THE COUNCIL FOR MEDICAL SCHEMES (CMS)

INQUIRY UNDER SECTION 59 OF THE MEDICAL SCHEMES ACT

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ADV TEMBEKA NGCUKAITOBI: Good morning. We are continuing the Section 59 Investigations. Today we have two experts the first is Professor Melissa Steyn to give her expert testimony. Professor Steyn, we generally don't take an oath from an expert so you are free to tell us what you came here for.

PROF MELISSA STEYN: Is this on and is it recording, its fine okay. So Chair thank you very much for the opportunity to be here and to present a perspective to you. I believe that I should just indicate
10 something of my background in the field.

Well, I've been working in the areas broadly related to questions of race since the late 80's- late 1980's. I first worked in the area of Intercultural Communication and then moved my attention more specifically into Critical Race Theory in the mid 1990's and in particular into Critical whiteness Studies.

I read the first book on Critical whiteness Studies in South Africa which was published in 2001. And I have subsequently expanded my focus somewhat into what I call Critical Diversity Studies. And I established that at – first at UCT in 2000 and then brought it to WITS
20 where I established the WITS Centre for Diversity Studies in 2014.

So I'm the Founding Director of that centre but I am also the National Chair – the South African National Chair in Critical Diversity Studies. So that gives you some idea of my background.

ADV TEMBEKA NGCUKAITOBI: What is a Critical Race Studies or Critical Diversity Studies?

PROF MELISSA STEYN: Okay I'm going to speak a bit more about Critical Race Studies but generally I would say that Critical Diversity Studies is the study of how difference gets positioned within unequal power relations and how it gets constructed within unequal power relations in such a way that you end up having different outcomes for different people.

And so that there is almost like a systematic unfairness that gets built into society through the way in which difference gets to be constructed and understood and wielded in our society. So we try to

10 make visible the kinds of power dynamics that normative society with its invested interests sitting to want us not to see. We try to make those visible.

So Chair the inquiry is framed in terms of racial profiling. I have looked into some of the literature on this and it's clear that most of the work that is done on racial profiling occurs in the context of policing which I think is not irrelevant because the Forensic aspect of medical aids obviously is you could say in a way the Policing Department or Division of the sector.

What I have found particularly useful is that the United Nations

20 issued a publication this year, 2019, that speaks to racial profiling and policing and just generally provides us with definitions understandings of what it is and also where is which successful interventions have happened that could help one to deal with it as an issue.

As the document defines it, racial profiling generally concerns a quite specific use of race as a sole criterion or a default criterion

when, you know sort of identifying potential criminals or, you know even in ways in which people are handled in policing.

ADV KERRY WILLIAMS: Professor Steyn, sorry to interrupt. Can you just give us the title of that UN document or the reference?

PROF MELISSA STEYN: I do actually have it but could I provide it to you afterwards? It is Racial Profiling of People of African descent internationally.

ADV KERRY WILLIAMS: That's fine, afterwards is fine.

PROF MELISSA STEYN: *Ja.*

10 **ADV KERRY WILLIAMS:** Sure.

PROF MELISSA STEYN: But certainly I will give it to you. And advocate Williams if I could say that applies for anything else that I refer to I have got obviously all the documents I can make available to you and I could also make available to you a written copy of what I'm dealing with today.

ADV KERRY WILLIAMS: Thank you okay.

PROF MELISSA STEYN: Okay. So that would be the way in which the United Nations helps us to understand and they refer to the various instruments and like the Durban Conference on race and xenophobia

20 related discriminations.

So they're drawing on that sort of international literature on racial profile, but importantly the report also mentions the question of implicit bias and of offices not really being aware and falling back on unconscious assumptions and the kinds of things they talk about is that a well meaning person who might think that their biases are gone have

been socialised to ignore race and that can that these effects of bias actually – well this is then the work on implicit bias specifically indicates how bias is actually present in everything that we do. So it's not something that we can assume that we have written out in a policy because we formerly achieved some sort of absence of race in the policy.

But they make certain suggestions like involving communities, diversifying the police forces, more training and very particularly checking if there are any patterns in the data that emerge. So I read
10 the documents that were forwarded to me and what struck me is that the medical aids whose processes I was able to look at are at pains to avoid any obvious racial profiling.

And I think that that is you know clearly something to their credit and in some ways if you look at this UN report, they recommend for example anonymising in data basis, anonymising identities of people involved as a way of ensuring good practice.

And so you can see that those kinds of things have been introduced and also you know sort of quite a lot of procedural checks and balances that are there and so. To me at the level of form it is
20 quite clear that the companies are at pains from falling into any kinds of naive traps around racial profiling. And I think that one would say that one should assume that this is done sincerely with the intention of doing things correctly.

This could be seen to be an attempt to be rigorously colour blind and for me with my background in critical race theory which I'm

going to come back to. It seems to me that the problem lies more in what's not there than in what is there. Because I don't see anything in these procedures that would indicate any deliberate or thoughtful engagement with how to address – identify address or eliminate any form of bias that may be implicit within their systems.

So critical race theory would start with the assumption that race is a social fact. So we not going to go into all those obvious debates around biology and stuff but it's a social fact. That in terms of our history it's and economic, it's illegal, it's a socio historical reality

10 that is in our societies and is informs every aspect of our societies that race is in fact constitutive in shaping our societies through the period of modernity. And that this means people have been positioned very differently in relation to each other.

This would apply obviously in relation to things like resources like access but also in terms of how different processes would impact them because they are differently positioned. So critical race theory as I said the most important thing is that it would assume that race is always already there in whatever issues we're dealing with in our society and in South Africa I think this becomes particularly salient.

20 And so to ignore it in our thinking, in our planning, in our implementation is to be at best naive but probably indifferent or even deliberately blind to have different people or effected differently about the same process. And critical race theorist would ask who owns your experience? Given the kinds of power basis from which policies are formulated it will be a question of definitions coming from outside that

interpret your experience and act on your experience from a dominant frame that may not include or be cognisant of the way in which you are being impacted or the realities from which your own life is lived.

ADV TEMBEKA NGCUKAITOBI: Sorry, can I just ask around that issue because you see earlier you said that you've interrogated the policies of the schemes that have been given to do. What you have established is a problem is what is not there.

PROF MELISSA STEYN: H'mm.

ADV TEMBEKA NGCUKAITOBI: And what you say is not there is the

10 absence of a system that identifies and addresses forms of bias which may be implicit in the systems.

PROF MELISSA STEYN: H'mm.

ADV TEMBEKA NGCUKAITOBI: And you're saying that the consequence of that is naivete, indifference and deliberate blindness.

PROF MELISSA STEYN: It could be.

ADV TEMBEKA NGCUKAITOBI: *Ja.*

PROF MELISSA STEYN: I'm not imputing those things I'm just speaking in general terms.

ADV TEMBEKA NGCUKAITOBI: Yes.

20 **PROF MELISSA STEYN:** And it's not so much the consequence, it's more an informing ethos that can lead to unequal outcomes.

ADV TEMBEKA NGCUKAITOBI: So you would say that as – I mean of course you are not here to interrogate the policies of the scheme.

PROF MELISSA STEYN: No.

ADV TEMBEKA NGCUKAITOBI: You are here to give us expert

testimony. But you would say that if there is a system that is – that does not thoughtfully engage and identifies and addresses the implicit biases in the modalities. One of the consequences is what we describe as naivete indifference and deliberate blindness.

PROF MELISSA STEYN: I'm saying well, it is a consequence but it's also – I don't like to use cause and effect but I mean you could say that as I said it's like the informing ethos ...(intervenes)..

ADV TEMBEKA NGCUKAITOBI: *Ja.*

PROF MELISSA STEYN: That brings about the fact that there isn't any

10 consideration of other positionalities that it's just written from a particular dominant point of view.

ADV TEMBEKA NGCUKAITOBI: *Ja, ja, ja.* So you saying that part of the explanation as oppose to consequence ...(intervenes)..

PROF MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: Part of the explanation for the absence ...(intervenes)..

PROF MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: Is precisely this indifference and deliberate blindness.

20 **PROF MELISSA STEYN:** Yes.

ADV TEMBEKA NGCUKAITOBI: Okay.

PROF MELISSA STEYN: Yes. And I think I'm going to say a bit more about it later but I think that it is important to recognise that this is not necessarily conscious although it's very difficult to know what the exact mix of intention and awareness and unawareness is in any person's

actions.

ADV TEMBEKA NGCUKAITOBI: *Ja* and then I think that is fine because you are introducing another element which is this itself can be explained further by the dominant frame ...(intervenes)..

PROF MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: That imposes an ethos depending on the power relations.

PROF MELISSA STEYN: Yes and that's exactly – the rest of my presentation is also exactly of this point Chair.

10 **ADV TEMBEKA NGCUKAITOBI:** Alright, thank you.

PROF MELISSA STEYN: So the important question then becomes how do policies like these, lands differently on people who are differently positioned. And you know the kind of example that is often given and Chair you've probably heard it, it will give it in other context but you will be like saying the Mayor of this town doesn't allow anybody to sleep under bridges whether you're rich or poor.

Formerly that is completely fair but it doesn't take into account the lived experiences who are homeless as to oppose to those who have a home. So it's that kind of point that I'm making. So not be

20 conscious of the ways in which we are positioned differently within society given our history is to trivialise and to delegitimize the plight of those who are either in the system.

So I want to say a little bit more about colour blindness because as I said I mean it's to me it's very clear that with and probably with the very best intentions these policies that you know work

on the assumption that if you're colour blind then you're above any kind of culpability or implication in something that could be unfair.

The question about colour blindness is that it represses the kinds of discussions exactly around what we talking about. With colour blindness usually the person who names racist seem to be the racist in colour blind. So you keep race right out off everything that you – however you formulating your processes.

So it actually represses the kinds of discussions that the complainants I think are bringing to the panel, it represses exactly

10 those kinds of conversations and ironically it allows for processes of implicit bias to operate without being able to name or examine or work to change how different racial groups are being impacted.

So working here with the work of Professor Redding it makes it very hard for any discussion to happen that will actually make these kinds of racial – these implicit racial factors visible. Professor Tastit has talked about what he calls racial blindside and he identifies the colour blindness operating to create blindness in terms of hindsight that is in terms of the history that brings one to a particular position and how that is creating different realities for people alright.

20 He talks about blindness in foresight ...(intervenes)..

ADV TEMBEKA NGCUKAITOBI: Sorry, there is someone who has either a cell phone or something else that's playing in the back. It's a recorded that's just replaying. Nevertheless, I think let's carry on.

PROF MELISSA STEYN: Alright. He talks about blindness in foresight because if we can't actually grapple with these things directly we can't

anticipate the ways in which policies for example may affect people differently. He talks about blindness in now-sight which is how it is actually impacting people right now but then he also talks about what he calls fo-sight which about perhaps a more deliberate not wanting to know and that panel again, that's published in the higher state journal of criminal law and I can make that available to you.

But the point that comes out of what I'm saying is that what is considered neutral comes from somewhere and it has a history and it arises out of power relations that have been settled previously in a
10 particular kind of way or power contestations, it would have been settled in a particular way previously in favour of those who are now in the position to define the terms of neutrality. So there's a history to what is regarded as neutral. And as I've said already, it's always already racially informed. We can't escape that.

So Steward Hall has come up with a very helpful notion of what he calls inferential racism which I know that Advocate Trengove spoke about indirect racism and this would be in some ways almost like an explanation of how indirect racism could come about.

He talks about naturalised representations, things that have
20 come to seem normal commonsense ordinary that have racist premises or propositions inscribed to them – in them as unquestioned assumptions. So in other words, people would not be aware of the racial predicates on which the systems are grounded. So that would be inferential racism.

ADV TEMBEKA NGCUKAITOBI: Let me just explain I mean the one I

suppose push back could be that the test you are postulating is not administrable, it's impossible to actually apply in practice. So take – I mean you've made the example that most sort of normative standards themselves are positioned from a historical power relation. So the phrase is neutral.

PROF MELISSA STEYN: H'mm.

ADV TEMBEKA NGCUKAITOBI: But the outcome depends on application and on application you have to look at the positioning of different I would say recipients ...(intervenes)..

10 **PROF MELISSA STEYN:** H'mm.

ADV TEMBEKA NGCUKAITOBI: Of these so called normative standards but if you apply that in practice – so you've made the example no one is allowed to sleep under a bridge rich or poor.

PROF MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: But take a different example that may be applicable closer home. Everyone who has committed fraud must be investigated black or white.

PROF MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: So I'm trying to figure out what is an

20 administrable standards. So maybe forget about schemes take an exam, those who obtain 50% will pass regardless of whether they ate before they wrote the exam or whether they didn't eat before they wrote the exam.

PROF MELISSA STEYN: H'mm.

ADV TEMBEKA NGCUKAITOBI: So at some point one needs to grapple

with what standard is actually administrable in order to apply critical race theory.

PROF MELISSA STEYN: Yes. So I think in the example you give of the exam, you know the question would be, do we understand the positionality of people who come to write exams hungry and are we making the right kind of social plans to ensure that nobody writes an exam when you're hungry and you're at a disadvantage.

So that would be the kind of effect of what I'm talking about. So it would have to do with understanding those different positionalities

10 and how the neutrality actually has different impacts depending on peoples actual lives.

ADV TEMBEKA NGCUKAITOBI: Yes I mean you could expand also to this – to the example we grappling with you know, but what is the subject matter of this inquiry is perceptions of racial profiling. People saying – the scheme saying well, we investigate everyone and we apply the same neutral standard. I know you're critical about the phrase "neutral standard" because that standard itself is an outcome of an unequal power relation.

PROF MELISSA STEYN: H'mm. Yes but I think that one would –

20 perhaps I can just continue and we can and then I think you would probably see where I'm coming or going to and we could talk about that more fully. But I think an example that we've seen quite clearly is for example in education around questions of curriculum and the whole decolonial movement where so much of what has been assumed which has been neutral knowledge has actually been a very specific trajectory

of knowledge constructions and epistemological systems that have been the outcome of previous power contestations that were settled in favour of Eurocentric knowledge. So I think that that's the kind of logic that I'm talking to.

So Chair what as a critical race theorist one would argue for is what we would call racial cognisance as opposed to colour blindness and I would certainly maintain that you can't come out of a system with a history like ours which has been thoroughly racially inflicted but it's more than that, it's actually as I said earlier I think racist constitutive

10 of our society.

You can't come from there straight into some sort of race neutral system. There has to be racial cognisance in which you really are taking these issues really seriously and factoring that into how you formulate things like policies.

ADV ADILA HASSIM: And it wouldn't matter what race you are? It would be necessary for any person regardless of what, ja to take that kind of approach of racial cognisance. Would you agree?

PROF MELISSA STEYN: Yes it would. But it would also obviously involve a proper historical understanding of how race has been

20 constructed and who have – has been dominant and who has been oppressed by the system. So you can't sort of just simply present these as equivalents as there are real power imbalances that are very deeply built into our system. And you would have to look at how people are positioned relative to those.

So what racial cognisance would then also ask is that – argue

is that where inferential racism at work, where it becomes visible because it operates at that level of these normative assumptions that aren't actually interrogated or aware – conscious. Is that where they become visible is where the system pinches.

Okay so it would be where you start getting systematic voices speaking out and saying this is hurting me. Alright and that would be the place that we need to take very seriously in order to see whether there is inferential racism within the system. So as I've spoken before with power inequalities we have this kind of systematic ignorance's.

10 What I've spoken about in my own work is the ignorance contract. This agreement and willingness to just not know and not to acknowledge that you know that you're not knowing. So it's quite I think interesting work around how these systems maintain themselves.

ADV KERRY WILLIAMS: May I ask you a question?

PROF MELISSA STEYN: Please.

ADV KERRY WILLIAMS: Just in relation to this point. Why were there system pinches? Why must we take this more seriously?

PROF MELISSA STEYN: Because the power relations operate from the position that's established as the norm and so it operates for the

20 comfort and the benefit of the powerful norm. And it works to not only establish privilege but also to maintain and secure privilege and prevent privilege from being eroded.

So if you wanting to see how that normative system is creating unfair consequences, you have to take those people in the positions who are telling you this isn't working for me. You have to take that

very seriously. You have to try and really track where the problem actually lies and where the injustices are coming from. I don't know – that is clear. So when we have a position where the normative position has established and created a notion of the neutrality of a system and is able to act unilaterally, the point is that the people who are shaped within those positions – whose subjectivities have been shaped within those positions, generally lack insight into the relational dynamics of what they are actually establishing. They are in a position to define the problem, to implement and act upon it to what would be satisfactory outcomes. And
10 that is that position, that normative position of power that is able to do that.

And I think, as I have now said a couple of times, that generally you would find that people in those positionalities tend to be either unaware or indifferent to the impact that this has on others. And I want to emphasise Chair that this is not just in relation to the particular context that we are talking about. This obviously applies across the board and I think, you know, I am going to make the point that it places a particular onus on us and on people in those positions.

So, what the implication of this is, that in formulating policies it
20 is important for people in those dominant positions to seek out the perspectives of others and critically to assume there is racial bias in their system. Not to start with the assumption that somehow you have been able to, you know, clean it out through formal policy. It is there in the system and to work, it is a very big paradigm shift to assume that there is racial bias and that it is not good enough just to avoid doing wrongdoing,

alright, and sort of like leave it to someone else to sort out questions of injustice. But, actively, to take steps to ensure that one is thinking through how these things may be operating within your ecosystem. So, it seems to almost be like an irony that even though it is important to do things like anonymise data bases, at the same time we also have to reintroduce race and keep race very clearly in our thinking as we formulate policies, as we formulate implementations, as we look at how things play out.

We have got to keep race present in our thinking and that we

10 have to do both of these in the interests of fairness. So, we have to ensure cognisance and we have to work much harder at understanding the racialised realities of people on the ground. So, I was looking at some of the things that people having been working on in terms of how can organisations or industries or governments, you know, actually do this? So, an interesting concept that is emerging and it is sort of quite new, is what people are calling a racial impact assessment. Which is similar to like an environmental impact assessment and it is a tool that is being introduced in public policy but also as an organisational tool. And one example there, there are a couple of people who are working on this

20 but one is the centre for racial justice and emanation in the States and they argue ... (intervenes).

ADV ADILA HASSIM: Sorry, where is this being implemented, in the US, you say?

PROFESSOR MELISSA STEYN: Well, the examples that I saw were from the US. But if I am not mistaken, it is actually also being picked up in the

UK in certain places and I can double check that. And it is being recommended as a form of due diligence that we should actually be doing this racial impact assessment at every stage of our work, explicitly looking at how race could be informing and also how it could have – our work could have racial impacts in different kinds of ways.

As I said, it is sort of similar to an environmental fiscal impact and the idea is that it helps people to anticipate and address racial and ethnic disparities that happen with systemic racism because our crucial question is not always, Chair it relates to what you asked earlier, it is like
10 how do we deal with systemic racism? You know, it is sort of, it is so everywhere and it is so often so difficult to pin down. But unless we work consciously in this kind of way and do this kind of thinking, where we really are interrogating, is it possible that this could have different impacts for different people depending on their racial positions?

And then it also enables people to consider alternative policies to accomplish the same goals which will avoid the disparities. So, it is really a kind of a thinking tool. And the two key questions would be; are there any potential unintended consequences on a particular racial population? And Chair, I am talking about race because this is what the
20 enquiry is about but obviously, you know, as a diversity person I would say that we need to be looking at this, you know, in a complex way, with looking at gender and various other dimensions of difference. So firstly the two key questions; what are the potential unintended consequences on any particular racial population, and then secondly, what are appropriate alternative courses of action? And to enter into that in good

faith, you know, to really deeply interrogate those possibilities.

The second thing obviously is the question that we all talk about which is diversifying organisations because, there is obviously a much greater chance that implicit bias that is operating within a system could be picked up if you have people who have different life experiences and different, you know, whose sense of themselves have been shaped by different historical processes, could pick that up and name that. And creating the kind of organisational culture where that is welcomed, you know, and actually taken really seriously. The third one – so, the third
10 one would be, and it is linked to these others, you know, to scrutinise, because if you look at these different processes, there are always moments at which decisions are made and wherever a decision is made there is the possibility for an implicit bias to enter into the final outcome or the final product.

And so it is really important to work with people in our organisations to develop what I would call critical diversity literacy. And to able to sort of like really ask those questions of decisions as they are made at each stage of the organisation. How might this decision be centring a particular positionality and how might it be ignoring the
20 realities of another? How might there be inferential bias? And then the fourth one, and I really do want to emphasise this one, is there is an onus on all of us in our institutions, in our organisations, but particularly where policies have such large-scale effects on populations. You know where there is such an incredible amount of impact and potential for harm or for unequal outcomes, to do proper research and to monitor outcomes for

skewed effect.

So if we have an outcome where almost everybody in a particular process is seen to be as I pick up, might be sort of like black or Indian, there has to be real research to ask what assumptions might have been introduced despite our best efforts? What implicit bias could there be and to take that really seriously and that would involve actually, you know, working in an open-minded way with the populations where I said where these things pinch. To really try to understand how might these particular processes, the implementation processes, the procedures that
10 we are working with, how might they not be taking into account, the lived realities of the people in this particular positioning?

And so the question really becomes, you know, if you have that kind of outcome and you understand that there are possibilities of implicit bias – are you – do you remain comfortable with an outcome that seems to say all our processes are fair, all the people who are fingered are black or Indian? Are you comfortable with the implication that the criminals in our system are black and Indian? I think that that becomes really the big question because if you are comfortable with that as the inference from your results then I think you have a lot of explaining to do.
20 I mean, I think if you get such skewed outcomes there is a real onus on you to reach into that and try to work out what is happening in those spaces rather than just to make an assumption that your processes are fair and that you have produced some sort of, you know, completely objective outcomes that point into this direction.

And Chair, just to say, that I mean, the implications of not acting

in that way are very consequential, you know – we know that things like racial profiling where we have these kinds of outcomes, lead to a breakdown in trust. Well, it certainly comes out in the policing literature. A breakdown in trust which makes it even harder for the system to operate and it can affect the – obviously an entire industry, but more importantly, it affects all of us because these are racial relationships that need to be addressed with a great deal of care and sensitivity because in the end we all live in a country that is more fraught.

ADV TEMBEKA NGCUKAITOBI: What is your inference on this issue? I

10 mean, so your last point is that you say a scheme, just talking a hypothetical scheme, has neutral policies but the outcomes are racially skewed and the scheme does nothing about that, is that still intentional, or is it now, because it seems there is one difference to say well, my policies are neutral and that is my interest but once you know that they are producing unequal outcomes ...(intervenes).

PROFESSOR MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: And racially unequal outcomes

PROFESSOR MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: I mean, you say there is an onus there

20 ...(intervenes).

PROFESSOR MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: But it seems at some point it does becomes intentional?

PROFESSOR MELISSA STEYN: Intentional to have those skewed outcomes?

ADV TEMBEKA NGCUKAITOBI: Yes, well intentional to do nothing about the skewed outcomes?

PROFESSOR MELISSA STEYN: Yes, intentional to do nothing about them. I would say that there is, you see I think the whole point is that what emerges in these kinds of really unequal power relations is that – is indifference really, it is indifference to that. It is not – you know I mean I would never go as far as to say that anybody is sort of like intentionally wanting to target black people. That does not seem to me to be there in what I saw or would deliberately like, you know, to sort of like scupper

10 the livelihoods of any particular group or anything like that. I think that is a stretch too far. But certainly, the indifference would be one of the, a fair inference I think to make in terms a critical race analysis.

ADV TEMBEKA NGCUKAITOBI: Yes, now I understand, I mean there is that two forms of intention, the one intention ...(intervenes).

PROFESSOR MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: And intention to produce a skewed outcome.

PROFESSOR MELISSA STEYN: Yes.

ADV TEMBEKA NGCUKAITOBI: I think no one is actually making that

20 ...(intervenes).

PROFESSOR MELISSA STEYN: No.

ADV TEMBEKA NGCUKAITOBI: That point. But there is a second intention which is the intention to do nothing about skewed outcomes.

PROFESSOR MELISSA STEYN: Yes, which I would ascribe to indifference.

ADV ADILA HASSIM: Sorry, can I just probe you on that because if the outcome is that black doctors – the ultimate outcome would be that black doctors are investigated and penalised for having committed, let us use a broad term of fraud, sometimes it is called other things okay? Then what the schemes must accept in their, at some point that it must correct that black doctors are just more fraudulent.

PROFESSOR MELISSA STEYN: Exactly. So, and that is what I am saying is ... (intervenes).

ADV ADILA HASSIM: But you have to accept that if you do not do
10 anything about it ...(intervenes).

PROFESSOR MELISSA STEYN: Exactly.

ADV ADILA HASSIM: It must mean if you do not enquire into why there are greater number of black doctors ......(intervenes).

PROFESSOR MELISSA STEYN: Yes.

ADV ADILA HASSIM: It must mean that you accept ...(intervenes).

PROFESSOR MELISSA STEYN: Yes, and that is my point and I would say that if you are comfortable with that, then you have something to explain. Because I mean obviously we are again looking at questions of implicit bias, that you know, that would suggest that in some ways there
20 are those inferential assumptions that have not been surfaced around expectations of greater criminogenic behaviour, that black people are more likely to be produce crime. I mean that would be obvious to me that that would be an underlying assumption that made you comfortable with that outcome.

ADV TEMBEKA NGCUKAITOBI: Thank you. Do you have any further

points to make?

PROFESSOR MELISSA STEYN: I think I have covered it. I would just like to know if you do want this presentation to you.

ADV ADILA HASSIM: Yes, definitely.

ADV TEMBEKA NGCUKAITOBI: Yes. It would be much helpful, and your sources as well.

PROFESSOR MELISSA STEYN: And the sources, I can definitely give the sources, yes.

ADV TEMBEKA NGCUKAITOBI: Thank you Professor Steyn, it has been

10 a pleasure listening to you. You are now excused.

PROFESSOR MELISSA STEYN: Thank you so very much.

ADV TEMBEKA NGCUKAITOBI: We will recommence at 12:00 for Advocate Hasina Cassim. We are adjourned.

INQUIRY ADJOURNS

INQUIRY RESUMES

ADV HASINA CASSIM: So thank you very much for the opportunity of being able to make an oral submission. I did make a written submission. Just to clarify, I'm not a complainant in case anybody misunderstands my presence here. I'm really only here as an aid to the panel in terms of my

20 experience that I've had in representing several healthcare providers in their investigations and enquiries with medical schemes.

ADV TEMBEKA NGCUKAITOBI: Thank you.

ADV HASINA CASSIM: So this are my qualifications, I am an advocate at the Johannesburg bar but prior to that I actually qualified as a pharmacist, I'm still registered as a pharmacist. And in my experience in

the healthcare sector I was able to in fact fulfil roles as a pharmacist as well as having worked in pharmaceutical industry.

And then in the latter part of my career as a pharmacist I actually spend just under 10 years in a major healthcare funder. So I do have somewhat of an inside track and an understanding of the funding business and managed care.

ADV ADILA HASSIM: What was your role in the – did you say healthcare funder?

ADV HASINA CASSIM: Yes. So I actually was employed by an

10 administrator and my role there was as a risk manager. In that function I actually did various things so I managed a low income plan as a risk managed a low income plan as well as medical devices and pharmaceuticals.

So in light of the fact that I have the experience many healthcare providers when they found themselves in difficulty with medical schemes or administrators approached me to actually assist them in their investigations or in their consultations.

My colleague who's with me today Nabeela Moola is one of my instructing attorneys. There are others as well but I think for the sake of

20 just trying to keep this as smooth as possible, I actually just asked her to assist me if any specific queries come up about any of our specific clients.

So I made the submission to the panel in my personal capacity as I mentioned and explained in the submission itself. It is based on a collective experience spanning various schemes, administrators and

various types of healthcare providers. I'll provide a little bit more insight into the various disciplines that I had represented and I'm hoping that in fact through my not having been directly involved in these investigations that I can actually give you a more objective and maybe to some extent slightly subjective assessment and analysis of those investigations.

So to give you an idea of some of the demographics of the professionals represented in terms of gender mix it's almost 50/50, 47% male, 53% female. In terms of racial mix, whites and because the specific inquiry this would not be something I would normally collate but

10 because the inquiry is around discrimination, I have included that information. About 13.3% of the healthcare professionals were white and for the remainder they were a mixture of black, Indian and Coloured. In terms of the disciplines that I represented, specialist made up about 27% of the clients. General practitioners 20%, Allied Healthcare Professionals 46% and pharmacists 7%.

The Allied Health Professionals actually were a whole myriad of them but it – in my presentation you will see there seems to be a trend. So from time to time there's an investigation to a specific area of healthcare and so there were significant number of clinical technologists

20 in fact that were actually part of my client base over this period of time.

So I just wanted to make – clarify that there actually are different types of investigations. And I think you had Dr Adri Kok present to you and the emphasis in Dr Adri Kok's presentation was in fact on a very specific type of investigation. I've included in that pack which you'll receive shortly an idea of the type of analysis that's done when in fact it's

a quality assessment which I will refer to in this instance as a Risk Management intervention.

It's a very different investigation to a Forensics Investigation and now let me talk about the Forensic Investigation firstly because that actually forms the bulk of the ones that I was involved in. Only two of the investigations that I was involved in were actually Risk Management, for the remainder they were all Forensics.

And maybe I'll start off with in fact with the Risk Management Investigation. The Risk Management Investigation is almost exclusively

10 for consulting disciplines. Now, just to explain a consulting discipline …(intervenes).

ADV ADILA HASSIM: Sorry, I just wanted to understand the difference between a Risk Management Investigation and a Forensic Investigation.

ADV HASINA CASSIM: So firstly it emanates from different parts of the healthcare funder. There's a Forensics Department that handles the Forensic Investigation whereas the Risk Management Investigation are born out of the Risk Management function of an administer or managed care entity.

So it actually becomes a subset of all the other Risk

20 Management interventions that involved in so contacting for example or setting up of networks. So all part of Risk Management interventions and this form of analysis is born out of the Risk Management function and it is a slightly different and I included in the information that you going to receive and example which I've redacted of a profile that emanates from Risk Management interventions.

ADV KERRY WILLIAMS: Can I just ask a further question about this? Would you say – is it all the administrators or schemes that do this or are you talking to a select few because this is the first time we hearing this distinction.

ADV HASINA CASSIM: I would think it's a select few and in particular the one of the major administrators is the one that actually has the specific Risk Management intervention or analysis that they undertake.

ADV ADILA HASSIM: What administrator is that?

ADV HASINA CASSIM: It's Discovery Health and in fact Dr Adri Kok in
10 her presentations spoke extensively in fact about the Risk Management Investigations as oppose to the Forensics ones.

ADV KERRY WILLIAMS: So is your evidence then rather that in relation to Discovery there's this distinction between Forensic Investigations and Risk Management Investigations?

ADV HASINA CASSIM: Correct. I'll have to limit that to what my factual knowledge is and that in Discovery there are two different and distinct ones.

ADV ADILA HASSIM: And the Risk Management Investigation wouldn't emerge from the basis of a complaint to that administrator?

20 **ADV HASINA CASSIM:** No it wouldn't.

ADV KERRY WILLIAMS: And further Risk Management Investigations, do they result in claw backs in terms of Section 59?

ADV HASINA CASSIM: So they do but in fact that is almost always a very last resort and this is a very important distinction because in fact in the Risk Management intervention where – the manner in which they

classify an outlier is very different to the manner in which a Forensic Investigation will classify an outlier. And the major factor – the distinguishing factor is that when a Risk Management Analysis is done a significant amount of the time is spent in very robust analytics in trying to understand a practice demographic and distinction.

So they'll take into account things like risk adjustment, has this particular practice got primarily geriatric or paediatric patients. And they make adjustments for those things and the fact – the parameters of the ...(intervenes).

10 **ADV KERRY WILLIAMS:** Can I ask ...(intervenes).

ADV HASINA CASSIM: Outcomes that they look for are quite distinct from a Forensics Investigation.

ADV KERRY WILLIAMS: So what data underlies the Risk Management Assessment?

ADV HASINA CASSIM: It's primarily it emanates – the starting point would always be the coding but what they take into account would be all the cost related to a specific event. And this is actually one core factor that I need to explain ...(intervenes).

ADV KERRY WILLIAMS: I'm going to slow you down, sorry, because you

20 going to lose us or you'll certainly lose me quickly.

ADV HASINA CASSIM: *Ja.*

ADV KERRY WILLIAMS: The Risk Management Investigation, is it directed at a particular practice only?

ADV HASINA CASSIM: It's directed at a discipline level so for example they would say, let's analyse all physicians and all physician practices

will be analysed and they'll be plotted on a scatter graph and in fact what they'll only focus on are the ones that are indistinctly outlier practices where in fact the cost related to that particular practice are significantly higher than all other practices or similar practices.

So there a significant amount of risk adjustment, they do trimming so they take out all the very low cost very high cost and they only analyse what they honestly believe are in fact relevant parameters. If I can just take a minute to explain, so if we look at a physician Risk Management Investigation.

10 What they would do is they would do is they would take a specific practice and they would look at their in-patient and out-patient cost total per episode. They adjust that based on the coding and they would take into account things like comorbidities of patients, they would take into account other underlying risk factors. So there's a very robust risk adjustment that takes place before they actually classify a practice as an outlier practice. But what is important is that when there's an admission all cost relating to that admission will default to the primary or the admitting doctor.

So if a patient was admitted through casualty and they presented 20 with a headache and they were allocated to a specific physician but the physician felt that what this patient needed was in fact a neurologist to come in and assist with the investigations, all the neurologists cost would also be attributed to the physician as part of their total cost per episode. All MRI's, CT scans, pathology, if they called in a physiotherapist, if they called in clin tech, all of the cost related to that admission would be

attributed to the primary doctor in that admission.

And that's why this is quite a different type of investigation to a Forensics Investigation where it's looked at almost a more two dimensional whereby you look only at the practice type from the numbering system and you look at codes and you look at the frequency of use of codes as opposed to a total cost per event.

In fact what's interesting and you'll see in the example that I've given you of a Risk Management intervention is they also take into account things like ancillary factors about quality measurement so
10 readmission rates. They take into account if it's diabetic patients, what are the HBA1C results from that particular patient. So they – it's a more robust and a comprehensive analysis as oppose to what you get from a Forensic Investigation.

ADV KERRY WILLIAMS: So how did you know that Dr Kok, if I remember she represented the consulting physicians. How do you know that she was presenting in relation to Risk Management Investigation?

ADV HASINA CASSIM: Primarily from the information that she was sharing with the panel as well as the fact that she actually is on the advisory panel or was at the time on the advisory panel for
20 ...(intervenes).

ADV KERRY WILLIAMS: But what do you mean the type of information? What information made it appear to be a Risk Management?

ADV HASINA CASSIM: So she spoke about John Hopkins and she spoke about how it was actually modelled on the John Hopkins and I know as a fact that that was actually based primarily for the Risk Management. And

in fact there were various other things that she spoke about.

The fact that in fact the foundation or her organisation was involved in the interventions in forms of counselling with providers as well leads me to believe that that was primarily what she was talking about was in fact Risk Management interventions. Because ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Can I just ask you – I mean to make sure that I understand the distinction because a scheme will argue that a Forensic Investigation is also Risk Management because they are trying to anticipate risk, manage it and if there's money lost, claw it back.

10 So you could either have a scheme that says we've got two different procedures, one is Risk Management and the other is Forensic and they maybe draw a distinction. The other is you could look at it after the event and say okay well, this looks like it was a Forensic and this looks like it was Risk Management and so. But in other cases the distinguishing line may not be clear. You may start an investigation as quote unquote Risk Management, you realise that actually I need more facts and therefore it must migrate into Forensic.

So what's unclear to me is are these distinctions things that you have drawn yourself or are this apparent from the policies of the schemes

20 or – especially if they all ultimately lead to a Section 59 claw back.

ADV HASINA CASSIM: So I can only talk on my personal experience. I was able to distinguish that by asking a specific question, where does this investigation emanate from, is it from the Risk Team or is it from Forensics and in fact when we go in with our providers into what is typically a Forensics Investigation the one question I ask always, was

there any risk adjustment done in this analysis and the answer is always no, no risk adjustment is done.

It's purely on the coding and it's purely on the practice type. It's not where they take into account the factors relating to the patient. That may well come out in some of the defences that the doctor puts forward but it's not part of the analysis that's done by the Forensics Team.

ADV TEMBEKA NGCUKAITOBI: So you would say that because it comes from the Risk Team then it has the attributes of Risk Management.

ADV HASINA CASSIM: H'mm.

10 **ADV TEMBEKA NGCUKAITOBI:** And because a different one comes from the Forensics Team then it is a Forensic Investigation.

ADV HASINA CASSIM: Correct but I can – your point is quite correct. Both actually are potentially Risk Management strategies.

ADV TEMBEKA NGCUKAITOBI: Yes.

ADV HASINA CASSIM: What I'm trying to create is that distinction is in terms of the analysis that's done and in terms of the process that then follows. So I want – even though they may both ultimately land up in 59 claw back, what's really different about the two different types of investigations is the Risk Management intervention, the one that

20 emanates from the Risk Management Team is – allows a practitioner to be counselled.

There's a lot of – if we can use the legal term, performance management that would take place, they would consult with the practice on several occasions. They'll call them in and say, can we understand why your practice is different, are you able to do this and that differently.

And so there's a fair amount of counselling and almost remediation that takes place as opposed to in the Forensics Investigation where in fact the ultimate goal is in fact the claw back. It's not about changing the manner in which the practice actually practices.

So if I can just share with you one little thing about when the investigation emanates from the Risk Management Department and there are various interventions including in calling in specialist like Dr Adri Kok to assist the practice in trying to change and modify their behaviour or the manner in which they treat patients. All of those are interventions.

10 What happens which I think is quite different is that the practice is allowed the opportunity to look at where perhaps even though the coding is used and cost is used where the practice may be going wrong. So in terms of one particular practitioner that I was involved in, what they were not doing correctly was coding properly at the end of the event so at the discharge point.

So they were coding based on the initial assessment of the patient and not including for example the file diagnoses that the patient had. And that changed completely the outcome of that analysis because if the doctor codes again and properly codes for comorbidities which is 20 what the funder then eventually receives and tracks in terms of their analysis. That practice may well not be an outlier because when you take into account comorbidities, if you take into account other risk factors that the way the practice manages that particular patient may well be in line with all other practices.

So by changing coding alone or by defining or improving on the

coding, that particular practice no longer was classified as an outlier practice. That type of opportunity does not exist when the intervention is purely Forensics.

ADV TEMBEKA NGCUKAITOBI: *Ja.* Now you see that's part of the complication is that you could have these distinctions as rigid or you could have them as fluid. And what we have heard on the evidence is that they are in fact fluid because an investigation could commence as Forensic but it could migrate into Risk Management and that is all the choice the scheme makes. Another investigation can start as Risk
10 Management but it could quickly turn into a Forensic.

And so that's why I wanted know whether you were saying you've drawn these distinctions yourself and alternatively you were taking them from the schemes that the schemes have separate and distinct policies. Because the evidence certainly as I remember it is that some investigators will take a more interventionist light, they'll say well let's try and help you. But another investigator will say there's no point in helping you, let's just try and claw as much as we can.

So I don't know where the – I mean I see the point you are making that a Risk Based Instrument is better because it's intended at improving
20 behaviour whereas a Forensic Based Intervention is bad for the doctor because it's intended at punitive action. But I'm just not sure whether as a modality of investigation there is any basis to say that these are distinct practises because it seems to be a lot of combination of the strategies.

ADV HASINA CASSIM: So I can only share from my experience

...(intervenes).

ADV ADILA HASSIM: Sorry, I'm sorry.

ADV HASINA CASSIM: H'mm.

ADV ADILA HASSIM: Advocate Cassim before you respond, in your response can you also just clarify how – because one distinction you see when you look at a letter from the administrator from a Forensic Investigator, it says we have been identified – you have been identified as an outlier at the following respects. And that emerges from what we are told is data base and algorithm program that kicks out the outliers.

10 And how is that different from what – how a complaint is initiated from a Risk Management perspective? Is there a different way in which the outlier is identified?

ADV HASINA CASSIM: There's a completely different way in which the outlier is identified and in fact ...(intervenes).

ADV ADILA HASSIM: I did not want to destruct from the question that the Chair puts to you so if you can address both, thanks.

ADV HASINA CASSIM: Okay. So it is possible that the one migrates from the other. I can only share with you from my experience however in my experience the first letter that the provider receives is usually

20 indicative of what type of investigation.

So it will always say the Forensics Team of that particular healthcare funder or administrator if it came from a Forensics Department. In my experience in investigations that emanated from the Risk Management Department, they were not presented with that type of letter.

In fact what I will show you when you get your pack is an example of what's presented to the provider when it's a Risk Management Intervention. And the data sets are completely different. In fact when Forensics – when it emanates from Forensics there's very little supporting documentation that goes with the invitation to meet whereas with the Risk Management Intervention there's a booklet and it's I think about 30 pages of information about that particular practice and how that practice has- compares to the universe of practices – similar practices.

So it's a far more robust analytical process and I think what's
10 indicative is where it emanates from and just to clarify in our experience none of them have actually migrated from the one area to the other. So and I'm only talking about my experience. Where it starts out in Forensics it usually ends in Forensics, if it starts out in the Risk Management Department it will end in the Risk Management Department.

ADV KERRY WILLIAMS: It's just it seems to me that the Risk Management component doesn't relate to fraud, waste and abuse.

ADV HASINA CASSIM: So the reason why I raise that is because in fact it still deemed to be the outlier because what Dr Adri Kok specifically presented to the panel who related primarily to the Risk Management
20 Intervention and does not apply necessarily to the Forensics Interventions.

ADV KERRY WILLIAMS: I think my last questions are – I have just looking at Discovery's submission because what's also troubling me about it – this is that it's not a distinction that Discovery itself draws and they say they have refined their risk rating tool to be more effective and

identifying potential fraud, waste and abuse cases. So it does – I mean I must be honest the scheme has to explain this to us itself if it's correct what you saying.

ADV HASINA CASSIM: I think it would be a very valid question to put to the scheme and I think the documentation that I'm going to be showing you in fact will look – is quite different when it's a Forensics Investigation versus a Risk Management Intervention.

And I'd like to also emphasise it when we ask and we ask to accompany a provider into a meeting, the one question I always put when

10 the analytics are presented to us is, was there risk adjustment. And in every case there was a Forensics Investigation we were told no.

ADV KERRY WILLIAMS: So is the risk rating tool that Discovery uses, is it used in the Risk Management Investigations?

ADV HASINA CASSIM: It is used in the Risk Management Intervention but not necessarily and I can't say categorically that it's never applied in the Forensics Investigations. But in the investigations that I've been involved in, when the question is put to the Forensics Department, was there any risk adjustment taken into account here, we are told categorically not.

20 **ADV KERRY WILLIAMS:** So your evidence completely contradicts then what I've just read out to you? Okay, we understand that.

ADV HASINA CASSIM: Also my colleague has just reminded me that in fact where it's relevant we've actually asked for the Forensic Department to include the specific people from Risk Management in our representations. So we've asked for the Clinical Coding Departments for

example for their representatives to be brought into our consultations. They not ordinarily part of a Forensics Investigation.

So I'm not going to go through the details unless you want me to but I – why I distinguish between those two types of investigations. But I also want to just explain one important point under the Forensic Investigation. Often times the Forensics Investigations happen in waves as I've mentioned earlier. So they take disciplines and they investigate specific at a discipline level but sometimes they also initiate it because of a tip-off or the probes.

10 None of the investigations that I was involved in included the probes so I really won't be able to answer any questions around whether there was entrapment or whether there were probes and what the mechanism are of people going in there and in fact sort of in the clandestine way trying to uncover information about a practice.

Most of them – a number of them actually did refer to tip-offs and what's important and I talk about this in terms of the procedural concerns that I have around investigations is that when information is requested about those specific tip-offs, they never provide it.

ADV ADILA HASSIM: Is that why you use the word "purportedly"?

20 **ADV HASINA CASSIM:** Yes.

ADV ADILA HASSIM: And you'll be telling us more about that.

ADV HASINA CASSIM: I will and then often times the Forensics ones are on practices where there's time based, again another distinguishing factor in terms of the Risk Management Investigations is that they primarily disciplines that are as I mentioned earlier consulting disciplines. I don't

think the techniques have been refined enough to be able to do proper robust analytics on practices that are more surgical based or combination practices.

So the majority of the ones where in fact there were Risk Management Interventions are physician practises, paediatric practises, I'm trying to think there was a third one, but those are the ones in fact they are primarily consulting based disciplines and sort of lend themselves to some type of analytics. Oh yes, the other my colleague just reminded me, psychiatry, psychiatry was the other one where in fact
10 there's a – is more Risk Management.

So this is what typically a Risk Management report would look like. It would - it's called a Quality Report. It has a number of parameters that are measured as I said including in hospital event cost, readmission rates, length of stay, the use of ICU High Care, all of those parameters are actually considered in this type of an investigation. And usually it goes through various stages, the providers consulted with, there's counselling provided and only when it comes to a point where they believe that the practice is actually being recalcitrant in some way, not offering information, not willing to change will it then become a slightly
20 more intense type of engagement and I'm often called in at that stage only.

So what I wanted to highlight though this comes from a very separate type of investigation, it's got nothing to do with the Risk Management Investigations that I was talking about. But this comes from what authority does the administrator or the managed care entity actually

has to conduct investigations. And it really comes from a very specific investigation relating to pharmacists where in fact the questions was then put to this particular scheme, on what strength did they actually asked the information that they were asking and we wanted to know how they were mandated.

Now we know its schemes, creatures of statute and when they actually engage the services of an administrator of a managed care entity, there's a proper contract and a mandate that has to support that. When we were told that no, this is part of the scheme rules and then we

10 said point us specifically to which scheme rule. And they pointed us to this particular scheme rule and low and behold that particular scheme rule specifically refers to member fraud. There's nothing in the scheme rules that refer to Provider Investigations. We then asked on what strength they actually were requesting the information. We were told there's a fraud policy. We asked for the fraud policy, it never materialised.

I have grave concerns and I think the question should be put to every single funder that you going to be investigating to ask on what authority any of these investigations are preformed. And I want to

20 emphasis one point, we know that we working a third-party payer module in the private sector. The relationship is between the scheme and its member and there's a separate relationship between the patient and the doctor. There may or may not be a direct relationship between the scheme and the provider and that's ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: And why do say that at Section 59 of the

Act doesn't apply, why do we have to go to the rules, because my understanding is that all of these investigation and recovery are done under the Act.

ADV HASINA CASSIM: The fact that they actually doing the analysis on a practice has to come from some instruction. Section 59 itself doesn't say that you can actually do the type of analytics and investigation into a practice. That has to come from a mandate that the scheme would give an Administrator or Managed Care Entity or Forensics Department to say you can take at a practice level do the analysis. And I will talk about

10 Section 59 ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Why do you say that?

ADV HASINA CASSIM: I'll talk about Section 59 and regulations 5 and 6 at the end of my presentation, if you don't mind. But this was a grave concern to me and I'll – the other reason – issue that I wanted to raise and I emphasise it, the scheme rules are designed and written in a manner which creates – brings about clarity and the relationship between the scheme and its membership which creates a difficulty when the scheme actually then takes it upon itself to investigate and sanction providers because the question is about whether they have the authority

20 or the jurisdiction to do so.

The other factor that we want – I wanted to emphasise here is that it becomes easy to understand your rules, the scheme rules if you're a member that belongs to a specific scheme. I mean I know that at any one point in time a member can only belong to one scheme. But to expect a provider to be *au fait* with the rules of 82 schemes and various

options is impossible or if – to be on that side a very difficult task and that to revert to because the question was put once and I asked them, why would you impose this requirement on a provider and they said but our scheme rules say so. And I said is the expectation then that every single doctor who practices has to know the scheme rules of 82 different schemes in the country?

It is not practical. And often time a patient walks into a doctors rooms unannounced or they land up in casualty. For the doctor to have to apprise themselves of the scheme rules of every single scheme, I don't

10 believe that was the intention of these rules. The intention of these rules was to govern the relationship between the member and the scheme.

ADV TEMBEKA NGCUKAITOBI: I mean I think we can accept that. I think the real issue is whether or not Section 59 empowers the scheme to claw back monies from doctors.

ADV HASINA CASSIM: *Ja,* I will – I wanted – I will talk about that. I have got my own interpretation of Section 59 and regulation 5, 6 and – 5 and 6. And ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: I mean all I'm saying is that I think that the criticism that a doctor should know each and every rule, I mean that's

20 fine but for a different exercise because the statute source that's been put squarely before us is Section 59.

ADV HASINA CASSIM: Okay, so in terms of systemic issues, I wanted to explain this. This did come up, the whole issue is around discrimination, I have to state categorically that in our experience we do not see any racial considerations applying in what initiates an

investigation. However, I do think it is important for the panel to understand that there are some systemic factors that may result in why practices that operate in primarily low socio-economic areas are the ones that are actually more susceptible to these forms of analytics.

The one aspect is that we know that the scheme membership is primarily in LSM 7 to 10. Okay? There is a study from Econex that actually confirmed that. So that is your higher socio-economic groups. But is has evolved over time where in fact members have in fact become members of schemes through their employer agreements and

10 there was in fact a great effort made to try and bring in the low income groups into the medical scheme industry, however, the scheme design did not evolve and change in accordance with that drive to bring in the more blue collar workers.

What is prevalent and remains in place are the levying of co-payments when patients actually go out of network for example when they use afformed medication. There is also deductibles, so if you electively choose to be admitted in a facility that is not part of the network that you belong to you can be levied with a deductible. This concept of savings accounts as well, it is all part of the new generation

20 schemes and the scheme rules themselves actually create some of the problems that I think providers actually have to deal with. Things like exclusions for outpatient diagnostics. So, if you have a patient that has recurrent headaches and you really want to do an MRI on this patient and they do not have disposable income or do not have a savings account, the chances are that the doctor would want to admit

that patient, to able to perform some of those diagnostics which probably in the longer term will create a slight distortion in that practice because that practice will have a higher admission rate than a practice that does not have to admit because they actually operate in a higher socio-economic area where in fact patients are quite willing to dip into their pockets and pay for some of those diagnostic tests. So these are systemic problems.

There is also non-payment for certain functions that providers are expected to perform and they are expected to perform that either by

10 the scheme themselves or by employers or by members. So, for example, doctors have to write reports, especially psychiatric, psychiatrists have to write reports when the patients need to be either given absence from work for a long duration of time, all of those reports that take a fair amount of time to compile are not funded by medical schemes. And it is probably unrealistic to expect a patient themselves to pay for those reports.

So what happens is that the doctor may well, and I am not saying it has happened; consider claiming for a consultation in lieu of having to write a report. Again it creates a distortion in that particular

20 practice. Similarly, when a doctor has to apply for PMB, which is really part of what the scheme demands, okay? That application for PMB benefit is not covered by the scheme out of the risk benefit. It is paid for, if at all, from the MSA and at MSA often patients really try and protect their MSA where they have that. So those activities that a doctor is expected to comply with are not being covered in the normal

scheme of what a scheme should pay. And so, some of the providers circumnavigate these restrictions by either charging for a consultation *in lieu* of either a teleconsultation or a report that they have to write.

In terms of procedural issues that we have had with the investigations, and I speak primarily in this instance about the Forensics Investigations, there is definitely an asymmetry of power and resources. Providers are summoned into fairly big organisations in the big cities, to come in and present their cases. They are given very

10 short notice. There is a conflation in terms of whether this is a fraud investigation, abuse or waste. It is not clear from the letter that providers are given exactly what the investigation is about. They are given unreasonable timelines. They are asked to bring in significant patient records within a very short period of time. And often the time frames they are given or the number of patient files they are expected to bring in is inconsistent. It is not the same for different providers even within the same discipline.

In terms of the conducted hearings, it is very inquisitorial, often led by the investigators themselves. It has been described as a

20 mediation. It is anything but a mediation. In legal terms we know what mediation entails, you would have an independent person who would preside over a mediation. That does not exist. There is a dearth of information that is provided in fact at the outset. It is very intimidating so it is not unusual to find that the entrance to a Forensics Department a sign that says, smile you are on camera so that you know that you

are actually being scrutinised and every single word you say is going to be recorded. You are asked to sign a record of proceedings at the very end of your engagement. You are not allowed the time to peruse the document properly. You are not allowed to take the document home and return it the next day or when you are comfortable with the content. You are expected to do it then and there.

Oh, yes, and that is an important point that my colleague has just reminded me of, is that if you actually dispute any of what they have recorded in the record of proceedings, you are not allowed to
10 make an amendment. They will not allow you to do so. If you asked about the tip-off again, you are lured into the meeting because they ask you to bring these records and when you arrive at the meeting they tell you about this tip-off and you ask about the tip-off and you are not given any information about who complained, what the nature of the complaint was, the date, time or any of the aspects about the complaint. When asked whether that information will be forthcoming you are told that in fact it is subject to whether the patient, or whoever the informer was, will consent to you being given that information.

And then in terms of consents, a lot of our providers have
20 raised the issue of patient consent. I know it has come up several times in submissions that you have heard where patients, where providers are concerned about divulging clinical information to third parties. We advised most of our providers not to make this an issue because we realise it goes nowhere. If you resist and you say I am not prepared to provide you with the clinical information, basically they will

just suspend your practice. So, we encourage them to in fact provide the information but we prefer that the information be presented in person so that in fact when you are going through the files you are not handing copies of clinical notes. You actually are explaining what those notes actually mean.

However, and it really comes to my next category which is the substantive issues around this consent. So some of our providers are still quite skittish about having to provide this information, so we have asked the funders if they are comfortable that they have a right to
10 access this clinical information. Would they be prepared to indemnify the provider in the event of litigation where in fact the patient or family member says you disclosed what was confidential and I am now suing you for having breached confidentiality. Would you be prepared to indemnify these providers? They are never prepared to indemnify the providers.

So if they are as confident as they are that they have every right to access that information, why will they not indemnify the provider? We have got written proof, it is in the pack that you will receive, of responses we have received, from various funders saying
20 that they will not indemnify providers. So, in terms of the substantive unfairness, the letter that actually invites the doctor in for a consultation is vague. It lacks details. All you are potentially asked for is to bring in a set number of files, and what is interesting and I think I do mention it specifically but before I lose that, you are asked to bring in say, 10 or 15 files. But, what you are presented with is in fact three

years of history about your practice. So you are completely taken aback and you are unprepared for the type of questions that are raised in that investigation.

Okay. Can I ask my colleague to just explain what she has just did, because I am going to be a parrot otherwise ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Indeed.

ADV HASINA CASSIM: Okay.

MS NABEELA MOOLA: Thank you very much, Nabeela Moola from N Moola Incorporated. Just in terms of the letter where it states that it is
10 vague and it lacks detail, from experience the initial letter received simply states, we would like to invite you to a meeting for an enquiry into your practice. Please provide us with a date and time when you are availability and that is essentially where it starts and ends. Often I have to then email the relevant schemes and say to them, we acknowledge receipt, place ourselves on record and please advise the nature of the investigation and what information is specifically required which is when we receive the patient information or the files that they require for purposes of the investigation.

In addition to that, it is also when they ask for the provider's
20 diaries, you know, clinical records, etcetera and that is essentially where the dispute then starts.

ADV TEMBEKA NGCUKAITOBI: Just tell me about these tip-offs. I mean, what is the complaint there? The scheme is saying you are not entitled to a tip-off, it is anonymous for a reason. So, but you seem to believe that actually there is no tip-off at all. I mean, I do not follow.

So you could have one or two alternative ways of looking at it. The one is that the scheme is entitled to withhold the identity of the anonymous whistle blower because that is the law in this country. The other is that there is no whistle blower and that is why you are not being told. So, I do not see what the complaint here is?

ADV HASINA CASSIM: I think, you are correct, it could be one of those two scenarios. I think, however, the provider would need to know a little bit more information about what is the nature of the complaint, or the tip-off. So, was it about him not in fact providing care, is it

10 about the type of care that he rendered? Whatever the complaint might be I think he needs to be afforded the opportunity to at least understand what the nature of the complaint is. No information is forthcoming about what the complaint is.

ADV TEMBEKA NGCUKAITOBI: But I mean, disclosing that might inadvertently disclose the identity, so if one takes seriously the obligation on schemes to keep whistle blowing information confidential, it is unclear why you say these are phantom complaints. Is there any other information other than the refusal by the scheme to disclose whether it is the nature of the complaint or the identity of the

20 complainant, what is the reason that you say that these are so-called whistle blowers?

ADV HASINA CASSIM: Well, I think it is primarily for the reason that, in fact, no information is provided and you are right, maybe that is in terms of protecting the complainant. However, in one particular instance, after information was provided about the practice, in fact it

turned out that there was no – what was purported to be the issue that was raised in the complaint or the tip-off actually never materialised. It was a non-issue. The provider was able to substantiate every single claim that he actually presented. So, which led us to believe that maybe this was just a ruse.

ADV TEMBEKA NGCUKAITOBI: I mean, I suppose even there, they still have comeback from the schemes, which is – if a whistle blower, let us assume there is a whistle blower, complains about X, they may be entitled to also investigate Y because usually an indication of

10 malpractice in one area might be indicative of a larger – I mean I suppose you could say, what I want is not the identity of the whistle blower and I do not want the nature of the complaint, what I want is to be sure that there is in fact a complaint and if you can satisfy me that there is in fact a complaint and that you did not initiate this your own, then I will co-operate. And that the flaw in the system is the complete refusal to disclose even the existence of a complaint and that they expect you to accept their word that there is a complaint.

ADV ADILA HASSIM: Agreed.

ADV KERRY WILLIAMS: I am concerned about this because we have

20 been provided with copies of whistle blowing reports so I am concerned about what the nature of your allegation is?

ADV HASINA CASSIM: Well, my concern is really that in fact no information is provided. Not even a date and a time when a call was made. Or whether it was actually a call? No information about what this so-called tip-off is.

ADV KERRY WILLIAMS: So, you are arguing that in order to be fair to the provider, a certain amount of information has to be provided in relation to tip-off and that would be the date of the call?

ADV HASINA CASSIM: The manner in which the complaint actually was brought to the attention of the fund, the date and the time, something to that effect. Even if they, some vagueness, some indication of what the nature of what the complaint is.

So, information about how the provider is classified as an outlier, as I emphasis this relates specifically to the Forensics. I think

10 I do not really have an issue with the manner in which an outlier is classified when it comes to Risk Management Intervention. But when it comes to a Forensic Investigation where we ask why do you classify this practice as an outlier? Often there was a very crude analysis done at a coding level. Well, this particular provider is the highest utiliser of this specific code in the entire country is what we are told. Without any further adjustment for how busy is this practice? What is the nature of the patients that frequent this practice? So that level of detail often is not – is not provided or is not taken into account from what we understand, in this particular analysis. So, for example, with a

20 psychiatrist who happened to have fairly long consultations according to the Forensic Investigators, I put to them, I said can you please show us what this doctor's admission rate is as opposed to his peers? Because in fact, perhaps a slightly longer consultation can avoid the need for an admission. Can you tell us what the re-admission rate is? Can you tell us what his ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Can I ask you something you mentioned earlier? When you say you have not identified instances of racial profiling but you have identified instances of a systematic or systemic impact, I do not follow what the distinction is. I mean, you have done this work for a while and you have shown us your figures. I mean, out of the figures you have shown, what is the amount of people that are being investigated? Are they black or white and what are the statistics there?

ADV HASINA CASSIM: So, you did see what the statistics are in terms

10 of black and white and why I say it could be systemic as opposed to, that is not the starting point of the investigation. It is not as if a funder is saying, let us look at all our black practices and let us try and understand what is going on in the black practices.

ADV TEMBEKA NGCUKAITOBI: Your stats are 87% black and 13% white.

ADV HASINA CASSIM: Yes. Just ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Now, that is just a what, I mean, if you deny that that is racially loaded, I mean there has to be another explanation why your figures show 87% black and 13% white.

20 **ADV HASINA CASSIM:** So, I cannot talk for that particular type of imbalance in my numbers. I also just want to just say we are a referring profession, so there could be a referral bias in my figures so that in fact black doctors talk to other black doctors to say, try and use Nabeela and Hasina to try and assist you in your investigation. So it could well be that the clients we are dealing with through word of mouth

referral, that is why the stats are skewed like that. However, I am more inclined to believe that there are more underlying systemic issues and that they are around the things of trying to avoid of having to ask a patient to pay a co-payment. Having to avoid – I want to emphasise another aspect and that is as much as we have cross-subsidisation in schemes, there is cross subsidisation in practices as well. And in fact, practices that operate in low socio-economic areas where they in fact either *pro bono* services or at a lower cost for cash patients are probably utilising the medical scheme funded base of their practice to
10 subsidise the balance of their practice. And which can skew claiming patterns.

ADV KERRY WILLIAMS: So, the difficulty with what you are saying as far as I understand it, I can understand it as a description of a social reality but you are referring to circumvention and the schemes administrators would refer to it as fraud or abuse and I think the law might be on the side of the scheme and administrators ...(intervenes).

ADV HASINA CASSIM: It may. Can I just emphasise as well that none of the clients that I dealt with did that actually emerge as a problem. Almost all of our problems were billing irregularities where the
20 ...(intervenes).

ADV KERRY WILLIAMS: But then if you have not got any personal experience of it then we have to treat it with some circumspection.

ADV HASINA CASSIM: Correct.

ADV KERRY WILLIAMS: Can I just ask, what is the total number of clients you have had which got you to this figure of 87%?

ADV HASINA CASSIM: 15. There were 15.

ADV KERRY WILLIAMS: So it is 15. Okay.

ADV HASINA CASSIM: There have been several others since.

ADV KERRY WILLIAMS: Okay and that is obviously a very small proportion of the total.

ADV HASINA CASSIM: It is a small. It is a small.

ADV KERRY WILLIAMS: Okay.

ADV HASINA CASSIM: So, as I mentioned previously and I think we spoke about it quite extensively, there were no risk adjustments or
10 outcome measurements in the Forensics Analysis that were performed. Providers were asked to come in with a small sample of files but then the investigation includes all patients from all schemes administered by the administrator spanning three years. And, the type of information requested often exceeds what in fact the schemes' mandate is. Now, I can fully understand that the scheme has a right to ask for the clinical information pertaining to a particular claim. However, I have my doubts about whether a scheme is entitled to ask for invoices – for purchase invoices, for example, of a pharmacy. I have my doubts about whether ...(intervenes).

20 **ADV TEMBEKA NGCUKAITOBI:** Why do you accept that they are entitled to the clinical information? I mean this is one of the big disputed areas in this enquiry. The doctors have told us that no way are the schemes entitled to clinical information, in fact, they are under an obligation under the National Health Act, in Section 15 of the Act,

specifically not to disclose clinical information absent the consent of the patient.

ADV HASINA CASSIM: So, if the information that explains the claim is clinical information then I think the scheme is entitled to understand that. So on what basis did you diagnose this patient as having – you are claiming for admission for bi-polar, is that in fact the diagnosis? For example that would be the kind of information that the doctor would have to provide to confirm that in fact the code that he used was the appropriate code in billing.

10 **ADV ADILA HASSIM:** And how would the doctor provide that information?

ADV HASINA CASSIM: So, the way our doctors do is they actually go in with their files. We try to avoid them having to send reams of paper through. They will walk, step into the consultation with their files and explain based on the patient number and the information that in fact or the diagnosis that they made or the claims on specific days and what they did for that particular patient at every engagement or consultation.

ADV KERRY WILLIAMS: I have begun to wonder why the patient cannot be engaged to confirm a diagnosis. Have you got any comments

20 on that?

ADV HASINA CASSIM: No, I do not really have a comment on that except to say that I think that a patient can comment on the diagnosis but probably not on the various billing codes. I do not think they have that level of understanding to be able to say for each ...(intervenes).

ADV KERRY WILLIAMS: I am limiting my question to the need to see the clinical notes for diagnosis purposes.

ADV HASINA CASSIM: Can I just explain one thing, the reason why in fact in the consulting practice, the reason why the schemes explain why they need the clinical notes, and it is a very crude manner in which they utilise it. In a consulting practice which is a time base practice, the volume of the notes gives them some assurance of the duration of the consultation which in fact one cannot tie the one with the other because if you are seeing a patient repeatedly you may well have to do
10 a fair amount of counselling if it is a consulting practice and if you doing something like a psychiatric consultation.

You may only have to put down one or two words to confirm exactly what was done because a diagnosis is already made. You do not have to put reams and reams of notes.

ADV TEMBEKA NGCUKAITOBI: Can I just take you to this because I do want to get your evidence. So, you can take a practical view that listen, if you do not provide clinical notes, you are going to be cut off. So, do the right thing, just give them. Or, you can take the view that the legally correct thing to do is to disclose. Now what is your actual
20 evidence? Are you saying that you have decided on the pragmatic route that in order to save your practice from an arbitrary termination, disclose the notes. Because it is quite clear the doctors who have come to give evidence before us and the medical associations are refusing to disclose these notes on the basis that they are under an

obligation ethically as well as legally, but you are saying you have advised your own clients to just disclose and dispense with it.

ADV HASINA CASSIM: Yes, I have and it is for that reason.

ADV TEMBEKA NGCUKAITOBI: The basis for that advice could be pragmatic and nothing more.

ADV HASINA CASSIM: Absolutely and it is that. So our advice to them is that if you want a stand-off then you can expect your practice to be suspended. If you can withstand that, fine, you know we are creatures of instructions we will take that route, however, our advice is
10 to rather provide them with the clinical notes, especially if you know you can justify all your claims and allow this matter to be resolved expeditiously.

We also use that approach by the way when it comes to having to accept some of the calculations in the claw backs. Even though they may not be correct, either because of the interpretation of a billing code, for the simple reason of resolution, we would advise them sometimes to accept a lower amount or negotiate a settlement.

ADV TEMBEKA NGCUKAITOBI: Just tell me, on the clinical notes, has Discovery ever asked or told you that you can redact certain
20 information or do they want the full scope of the clinical notes.

MS NABEELA MOOLA: If I may just come in there, they actually do not permit it, they want the documentation in original form and it gets compared in the investigation, the electronic versus the hard copy to make sure that nothing has been redacted or changed. And they even go so far as to enquire why things are written in pencil and not in pen.

ADV TEMBEKA NGCUKAITOBI: Thank you.

ADV HASINA CASSIM: So, I do want to talk about the information that they ask for because what they do ask for which I think is quite invasive as well is things like doctor's diaries which in fact I do not believe any particular scheme has a right to access. It is an issue of privacy and we have actually withheld that level of information. We have also advised our clients not to provide information like invoices – purchase invoices, and as you said, oftentimes we are saying to them provide information that will allow us to dispense with this whole
10 investigation.

MS NABEELA MOOLA: Can I just go back to disclosure of clinical records. We have had an instance where members were contacted to notify them that we need to disclose your clinical records to a medical scheme for purposes of investigation and we have received affidavits from members stating that they do not wish for these disclosures to occur. These affidavits have been submitted to schemes informing them that the members have directly not consented to the disclosure and irrespective of that they still have demanded that records be disclosed. So, it is also important to understand that when a member is
20 under investigation, that scheme that is investigating them holds 90% of their income. So, it is a matter of whether they are able to live without the 90% versus disclosing it and going through the process.

ADV HASINA CASSIM: You mean the provider?

MS NABEELA MOOLA: *Ja.*

ADV HASINA CASSIM: In terms of the blanket consent, we have been told repeatedly, and that was the other point that you made, was you know we have advised our clients to try and just provide the minimal amount of information to allow them to continue with the investigation. But the explanation that we have been given by schemes when we ask on what basis they have a right to ask for the information, has been this blanket consent. Now this blanket consent is when you sign up to be a member of a medical scheme. Things change. When you joined you could have been a 21 year old young, healthy person. Ten years

10 later you may well have contracted HIV. That information, that blanket consent, I am not convinced actually would cover instances where in fact information of a sensitive is demanded.

ADV TEMBEKA NGCUKAITOBI: I think we read that clause at the commencement. My understanding is that it was a contract between a member and a scheme. It is not binding in any event on the doctors.

ADV HASINA CASSIM: And then the other bit that actually ...(intervenes).

ADV ADILA HASSIM: And presumably consent means informed consent.

20 **ADV HASINA CASSIM:** Informed consent at that point in time. There is also this – and then again sometimes for pragmatic reasons again we just say let us just you know, work with them, co-operate and this matter can actually go away. Because what they threaten, and it is a threat, is that they will disclose the outcome of the investigation with other schemes and funders and they have done it on several occasions.

My concern is whether they have the authority to do so, whether they then become the tip-off or the informer to another medical scheme, and we see a pattern, within weeks of an investigation, another medical scheme or administrator will undertake an exact same investigation and call the provider in for a very similar reason.

ADV KERRY WILLIAMS: May I just pause you there and take you back to your theme of what information is often demanded from providers? And you have made the point in your written submission at page 28, paragraph 86, but you were touching on it but did not complete the
10 submission I do not think. But it was about when pharmacists are required to produce their purchase invoices for stock and in your submission you say that if a pharmacist is unable to produce an invoice it does not automatically mean a legitimate service was not rendered. Can you explain why?

ADV HASINA CASSIM: Okay. So, you know that I am a pharmacist and I have worked in retail as well as in hospital pharmacies. Oftentimes you have a patient with you for an item that you actually did not purchase. You borrow. You borrow that from another pharmacy. You do a bit of an exchange. You allow another pharmacy to actually
20 provide you with stock in exchange for other stock. In some instances the pharmacy will purchase for several pharmacies. One pharmacy will purchase. So there is a lot of that type of exchange going on. It is also just a proxy because one particular medical scheme will only deal with specific claims and your purchase invoices may be completely unrelated to that particular claim that you submitted to them. Worst

case scenario, worst case scenario, if a provider of health care services is obtaining their products from an undesirable source, it does not mean that the service was not actually provide and that is a totally different type of investigation. That becomes theft or fraud or whatever that might be. But the simple fact that you do not have an invoice does not necessarily mean that you did not provide the service.

More often than not is that you do not have the item in stock, you borrow it from another pharmacy. You basically just have a trade-off, you exchange for other similar value products and you do not

10 necessarily have to buy, especially low-moving items, you will not keep everything in stock.

ADV KERRY WILLIAMS: And is that borrowing lawful?

ADV HASINA CASSIM: Yes. Yes it is. On that point of pharmacist's claims by the way, the other point that funders repeatedly raise is that there was not a consultation that precedes the issue of medicine. Well there does not have to be because firstly, in many case you can get telephonic scripts without any consultation. If you like me, I have family members that write up scripts for me and I don't actually have to consult them and they won't charge me.

20 And in one – the one particular incident – one investigation there was a practice that actually generated the scripts for the pharmacy was already put on direct payment. So in fact there were not – there were no reimbursements going through to that practice that generated the scripts of the doctor's consultations. So he had cash practice and in fact the – he still generated scripts which the

pharmacist could actually fill. It doesn't mean that there's no consultation with the doctor that precedes the issuing of the script that in fact there's something untoward around that.

Okay. So just in terms of the substantive unfairness that continues so you asked to bring in a specific number of files, you – they may raise an issue with the manner in which you code and you bill etcetera on that sample size. But then they extrapolate all of that information to your entire practice for three years and that's what the claw back constitutes. And now I'll – in terms of considerations of

10 Section 59 and Regulation 6 I'll explain to you why I don't believe that that is actually allowed in terms of the Act and Regulations.

There's also the coercion in signing the AOD, we have had instances where in fact providers come to us after having signed the AOD and we say to them, unfortunately, now I'm dealing with what in fact the Council for Medical Schemes have ruled which is the law of contract now and for you to be able to unwind that particular signing of the AOD is going to become hugely difficult so in many cases that fact you know just goes nowhere.

In terms of the automatic suspension, that can happen literally

20 in the consultation even if you deferring certain aspects of the consultations. So we've got a specific in – case where which is still pending where the issue arose around whether the provider was entitled to employ technicians to assist in the provision of services. This whole matter revolves around students and technicians as opposed to qualified technologists which the age- and the provider was

reported to HPCSA. Notwithstanding that the HPCSA cleared the provider, did not find that there was anything untoward or unacceptable about the practice. That practice has remained suspended.

So without any further ado they will suspend the practice then in the interim, it doesn't matter what the outcome of the investigation is. We will not reinstate this practice for direct payment.

MS NABEELA MOOLA: This particular practice is also reported to the SAPS and obviously nothing became of it.

ADV HASINA CASSIM: And then when we asked about interpretation

10 of billing ...(intervenes).

ADV ADILA HASSIM: Why do you say obviously nothing became of that?

MS NABEELA MOOLA: It wasn't a fraud related incident so I mean I don't understand under what referral they would have made it to the South African Police in any event because there was no issue or element of criminality.

ADV TEMBEKA NGCUKAITOBI: But I mean I don't think we've come across a single instance that was successfully prosecuted even though it was designated as fraud but maybe you have.

20 **ADV HASINA CASSIM:** Neither have we. In terms of – I want to come to the subconscious bias in a bit but I want to continue with the issue of experts. Most as I've mentioned most of our investigations or where we were assisting revolve around interpretation of codes and the use or the alleged misuse of codes.

When we ask on what basis the funder believes that the interpretation is correct, we're often told it's because of an expert that advise them, when we ask who that expert is, that information again is not forthcoming. Now in one particular instance ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: What information is this that they ...(intervenes).

ADV HASINA CASSIM: Who's your expert?

ADV TEMBEKA NGCUKAITOBI: No, I'm talking about the nature of the information provided by the expert.

10 **ADV HASINA CASSIM:** It's in terms of the interpretation of codes. So can this code be used for this particular type of intervention? I think you've received a fair amount of input in terms of the billing codes and the issue. I'm not going to go into a lot of that. I think I have one little slide that'll touch a little bit on it but the interpretation of code is a huge problem especially where medical science is actually evolved and in fact the billing codes have not.

So there's a need to try and use similar codes for the type of services that are being rendered. When we – in one particular instance where a provider happen to pick up on an email trail and was able to

20 identify who the so called expert was that was advising the medical scheme. It turned out that particular expert didn't even belong to that sub speciality of that practice. So they relying on information from experts that in fact were probably don't even qualify as experts.

I also want to emphasise one other aspect which I think is of huge concern. These so called experts that funders rely on are often

times the heads of societies. Societies voluntary associations, they not representative of all providers out there so when take the societal view as being authoritative in the interpretation of codes, it may not be inclusive of all practices out there.

Having said that and you've had submission from one of the societies as well, we – I specifically have some concerns around the use of some of the societies especially when those societies are aligned organisations that are in fact service providers to medical schemes. My concern is how objective is that information that you
10 receiving and those very associations and representative organisations are involved in some of these Forensics Investigations.

They conflicted, they're client is the scheme. How can you be advising a scheme or how can you be representing a provider in their dispute with the scheme when in fact your significant portion of your income comes from that very scheme or administrator. And so I have grave concerns about it.

In terms of the subconscious biases, I want to mention that in for one of the very large Forensics Departments up until recently it was primarily only white. There were no investigators that were of any
20 other colour. They were engaging with providers. Only recently did we find that there is one Indian person who was brought into some of these consultations with our providers.

There's a subconscious bias that comes with that so when we put to this scheme that in the instance where there's a significant co-payment or there's a claim that is not part of the benefit design of the

scheme, what do you expect a provider to do in that instance. The kind of very flippant answer that we get is, well the patient should just pay with their credit card. That shows complete ignorance of the type of practices that some of these doctors actually operate and the areas in which they operate.

Many of the patients who – our doctor who frequents some of the practices that – practices that we've actually represented don't have disposable income. They really, really don't have access to the kind of monies that will just pay out of pocket for very high cost
10 interventions. And that's where I say the subconscious bias comes in.

The issues with coding – I'm going to go through this quite quickly because I think you've received a lot of input on that but there are time based and procedure based codes and we've put in an example in our pack for you as well of a specific coding where in fact in some instances the codes are quite explicit. They say you cannot use this code when that other code is used.

So it's quite explicit in the definition of the code when you can and can't use it. That logic is then applied by the medical schemes for other codes and when we actually enquire why – what – on what basis
20 they arrive at that interpretation, they can't provide us with that insight. So even on a literal interpretation of the code, it becomes very difficult to understand exactly what their rational is for why they excludes it in combination of codes from being used.

There's a lack of ownership of the codes, I think you've heard enough of that. There's no consultation between providers and funders

on how to properly interpret these codes. Again we asked, we urged funders to try and assist, provide us especially providers that are new practices to allow – assist them in how to interpret the codes and we were told that's not their job.

And also providers who don't belong to societies where they can get that information through the guidance of societies are hugely disadvantaged, they don't have the benefit of that type of guidance, they don't have the type of mentorship that comes with being a member of a society. But it shouldn't really – they shouldn't be discriminated

10 against and in fact there should be a fair amount of transparency and engagement between providers and funders in terms of the proper interpretation of codes.

What is quite important and I want to emphasise it, in consulting practice and they're very much like us, we sell time, they sell time. When we did an analysis for a specific practice in terms of his income per hour, this is a specialist with many years of experience. His income per hour is less than a ...(indistinct) attorney. That these codes and the kinds of units and cost that are allocated to these codes are completely out of line with the level of expertise of providers out

20 there and I think some cognisance needs to be had to that issue.

ADV ADILA HASSIM: I don't know whether the professional legal fields are a good comparative but I hear your point.

ADV HASINA CASSIM: Probably not.

ADV TEMBEKA NGCUKAITOBI: I mean I suppose because you know you could charge anything you want if your patients are willing to make

co-payments. I mean that's the counter that one gets when you complain too much about the low tariffs.

ADV HASINA CASSIM: I think in many instances I think providers don't have that luxury. They have to work with – an – in fact in some instances as I think we've heard and what Nabeela was alluding to, when your practices is so reliant on a specific scheme or administrator group, you can't risk not being paid by them.

But not only that I mean many instances in the low socio economic areas practices are reliant on direct payment, not only on the

10 income that they get from the schemes but form direct payment from the schemes. Because they really can't afford to have to claim immediately from patients or have to chase up on payments when in fact members have been paid directly by their schemes.

The complexity of the procedure sometimes is the disconnect between the level – the coding and I'm really not going to go into that, it's got nothing to do with an investigation like this. But I just want to share one example with you. One of our providers happen to be a contractor provider for low income plan and so he's often called in because that low income plan only pays for PMB and these PMBs are

20 often only emergencies. He's then called in at any time of the day or night to deal with an emergency procedure.

He explained to us that in one instance he spent six hours in theatre and he got paid about R3 000.00 somewhere in that region for that entire – he was linked to a motor vehicle accident. Because there were no codes that in fact that particular scheme would actually cover

or they would refuse to cover all of the other codes and the modifiers that he would have used in that instance for any other patient.

Just in terms of the modifiers and I think it's quite important that I also explain one aspect of interpretation of codes for this particular provider happen to be an orthopaedic surgeon. There's a code which says you can use a specific code for when you actually – when a joint is involved in this – when the joint is violated. When the doctor had to perform the procedure, he had to violate the joint as part of his treatment and they refused to pay for it.

10 They were only prepared to pay for that particular code where in fact the cause of the injury was a violation of that joint. They do not take into account that in fact having to treat the injury meant that he had to violate the joint and they wouldn't pay him that particular code. So I just – you know I think it's very important that there should be proper engagement between providers and funders to come to some resolution around these issues.

Examples of misalignment of codes with between funders and providers at particularly in cardiology and the example I want to sight here is where a clinical technologist are involved with cardiologist in

20 for example the insertion of stents. The kinds of coding the cardiologist are allowed are totally misaligned with the coding that the clinical technologists are allowed for the very same procedure for the very same patient. So they will restrict a cardiologist only to at vessel level but it doesn't matter how many stents you put in. But they will

restrict a clin tech to one – the use of that code once only for the entire procedure, so there's a misalignment.

And again here in terms of resolving this issue the responses from funders are different. So one particular major funder was quite happy to try and create some sort of conformity between different disciplines involved for the same type of care and the other ones said no ways, we're not prepared to entertain that.

ADV ADILA HASSIM: Isn't that – aren't you describing something that's not really within our agreement? I mean how the funders and
10 how this funders the schemes and providers resolve that problem is not something we need to consider.

What is it the issue for us is where codes are used and the scheme says you used these codes incorrectly resulting in either – in an over billing. So in those circumstances why is it not – why would it not be that an explanation from this, let's say the doctor, why would that not be sufficient to explain how the codes were used and the problem goes away.

ADV HASINA CASSIM: So I want to bring that because it does have a direct bearing on this investigation because the reason why a specific
20 clin tech uses those codes is because in fact the doctor is allowed to use the codes in the same quantum or in the same quantity for a specific event and he's not and he's actually called in as an outlier because of the number of times he uses a specific code. So it has a direct bearing on this investigation.

ADV ADILA HASSIM: But once you explain that this is why it happened, why would that not then resolve the problem because you're not an outlier.

ADV HASINA CASSIM: They find it unacceptable. They saying that the cardiologists are entitled to charge us in multiples but the clin tech isn't. They've not been able to resolve that issue. The inconsistency in the manner in which these investigations are also resolved, I want to highlight that because you just reminded me of something else.

When you said the doctor explains, in some instances the

10 doctors are more than willing to come in and accompany their clinical technologist are part as the investigation. In other instances they not and when we ask why in fact they say we don't want to actually have the spotlight turned on us. I'm not prepared to go in there to back clin tech because in fact they may then start investigating me.

And we had instances where in fact the outcome of exactly the same and this I will emphasise it here and say this is not my direct experience, where the outcome for the same professional who went in with their referring doctor was different in – the issue was resolved differently to when a clin-tech went in on their own without their

20 attending doctor for exactly the same complaint, which also talks about inconsistency in terms of the sanctions that it just so happens that instance by the way that the clin tech that actually had the issue resolved speedily and amicably without having to have any claw back, happen to be white in that instance and our clin tech our client who's doctor was not prepared to come in with him and support him happened

to be a black professional. Just to put that out there.

So what Nabeela is explaining – but it boils down again to the interpretation when the funder is not prepared to accept even the logic an explanation from a provider, it really doesn't help to actually have them in to support you.

So Chair just to – this is the part that you were actually asking me about. This is – I think you quite familiar with Section 59 and Regulations 5 and 6. But I've emphasised in terms of Section 3A so this is what when we've asked on what basis they actually allow to

10 sanction, claw back or investigate, they often fall back on – this is the funders, fall back on 59 3(a) which is;

> *"Any amount which has been paid bona fide in accordance with the provisions of the Act to which a member or supplier of healthcare is not entitled."*

That definition of not entitled has not been fleshed out. This by the way originates form in fact normal insurance policies where in fact they not entitled to claim for what's not covered, for assets that are not covered by their policy and for individuals that are not covered by policies. But this issue of not entitled in terms of the Medical Schemes

20 Act has not been fleshed out, explained or elaborated on.

Then (b) which is where the claw backs can actually be invoked;

> *"Applies specifically in instance of theft, fraud, negligence and misconduct ..."*

ADV TEMBEKA NGCUKAITOBI: And how do – in the insurance industry, how do they deal with fraudulent claims?

ADV HASINA CASSIM: They – so in the insurance industry, remember there's the purchases and the payer are different people to in healthcare where you have a third-party payer. So they will claim back directly from the person who was the policy holder and often times they'll cancel that policy whereas in this instance they claiming back from a third-party that they actually remunerated or reimbursed. It's a very different dynamic.

10 **ADV TEMBEKA NGCUKAITOBI:** But I mean the suppliers stands in the shoes here of the beneficiary of the service. Now I'm trying to test why you draw a distinction between not entitled and fraudulent because it seems to me that it can be interpreted widely.

ADV HASINA CASSIM: It may well be, I just wanted to emphasise that it has not been clarified in terms of on what basis you allowed to actually claw back where you believe it's not entitled. So I want to go back to this issue around interpretation of codes. If I have specific interpretation of a code and I use that code in a manner which I am convinced is appropriate and you differ from me, does that mean I'm

20 not entitled? And that's really ...(intervenes).

ADV KERRY WILLIAMS: Isn't this exactly the reason why we sitting here?

ADV HASINA CASSIM: Yes.

ADV KERRY WILLIAMS: Because there's a fundamental difference between what the schemes and administrators think and what the providers think.

ADV HASINA CASSIM: Correct and I don't actually have a clear answer, I'm just sharing with you where I'm not sure that this issue of not entitled can be applied in such a rigid way when in fact there's a clear misunderstanding or a disagreement in terms of interpretation. It's not as if it's illicit fraud.

ADV TEMBEKA NGCUKAITOBI: I can accept that if there is no fraud
10 then you were entitled to claim. If there's no fraud and no excessive billing, then you are entitled to claim and entitled to be paid. But if there is fraud then the fact that in the insurance context and entitled means covered with in the frame of the contract is not decisive because you are still not entitled if you are fraudulently claiming.

The question is what is the method of recovering that which was paid outside of the terms of the agreement? So the one view is that the schemes themselves become the judge, jury and executioner. The other view is that perhaps there should be a third-party making those decisions and there's a push-back around the idea of a third-
20 party because the risk is bigger to the entire pool of the membership and there has to be an effective way that expedites the clawing back.

ADV HASINA CASSIM: I make some recommendation which if you – I think it's in my final slide and how I believe this could be resolved. But I think in terms of regulation ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Sorry, I thought you also wanted to talk about sub (b), you only spoke about sub (a).

ADV HASINA CASSIM: Oh yes, so what I want to say about (b) is that in the instance and I think I agree with you that where it's clear fraud, negligence and misconduct, they would be entitled to claw back. Where it's simply because of an interpretive issue, I'm not sure that it actually qualifies under (b) for – that it needs to be deemed to be a loss as (b) explains.

ADV TEMBEKA NGCUKAITOBI: Well I mean there's another thing that

10 arises in this inquiry is precisely what does theft, fraud, negligence, misconduct actually mean and whether there should be someone else objectively establishing those as jurisdictional requirements before the power to claw back.

The complaint is the power is overly concentrated in the schemes so they decide what constitute theft and they decide what constitute fraud and often those decisions are themselves loaded with all sorts of objectives which are intended at recovering as much as they can.

ADV HASINA CASSIM: H'mm.

20 **ADV TEMBEKA NGCUKAITOBI:** And they ignore the objective reality that actually there is an innocent explanation to any or most of these claims.

ADV HASINA CASSIM: Agreed. I think the issue of fraud I think for me is far more – it's clearer. Where I mean if you look at the elements of fraud even in law, I think of those elements are met in the manner in

which your claim is submitted to a scheme, I think it becomes – it's pretty simple to say that that is fraud. But I think for the others ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: But the question is who decides that it is fraud? I think that is really the issue. The scheme will say from our point of view its fraud and the doctor will say it's not fraud ...(intervenes).

ADV HASINA CASSIM: You do not have the ...(indistinct) and the adjudicator, agreed. I wanted to spend a little bit of time in terms of

10 Regulation 5 and 6. I think it's quite important – and this is my interpretation. There's a very specific reason why Regulation 6(2) refers to a time period within which a dispute has to be raised. And it's for the exact reason that the difficulty that we've experienced in some of these enquiries or investigations by medical schemes.

The idea is within 30 days if you pick up something that is of concern from a claim that has been presented to you that you need to actually raise that dispute within 30 days. It's – the 30 days are quite important, it's – everything is still fresh, information is readily accessible. When you try and apply claw backs that span three years,

20 it becomes it very difficult to be able to substantiate the claims which why 6(2) gives the 30 day time period.

But then 6(4) says that if that isn't done the onus shifts. The onus of – will shift to then to the scheme who must bear the onus of proving that such an account, statement or claim is in fact erroneous. That is not what we are seeing in these investigations. The onus still

stays – sits with the provider to be able to proof that in fact his claim is legitimate.

ADV KERRY WILLIAMS: Advocate Cassim, are you arguing that Regulation 6 implements Section 59?

ADV HASINA CASSIM: Yes.

ADV KERRY WILLIAMS: And what you make of the different wording then when Section 59 as you've referred us to refers to not entitled theft, fraud, negligence, misconduct. And regulation 6 refers to erroneous or unacceptable which seem to be different concepts.

10 **ADV HASINA CASSIM:** Ms Williams, I haven't actually looked at that in detail so I prefer not to but I'm quite happy to apply my mind and then revert if necessary. I want to just make these following points and I'm almost at the end.

So Regulation 6 recognises and caters for the huge administrative burden of claims and payment administration. And importantly it imposes statutory timeframes within which steps must be taken, specifically 6(2), (3) and (4).

Regulation 6(2), requires medical schemes to raise any challenge on account, statement or claim within 30 days and to state

20 the reasons. If a medical scheme fails to act within the aforesaid 30 day period then in terms of Regulation 6(4) the onus shift to the medical scheme.

The Act through stipulations in Section 59 and Regulations 5 and 6 make it patently clear that a claim for a service by a member or a healthcare service provider must be honoured when the member is a

valid beneficiary of the scheme, when the service falls within what's defined in that scheme and when the claim has been submitted in accordance with the prescripts of the Act.

Now I want to raise a very important point here. The ability for a medical scheme to sanction a practice and to withhold payment is in direct violation of this because in fact in that instance neither the patient nor the provider get reimbursed for a service that may well be legitimately rendered. And in fact the question is whether in fact the scheme isn't being enriched through that process.

10 Funders have adopted a blanket approach and have failed to meet obligations recreated in terms of Regulations 6(2) which said that the dispute must be declared and in order not to fulfil its obligation that arise in terms of the Medical Schemes Act in respect of honouring a claim that it must proof that each and every claim that forms part of the dispute is either erroneous or unacceptable.

And Ms Williams just in answer to your question that specific Section talks about a claim specific to a single claim. It has to – that dispute has to be declared for every single claim. You can't go back for three years and submit one claw back as a claim. It has to be done

20 at a claim level.

ADV TEMBEKA NGCUKAITOBI: But I mean disputed where because the Section says in the event of a dispute. But there's no dispute, there is a scheme and a doctor. The scheme decides what it wants to do and the doctor might say, I disagree but there's no way to declare a dispute. The scheme just does what it wants to do.

ADV HASINA CASSIM: H'mm agreed. So where a medical scheme opts to claw back, it must do so within the prescripts of the Act and Regulations and only in terms of claims where a medical scheme has paid bona fide but which payment it has subsequently determined the member or the service provider was not entitled to and that comes again in terms of interpretation of what's the entitlement is.

And so it is my interpretation in the instance of 59(3)(b), the test is that the medical scheme must have suffered loss as a result of theft, fraud, negligence and any misconduct. And you rightly said that 10 in fact in terms of whose interpretation of whether that has occurred. So in terms of the so called billing irregularities it is my submission that in fact the schemes have failed to make a case for any of the above. In terms of conclusion and recommendation – I do think it's important for this panel to look into these claw backs in a little bit more detail. I think it becomes – it's quite important to follow the money trail. So not only did I raise the issue about the authority about whether they have the mandate but I think when the claw back has occurred.

Now in our experience we know that in fact the claw backs are 20 done at a scheme level but it goes beyond that. In many instances these claw backs are for claims that potentially were paid out of members savings accounts. And the question arises then that when you do a claw back, do you reimburse the member's saving account. What happens if the member's left the scheme? We know there's a huge amount of churn is this industry. What happens if when the

member has demised, does it go into their state of that particular member?

Because the claim originally could well have been paid from a member's saving account and so when the claw back is made and it goes simply into the scheme pool, that is probably incorrect, it probably needs to go back in the total reversal right into where it originated from, it needs to be reversed.

ADV TEMBEKA NGCUKAITOBI: Have you represented anyone who has been subjected to a claw back?

10 **ADV HASINA CASSIM:** Yes.

ADV TEMBEKA NGCUKAITOBI: And what has happened eventually to the money?

ADV HASINA CASSIM: So we haven't followed the paper trail, we have not followed. All we've received is in fact invoices or a claim by scheme level. We've not seen it in terms of that level of granularity where in fact they able to tell you which specific patient, which date claim and when in fact the original claim was paid out of. So I think it is important that in fact that information be disclosed by funders.

We also have and this is an example and this is – just could

20 potentially just be insinuations but we are advised that in fact a number of these Forensics Investigators are incentivise in terms of the monies that they actually able to recover.

ADV KERRY WILLIAMS: Sorry, just to go back to your previous point. If your argument is that the scheme must have suffered loss in order to

trigger Section 59, why would the scheme then have to pay the money back to the beneficiary if the scheme is suffering the loss?

ADV HASINA CASSIM: Well we don't really know if it was the scheme that – where the losses came because in fact that calculation is done on a crude analysis of claims paid.

ADV KERRY WILLIAMS: But I'm saying – I understand that's your factual submission but in relation to the legal point you argue that in order to trigger Section 59, the scheme must be able to show that it suffered loss.

10 **ADV HASINA CASSIM:** Yes.

ADV KERRY WILLIAMS: Therefore in order to fix that loss they claw back or deduct. So why should they have to pay it back to the beneficiary?

ADV HASINA CASSIM: In the instance where it is a true scheme loss and I would argue that in fact the original claim originated from the member's savings account it is not a scheme loss.

ADV KERRY WILLIAMS: So you're also saying then that the scheme is not entitled to claw back when claims were paid out of member's savings account?

20 **ADV HASINA CASSIM:** Agreed. So – oh yes I just wanted to clarify my interpretation of direct payment as a sanction seems to be a little bit different, I think there's – I got the feeling when I listened to one or two of these submissions made is that – and I want to explain my understanding and I think the schemes would have to explain it a lot better, is that sometimes a tacit agreement exists between the scheme

and the provider, and the provider is then paid directly for claims that are submitted. When a sanction is imposed and they impose what they call a direct payment what the scheme actually does in that instance they pay the member directly, and then there's another definition and a further sanction is when they suspend the provider's practice totally in which instance no claims are actually paid, not to the provider and not to the member, and then there's a further sanction which is like you must have really, really been a bad boy and that is when they blacklist you and in that instance it opens up a whole other myriad of concerns
10 which is, is a scheme allowed to interfere in a patient's right to actually access service from a preferred provider that they have chosen.

And what schemes are doing they are sending out communiqué which I have asked for and I haven't yet received by the way to confirm, to referring practices to say you're not allowed to use this particular Allied healthcare professional going forward because we will not honour any claim submitted by this particular healthcare professional.

Now that blacklisting in terms of the right to practice the right of a patient to procure services, it just opens up a whole myriad of concerns and issues that I think has not been unpacked correctly, or to
20 date that I am aware of.

I think you know – I think we spoke about the manner in which these investigations ought to be handled, which is my submission that in fact when there's not clear-cut fraud, when there is a ...(intervenes).

ADV ADILA HASSIM: Sorry Advocate Cassim I just want to take you back to a point that you made earlier but on the – on Section 59 and

the loss, it has to be a specified amount, so you had mentioned the claw back that goes back over a period of time, how does that calculation of the amount over the period of time relate to this specific loss to the scheme?

ADV HASINA CASSIM: So I – we don't really have that level of – all I do know is that when we are presented with the alleged losses they are calculated at a line level, so it's the member and a claim, we don't really know from which pool, which bucket that particular claim actually originated from. It's just really at a coding – a code and a value level,

10 and that is how they calculate it for a three year period. For every single patient that in fact that code may have been used, and that's how they calculate the claw back, so it is signed retrospectively and it is actually extrapolated from a sub-set of investigations that they have undertaken, but they do provide in many instances that spreadsheet but what we can't see is the pool from which that payment was made, whether it came from the risk benefit or whether it came from the medical scheme's account.

ADV ADILA HASSIM: No sure, but that's not my question, my question is more about how the amount is specified and whether it is specified

20 and you're saying there is a specification that is provided, you have given a spreadsheet …(intervenes).

ADV HASINA CASSIM: Yes, we have given a spreadsheet, we have shown how many times that code was used and how they have actually gone about the calculation for that period of time. It is my submission that in fact that fraud has to be distinguished clearly from waste and

abuse as well, because I think it needs to be dealt with in a very different way, I think it would be advisable that in fact one of the – I am hoping that one of the outcomes of this investigation will be that the trust relationship needs to be re-established between funders and providers and between the public in fact and providers and in fact there should be some sort of a remedial type of step, where there's some form of consultation, there's some engagement, there's some remediation to assist with the issues around waste and abuse, maybe not so much abuse but waste.

10 In many instances services are provided because in fact at that particular point the provider deemed that necessary or it was a – it could be defensive medicine, we know that the litigation is in issue, so the number of tests that I actually requested could well be in excess of what the funder may deem appropriate or necessary but that type of engagement with providers needs to take place.

When investigations and sanctions are undertaken they should be in accordance with proper legal prescripts which is they should be substantively and procedurally fair, there should be consistency in the manner in which these investigations are undertaken, there must be al

20 level of certain – you must know what the allegations are against you, almost like a charge sheet. There must be independence and adjudication I think the Chairperson alluded to that, unbiased adjudication, not the fund deciding for themselves what is fraud, loss or abuse. Proper representation, an opportunity to put a case forward, there should be allowance for a time frame for a pending investigation

without a sanction being imposed, so if there is uncertainty, if there are issues around interpretation allow the practice to at least be given a fair opportunity to resolve those issues before you apply a sanction which often isn't done.

There must be the fundamentals of evidence, there must be proof, I don't want to – I haven't had any experiences with the entrapment issue so I am not going to talk any further on that point just to say that there were concerns around entrapment where in fact these probes are sent out into practices and then I do believe that there is an

10 opportunity for conciliation, mediation and arbitration in the manner in which these investigations and the sanctions are dealt with. I think that is my last slide, yes I think just in closing I mention that I do believe that there should be rekindling of a trust relationship between the various players in this sector – in this industry.

ADV KERRY WILLIAMS: The schemes have a legitimate concern in protecting their pool, the funds, because it is to the benefit of the members, and they have told us the billions that are lost to fraud, waste and abuse. In the context of – it was 28 billion I think Discovery spoke about, well what do you know about the amount that is lost, if

20 anything?

ADV HASINA CASSIM: So the 20% is as you say it's all of those what they deem to be losses or unacceptable claims grouped together. If you unpack it into what is true fraud and then the definition of what they deem to be abuse all waste has to be separated, it is not, the figure is not as high as that. I think the clear cut fraud is much lower,

a lot of these issues would not arise if there was clear understanding on how to actually use those codes and the proper billing, and so I don't believe that in fact the figures are as high as they suggested is.

ADV KERRY WILLIAMS: Okay, but even if it is not fraud, if there is over-servicing, that's also – doesn't work to the benefit of the members, so the – that's what results in the premiums increasing, is they are inflating cost of healthcare services, so even if it is not fraud the scheme still have a legitimate interest in curbing over-servicing.

ADV HASINA CASSIM: I agree that they have those concerns, I do

10 think think that they have to take a really good hard look at their own benefit design, which lends itself to hospi-centric care, which lends itself to over-servicing, which lends itself to higher levels of care being provided because that is what funders will pay for, as opposed to obtaining care at a much lower level potentially out of hospital at a much lower cost, so by not for example paying for diagnostic procedures out of hospital what you inadvertently doing is you're driving admission rates, you're driving the utilisation of a higher QIT centre of care when in fact you could well be paying for a legitimate investigation in an outpatient basis without having – without expecting

20 the patient to dip into their own funds to pay for that service, so they really need to take a good hard look at their own benefit design which in fact can't be separated from the systemic problem of why we see an increase in utilisation, and if you look at the health market enquiry that is not a logical explanation, the demographics of the scheme have not changed to such an extent that it actually justifies – well I suppose you

are saying well that is exactly their case that the utilisation should have gone up the way it has.

ADV TEMBEKA NGCUKAITOBI: I mean isn't that the true systemic issue is that specialists in private hospitals are in a quasi-relationship with the schemes, I mean that was one of the criticisms and yet individual practitioners in outlying areas are systematically turfed out and subjected to Section 59. If one is looking truly for what is the systemic explanation that is the systemic explanation.

ADV KERRY WILLIAMS: And the fact that there isn't enough benefit

10 to allocate it to lower levels of care I mean the whole benefit design is geared towards specialists and hospital care.

ADV HASINA CASSIM: I don't know if I've answered your question.

ADV TEMBEKA NGCUKAITOBI: What I did at the beginning I didn't take your oath on the basis that you were an expert but it became clear during the course of your evidence that although you have expertise you are not an expert witness, so let's take the oath retrospectively. What are you going to do, the oath or the affirmation?

ADV HASINA CASSIM: The oath.

ADV TEMBEKA NGCUKAITOBI: The oath alright, would you say then

20 after me I and your name.

ADV HASINA CASSIM: I, Hasina Cassim.

ADV TEMBEKA NGCUKAITOBI: Do confirm.

ADV HASINA CASSIM: Do confirm.

ADV TEMBEKA NGCUKAITOBI: That the evidence I have given.

ADV HASINA CASSIM: That the evidence I have given.

ADV TEMBEKA NGCUKAITOBI: Was the truth.

ADV HASINA CASSIM: Was the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

ADV HASINA CASSIM: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

ADV HASINA CASSIM: And nothing else but the truth.

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

ADV HASINA CASSIM: So help me God.

10 **ADV TEMBEKA NGCUKAITOBI:** And your attorney also spoke and so let's take the oath for her as well. You will also take the oath? So will you say after me I and your name.

MS NABEELA MOOLA: I, Nabeela Moola.

ADV TEMBEKA NGCUKAITOBI: Do confirm.

MS NABEELA MOOLA: Do confirm.

ADV TEMBEKA NGCUKAITOBI: That the evidence I have given.

MS NABEELA MOOLA: That the evidence I have given.

ADV TEMBEKA NGCUKAITOBI: Was the truth.

MS NABEELA MOOLA: Was the truth.

20 **ADV TEMBEKA NGCUKAITOBI:** The whole truth.

MS NABEELA MOOLA: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

MS NABEELA MOOLA: And nothing else but the truth.

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

MS NABEELA MOOLA: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you very much. We will adjourn the hearing, this was meant to be the last of the schemes, sorry not the schemes, the complainants and experts but we received a request from I think BHF that they want to offer an expert, we will consider the request, but the next sittings should now focus on schemes, we are trying to arrange that for the week of the 11th of November, the whole week of the 11th of November, we should be hearing from the schemes but I think that there will be a notification from the Secretariat to that
10 effect.

The hearing is adjourned.

INQUIRY ADJOURNS TO 11 NOVEMBER 2019

20

TRANSCRIBERS CERTIFICATE FOR

THE COUNCIL FOR MEDICAL SCHEMES (CMS) INQUIRY UNDER

SECTION 59 OF THE MEDICAL SCHEMES ACT

HELD AT

BLOCK A, ECO GLADES 2, OFFICE PARK, CENTURION

DATE HELD : 2019-10-18

10 DAY: : 13

TRANSCRIBERS : B DODD; C LEHMANN

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