SECTION 59 INVESTIGATION
Day 16
Minutes of the Inquiry

Date	Tuesday, 28 January 2020
Time	10:00
Location	420 Witch-Hazel, Block A, Eco Glades
Chairman	Adv. T. Ngcukaitobi

Agenda Subject	Discussion
I. Call to order	Chair Adv. Ngcukaitobi called the meeting to order at 10:06 am. Chair began with pointing out that there was an objection to him chairing the proceedings of the inquiry because he once acted for GEMS in 2012/13 However, the objection was rejected and overruled. Chair also added that they had their reasons to why they rejected the objection. Advocates Williams and Hassim concurred the ruling.
II. Presenters swore under oath	Chair called the motion to have the presenters from GEMS 1. Dr. Stanley Moloabi, 2. Dr. Gunvant Goolab, 3. Mr. Ishmael Mohapi, 4. Dr. Solomon Motuba, 5. Mr. Frank Wilshire, 6. Mr. Nias Abraham, 7. Ms. Anita Du Toit, 8. Ms. Lynn Geater, 9. Mr. Craig Getz, 10. Prof. Paul Fatti to take an oath and to then begin with their presentations.
Dr. Goolab's presentation	Chair informed the GEMS representatives that they would determine how they would go about their presentations, however, they should note that there would be questions asked while they do their presentations and would not be waited for to finish before questions came up. Dr. Goolab then began his presentation with giving an introduction to GEMS. He first pointed out that he was the outgoing PO and that his term was ending on the 31st of January. He then touched on the vision, mission and values of the scheme stating that GEMS vision is "An excellent, sustainable and effective medical scheme that drives transformation in the healthcare industry, aligned with the principles of

	universal health coverage." He also pointed out to the mission which is providing all members with equitable access to affordable and comprehensive quality healthcare, promoting member well-being." Furthermore, he touched on the scheme's values which are excellence, integrity, member value, innovation, and collaboration." **Business of a Medical Scheme** He then stated that the MSA defines the business of the scheme. He quoted the contents of the MSA 131 of 1998 which states, the "business of a medical scheme" means the business of undertaking liability in return for a premium or contribution- a) to make provision for the obtaining of any relevant health service; (b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and (c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme; **Introduction and Background** Dr. Goolab continued and explained that GEMS is a restricted medical scheme that commenced operations on 1 January 2006. Furthermore, he stated that the scheme has a variety of benefit options namely, •Tanzanite One (Sapphire) •Beryl •Ruby • Emerald, Emerald Value (efficiency discounted option based on Emerald option) •Onyx He also highlighted that GEMS is the second largest medical scheme with over 1.8 million beneficiaries and 726 621 principal members. He also mentioned that GEMS' objective is to ensure that public service employees and their families get the best healthcare at affordable rates. He also mentioned that in 2016 the scheme was faced with high claims which was publicized all over the media. **GEMS' Outcome and Impact** Dr. Goolab then shed light on the scheme's contribution over the past years since its inception. He pointed out that GEMS has reduced the public sector patient load and brought a reduction in the demand on the public sector's resources. He also noted that the scheme has been influential in the healthcare industry by providing adequate healthcare coverage to public service

	employees that is not only efficient but also cost-effective and equitable. He also pointed out to another contribution which was that the scheme has curbed the problem of its members paying excessive amounts of money but not getting the best value for their money. He also noted that in excess of 1 million GEMS beneficiaries did not previously belong to a medical scheme. **2017-2021 GEMS' strategy journey in the context of NHI** Dr. Goolab then took the Panel through the scheme's strategy journey in alignment with NHI so to be the blueprint for NHI. He noted that the scheme has a 5-year plan that is categorized in 3 strategic themes namely, stabilize for sustainability, redesign for growth and efficiency, and innovate member value proposition. Furthermore, he highlighted that the scheme also has strategic elements along with these strategic themes. He also mentioned that the Scheme has made significant progress in implementing its 5-year strategy. **GEMS is a transformative organization** Dr. Goolab also brought the panel's attention to the fact that the multi-party administration model was innovated and introduced by GEMS to the industry based on the requirement for expanding B-BBEE as such enabling more entities to contract with GEMS and expanding the pool of capable service providers. Furthermore, Dr. Goolab noted that the scheme has policy principles which are to drive the country's transformational agenda in GEMS' sphere of influence, leverage GEMS' position as a strategic purchaser of healthcare service, bring about much-needed positive socio-economic transformation, encourage increased participation of black people as well as the empowerment of suppliers, promote accelerated and shared economic growth, and preferential procurement promotion strategy. Chair made reference to the fact GEMS is said to be transformative and noted transformation is also about practice. He then pointed out to the allegations of racial bias/ discrimination against GEMS and noted that it was surprising that the scheme had not done anything to address or respond to them. He pointed out to how GEMS hadn't had any engagements or discussions around this. He said that he agreed that transformation was a valid claim, however, he struggled to understand why there wasn't a consistent pattern in proactively addressing this issue. Dr. Goolab explained that there had been meetings held centered around discussing such issues. Chair made reference to Dr. Gumede who has come with a list of doctors that were complaining about GEMS' racial discrimination and were targeted by the scheme, he called this list, "the black". Dr. Goolab said that they had been

	engaging in meetings trying to resolve the matter and have been responding to the allegations. **Governance: Board and Standing Committee Structure** Dr. Goolab continued and expounded on the scheme's governance. He explained that the Board is responsible for providing the Scheme's strategic direction, overseeing the implementation of the Scheme's strategic plan by scheme management and overseeing the management of risk. **Good Governance Features** Dr. Goolab noted that GEMS operates in a well-established control environment which is well documented and regularly reviewed. Furthermore, he concluded saying that GEMS is in compliance with the Medical Schemes Act 131 of 1998 and its Regulations, including section 59, and that is, by design, a transformative organization that demonstrates good governance. He then stated that his colleagues would shed more light on what he had touched on in their presentations.
I. Dr. Moloabi's presentation	**GEMS Reducing Inequality** Dr. Moloabi started his presentation by pointing out that GEMS has been successful in reducing inequality. He explained that the broadest beneficiary definition has provided access for more than 1.18 million previously uncovered lives and that 5 generations could be covered under a single membership. **65% of GEMS membership previously uncovered** Dr. Moloabi asserted that without GEMS, these lives would not be able to find affordable cover in the open scheme market. He also pointed out that the scheme had provided R15.7 billion in benefits paid to these families in 2018. To give an example, Dr. Moloabi shared Thandi's story. He narrated that Thandi was one of the first members to join GEMS in 2006, she earned below R 6000 when she first joined the scheme. She currently has 8 dependents; started off with 2 dependents. She was never covered before she joined GEMS. Her 2018 claims = R223 431 in claims; since she joined R1.9 million of claims were paid to her. **Membership**

	Dr. Moloabi explained that GEMS' race classification is not a mandatory field during the membership application process. However, members who voluntarily share their race information equate to 51.1% of the membership as at August 2019. Based on this information it is clear that GEMS has significantly more black members. He also noted that there are 240 eligible government departments and a number of public entities whose employees are eligible to join GEMS. He said that the KZN Department of Education is the largest employer group with 57 531 registered members as at the end of August 2019. He also asserted that GEMS has a large representation in rural areas. Adv. Williams asked if he knew the race of the scheme's whole membership. In response to this, Dr. Moloabi said that he didn't know because race was not a factor in how the scheme is operated. **Contributions and Claims** Dr. Moloabi then explained the scheme's contributions and claims noting that GEMS adjudicates all claims within 30 days (beyond validating it against the requirements for a valid account provided for in Regulation 5). The scheme receives about 268,364 Claims daily, 8,162,745 Claims received monthly, 7,815,322 Claims paid within a month, 95,7% Claims paid within 30 days, and 4,3% Not paid within 30 days relate to benefits depleted, erroneous claims. Chair then asked what the mechanism or system of validating claims is. In response to this, Dr. Moloabi said that the claim's system was too technical and he would get back to it. Adv. Hassim asked what happens after the 30 days. Dr. Moloabi said that the scheme adjudicates the claims. Adv. Hassim asked what he meant by adjudicate and not validate. Dr. Moloabi explained saying that in adjudication the scheme processes the claims which have been validated and also inform members of accounts have been depleted and in validation they pass through the system to be weighed and approved. Dr. Moloabi pointed out that FWA played a role in the decrease of the scheme's reserve in 2016. Adv. Williams asked why Dr. Moloabi was saying that. He answered that it was because there were a number of factors that contributed to the low reserves in 2016. **GEMS Claims Management Forum** Dr. Moloabi explained that GEMS took action in order to immediately improve the negative claims experience, by:

	•Establishing the Claims Management Forum ("CMF") to understand the drivers that lead to the increase in the claims experience; and •Understand what appropriate interventions could be implemented to manage the significant increase in claims. •The aim of the CMF was to also focus on FWA and make use of data analytics performed by both the Scheme's Actuaries, Strategic Managed Care providers and the Administrator of the Scheme to identify potential outliers. It is clear that the introduction of the CMF not only reduced the loss in 2016 but was also responsible for the better 2017, 2018 and 2019 financial performance. Adv. Asked what caused the loss. Dr. Moloabi said it was a projected loss. The scheme introduced a number of interventions that resulted in saving. Chair requested for the CMF report, Dr. Moloabi affirmed that it would be submitted.
Dr. Solomon MO tuba and Mr. Ishmael Mohapi's presentation	**GEMS Investigations and Sanctions Process** Mr. Mohapi first noted that in his presentation, he would be assisted by Ms. Lynn Geater and a representative from Metropolitan the scheme's administrator. Mr. Mohapi asserted that at the core of GEMS's commitment to deliver the best possible healthcare at the most affordable rates to its members is the need to mitigate risk, with specific reference to FWA. GEMS understands that FWA is driven through an individual or group of individuals' need to act in a manner that may prejudice the Scheme, its beneficiaries and other providers, if this is not prevented. **Who investigates FWA** Chair mentioned that the panel had received a number of complaints that no medical professionals are involved in the FWA investigations and these non-medical professionals are the ones that decide whether a service provider's service services were necessary or not. He also asked where these investigators that have no medical knowledge or training come from. Ms. Geater responded by saying that they do consult with medical professionals. Chair also asked at what point would the medical consultant be contacted. Mr. Mohapi pointed out that the MH HIU provides the investigation capability on behalf of GEMS and that the multi-skilled team includes medical doctors, nurses, psychologists, attorneys and investigators some of which have 10 plus years' medical aid investigation experience.

	Chair then asked further if these medical professionals are always present when these investigations occur. Mr. Mohapi together with Ms. Geater explained and acknowledged that it is not always that these professionals are present but are available. Adv. Williams asked if there's have specialists in every field. Mr. Mohapi affirmed that it was so. Mr. Mohapi pointed out to these points regarding managing FWA: •Create a culture of ethics and intolerance to FWA •Prevent FWA •Detect FWA •Investigate FWA •Take action Chair referred to page 600 and 602 that in the Standard Operating Procedure the definition of fraud is not the same as the one in the policy. He then asked what then prevails when defining fraud. Mr. Mohapi affirmed that it is the policy that prevails. FWA Management Process: Assessment Criteria Adv. Hassim asked how service providers are identified and how the investigation goes. Mr. Mohapi shed some light on the assessment criteria for FWA. He noted that the assessment process is designed to assess information received, against a set of criteria, to determine the extent of the risk and the existence of potential FWA and determine the actions required. Furthermore, the process provides a view of the structured approach and detailed consideration in the selection of a provider for investigation. He also stated that this can happen by the aid of industry tip-offs, behaviour analysis. With regards to how the investigation goes, Mr. Mohapi explained that Metropolitan Health is in charge of the FWA management process and they identify the outliers, GEMS then sets up a meeting and Metropolitan makes certain recommendations. Chair interjected by asking how much Metropolitan is paid and what it is that they get paid for. Dr. Moloabi responded by saying that he wasn't in a position of disclosing such information but would make it available to the panel to view without publicizing it. Chair asked once again if Metropolitan is paid a set fee or based on recovery. Dr. Moloabi affirmed that it was based on a set fee and not on recovery. Chair asked how the relationship between GEMS and Metropolitan is monitored. Mr. Mohapi explained that Metropolitan gives monthly and quarterly reports and they meet frequently for the Claims Risk Forum where they discuss cases in detail and decisions regarding investigations. There are bi-weekly and monthly meetings where a plan of action is devised in accordance with the number of risks.

	Chair then asked what GEMS role is when Metropolitan has identified the outlier. Mr. Mohapi explained that GEMS comes at the tail end of the investigation. Adv. Williams interjected stating that what Mr. Mohapi was saying was contradictory to evidence that was given earlier. He affirmed that Metropolitan drives the investigation. **Geographic concentration of allegations received** KZN was identified as one of the focus areas for FWA in 2016 because of the increase in hospitalization claims. Chair asked if this was endorsed by the executive management of GEMS. Dr. Goolab affirmed that it was so. Chair also asked if this was communicated to Metropolitan. Dr. Goolab stated that Metropolitan was part of the process when the decision was made. At 12:09, Chair announced that the inquiry would adjourned for a 10-minute break. The inquiry resumed at 12:23 and Mr. Mohapi continued with his presentation from page 48. **Sanctioning of Providers** Mr. Mohapi explained that sanctions are imposed on providers who are found guilty of Fraud, Waste or Abuse. He noted that in line with the GEMS sanctions document, the following sanctions may be imposed on providers, where evidence of FWA activity has been found and include but are not limited to: •Reversal of all irregular claims, •Issuing a final warning, •Termination of direct payment, •Monitoring claim submission, •Longer claims payment cycle, •Placing provider under review or removal by network management, •Termination of the network agreement where applicable Reporting a provider to the relevant professional body (HPCSA, SAPC, SANC), •Recovery of losses through civil litigation or negotiated settlement, •Proceeding with a criminal case. **Sanctioning of Members** Member sanctions may include, but are not limited to the following: • Issuing a final warning, • Terminating membership, • Proceeding with a criminal case, • Recovery of losses, • Reporting the member to their employer.

	Reversal of Irregular Claims Mr. Mohapi narrated that prior to 2017, GEMS reversed all claims it deemed questionable or irregular in instances where providers failed to respond to anomalies identified and/or where explanations provided were not suitable to address FWA findings. He also mentioned that during 2015 and 2016, claim reversals by value were exceptionally high and related primarily to claims for Group Practices and Physicians in 2015 and Clinical Psychologists and Registered Counsellors in 2016. Process prior to 2016 and developments up until 2019 in respect of recoveries Section 4.4 of the GEMS Fraud Policy and Prevention Plan sets-out the requirement for recoveries for forensic debt. **Reinstatement of Provider on Direct Payment** Mr. Mohapi stated that GEMS has since its inception offered providers an opportunity to be reinstated on direct payment and to receive payment directly.
Other business	**<u>Investigation Example 5</u>** The provider launched a purported urgent application in the Western Cape High Court. The provider sought payment, on an urgent basis, of claims submitted to GEMS by the provider and also sought an interim interdict "... barring the Plaintiff [GEMS] from contracting a Designated Service Provider in the following areas namely Lutzville, Vredendal, Papendorp, Klawer and Strandfontein on the West Coast as the Applicants are the only service provider that provides renal dialysis in those areas." GEMS opposed this application and raised concerns about the motive in bringing the application, given that the disputes were already subjudice in the trial action and, furthermore, given that the provider and were seeking to obtain a court order excluding competition from the above areas to the detriment of dialysis patients in need of treatment. The urgent application was heard on 23 August 2019 and was dismissed with costs as the court found that the application amounted to an abuse of process and further due to the relief not having been urgent.

SESSION 2

Date	Tuesday, 28 January 2020
Time	14::58
Location	420 Witch-Hazel, Block A, Eco Glades
Chairman	Adv. T. Ngcukaitobi

Agenda Subject	Discussion
I. Call to order	Chair Adv. Ngcukaitobi called the meeting to order at 14:58
II. Introduction	
III. Presentation by Ms. A. Du Toit	**Legal – Section 57** Ms. Du Toit started her presentation with pointing out that GEMS has consistently endeavoured to conduct itself in accordance with all the laws of South Africa. In what follows below, we set-out our understanding of the legal principles relevant to the medical scheme environment and the matters forming part of the terms of reference of the Panel. **Legal - Relationship between the scheme and its members** In the Genesis case the court held that: "the definition [of "business of a medical scheme]" posits two contracting parties, and a mutual exchange of value (quid pro quo). The parties, obviously, are the scheme and its member. The quid pro quo is that the scheme undertakes liability — the kinds spelled out in the definition in exchange for money. The statute calls this 'a premium or contribution'... **Legal – Section 59, Regulation 5 and Regulation 6** Ms. Du Toit also mentioned that GEMS's understanding of the MSA and the Regulations is that if it was the intention of the legislature that all claims should be finally adjudicated within 30 days, it would not have included Section 59(3) which enables schemes to recoup losses of undue claims which it had paid out bona fide. The question then was, what is the purpose of Regulation 6 and when should the process stipulated therein be followed? GEMS holds the view that Regulation 6 should be interpreted in the context of Regulation 5. Regulation 5 clearly stipulates what information an account, statement or claim should include before a medical scheme can make payment thereof. It is submitted that Regulation 6 is not intended to apply in cases where FWA features (especially fraudulent or other invalid claims which are not ex facie the account, statement or claim fraudulent or invalid), since it would not be possible for a scheme to fully and finally adjudicate claims accordingly within the limited time period provided. **Legal – Section 59 (2) – Case Law** To supplement her explanation, Ms. Du Toit made reference to the case below:

	GEMS's interpretation of Section 59(2) has been considered by our courts as well as by the CMS, upholding the above application by GEMS of the relevant principles. 78 Twala v Allcare Administrators (Pty) Ltd & Other In Twala v Allcare Administrators (Pty) Ltd & Other, it was held by Prinsloo J that: "the [medical Schemes] are by statute authorized to decide whether to pay the doctor or the patient directly. [The Court] referred to section 59(2) of the [MSA]. [The Court] also referred to paragraph 17.5 of the [Schemes'] rules, which contains a similar clear provision." Tshwane Pharmacy v Government Employees Medical Scheme In the case of Tshwane Pharmacy v Government Employees Medical Scheme (Case Number: 28532/11 in the North Gauteng High Court), Southwood J summed up the effect of the provisions of Section 59(2) as follows: "Interpretation of section 59(2). [9] ... The subsection does not create an obligation for the Medical Scheme to pay the supplier. [10] In any event, the subsection clearly provides that payment is subject to the rules of the medical Scheme which state unambiguously that the respondent has the right to pay either the member or the supplier of the service (Rules 15.7, 17.3 and 17.5"). **Legal – Consent** Ms. Du Toit stated that the issue of consent does not fall within the terms of reference of the Panel, but it has been addressed at length by some of the providers and/or societies. GEMS does not agree with the contentions advanced during the public hearings and thought it appropriate to ventilate its views on the issue. Legislative framework Ms. Du Toit pointed out that there are four statutes that are considered in relation to the aspect of member consent and personal (medical) information being shared with a third party. The legislative framework is as follows: • MSA; • National Health Act 61 of 2003 ("the NHA"); • Protection of Personal Information Act 4 of 2013 ("POPI"); and • Mental Health Care Act 17 of 2002 ("MHCA") Questions were posed regarding the members' awareness of the blanket consent regarding their records. Ms. Du Toit stated that she didn't know whether they were aware of the contents of the membership form they signed upon joining the scheme. She also pointed out that GEMS never asks for detailed information just enough information to validate claims. Adv. Hassim asked if the scheme ever asks for records to be emailed. Du Toit affirmed that it was so and that it is normally enough information to prove that the services were rendered and also necessary.
IV.	**Legal – Section 59 (2) – Case Law** Ms. Du Toit made reference to another case:

	GEMS v Council for Medical Schemes & Others In GEMS v Council for Medical Schemes & Others, the service provider, had received notice that payment would henceforth be effected directly to members, yet chose to continue to make claims to GEMS. Goldblatt J held that any contractual nexus was terminated once notice of the change in payments process was given and therefore it "had no right to claim payment from GEMS". The court held as follows: "without a specific contract between a scheme and the service provider no debt owing by the scheme to the service provider is created merely by such provider rendering services or supplying goods to members of the scheme." Medscheme Holdings (Pty) Ltd and Another v Bhamjee The Supreme Court of Appeal in Medscheme Holdings (Pty) Ltd and Another v Bhamjee 2005(5) SA 339 (SCA) also held a similar view where the court stated: "Dr Bhamjee was not entitled to insist that the schemes continue supporting his practice by accepting his claims directly.
V.	Adv. Ngcukaitobi asked if it didn't matter that GEMS is a government scheme. In response to this, Ms. Du Toit said that GEMS is a private entity. Chair voiced out his concern about how GEMS has not been leading by example when it comes to fair administration seeing that they are a government scheme. He further expressed that he had heard all the claims that the scheme had made but sadly were not accompanied by corresponding actions. There was no behavioural change.
Mr. Craig Getz and Prof. Paul Fatti's presentation	**Background | Synopsis of the Report Subject to Review** Proportion of black practitioners flagged VS Proportion of non-black practitioner flagged. Mr. Craig began his presentation by mentioning that he is an independent expert whose review was mandated by GEMS. He also stated that he was reviewing Dr. Kimmie's report and he found some technical flaws. He asserted that there is no definitive registry which details race and infers race based on surname/ last name. Dr. Kimmie's research findings suggest that GEMS has racial bias. **Technical Flaws** Mr. Getz concluded that Dr. Kimmie's findings are flawed. The first technical flaw is exposure. He expounded on this point stating that assuming that all GEMS members live in a region where only black practitioners are accessible. Members would only interact with black practitioners. Which makes black practitioners have an opportunity to perpetrate FWA whilst non-black healthcare practitioner would not. He went to say that the unavoidable consequence is that only black practitioners would be flagged as possibly guilty of FWA. Adv. Williams asked if he had tested this in order for it to stand as a fact. He said he had done so.

	Furthermore, he argued that the other technical flaw was corporatized and state practices. He argued further that corporatized and state practices do not have surnames. By virtue of their practice names, these practices are typically deemed non-black. Another technical flaw that Mr. Getz brought forward was group practice and also added that classification error was a concern. He asserted that there are several fundamental flaws in the report prepared by the by Dr. Kimmie, appointed by the Section 59 Investigation Panel. He said that these flaws relate both the underlying methodology and the interpretation of results. Technical shortcomings pertain to: •A failure to adjust for exposure •The inclusion of state and corporate disciplines •The inclusion of group practices •Incorrect racial classifications He said that according to him the race ratio reduces from 1.78 to 1.47. Chair asked him if the results of his own findings still prove that there is racial bias or discrimination in the outcomes. Mr. Craig argued that it was not so. Investigation Panel will need to perform further work to remedy these shortcomings (in particular incorrect racial classifications). •Shortcomings relating to the interpretation of results pertain to: •The mistaking of a difference between black and non-black practitioners as racial bias as indicated by the fact that the GEMS results are consistent with that of a wholly independent process. Mr. Getz said that race may not only be the reason for the FWA there are also some other extenuating factors. Chair then asked Mr. Getz to specify those extenuating factors. Mr. Getz said that he could not think of any. Chair also asked him how he came to the 60% which is just 30% lesser than Dr. Kimmie's findings. Mr. Getz said that he tested this and used a sample of GEMS's. Chair asked if using a random sample would not have been better or more ideal and if using a sample from GEMS was statistically sound. Chair asked both Mr. Getz and Professor Fatti what their recommendation was. He asked if the panel should take their findings and if they agreed that they still indicated the prevalence of racial discrimination in the outcomes although it was not intentional. Professor Fatti stated that he agreed, however, Mr. Getz still could not agree.
VI. Conclusion and recommendations.	Dr. Moloabi pointed out to the following: Section 59 and the application thereof is a complicated topic It is a necessary tool for medical schemes in order to protect the interests of their members and the schemes' ability to continue performing their mandate. GEMS put requisite processes in place and continues with its endeavours to ensure that due processes are followed during its investigations, and that decisions that are taken are not arbitrary

	These processes are also constantly evolving to adapt to any additional requirements and changing landscapes. He also said that GEMS acknowledged that there is room for improvement. He also put great emphasis on the fact that GEMS' FWA processes do not involve considerations of race, and that GEMS does not, and never have, conducted racial profiling of healthcare providers. It is submitted that any introduction of racial data to medical scheme processes should not be considered lightly. **Based on the analysis, GEMS is not guilty of racial profiling** Dr. Moloabi stated that there is no explicit racial bias in the analytics systems used to identify potential FWA cases. **GEMS Recommendations** Dr. Moloabi asserted that GEMS acknowledged that the present inquiry was necessary against the backdrop of the history of our country and that the complaints received have to be investigated. He also mentioned that universal health coverage and transformation in the industry are very important and that GEMS continuously strives to find new ways to facilitate this and other industry role-players should endeavour to do the same.
VII.	**Racial profiling** Dr. Moloabi pointed out that it had been submitted to the panel that schemes do not provide for the inclusion of data reflecting the race of providers in their systems, nor is it included in the BHF provider file that is shared with administrators. GEMS confirms that this is correct and that its systems also do not contain a race category. GEMS submits that bearing in mind the facts that have been presented to the Panel, that GEMS is not involved in any form of racial profiling. GEMS is of the view that it is not necessary or advisable to include racial data in its provider files. Should racial data be included in a scheme's database, it might, ironically, result in racial profiling and also create room for other possible unintended and currently imponderable consequences. If schemes were to compelled by law to include racial data in the schemes' databases, clear and careful guidance would be required of what schemes are required to do with such information when it came to their investigation processes
VIII.	**Section 59 and FWA** Dr. Stanley acknowledged that FWA is common and endemic in the industry and medical schemes need to have the option of mitigating their risk. Accordingly, the concepts of suspension of payment, termination of direct payment and recoveries of illicit funds should be options that remain open to the schemes. In other words, the provisions of Section 59 should continue to allow schemes to implement the necessary measures. It is pointed out that the HMI did not take issue with Section 59 or the implementation thereof. Furthermore, he noted GEMS continuously endeavours to adhere to the principles of natural justice. GEMS has good governance. It follows King III and IV principles and it functions in an environment that is policy driven.

	He also affirmed that the Panel recommendations pertaining to investigations and sanctioning which would balance the right of the schemes to protect the interests of the scheme members and the interests of providers, would be welcomed by GEMS.
IX.	**Lack of education and training** Dr. Stanley expressed that some of the issues which were brought to light during the inquiry, which were already to some extent known to the industry, is the lack of education and training of providers in relation to coding and good business practice. He asserted that the providers ought to take responsibility to ensure that they acquire the necessary training and skills and that they are kept abreast of developments, as is required of all professionals He then noted that GEMS was already providing assistance with the education of providers by introducing GP summits. GEMS recommends that coding and good practice should be added to the curriculum of the medical professionals' respective tertiary qualifications. Alternatively, it should be mandatory for medical professionals to attend to training workshops prior to being allocated a practice number by the BHF
X.	Dr. Moloabi then thanked the panel for the opportunity given to them. Chair thanked everyone for coming and adjourned the inquiry.
XI. Other business	**None**

Adjournment: Adjourned at 17:23 to hold the next day, at 10:00 Wednesday, 29 January 2020