBEKA NGCUKAITOBI: But I mean am I right that there are really two ways of concluding a case? The scheme accepts your explanation or it doesn't your explanation. Where it doesn't accept your explanation, the real option you have is that the scheme might suspend your payment and put you on so-called indirect payment.

DR MVUYISO TALATALA: Ja.

ADV TEMBEKA NGCUKAITOBI: Alternatively remove you altogether from the practitioners that are recognised by the scheme. But if you don't want either of those, you sign an AOD, that's another way of concluding the case.

DR MVUYISO TALATALA: I think that's how they conclude it. Yes, that's how they conclude it. But remember at the time you are signing that settlement, it's not that – they've already, they've pushed you to sign it because ... (intervenes).

ADV TEMBEKA NGCUKAITOBI: No I accept that you may sign it even if you don't believe that you are guilty.

DR MVUYISO TALATALA: Yes.

ADV TEMBEKA NGCUKAITOBI: I'm not saying that a case has been concluded fairly but a case is brought to an end either by the scheme accepting your explanation or by the doctor signing the AOD even where a doctor protests their innocence.

DR MVUYISO TALATALA: Yes, advocate. The other – in this next slide I'm substantiating the unethical process. The first one is calling of

patients to verify services. So if the scheme wants to know whether the patient was actually seen they have in the past called a patient and asked, did you see doctor so and so in May or January and for – and they'll ask the time and the details of the consultation. We've protested and objected to that, some of them have stopped. But the problem that we had with that is that they would then use that call as evidence that the patient was not seen according the time that has been charged. But it is impossible to remember as I don't know how much time I have been here sitting here. It is impossible that when you are in a psychiatry consultation you would remember how much time you were sitting in that consultation. It is worse if you then asked how much time did you sit in that consultation, two weeks ago, a month ago, two years ago or three years ago. The investigations usually last for a three-year period from the – they look at the patients for a three-year period prior to the time you are investigating. And it also does affect – the calling of the patients also affects the therapeutic relationship between the patient and the doctor because if they are disagreeing especially if there are pathology in the patient then it becomes – it does affect the treatment of the patient. That's why we feel that's unethical. The second one has been ... (intervenes)

ADV ADILA HASSIM: Sorry Dr Talatala, which schemes do this? Call patients?

DR MVUYISO TALATALA: The one that has done and we fought over years and eventually they agreed to stop was Discovery Health. Then there's the ... (intervenes).

ADV ADILA HASSIM: Did you correspond with them in your engagement and your discomfort about this procedure they used or how did you engage with them?

DR MVUYISO TALATALA: We met several times. There would be emails because we have put it in writing. There will be emails between us and them. I think if we had to look back to our records because this didn't happened over a short period of time, it happened over a prolonged period of time. So there would be emails. So we spoke to them in meetings and we – there would be notes of meetings and I think if look, there would be emails where we protesting the … (intervenes)

ADV ADILA HASSIM: Would you be willing to share that with us?

DR MVUYISO TALATALA: Yes, I would be yes.

ADV TEMBEKA NGCUKAITOBI: My understanding is that you say they stopped. They no longer call patients as a matter of investigation.

DR MVUYISO TALATALA: Yes, they told us that after many years they then stopped calling the patients. They said they stopped. Then …(intervenes)

ADV KELLY WILLIAMS: Just let me clarify this point. I'm reading from your written submission at 3.1 but it's not entirely clear from that submission if you, in fact, just let me just ask the question and then you can make it clear. But whether you object to the calling of patients per se to ask anything or are you to ask whether you went to the consult or how long the consult was or if your objection is that you object to calling patients to verify the time for the consult. Can you just clarify that?

DR MVUYISO TALATALA: We object to verify the services.

ADV KELLY WILLIAMS: So across the board. So both of you are going to try verify time or if you're going to try verify whether a consult's good.

DR MVUYISO TALATALA: I think they can say is Dr Talatala your doctor? That would be fine. But if I had to explain, I don't think that it's their members they can say that. But what would be a problem if I'm not putting it clearly is where they phone want to ask the time or the content of the discussion in that therapeutic session.

ADV KELLY WILLIAMS: So it's your submission that it's permissible to phone a patient to ask if you saw the doctor?

DR MVUYISO TALATALA: I think because they are paying, they would know or firstly they would know that you – I don't think there's any confidentiality there because they know that patient X is seeing Dr Talatala. It's in their information. If they can phone and say, did you see – is you psychiatrist Dr Talatala, that's fine. In fact, they do that even sometimes to help the patients. They've got their – some schemes have got in-house – they make the patients join a program and then they phone them to support them. So I don't think we can say they mustn't phone patients at all. They can phone for various reasons. But it's to deal with the content of the support therapy session that has taken place.

ADV KELLY WILLIAMS: We have heard submissions and I now can't recall if it was from a psychiatrist but it was in relation to psychiatry where the objection was calling patients at all because patients may be mentally ill and may not properly recall events.

DR MVUYISO TALATALA: Sorry, I didn't hear the last part.

ADV KELLY WILLIAMS: So I'm saying we have heard submissions and I can't recall if it was from a person practicing psychiatry but it related to psychiatry. And the objection was that schemes or administrators were calling patients who were mentally ill and that was per se unfair because those patients were mentally ill and potentially couldn't recall events. *Ja*.

DR MVUYISO TALATALA: I don't think it's unfair to call them but it's unfair to deal with the content or to even use the content of the information to justify whatever the reasons. I mean the patient can be – let's assume the session ended on a bad note which does happen in our profession. That the patient says, no I walked out after 1 minute, cannot be concluded that that is for sure the truth. Or maybe the patient is telling what they can actually remember as I've said I can't remember how much time I've sat here.

DR SEBOLELO SEAPE: No, I was saying that with regard to the calling of the patient as Dr Talatala has mentioned. If they were just wanting to know who are your psychiatrist or are you seeing a psychiatrist or something like that, it would be enough. But unfortunately mostly the schemes especially if I may enumerate Discovery, that not – the point is not just to see that you seeing a psychiatrist but it would be the issue of time. And really timing is very difficult to measure when you are not aware that that's going to be an issue, number one. Number two, the average person who is consulting with you is in distress so to remember time is not necessarily what they're going to do well. Thirdly, patients need their medical aids and when the medical aid it's sort of like your authority, they phone. You feel desperate because you don't want to lose

your medical aid and patients – the average patient doesn't know exactly how the medical aid works. So they will comply to what the medical aid wants because they don't want to lose their medical aids because they need it. So it is unfair in all those areas because it becomes a threat. As soon as they, if I may – I'm allowed to make an example, if SARS phones me, I'm scared already even if I hadn't done anything so it's the same thing. When the medical aid phones you, you're worried. I mean are they going to stop my medical aid? What am I going to do? So it already is it's biased against the patient and the patient is ready to comply with what the medical aid wants. And of course the main – the biggest thing is, is this memory of a distress's person of a time when they were not actually aware that that's what they'll have to be doing. Or even the content averagely I mean the average person doesn't remember like you said we don't know how long we've sat here already.

ADV TEMBEKA NGCUKAITOBI: Let us push further on this discussion you're having with Ms Williams. So I mean scheme X is confronted with a claim they believe is fraudulent. What do you want them to do because the way it decides whether it's genuine or not may include contacting the patient to find out if the patient is not being defrauded by the doctor?

DR MVUYISO TALATALA: That is why our proposal is that there must be an Independent Audit Body that must develop systems for auditing psychotherapy. We have not as an industry had – schemes or stakeholders must sit down and agree on an ethical way of verifying psychiatric services. And I do not believe that we should compromise ethics and care of patients today because the industry had not done that

and used the wrong ways of doing this. It is like you want to catch a murderer and you actually commit a murder so we can't do wrong things today because we have not stepped up as leaders to find a way of verifying psychiatry – I don't say psychiatry services, all psychotherapy services whether it's done by psychiatrist or a psychologist or a social worker.

DR SEBOLELO SEAPE: Just to add to that. I think I mean we do agree that it's in the interest to find out if services have been rendered but it cannot come out in this unilateral way that hasn't been discussed and the patients are not even aware themselves. If at least maybe, I mean we want to suggest that there should be a system that should be developed by all sides, you know, the schemes, the doctors and maybe any other parties that may contribute positively to the discussion, how are services going to be rendered or verified. And beyond that the patient should be aware that this is going to happen because as soon as that phone call comes, the patients just to – is very uncomfortable. And the therapeutic relationship between the doctor and the patient is now destroyed because it's almost saying to the patient that your doctor is a fraud and it just breaks up everything. And for a patient for example that is paranoid, it's a problem.

DR MVUYISO TALATALA: And I think in that multi – in that independent body, the users of the services themselves should be consulted how should their services be verified. They should be part – they should contribute to the process. We should not, not psychiatrist, not

psychologist, not the schemes should just come unilaterally and decide how the services should be verified.

ADV TEMBEKA NGCUKAITOBI: I mean I suppose I wonder how this actually works in practice if you can enlighten us because you see what we've heard is that so the claim is submitted, it's paid in good faith within the period of 30 days as prescribed. What you are describing is not the verification of services, it is an investigation usually conducted exposed. And so that's why someone is being asked to recall whether something happened three years earlier. But it's not that the scheme is trying to find out whether they should pay the amount because they paid the amount on mere submission, on their version in good faith. So you would say, well in that event there is no need to presuppose that I've committed fraud because you can decide a better method of gathering the facts and there's no urgency in doing it which would require a direct contact with the patient who incidentally is also a member of the scheme and so they have a separate relationship which contractually entitles the scheme to contact them anytime.

DR MVUYISO TALATALA: Yes Advocate. It's actually strictly speaking its sub verification service I agree with you. They would have paid. It's actually probably investigation into fraud. But we are saying that – we are proposing that there should be because the schemes pay in good faith, there should be a way built-in system that can audit psychotherapy so that everyone can trust that what they are paying for trusting is actually happening. And I saw something, auditing of psychotherapy or clean-cut audits are done in other countries.

ADV TEMBEKA NGCUKAITOBI: I always thought that the issue about this particular education and that what you are objecting to is that specifically because of the nature of the patients that you are dealing with, it is inappropriate to get these calls that are investigative from the medical schemes because it ignores the particular nature of the vulnerability of that your patients are faced with. But the problem I'm struggling with is that when you were asked the same question by Ms Williams, you seem to equivocate from the principle stands that you shouldn't be speaking to mentally ill patients because you are aggravating their anxiety.

DR MVUYISO TALATALA: Maybe I didn't answer the question well. I don't think we can say the schemes must never phone a particular group of their members as I've already substantiated that sometimes they develop programs to support their members. So to call the ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: The issue is they are investigating and they are accusing, as Dr Seape says, they are accusing the service provider, the doctor of committing a fraud. The question that is within our scope is when they are doing a Section 59 are you saying you object to them conducting that investigation by the direct contact with the patient?

ADV KELLY WILLIAMS: Can I just add to this, I mean can we separate our situations where the scheme is involved in some kind of managed care in relation to psychiatry because I think that is quite distinguishable, perhaps that will be helpful just to understand your position. So it's a Section 59 Investigation context.

DR MVUYISO TALATALA: No we object, thank you for the clarification, we object to the calling of the patients for investigations. We don't have a problem with when they are calling them for other reasons.

ADV KELLY WILLIAMS: Okay but to carry on, on this point, you've accepted that there's some difficulty that the schemes face in verifying whether services were offered *per se*. There're two mechanisms to do this, one is you phone the patient and there seem to be some issues in relation to that, the second is you engage the psychiatrist. Now in your submission you've spoken about your objection to providing psychotherapy notes, clinical notes which we've heard many submissions on and we understand those objections. I'm interested if there's some via media, so would a psychiatrist be willing to disclose his or her notes which are redacted so that all patient confidential information is removed but it provides proof that a consultation took place?

DR MVUYISO TALATALA: That is also impossible to do and I'll give you an example. If I had consulted someone important or someone working at Discovery who is fighting with a manager at Discovery, which happens in real life, by disclosing the name that that person is already consulting me to whoever it's already – that other party is already a breach of confidentiality and ... (intervenes).

ADV KELLY WILLIAMS: But the scheme in that situation would have the name.

DR MVUYISO TALATALA: Then the notes themselves of psychotherapy are very – if I were to clear my notes of the psychotherapy if I were to clear the notes there'll be nothing to use because the session was about

psychotherapy. So it's not like, it will not assist the scheme to say the blood pressure I took it, it was 120/80 because we are not verifying whether did I take the blood pressure, it's not just me seeing the patient the patient can confirm whether they're my doctor or not but want to confirm whether the psychotherapy did take place or not. So you will probably need the psychotherapy notes to confirm that. That is why we are then proposing that it should be taken out of the scheme. So to a process that the patient, before they even consult psychiatrists, they know that their notes could eventually go to that body that can verify and this audit can be done randomly to all psychiatrists.

ADV ADILA HASSIM: What if you used time sheets so that the patients sign in and out and it's dated and obviously with the signature, would that make any difference?

DR MVUYISO TALATALA: Some psychiatrists and at some psychiatrists have done that as a way to verify to time but it's also an extremely difficult process unless there was a software to do it and in my view it also increases the costs because when I – when we are done with a session then we have to go through the process of explaining why they have to sign because remember they have not signed, they have been to many doctors they've never made to sign to confirm that they attend. So it is a possible solution but it's a difficult solution to implement.

DR SEBOLELO SEAPE: Now when you talked about, I forgot, but the notes if you say delete like he says there might be nothing left of the notes because remember that psychotherapy is not just about the patient themselves, you know it's not about Peter only but in the notes that's in

my therapy I've also talked about Mary and Jabulani and Thabiso who haven't consented to their information being included in that. So that means I have so much deleted that in the end you get a date and blank or blanked out stuff which is not useful that's the one thing. The second thing is that we have to remember that different doctors write notes differently. I have a session with you for an hour and write three lines you know and somebody can have a session with you for 30 minutes and write two pages. So the actual notes themselves do not portray how much time was spent because it depends on how I write my notes on that day it's also on that day because some days are copious some days or not you know or depending on what the situation is. So it doesn't really serve you so much to have the notes if I had to block out all that and I think, I mean it might not be an important point right now but I mean if you are being asked to produce notes for three years that's a lot of notes and it becomes a little bit of a logistical issue in terms of blocking out all those. Because in three years I've seen maybe that one patient maybe, if I see them let's say maybe six times a year that means 18 dates of notes for one person, it could be a lot. With regard to the timesheets, yes some people are doing it or trying to see if it works but it also now adds onto the time and the issue would be that is that time as part of the therapy or now that's outside time because as Dr Talatala says you have to explain to the patient now we are doing this and of course patients are saying okay now why do we have to do this, I hear you telling me that, why do we have to do this, what's going on. You know it's, it introduces a different dynamic again to the therapeutic relationship that now we are

doing something that we never used to do and is it to prevent fraud, so were you in fraud, what's going on and what if I don't sign. And it is not irregular that our patients refuse to sign for all sorts of things. We ask to do reports and they must see the report and sign consent and they refuse and it damage the whole process and you don't know, there's nothing you can do. So it's not completely fool proof, there are catches in it.

DR MVUYISO TALATALA: There's also what the schemes have suggested that oh they will tell us that no the patient signed consent for the release of the notes. It is impossible to get consent for psychotherapy notes unless the patient sits with the psychiatrist and goes through the notes because if I'm seeing the patient for the first time I make certain observations that I don't want to share with the patient on the first day that I'm consulting with them that's the first thing. And at times they will then – they themselves will forget about things that they told me that are not related to the diagnosis, they may have come to me, the real diagnosis but they are not the diagnosis, there are not the supporting information for the diagnosis. For instance they can come to me with depression, I'm going to write their findings of the clinical signs of depression and anything that we've done but we're then going to talk about the affairs, about all other things that are not related, they are related, important therapy but not related to make the diagnosis. They may forget that they have shared that with me three years down the line so when they are signing to another party, even sometimes lawyers do or insurance companies do deny, demand files from psychiatrists which I always refuse because even if the patient signed with a lawyer or with an

insurance company that patient is not signing with fully informed consent because they have not gone back and read the notes and agreed then that this is what I told you and this is what I'm agreeing that you must give away. And also getting them to read the notes then has to be therapy because you cannot do it carelessly because maybe you've made comments as a therapist in the notes that could destroy the patient unless the information is shared in a therapeutic relationship and it's appropriate. I could have made actually even a wrong impression about the patient and I've long changed my mind six or seven months down the line, there's no point for me to tell the patient the wrong information that I've given, the wrong impression that I have made about the patient.

ADV TEMBEKA NGCUKAITOBI: Is there any specific rule that applies to, a professional rule that applies to psychiatrists in relation to disclosure of confidential patient information?

DR MVUYISO TALATALA: I don't think, I can – may be corrected, I don't think the Health Professionals Council has dealt with psychiatry separately on sharing of the notes, I think it's just treated as any medical laws. Then the process itself, how it's unfair. I said we feel that their samples are non ...(indistinct) in that this is significant. What they do, I would have seen let's say a thousand patients over three years and I've been paid R3 million for those patients over that three year period and the schemes feel that I overcharged them, let's use that layman's language, they will then say they want information on these 30 patients. Obviously, it's tough for them to ask all the thousand patients so they say 30 patients and they say this is a sample but that sample is not random,

they didn't just go over those thousand patients and select 30 patients then we'll see what happens. They obviously going to go for the patients where they suspect problems. So let's assume we go through the process and we agree on settlement. When we agree on settlement, assuming that they think that in those 30 patients there was a 50% error rate. They will then in terms of refunding the scheme they will then take that 50% error rate in that bad sample that was selected because of probability and apply it to the entire practice. We are of the view that if were to go to the sampling you can select the 30 patients to show the problem but then when it comes to sampling for the refund then you should run the – we should do a random sample to see if we did a random sample how often does the process – the error happens. Obviously if it happens 50% even in a random sample then we can apply it to everyone. But as things stands the percentage that is found problematic in the first sample that was selected that's the amount the psychiatrist has to pay back. We've then highlighted other problems that exacerbates the situation, the first one is the coding. We are of the view that our coding is outdated and ambiguous and it's the source for the disputes between the psychiatrists and the schemes. For instance I'll take one code that says you must see a patient between 21, we've written it, the profession has written it, you must see a patient between 21 and 40 minutes. But if you were to look at the value of that code it's valued at 40 minutes but a psychiatrist going to the practice sees the code says 21 to 40 minutes then they see 21 minutes, 28 minutes, 35 minutes any time. When the schemes are calculating time, they're likely to calculate 40 at the best at 30 minutes

and not at 21 minutes. So that's the first problem so the psychiatrists and the schemes don't agree on that. The second problem there's three psychotherapy codes one is 10 to 20 minutes, the second one is 21 to 40 minutes the other one is 51 to 60 minutes. If you then see, let's assume we're signing with, we'd agreed that we will sign for attendance, you see the patient for 18 minutes then at minute number 18 you start saying the patient must sign but patient has an argument, doesn't agree with this, you end up to 25 minutes. The psychiatrist as things stands either, in fact has to just charge for 20 minutes even though they've gone to 25 minutes because the schemes only recognised for 30 minutes to 40 minutes. This time between, a very critical time, the time between 21 minutes and 30 minutes is not really paid for which is a source of dispute. And on follow up psychiatry patients once you, usually if you are seeing a psychiatry patient you most likely will take, an average psychiatry patient will take an hour in the first session but the follow up sessions are usually around anything between 15 and 30 minutes. So that period between 21 and 30 minutes is a significant period that should be funded for because it does cover a lot of follow up psychotherapy session. So we do propose that the coding needs to be updated by the entire – by the profession and presented to the industry but the industry must be willing to cooperate and come to the negotiations and accept what is reasonable. Why we think the coding should be or how we think it should be reviewed and we're willing to negotiate this, instead of having these long periods we should have 10 minute periods that are more accurate for the time spent and we, after an hour it should go back to that one in terms of how

much we paid, it can stay the same as how much we are paid for an hour but instead of having that hour only charged at an hour we should have 10 minute blocks and I think in that way there'll be less ambiguity about the – we think that there'll be less ambiguity about the time spent and the coding.

ADV TEMBEKA NGCUKAITOBI: Can you just tell me about coding because in other submissions the problem is that there is no coding at all that is standardised and applied and is known across. In psychiatry is there standardised coding because you talk about ambiguity which suggests that a code exists but it's ambiguous?

DR MVUYISO TALATALA: Yes there is – there are codes for treating patients, I would assume in most – all disciplines otherwise the schemes wouldn't know how to pay for the codes. So the codes I think were originally developed by the South African Medical Association including the psychiatry ones. The profession would, obviously within South African Medical Association psychiatrists develop them and the profession it keeps – it's supposed to improve them as we realise problems. So there is a coding, a standardised coding for charging psychotherapy and there is a standardised coding for doing consultations in psychiatry. There is a coding for everything which can be charged for.

ADV ADILA HASSIM: But there're several different institutions that have codes, SAMA is one of them, there's also the RPL that we've been referred to and the ICD10 codes and so on. So are you saying that the standard code used by psychiatrists is the SAMA codes?

DR MVUYISO TALATALA: Maybe there's been a bit of a confusion, there

is coding for charging if I'd use that simple words, look coding for charging whether you are doing an operation or you are a GP consulting that is what you use to charge. There's coding for the diagnosis that will be the ICD codes, so that is a code for diagnosis for instance you've got depression then you've got F32.2 that's the code for the diagnosis different for the code for charging, I've seen you for an hour therefore I charge you code 2975. And then the reference pricelist that was a process to allocate cost to the code for charging which then went through its own problems and was eventually cancelled or I'm not sure ...(intervenes).

ADV ADILA HASSIM: *Ja* it was set aside by a court eventually but is a SAMA code the one that psychiatrists used for all medical schemes it's the same that you would use in your billing?

DR MVUYISO TALATALA: Yes, it is the SAMA code yes. It was developed by SAMA but the profession fits into it yes, yes but it's the same code for all psychiatrists.

ADV KELLY WILLIAMS: Mr Talatala on that point then do all the schemes and all the administrators for psychiatry accept that the SAMA code is the bible?

DR MVUYISO TALATALA: Sorry I ... (intervenes).

ADV KELLY WILLIAMS: Do all the schemes and all the administrators accept that the SAMA codes 2019 is the bible for psychiatry coding?

DR MVUYISO TALATALA: Okay that's where the problem arises, they do not, the schemes, that's why I was also been submitting that the changes should be accepted. The changes that we are proposing will be in the

SAMA code, we'll be updating the SAMA code but the schemes do not accept the latest coding that's one of the reasons why they will be one disputes and ambiguity. They will not accept, even if we did update because SAMA code for psychiatry has to be admitted by psychiatry and we submit to SAMA coding experts will then look at and make sure it makes sense and approve it or not approve it. Even if we go through that process for next year with these innovative changes that we think should be, it is not guaranteed in fact schemes are most likely unless things change they will not accept it.

ADV TEMBEKA NGCUKAITOBI: Dr Seape?

DR SEBOLELO SEAPE: *Ja* with the coding system Advocate Williams is saying is it their bible, I think that was a good analogy because there're so many interpretations to the same bible, same with the coding. You know as Dr Talatala mentioned you know the one code of 20 to 40 minutes yet if you see the patient for 21 minutes and code that code that says from 20 minutes you actually will be in trouble and yet that's what the code says because the interpretation is different because there's some schemes will accept it because it is 21 to 40 some will say no it is too little it should go up to 30, you should start to code at 30 despite the fact that the code starts at 21. So already the interpretation is not the same. Another problem that psychiatrists are falling into is the fact that the codes do not include all the other work that the psychiatrist must do to help with the diagnosis, to help with treatment, to help with management of the patient. Whether it's to get collateral, whether it is to communicate with the boss, whether it is to communicate with other

medical professionals with regard to the care of the patient no code covers that and yet it takes time. So you'll find that even if you have worked 12 hours, four hours have actually been to communications and things like that which are not included so it already causes a problem because somebody might be inclined to then add that time to the supposed to be psychotherapy or consultation whereas the new codes that we are proposing would include all the time that you've spent for that patient.

ADV ADILA HASSIM: Sorry just to clarify then what you – so the distinction is or what you're saying is that the schemes will use the SAMA manual but the interpretation of the codes in the SAMA manual will differ between the psychiatrist and the scheme?

DR SEBOLELO SEAPE: The interpretation by the scheme will differ.

ADV ADILA HASSIM: Well the interpretation between the two of you is, I'm saying ...(intervenes).

DR SEBOLELO SEAPE: Yes can be different.

ADV ADILA HASSIM: Will be different.

DR SEBOLELO SEAPE: Yes.

ADV ADILA HASSIM: So it's within one manual, it's not that the scheme applies another system or another code and says that's what you and you've used the codes.

DR MVUYISO TALATALA: It's within one manual but it will be a different version. Remember the professions have been updating the codes over there, it's within one manual but a different version.

ADV ADILA HASSIM: Yes.

ADV TEMBEKA NGCUKAITOBI: No I think the problem is still that the evidence we heard was that some schemes are using 2006 and yet there is a 2019 version of the SAMA code.

DR MVUYISO TALATALA: Yes that's actually – that's where the problem happens, it's the same manual different versions. Schemes may want to, especially when there's an investigation, they may want to stick to the 2006 version and the psychiatrist would have – some psychiatrists who were not even psychiatrists at the time, they would have been exposed. I don't think I've actually seen the 2006 myself. They would have been exposed to the latest version so they'll be using the latest version and that would cause the problems of interpretation, the ambiguity.

ADV KELLY WILLIAMS: Can I just ask one more question about the coding and this is with reference to a specific sample that you've given us this 2974 and the problem that arises with it. Is your submission that if you see a patient for 21 to 29 minutes I think you – for some schemes can use that code and for some schemes you can't use that code?

DR MVUYISO TALATALA: Yes there are – definitely there are schemes who – they've not – they won't tell you upfront that for our patients we want 30, it's not like they would have told you, but when there's an investigation they will not accept 25 minutes or 28 minutes.

ADV KELLY WILLIAMS: So are you saying that that code is the subject of clawbacks in terms of Section 59 where you've used it to charge for 21 to 29 minutes?

DR MVUYISO TALATALA: It's the most utilised code by the psychiatrist it is such that for clawbacks but I don't want to be strict about that

because the longer the code the higher is the risk of schemes disputing it and clawing back, it's not that the one hour psychiatrists don't use it as much. In fact if a psychiatrist chose to work correctly and decide to see eight patients a day and see them one hour each and spends nine hours in their practice and they do psychotherapy and I have got a psychiatrist like that who does psychotherapy only, that psychiatrist is guaranteed will have an investigation.

ADV KELLY WILLIAMS: Guaranteed to have an investigation?

DR MVUYISO TALATALA: Yes that will be an outlier, not that they've done anything wrong but because they've – and there are psychiatrists like that, we do need them, who are not busy with the rush of emergencies and short consultation and running to the medical ward who will set aside time to do a certain type of psychotherapy and do it over an hour for instance per patient and not see many patients per day, see seven, six, eight patients per day. But that will make you stand out and you'll be investigated and I've had a psychiatrist investigated because that's how their practice works and that's psychiatrist does not even prescribe medications, they are doing a type of psychotherapy that fits to that.

ADV ADILA HASSIM: And they would be an outlier, they would be picked up because they use the code for an hour consultation?

DR MVUYISO TALATALA: No they'll be using an hour code but they'll be the only ones who are using that code and it's a longer code, it's a more expensive code and then the schemes will think that they are being defrauded. May I move on?

ADV TEMBEKA NGCUKAITOBI: Please proceed.

DR MVUYISO TALATALA: We've already covered the increasing utilisation of mental health services which is a problem for us. We also do think that, and that is why we need an independent body, firstly health has got too many transactions as a discipline. Mental healthcare is even worse. There's an increasing number of patients that need care, there's increasing hospital ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Yes the example you gave in your previous exchange with Ms Hassim, do you have an actual case of someone who was using the longer code but because they had spaced out their consultation to an hour and six patients a day and the system, you remember that your initial point was the system contains a design flaw because it picks people that it shouldn't pick. Who is this person, do you have their details, can we ask the scheme to explain why their system picked this person?

DR MVUYISO TALATALA: We've got the person; I have not asked the permission in preparation to disclose her name but if she agrees we'll share the information. Her dispute with the scheme went on for a very prolonged period of time so I'll be sensitive in how I approach her but I will ask her if she's willing to share the information.

ADV ADILA HASSIM: What was the outcome of the dispute?

DR MVUYISO TALATALA: After months of engagement the scheme left the investigation.

ADV ADILA HASSIM: And was she placed on indirect suspension or anything during the time of the investigation?

DR SEBOLELO SEAPE: I can't remember if she was but I know that the investigation went on for a very long time to her greatest distress and she couldn't practice some of the time because she was now engaged in this.

ADV ADILA HASSIM: And which scheme was it?

DR SEBOLELO SEAPE: Discovery.

DR MVUYISO TALATALA: But we quoted – we can't share it because we really didn't ask her – we didn't ask any of our members whether we should share their names. So with the increasing money that's being spent on mental health we can already assume that there's going to be fraud in mental health and that exacerbates the situation but I think if we dealt with the audit issues, the errors and separate them from the real issues then we can find the real fraudulent people who may actually sometimes not even be psychiatrists but are still defrauding, whether it's the hospitals or other practitioners who are actually defrauding the system because of the exchanges of money within the mental healthcare space. So in summary we are proposing that we should – the psychiatry coding needs review. We've emphasised the point that we need an independent body to audit psychiatry practice, coding, services, utilisation and psychotherapy and audit of psychotherapy we can learn even from other countries it is done. And the other part I think with the increasing utilisation and the increasing burden of mental healthcare we need to start thinking out of the box and reorganise mental healthcare into a valued based care that is less hospicentric and that is based on outcome measures and I think if there was a system of making sure that the psychiatrists can themselves report their outcomes and psychiatrists

be judged on the value and the outcomes they produce most of these issues that we are dealing with here would not be even an issue to be discussed. I know it sounds difficult and it sounds like we are suggesting something big that can only be achieved far away but if you look at mental healthcare in South Africa it's not going to survive, it's going to crash with the number of psychiatrists that we have and we'll keep building new and new hospitals indefinitely unless we change the model of care that we have. Thank you.

ADV TEMBEKA NGCUKAITOBI: I mean what's the change on the Section 59 that you have in mind, I mean that is not to you know underestimate the importance of the structural changes? I mean I think as you explained at the beginning you know we have got a social and economic problem in the country and that is exacerbating the problem of mental illness so it's a long term process to think about or to reorganise society in order to reduce the incident of mental illnesses. But in that what we are dealing with is a narrow one which is the abuses attended upon Section 59. So the one is we need an independent body to administer, would you say it must administer Section 59 in its entirety so it's not left the power of the skill versus vulnerable doctor.

DR MVUYISO TALATALA: Yes, in terms of Section 59 that's the main submission that we – that's our main submission, that we should have an independent body so that it's not left to the supply schemes but also so that we can develop ethical ways of dealing with difficult issues like verification of services.

ADV TEMBEKA NGCUKAITOBI: I mean, I would still like the

underlying data that you were talking about and the specific examples because the plan, once we have finished this current session is that we need to put evidence to the schemes, we don't want to say that Dr Talatala said a doctor in Soweto experienced this problem because the immediate answer is going to be which doctor.

DR MVUYISO TALATALA: Yes, but thanks, Advocate, we're hoping that my colleague did make notes of all the ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: No, no, what we will do, we will send you a formal letter with a list of items that we would request.

DR MVUYISO TALATALA: Thank you, thank you, that will be easier for

ADV TEMBEKA NGCUKAITOBI: Oh good, will that be all?

DR MVUYISO TALATALA: Yes, yes, thank you.

ADV TEMBEKA NGCUKAITOBI: Alright it remains of me then to thank your Association for written presentation and your attendance today. We will be in communication then with further information that we may request. Thank you.

DR MVUYISO TALATALA: Thank you.

ADV KELLY WILLIAMS: Thank you.

ADV TEMBEKA NGCUKAITOBI: We will adjourn for – until 15:00. I think the next presentation is at 15:00, so we will adjourn for 15 minutes.

HEARING ADJOURNS

HEARING RESUMES

ADV TEMBEKA NGCUKAITOBI: Good afternoon, we are continuing the Section 59 Investigation. We have NHC Medical Centre. Who is

representing NHC?

MR HERMAN KOHLOFFEL: I am, Mr Herman Kohloffel from NHC.

ADV TEMBEKA NGCUKAITOBI: Let me just get your – make sure I've got your surname. Yes, is it Kohloffel?

MR HERMAN KOHLOFFEL: I'm happy to use my first name, but that's correct.

ADV TEMBEKA NGCUKAITOBI: No, no, no, I mean I can see it here but I just want to make sure I pronounce it properly. And Ms – is it Ms Potgieter? Alright, Mr Kohloffel, will you be the one talking?

MR HERMAN KOHLOFFEL: That is correct.

ADV TEMBEKA NGCUKAITOBI: Okay, I understand you have an application to make in relation to the matter being dealt with not in an open session?

MR HERMAN KOHLOFFEL: Correct, I feel that I will not be able to speak freely and given the fact that five days after the submission was made I was personally exposed to a particular event which includes – and we will lead that through the – to the panel. How do I explain this without opening the can of worms? So, in essence, five days after I received – after we did the submission, we were targeted in one of our divisions by one of the medical schemes, administrators.

ADV TEMBEKA NGCUKAITOBI: Yes. Now can I tell you something, we passed a rule at the beginning of the hearings that all hearings will be public.

MR HERMAN KOHLOFFEL: Correct.

ADV TEMBEKA NGCUKAITOBI: And we are doing it for being

transparent so that everyone who is accused or implicated knows publicly what the issues are they can come and explain. Now we have a discretion to direct that certain hearings should be *in camera* but we do not want to exercise that discretion without good reason because if we did that, everyone else will ask for *in camera* hearings so we would still like you to give us a reason why we should hold your hearing *in camera* so that in the future when we reconvene in September we don't get everyone – suddenly the whole character of the hearings changes and you would have seen the media is reporting on these hearings. In fact the whole country has an interest in these hearings. So I am not going to refuse your application but I will at least insist that you should give us some basis to consider it favourably. So I hear that you say that five days after you put your input a medical scheme targeted your company.

MR HERMAN KOHLOFFEL: Okay. So I serve as Managing Director of NHC Limited.

ADV TEMBEKA NGCUKAITOBI: Yes.

MR HERMAN KOHLOFFEL: Which made the submission. I also am the owner of an entire pharmacy division or a pharmacy group. Now it's my opinion that given that we are fairly outspoken as a group regarding this particular matter, Section 59 and this Inquiry, and have been so for many years prior to this regarding these kangaroo court investigations that this is being done to distract us perhaps and given the manner in which it has been handled – and I'm referring now to the five days after the submission. When I take you through that, you will understand that

there's actually no basis or no logic to that approach at all. It is impossible to determine from the approach made by the particular administrator whether or not there would be fraud or any irregularity in that business and the business was never ever targeted previously, neither have any of the professionals, that I'm aware of, within our health centres at all.

ADV TEMBEKA NGCUKAITOBI: Yes and by targeting you mean it was subjected to a Section 59 Inquiry?

MR HERMAN KOHLOFFEL: Okay. No, submitted to – what was submitted was the threat of direct payments being suspended.

ADV TEMBEKA NGCUKAITOBI: Okay. Is there anything else you want to say just on this application for an *in camera* hearing?

MR HERMAN KOHLOFFEL: No, I don't think there's anything else I can add.

ADV TEMBEKA NGCUKAITOBI: Alright. What we will do, we will take five minutes to consider the application. We will come back – if we grant it, we will then ask for the television cameras and the – I think that's probably just about it, to be switched off but for now we will just take five minutes to deliberate.

MR HERMAN KOHLOFFEL: Thank you.

ADV TEMBEKA NGCUKAITOBI: We are adjourned.

HEARING ADJOURNS

HEARING RESUMES

ADV TEMBEKA NGCUKAITOBI: Alright, thank you, we have considered the request. What we will do, we will allow the request on a

provisional basis and we will evaluate it after we've heard the evidence. So could I ask then that the television cameras should be switched off? Any media that is in the room should leave. Any members of the public should leave. Any representatives of medical schemes or any of the interested parties should also leave the room. We will take another five minutes whilst everyone is clearing the room.

HEARING ADJOURNS

HEARING RESUMES

PROCEEDINGS HELD *IN CAMERA*

ADV TEMBEKA NGCUKAITOBI: Can we start then by swearing you in, Mr Kohloffel?

MR HERMAN KOHLOFFEL: Sorry, could you just repeat that?

ADV TEMBEKA NGCUKAITOBI: I just want to swear you in. Will you take the oath or the affirmation?

MR HERMAN KOHLOFFEL: Do I have to stand for that?

ADV TEMBEKA NGCUKAITOBI: Will you take the oath – no, no, no, it's fine if you can sit down but will be the oath or the affirmation?

MR HERMAN KOHLOFFEL: Oath or – oath is fine.

ADV TEMBEKA NGCUKAITOBI: Oath is fine, alright. So will you just say after me I and your full names?

MR HERMAN KOHLOFFEL: I, Herman Joseph Kohloffel.

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

MR HERMAN KOHLOFFEL: Swear that the evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth

MR HERMAN KOHLOFFEL: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

MR HERMAN KOHLOFFEL: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing but the truth.

MR HERMAN KOHLOFFEL: And nothing but the truth.

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

MR HERMAN KOHLOFFEL: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. Can we do this - we decide to clear the room so that we don't have this conversation in the presence of everyone but you need to first tell us what exactly are the reasons why you cannot give your evidence in public because as I explained, we're trying to make sure that everything that is said is said publicly because you've already given us your written document.

MR HERMAN KOHLOFFEL: Correct.

ADV TEMBEKA NGCUKAITOBI: And there's nothing the written document that says it should not be disclosed so for all we know anyone get hold of it anytime. So let's start there.

MR HERMAN KOHLOFFEL: Okay, so perhaps let me take you through the approach that occurred on the 24th of July. The pharmacy group that I own, Cornerstone Pharmacies, received a letter from a medical administrator. The administrator indicated that any particular ...(intervenes)

ADV KELLY WILLIAMS: What was the name of that administrator?

MR HERMAN KOHLOFFEL: Discovery.

ADV KELLY WILLIAMS: Thank you.

MR HERMAN KOHLOFFEL: The administrator asked – or specifically asked for the top five products sold in a particular pharmacy, one of six, for evidence that these products were in fact sold through the pharmacy – no sorry, purchased by this pharmacy. Now understanding that Cornerstone Pharmacy is a group of six pharmacies, if we were deliberately defrauding in any manner or means to produce invoices that the entire group had paid would have been as simple as closing your left eye because it would be that easy. So we wrote back because the threat was to suspend direct payments. We wrote back to Discovery and said guys, what is the basis of this? You're threatening to suspend direct payments, what are you looking for? We've just – in fact we had just purchased this, I think it was one year prior, and what do you want? You're asking for the top five products that are sold through the pharmacy. If you were asking for a product that's one in a million we could possibly entertain the discussion because it would make sense but to ask for the top five – for products that are the top five sellers in pharmacies within the entire group for one branch didn't make any sense to us at all. So we wrote back and said please explain to us on what basis this request is being made. We're quite happy to comply, we've got no problem with that at all, but just explain to us what you've looking for because clearly there's something wrong or irregular in this request. We then received a note back and in that note ...(intervenes)

ADV KELLY WILLIAMS: Can you tell us who wrote to you?

MR HERMAN KOHLOFFEL: Oh goodness, I don't ...(intervenes).

ADV KELLY WILLIAMS: Who was the discovery representative?

MR HERMAN KOHLOFFEL: We'll pull that for you. We've got that. It was Irene Johnson. The lawyer that then replied was Steven Jacobs.

ADV KELLY WILLIAMS: Does Irene Johnson sit in their forensic division?

MR HERMAN KOHLOFFEL: Give us a second?

ADV KELLY WILLIAMS: And the second question while you're looking that up, if you have copies of the letters it would actually be helpful to see them but what was the subject line?

MR HERMAN KOHLOFFEL: You know what, it's not in this particular memo but the letter was peppered with statements such as:

> "If we cannot finalise or resolve our concern within 30 days we reserve the right to implement the appropriate measures to minimise the scheme's risk until this matter has been finalised."
>
> Secondly, comments such as:
>
> "Perhaps not purchased by the pharmacy."
>
> Let me read this.
>
> "This letter further requested that if Cornerstone Pharmacy Morningside Manor was aware of any items perhaps not purchased by the practice it was to inform Discovery Health or set up a meeting with Discovery Health to discuss these issues."
>
> By implication, what are you saying? What are you implying?

You haven't given us the opportunity to respond and you are already trying to push us into a corner. For what reason? Can we just go back to your original question? The title was Review of Certain Claims. I'm quite happy to submit that letter to the inquiry.

ADV TEMBEKA NGCUKAITOBI: Well, just the entire exchange of correspondence.

MR HERMAN KOHLOFFEL: We can do that. When we received the response back – I just want to pull this back and I'm quite happy to submit this paper to you. Discovery advised us that they were acting ...(intervenes).

ADV KELLY WILLIAMS: Sorry, over what period of time where they requesting this information?

MR HERMAN KOHLOFFEL: That was the other thing, they were asking for it for three years back, that's why we drew it to their attention that we only bought this pharmacy a year ago. When we asked Discovery on what basis were they requesting this, they immediately responded back, and I think this is the issue that we wanted to bring to the panel's attention, is they immediately responded and say no, no, it's not in terms of Section 59, it is in fact under Section 32 of the Act which then opens us up to a different situation where the scheme – where the administrator now can move from abusing Section 59 to now abusing Section 32. Now understand that from an NHC point of view, Cornerstone point of view, we have no issue – if there's fraud, we stand strongly by what we've said before and submitted that we want the industry to be cleaned up. If there is fraud, let's deal with it but not in

the manner in which of a bullying nature and secondly, running a quasi-legal system on the side of what really should be a properly regulated system.

ADV KELLY WILLIAMS: And what does Section 32 say?

MR HERMAN KOHLOFFEL: 32 – can I ask Corinne please? Section 32 says we have to comply with the medical scheme rules. So if you change the medical scheme rules you can do exactly what you need to do.

ADV TEMBEKA NGCUKAITOBI: So are you saying it was akin to Section 59 but it was called something different?

MR HERMAN KOHLOFFEL: Correct and the other thing – I can read you the Section 32:

> "The rules of a medical scheme and any amendment thereof shall be binding on the medical scheme concerned, its members, officers and on any person, who claims benefit under its rules or whose claim is derived from a person so claiming."
>
> That would include doctors, medical professionals as well.

ADV TEMBEKA NGCUKAITOBI: Alright, so I go to the first point which is you don't accept that they can ask for three years data because you only acquired the practice a year ago and if they'd one a preliminary investigation they would have found that out.

MR HERMAN KOHLOFFEL: Correct.

ADV TEMBEKA NGCUKAITOBI: And that's the first reason you submit this is linked to your participation in this panel. What is the other

problem with that letter? I mean, I take your second point which is that it shifts from Section 59 into Section 32.

MR HERMAN KOHLOFFEL: Correct.

ADV TEMBEKA NGCUKAITOBI: Because Section 59 is the subject of this investigation.

MR HERMAN KOHLOFFEL: Correct. So I think just to make the second point is that the mere fact that the request is for information based on purchases of the top five sold items in pharmacy in itself is indicative that the actual request is a nonsensical nonsense request because I can produce invoices from our other branches because we invoice this one group. I can't tell you whether this glass was delivered to Morningside Manor Pharmacy or Northcliff Pharmacy.

ADV KELLY WILLIAMS: So is your submission that they're basically making a request which is unfulfillable?

MR HERMAN KOHLOFFEL: Absolutely – well ...(intervenes).

ADV KELLY WILLIAMS: And if they're going to use that a reason to cut payment, just stop payment?

MR HERMAN KOHLOFFEL: I honestly can't see how they would get away with doing that. I mean, but if they could, I suppose they may try. But the reality is that it's not unfulfillable, I can produce those invoices and they know full well we can produce those invoices, they're the top five sold items in pharmacy.

ADV KELLY WILLIAMS: So what's the difficulty for you? Practically what would the difficulty be? You'd be able to produce the invoices for the past three years.

MR HERMAN KOHLOFFEL: There would be no difficulty. Sorry, so okay, wait, let me take you back. Hold on one second. So we'd be able to produce those invoices, not necessarily in the timeframe that they request because remember, the pharmacies take probably in the order around about four deliveries per day per pharmacy. Okay. And so we would have extrapolated and extract those items from those invoices and then submitted all of that detail to Discovery.

ADV KELLY WILLIAMS: And how much time did they give you to provide the information?

MR HERMAN KOHLOFFEL: 14 days.

ADV KELLY WILLIAMS: How long do you think it would have estimated you to do it?

MR HERMAN KOHLOFFEL: We sort of guessed that with a 100 million-odd purchases a year it would take us around about six weeks and we would have to obviously resource somebody to come and do that for us. So the other issue really is around Section 32, is that ...(intervenes).

ADV KELLY WILLIAMS: Sorry, before you carry on with the detail, just to help guide us. Big picture, why is this a justification to have a confidential or *in camera* hearing? Just big picture, you can come to it, but just tell us where you're going with this.

MR HERMAN KOHLOFFEL: Okay, so the concern that we're raising and that I'm acutely concerned about is that in approaching the providers to come and testify or allow us to use their data to put forward to the panel – because we were aware that the panel would require evidence to show the bullying. Remember – I mean, we've

submitted that we have not seen in our experience any issues of racial victimisation of doctors from our perspective. I've only represented unfortunately or fortunately only white doctors that have been brought in front of these panels by specific medical scheme and unfortunately, the only medical scheme I've dealt has been Discovery. The rest of the medical scheme I've deal with on a consultancy basis but not representing the doctors directly in their forensic units. So from our perspective and what I'm worried about is that these – given that the doctors see a social stigma attached to coming and allowing us to release that information, this panel is going to struggle to find enough evidentiary proof of the bullying that is occurring within the industry.

ADV KELLY WILLIAMS: Sorry, but you're not answering my question. Why is this a reason to have a confidential session or an *in camera* session?

MR HERMAN KOHLOFFEL: 67% of our business in NHC is Discovery. 67% of our revenue, that's excluding Bankmed. If we suddenly start having these kinds of letters being received as we've seen here in Cornerstone Pharmacy, which are – it's impossible to reconcile, no accountant can even justify this, no actuary would be able to work out.

ADV KELLY WILLIAMS: My difficulty is this. You are in a similar position to many other providers who have testified before us.

MR HERMAN KOHLOFFEL: Yes.

ADV KELLY WILLIAMS: And we haven't given them an *in camera* hearing or they haven't asked for one, so I'm trying to understand why this is distinguishable.

MR HERMAN KOHLOFFEL: So I'll put it to you that the victimisation that occurred happened five days after we submitted the documents to you and that's a cause for concern.

ADV KELLY WILLIAMS: And is this the first time you've ever received a letter like this?

MR HERMAN KOHLOFFEL: That is correct.

ADV TEMBEKA NGCUKAITOBI: Let's go to something else, my understanding is that your submission came to CMS under the CMS investigation email.

MR HERMAN KOHLOFFEL: Correct.

ADV TEMBEKA NGCUKAITOBI: And that it was not put for public consumption on the website.

MR HERMAN KOHLOFFEL: Not that I'm aware of.

ADV TEMBEKA NGCUKAITOBI: Yes, now do you know – I mean, I understand your point which is you can infer from the sequence that I submit my complaint and then suddenly I'm subjected to a classic Section 59 investigation which is then labelled Section 32 but other than sequence, what else do you have that would suggest that there is a linkage between the sudden investigation and your complaint?

MR HERMAN KOHLOFFEL: So I'm going to raise another issue. In the letter that we received, the wording was – so in the letter response that we received back from Discovery they referred to the pharmacy under the language of "it's" as if it's a kind of a third person and then suddenly they start referring to his. No stage is the letter actually addressed to me at all.

ADV KELLY WILLIAMS: I still think you haven't answered the question about the linkage between the submission to the CMS. I see that it was five – you say it was five days after. How would Discovery have known that you made the submission and that it was you as opposed to NHC?

MR HERMAN KOHLOFFEL: I think NHC and myself would be synonymous, I mean they're linked. So I think first of all I mean simple CIPC or you check would see that I'm the owner of the pharmacies. I think one has to understand that I served on IPAF, IPA Foundation and it is no secret that I have made numerous comments about the fact that the – the fact that this issue was opened up gives us a window of opportunity to address something that has been on the forefront of not only NHC's agenda but it seems many other groups' agendas to try and get this remedied and rectified into a system that is well-balanced. So amongst the various different leaders within the groups, within the healthcare environment there is no doubt that we would have discussed this and somebody may have inadvertently or just in conversation said, you know, the NHC will be doing a submission. And once again, I can't testify to whether or not other groupings – remember that we as an IPA, as a grouping, are somewhat different to the rest of the associations that you find within the country in that we have a business that owns in excess of 200 million in assets and turns over something like 400 million a year that I head up on behalf of 300 medical professionals who own that company and then I head up the pharmacy as well. So I can't say to you that there is – there's no ways it would have leaked out because there's no doubt it would have.

ADV TEMBEKA NGCUKAITOBI: You know, I guess at some point we need to allow you to start talking about the substance of what you can't do but we need to be also be satisfied that we've not creating a precedent that will be impossible for us to administer in the future. But it is interesting that – I mean, your organisation in some respects is a powerful player in the industry, that even somebody as powerful as your organisation is still scared about the likely repercussions from Discovery because it seems to me that in reality you would have asked to give evidence *in camera* regardless of whether you got the letter or not, the letter of investigation because any suggestion from your presentation that Discovery is somehow implicated in the abuse of Section 59 would have possibly yielded an investigation. So maybe your point really is not that there is a linkage, your point is that you are scared from a commercial point of view about what the consequences might be. But that notion of being scared from a commercial point of view, if I may tell you, you are not the only one. I mean, we've had many individual practitioners who say we're coming here, we have to speak but we know that the consequences, they will collapse us because this is how Discovery abuses its power.

MR HERMAN KOHLOFFEL: If I can respond to that. I guess on the one hand it would have been – you are absolutely correct. I think on the other side is that there was no reason to be concerned other than five days later when we get this nonsensical request and immediately from that point onwards the instruction within group and everywhere else was to keep the information as close to our chests as possible, we

were not expecting to be invited to submit, we'd already submitted the document. So being invited then opened up a different can of worms.

ADV TEMBEKA NGCUKAITOBI: Alright, I get it. Look we need to make a ...(intervenes).

ADV KELLY WILLIAMS: Just one last question, just for fuller understanding. The fact that you are here seems to expose you enough. I mean, Discovery, whoever else will know that you are here. So is there further information in your submissions that you fear might ignite further retribution?

MR HERMAN KOHLOFFEL: I guess the concern that we have right now is this oscillating and what we wanted to deal with the panel was the oscillating between Section 59 and moving to 32 because it's our opinion and it may be naïve, it may be ignorant, it may be ill-informed, but given the responses that we're getting already from the administrators and given that they've done this five days after requests for submissions and all the rest of it, I mean, there is no doubts in our minds that there is a blatant arrogance within the industry that persists within the administrators. I think the second thing and the thing that worries me more than anything else and most of all when I sit here as an individual, okay, as an individual owner of pharmacies or whatever, is that this utilisation of Acknowledgement of Debts to get money out of medical service providers – and let me take you back two seconds. Adrian himself has made the comment that they estimate fraud waste and abuse sits at ...(intervenes).

ADV KELLY WILLIAMS: Adrian who?

MR HERMAN KOHLOFFEL: Adrian Gore, sorry. Sits at around about 29 billion, between 22 and 29 billion. Given the lack of transparency and the methodologies used to collect or recover this money, this could be a bigger business than doing medical administration because we don't know what percentage of these recoveries that happen from pharmacy, from doctors, etcetera. It could be 50%. Now if you get paid 10% on a billion rand's worth of turnover through a million medical scheme and you get paid 50% on 500 million that you recover from the industry in terms of fraud, waste and abuse or fraud, for that matter. I'll do the numbers, it's a much or lucrative business. In fact I would rather be running that than a medical scheme. In reality that's the concern I have. And currently this panel and us as witnesses or as presenters stand between that amount of money and the industry. This is far greater than just a talk shop. We are standing in the way of a lot of money and these medical schemes have a lot of resources. You can infer from that whatever you like. I am just saying that it leads me to be very, very concerned hence the reason why I asked to sit here *in camera*.

ADV TEMBEKA NGCUKAITOBI: Alright, let's do this, let's carry on with your testimony. We've given you a provisional *in camera* hearing.

MR HERMAN KOHLOFFEL: Thank you

ADV TEMBEKA NGCUKAITOBI: Which means that we'll come back to it and then we'll give you a final ruling but for now let's carry on.

MR HERMAN KOHLOFFEL: Okay. Can I just clarify, Stephan Jacobs, he is the group forensic services manager? Just a point ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: For Discovery Health?

MR HERMAN KOHLOFFEL: For Discovery Health, *ja*.

ADV TEMBEKA NGCUKAITOBI: *Ja*.

MR HERMAN KOHLOFFEL: So just a point in terms of this claims process under 32. Under Section 32 the claims must be paid in 30 days and any queries must be dealt with within the 60-day window period, is that correct? Ja, if you read it with Regulation 6. So under Section 32 it is impossible to ask for three years' worth of purchase data or claims data. It seems to be ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: With that your point is really that this is a Section 59 inquiry, it's just called a Section 32 and that is part and parcel of the abuse.

MR HERMAN KOHLOFFEL: Yes, correct. I think we made our point there; I don't think we need to continue. In terms of the submission – and I mean, you know, just again, just to draw attention – I think I was asked the questions and so I've raised some of the issues that I wanted to draw to panel's attention.

ADV TEMBEKA NGCUKAITOBI: But I mean I do want to get – if we are now dealing with substance of your investigation, I mean, your point which was under the topic about whether you should go *in camera*, when you say as you, as witnesses and as us as a panel are standing between a lot of money. I mean, I do want to get that broken down to understand what you say the financial stakes, as it were – are.

MR HERMAN KOHLOFFEL: It's difficult to assess those because there's no transparency and there's no regulation in the industry. We

have no indication of how the money or the percentage that medical administrators are paid to follow these quasi legal processes save to say the following, is that given that there's been a tremendous growth in these forensic departments one of two things is prevalent, doctors are becoming more crooked or, alternatively, it's become the most lucrative business for medical administrators to be in and I put it to you that I believe that it's the second. Just in terms of my first point on my presentation was that one of the greatest difficulties that we have is the stigmatism – sorry, stigmatism, the stigma behind the approaches or the fact that a doctor has or a medical professional has been approached. Every single time the medical professional has approached me to represent them or advise them before going into a forensic inquiry, the first thing they've said is, you know, I really don't want this to get out and I think you've heard it from various presenters going forward – I mean previously, that this issue is a serious, serious issue. Your receptionists hear about it, your staff hear about it, your family hear about it and very soon it's in the community and that causes a lot of tea party talk and everything else, leading the doctors not to want to not cooperate – let's say that much, they cooperate with the scheme immediately and as soon as the first cloud is over they are quite happy to sign that Acknowledgement of Debt, despite the fact that they have not actually been found guilty. I think the previous speaker made a point regarding the coding and ambiguity and I think in the GP space specifically where I often find myself often representing the doctors, the ambiguity in those areas has been, to say the least, quite

frustrating. The doctors' understanding of the interpretation of the code, the scheme's understanding of the interpretation of the code and which year they are using to actually justify why they are finding the practice's profile to be irregular are quite frustrating. Again, it kind of allows the same oscillation as you have seen now suddenly between Section 59 and 52, we kind of can play the same space, and it just depends on which scheme you are talking to as to whether or not they are prepared to accept that interpretation or that wording because it has a big impact on whether or not that doctor looks aberrant and is not or is aberrant. The other thing that we have noticed in all of these enquiries is that the information required always is over a three-year span. Always. Now if their detection mechanisms are so advanced and so brilliant, how is it possible that they would ask for information over a three-year period. They should be able to ask information from the time they detected the behavioural change that they claim exists. It is our submission that in fact there is an ulterior motive to why they are always asking for three years or why they move after the two-and-a-half-year period. And it ties back to what I have said before, and that is this, is that this business of recovery through forensics is a very lucrative business for the medical schemes, sorry for the medical administrators. Why would you watch an aberrant doctor for two-and-a-half years and then swoop in on him on the third year? It is a question that none of the forensic departments have even been able to answer, but it is a pattern that exists throughout.

ADV KELLY WILLIAMS: Do you know, from your engagement with the schemes, when they flag you – or the administrators, when they flag you

as an outlier, do you know the time period over which that data is drawn from? So my question is do you know?

MR HERMAN KOHLOFFEL: No, we have no idea. Can I ...(intervenes).

ADV KELLY WILLIAMS: It is fine.

MR HERMAN KOHLOFFEL: Okay. What I can tell you though is the practice profiling usually relies on – we normally practice profiling three periods later. So in other words, we deal with a period every six months. So we are practice profiling in July 2019 for 2017 quarter. Does that make sense? So we are three quarters behind. So we are dealing with July-December 2017.

ADV KELLY WILLIAMS: Is that not more than three quarters behind, if we are in July 2019

MR HERMAN KOHLOFFEL: Well, if you count this quarter and you count the other two as halves.

ADV KELLY WILLIAMS: Okay.

MR HERMAN KOHLOFFEL: Okay, sorry. So, they deal in six-month increments, so it is six months, six months, six months. I think the period that – the other thing that we put in our submission that concerned us was the line between recovery, the quantum that has been recovered and how that quantum benefits the individual member who may or may have resigned or may or may not be a medical scheme member anymore. How that money flows back to benefit the medical aid itself, we have seen no proof over the last how many years of how these forensic departments running and all this money that has supposedly been recovered, where a

scheme has said you now, we did so well on our recoveries from last year that we are able to give you a 5% increase in contribution.

ADV TEMBEKA NGCUKAITOBI: Can I just ask you, I mean you know, this figure of R22-28 billion, which everyone in the industry seem to have accepted, we have not got any tangible evidence that shows that the medical schemes loses, I mean even a cent, as a result of fraud. When you ask them to say it is impossible to work out how much you actually loose etcetera. Do you know where the figure comes from?

MR HERMAN KOHLOFFEL: Speculation.

ADV TEMBEKA NGCUKAITOBI: *Ja*.

MR HERMAN KOHLOFFEL: That is all it is. Then assuming that these forensic unites were that effective and that they are recovering that that would have a very big impact on the consumers' reduction in their contribution that they would have to pay each year.

ADV TEMBEKA NGCUKAITOBI: I think the 22-28 is how much is lost because of FWA, the recoveries range from anything from R500 million to a billion, so again, we do not have a clear sense of actually what is recovered. What we do not know is that the annual financial statements of Discovery, on year reflected that 500 million had been recovered.

MR HERMAN KOHLOFFEL: And could you track where that money was paid? Was it paid into the scheme, was it paid into the administrator? Because there are two processes that are being used to recover money. The one is where a bank account number is given directly to a service provider who has signed an Acknowledgement of Debt to pay the money to. That bank account number is not the medical scheme's number, it is

the administrator's number. The second is off-setting, in other words, what we do is, we allow you to continue to practice because you have signed an Acknowledgement of Debt, and then what we do is, we off-set against the amount of money that we have a claimed that you have defrauded us by, we off-set against future claims as you claim. So we allow you to continue. The issue there is, that there has to then be, an invoice between the administrator and the scheme to show that recovery. In other words because you would be charging a percentage thereof, or a fixed fee. I doubt it is a fixed fee, I am pretty sure it is a percentage of what was recovered. But those are two different processes.

ADV TEMBEKA NGCUKAITOBI: The other thing I noted in your submissions is, so, the one way is Discovery which we have got the scheme and we have got Discovery health, and Discovery Health is responsible for implementation of Section 59, and it gets paid either by a percentage or by a fixed amount. The other is that that too could be outsourced to a specialist forensic firm, that the specialist forensic firm would be paid a particular fee or a particular percentage, so a smaller scheme that does not have the administration capacity would simply hire the group of forensic investigators, they would do the recovery on their behalf. And again we do not have a clear sense of how the payments are made as between the scheme and the forensic entities. The one doctor here said he understood that the forensic investigators were entitled to as high as 34% of what they recovered.

MR HERMAN KOHLOFFEL: It is not for me to perhaps comment on somebody else's submission, but I am aware of the fact that there are

documents that have been – what do you call it, affidavits that have been drawn up by certain staff members that have perhaps left schemes of whatever, that will be submitted to the panel and that will show at exactly what percentage they were incentivised at. So, there is no doubt I mean, you cannot be employing really good attorneys in these departments, without incentivising them, it's not possible, their salaries are just one part of it. And in fact, in one of the hearings where I sat in, where the amount was whittled down from R300-odd thousand to a stupid figure of something like 22 thousand. The comment that was made by one of the managers to me, on my departure was at least they will get something for all their hard work. And in that instance, the – again, the resources that the medical schemes utilise to run these departments, I mean, you cannot tell me that you pick up fraud only within the two and a half years later by a medical professional. You will pick up that outlier and you will start watching them immediately and then you should act if you believe that there is something untoward. Why would you watch them for such a long period of time? It is purely because it is an unregulated part of this process, and the moment regulation comes to play, this whole issue will die down to being more realistic and they will use their resources correctly. The resources that the guys have got available to them, cannot take them two and a half years to work out that a medical professional is aberrant in terms of his claims pattern, it is impossible.

ADV TEMBEKA NGCUKAITOBI: But you are saying that there are affidavits from staff members who have left the schemes.

MR HERMAN KOHLOFFEL: Yes, I believe they will be submitted to the panel, I had actually had sight of one of them.

ADV ADILA HASSIM: Who is going to be submitting it and...(intervenes).

MR HERMAN KOHLOFFEL: I would rather not say. I just had it, it just happened to be put in front of me, but I am sure you will get it.

ADV TEMBEKA NGCUKAITOBI: Alright, thank you, so you are still on the issue of the failure to account for the recoveries because no one knows what happens to that money and no one knows what the charges are because it is a non-transparent system.

MR HERMAN KOHLOFFEL: And it is an issue that we have been pushing with the schemes to understand what those costs are. We have – everywhere we go where a doctor, or a service provider indicates that they have got into trouble, we ask them for documents, settlement documents to have a look at it to see. That is how we picked up the change in the behaviour by the medical administrators. Previously they always did off-setting, they always off-set the accounts, in other words, against payments to be made, then suddenly in the last two years we started to pick up that there was the scheme account number, sorry, not the scheme's account number, the administrator's account number for payments. Now I do not know whether the quantum was so big that they thought they would not be able to off-set over, you know, over a 10-year period or whatever it was or whatever the agreements was, I am not sure. But the moment we saw that, we thought we were on to something more with regards to how this money is flowing. And understand this, I have

made it my mission to try and find out how this money is flowing between the scheme, how it benefits the patient and the administrator.

ADV TEMBEKA NGCUKAITOBI: And what is the result?

MR HERMAN KOHLOFFEL: The result is we are sitting here now. In that I have not found – I mean I can only give you what we have been able to see, we have never been able to work out the percentage because the percentage is something that we cannot see, what we are hoping is that, from a – if there is invoicing that takes place between the scheme and the administrator, that would then be put onto a transparent path.

ADV KELLY WILLIAMS: So it is not just going to be wrapped up in the administration fee which the administration charges the scheme?

MR HERMAN KOHLOFFEL: It could be because we have never found evidence of it.

ADV KELLY WILLIAMS: And does that not make it very difficult to interrogate?

MR HERMAN KOHLOFFEL: Almost impossible. Safe to say the following is that I do not think you would run a department if it was not lucrative. But it is incredibly frustrating, I think that you know, there is waste and there is abuse, and I mean abuse and fraud, very much the same thing but, I mean and that has to be weeded out. The reality is that we sit in a very grey box because there is no regulation. Regulation will bring this in line, in some or other way because it will force transparency, and that is all that – ultimately, we would like the outcome to be, is that this is done properly. Secondly, I think we have made it very clear in our submission that the funds that are recovered, and again, watching the

pattern of everything being two and a half and three years later, can never benefit the people – the patients who made the contribution that fundamentally, one could argue, one level down, other than the scheme, are the victims of the fraud. So, if you cannot do that, why are you moving that money back into that medical scheme? Let us put into an Equalisation Fund, it can assist schemes that are in trouble, patients that are in trouble, people that cannot access benefits, or something else. Let us do something good with money that was derived perhaps, from bad behaviour.

ADV NGQUKAITOBI: Yes, proceed.

ADV ADILA HASSIM: Just one thing, do we know what percentage of members' contributions go to administrative, to the process of the risk management?

MR HERMAN KOHLOFFEL: No. not at all. There is an administrative fee, and in my humble opinion, if forensics is part and parcel of that administration fee, then it should be embodied in that, that could be part and parcel of the service that the administrator should be offering to the medical scheme. And from a membership – member point of view, I do not know what the member expectation is, but the member expectation must surely be what any person would want and that is that the money is being well managed by the medical scheme who appoints the administrator.

ADV TEMBEKA NGCUKAITOBI: Is there any bias against the independence pharmacies, which was some of the evidence we heard?

MR HERMAN KOHLOFFEL: I am not in a position to say that. I mean pharmacy is just an investment that I have and it runs and we have never had any particular altercations with any medical administrators, I have not seen any bias particularly, I mean it's safe to say that the medical schemes have got the right to channel their patients to the bigger corporate groups or whoever they may be, because they have, you know, preferential agreements. But I think you know, on a commercial level, you know, we have accepted that that is the construct of the health care environment and if there is a pricing advantage then you know, we have to accept that that is the commercial side of business.

ADV KELLY WILLIAMS: One further question of clarification, the – you mentioned that you have picked up recently that payments are being made into the administrators' bank accounts, or current accounts, it says in your submission, which administrators are these?

MR HERMAN KOHLOFFEL: I am going to have to go and pull that document, I actually cannot – I do not want to say the name, I will submit it to you, but I do not think it was a Discovery administrator account but I have got the Acknowledgement of Debt and the full documentation that was signed. I am sure that the person concerned will allow me to release that to you.

ADV ADILA HASSIM: And you say you have assisted health care providers in these investigations.

MR HERMAN KOHLOFFEL: Correct.

ADV ADILA HASSIM: In any of the cases where, first of all – well let us say this. In any of the cases where some wrongdoing was found on

behalf of the health care provider, was that health care provider reported to their professional body?

MR HERMAN KOHLOFFEL: In all the instances where there was any grounds to sign an acknowledgment of debt, whether guilty or not guilty, through intimidation, non-intimidation, there was – it was understood, it was made clear during the discussions that the provider would not be reported, to the police or to Health Professions Council. That is the trade-off that they put on the table as you walk into forensic departments. You know, we do not want to do this, we do not want to do that, let us discuss this. I am not sure if there is anything else you would like me to discuss or any other questions, it's safe to say that as I have said in our recommendation is that we really do believe that if this process is brought in line, and be properly regulated, the only question that has then to be asked is how and when the funds flow to. Because I am not sure that after three years that it is correct that the funds flow back into the medical scheme that was defrauded. Their financial period ends 120 days after December 31st, so the money that flows back is now going into the pot, to the benefit of people that had no commiserate production of those fees to start with. And I have never seen evidence anywhere, where a medial scheme has acknowledged, that through recovery they have been able to reduce the contributions. So it is my point of view that, and my submission that that money should be put into a collective pool, that is managed by the CMS or by whoever, to the benefit of the greater insured population, or for that matter even the non-insured population. But I do believe that that will change the behaviour of the –

and the appetite to bully and that – and change the focus to being a proper transparent system.

ADV ADILA HASSIM: What would you say to the response of the schemes that contributions would be even higher if they did not recover money lost through FWA.

MR HERMAN KOHLOFFEL: They must show us on their financials.

ADV TEMBEKA NGCUKAITOBI: Let us tell you, maybe something you can help us with, why the schemes are able to exert this type of power, when we know in relation to individual practitioners that it is because of their isolation and their over-dependency on schemes. But from a pharmacy group perspective, why is schemes over to exert this much influence over a practice?

MR HERMAN KOHLOFFEL: So, perhaps let us take it back to comment that you made earlier, and that was around the fact that you know, NHC is seen as a big group, etcetera, etcetera. NHC, if you look at the numbers may appear as a big group, but if you have a look at its footprint, I mean it only has four centres, we are busy building the fifth centre in Thohoyandou at the moment, when it comes down to the basics, all the revenue starts with an independent practitioner, I mean these are not employees. They are not employees of NHC, so if there is an attack or a destabilisation of something in the system of NCH, it can rattle the cage and affect the dietician that is sitting there in her practice just trying to eke out a living. And so, the size, I mean we do not see ourselves as big at all, and our reliance on that dietician, on 67% of her revenue fundamentally coming from one medical administrator, in fact 67 plus

about 4 so it is, it is about 71% if you take Bankmed into account and Discovery administers Bankmed, there is good reason to have a lot of respect for that animal at number 1 Sandton Drive, I think that just goes without saying. So I think that you know, one will always have to be mindful, because it impacts on that individual, I think I may still get my salary at the end of the month, but if they start fiddling around too much, it can cause a massive impact on that individual practitioner that has merely got an administrative agreement with NHC, etcetera, etcetera, within the group.

ADV TEMBEKA NGCUKAITOBI: On the one hand one can say you have got the letter, as you described it, it is nonsensical and tell them to get stuffed, but it is causing you a great anxiety and that is what I am trying to get into.

MR HERMAN KOHLOFFEL: The anxiety is around the fact that we are concerned that that letter is symptomatic of the next bullying tactic that may come down the line.

ADV TEMBEKA NGCUKAITOBI: You see, I mean, the one motive for the bullying is that as you said, it is financial, we have got financial targets and we employ a random system or maybe not a random system, a tableted system but what we are trying to do is to get our half a billion, you know, so that we can get our bonuses. So in relation to yours, everyone will deny and say it is because there is a *prima faci* or a preliminary case to answer, but that usually will be linked to what type of information are they asking for. You know, they say they are asking for information that cannot point to any form of misconduct on my part and

that is why it becomes nonsensical, the top five selling products across the group, what does that have to do with anything?

MR HERMAN KOHLOFFEL: Well, I think the concern there is the threat to suspend direct payments, and utilising that as the backdrop to that query. Because you do not know where that is going to lead from there, albeit nonsensical, the threat still exists that we are going to suspend direct payment.

ADV TEMBEKA NGCUKAITOBI: And where do we get the idea that there is a threat to suspend direct payment? Is it being inferred from the type of information and it falls within the class of information that Discovery usually asks for as a precursor to what is the invocation of the suspension power?

MR HERMAN KOHLOFFEL: I just want to understand the question.

ADV TEMBEKA NGCUKAITOBI: Because if it is not in the letter itself, you see, a letter could say, give me this information, if you do not, I am going to invoke my powers under the Act.

MR HERMAN KOHLOFFEL: The letter says that.

ADV TEMBEKA NGCUKAITOBI: I see.

MR HERMAN KOHLOFFEL: Correct. In the letter it also says they do not need to make a finding to suspend direct payment.

ADV ADILA HASSIM: It uses those exact words, that they do not need to make a finding in order, and you are going to provide us with all of this correspondence?

MR HERMAN KOHLOFFEL: Oh yes. And then you are going to provide me with protection.

ADV ADILA HASSIM: You know we are a voluntary panel.

MR HERMAN KOHLOFFEL: But we will summit the letter to you.

ADV TEMBEKA NGCUKAITOBI: So I suppose your point is that once they have figured out your top five selling products across the group for the past three years, which does not exist, it will be for the past year, out of that, there will be an extrapolation which will be evened out and then you will be given a percentage to pay back?

MR HERMAN KOHLOFFEL: Well, I mean, I think what they are trying to infer is that the products that we have claimed for have not been dispensed, so they would have great difficulty in doing that, but you do not know what they are going to do, and given that they have given an indication that we kind of do not have to find anything anyway to suspend direct payment, I mean, it is so blatantly intimidatory, and especially if you are consider this fact, we deal with R400 million in claims, we have never ever, I have been involved in the health centre since 2002, I have been running the NHC since 1995, we have never had a forensic question because we pride ourselves with ethics. The doctors that run the NHC board are very, very proud about the fact that they practice cost effective quality healthcare is not just words, it is seen and if you look at our practice profiles, what made the Discovery approach even more silly is that Cornerstone Pharmacy is a Med Express pharmacy, it has achieved all their benchmarks, so we get paid the highest dispensing fee, because you know, you have got all these little things, if you are compliant and if you do all of this, so it is a nonsensical approach.

ADV TEMBEKA NGCUKAITOBI: I suppose in a proper forensic exercise you could say if my allegation is that the products you have claimed for is not dispensed, let us assume that is what they are asking for.

MR HERMAN KOHLOFFEL: *Ja*.

ADV TEMBEKA NGCUKAITOBI: Then they will tell you, you have claimed for these products, give us proof it was dispensed, so to ask you for a generic information about the top five dispensed in the past three years, I mean that makes no sense, that is your point?

MR HERMAN KOHLOFFEL: Absolutely, but if you ask for a branch, the branch, remember – I mean I can come and give you a story that I have moved stock into branch, they know these stories because I can tell you, from the documents and the settlements that I have seen, I have seen all those excuses being used by pharmacists to get out of trouble when they have done it. They know those stories.

ADV ADILA HASSIM: That pharmacy group procures the medicine centrally and then distributes it to the branches?

MR HERMAN KOHLOFFEL: Correct, what I am saying is, we do not do that, we actually, we procure centrally but what we do is we do not get it delivered centrally, we get it delivered there. But remember, that during the cycle of a month there is stock that gets moved between the branches because we will find that one pharmacy wants to order more stock, this guy is sitting with short stock or short dated stock, you move that stock around, okay? These are all – these are things that you can hide behind, if you are perpetrating fraud, you can come up with many different stories that the administrator or the forensic department would have to deal with.

You have to take a long shot here, to convince me that the forensic department which shoots a letter off to Cornerstone Pharmacy, Manor Pharmacy, specific pharmacy asking them for this nonsensical piece of information, knowing full well if there was fraud, or if there was something going on there, these guys would have every story in the book. We have got six branches, not one branch.

ADV ADILA HASSIM: And you are staying that the next step, now, this is correspondence that you have told us about, there is a threat of indirect payment and you are saying that the next step will be a settlement through an AOD?

MR HERMAN KOHLOFFEL: I do not think there will be a settlement because there is no ways, they are going to intimidate me to do that. But then I have got the resources and the experience and the knowledge to deal with them. But I do not know what next thing they are going. We know, to the best of our abilities that there is no shenanigans going on in that pharmacy division okay, and I mean we analyse customer service ...(intervenes).

ADV ADILA HASSIM: It will not stop them from putting you on indirect payment?

MR HERMAN KOHLOFFEL: It may not, they threatened it, I do not know. This is part of their letter.

> "Verification of claims is not reliant on a finding on our part. Furthermore does Section 59(3) not require a finding on our part".
>
> Why did they say that?

ADV TEMBEKA NGCUKAITOBI: Maybe they intended to say Section 59(3) does not require, they just got it the other way around. But I mean your point is that this was a Section 59 enquiry?

MR HERMAN KOHLOFFEL: *Ja*. So they use that in their response to us.

ADV TEMBEKA NGCUKAITOBI: I mean, you are saying that the next step would be to put you indirect payment, that is the implicit pressure point that they would use except that this time you are properly resourced to defend yourself but the bulk of the people we are dealing with in this panel are not resourced.

MR HERMAN KOHLOFFEL: Absolutely. Absolutely. I mean, I have to pay our attorneys all the time, that is hard work in itself.

ADV TEMBEKA NGCUKAITOBI: But be careful who you are talking to.

MR HERMAN KOHLOFFEL: But the reality is that you are 100% right, we are able to apply our minds and resource appropriate to deal with an issue like this. But this is the first time we have had to deal with this, it has always been on a periphery to the group dealing with independent practitioners, and independent businesses that ended up in forensic investigations.

ADV TEMBEKA NGCUKAITOBI: Thank you, is there anything else from yourself or your attorney?

MR HERMAN KOHLOFFEL: I do not think so.

ADV TEMBEKA NGCUKAITOBI: Thank you, we want to thank you for your presentation and the fact that you came despite the difficulties that you have been put under by Discovery. We will obviously be in touch with you, the one issue that I think we will definitely try and negotiate with you

is I have heard the evidence and I have heard the reasons why you feel this should be *in camera*, I do not think you have crossed the threshold of an *in camera* strictly speaking, so we will have to negotiate with you to put your evidence available online, the transcript of the evidence. But we have not yet made that decision now but my *prima faci* view is that you do not make the threshold of an *in camera* hearing. But we at least spared you from television, that is something to celebrate. We will stand adjourned then, until, we will announce further dates, they will be announced, what is the next date? So it is postponed until the 17th of September.

MR HERMAN KOHLOFFEL: Thank you very much, thank you to the panel.

INQUIRY ADJOURNS TO 17 SEPTEMBER 2019

TRANSCRIBERS CERTIFICATE FOR

THE COUNCIL FOR MEDICAL SCHEMES (CMS) INQUIRY UNDER

SECTION 59 OF THE MEDICAL SCHEMES ACT

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