Section 59 Investigation

Established in terms of Section 7(a)(b)(c)(d), 8(a) and (k) and 9(2) of the Medical Schemes Act, 131 of 1998.

Interim Report

INQUIRY INTO ALLEGATIONS OF UNFAIR RACIAL DISCRIMINATION AND PROCEDURAL UNFAIRNESS BY MEDICAL SCHEMES

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INTERIM REPORT OF THE SECTION 59 INVESTIGATION PANEL

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PART ONE

CHAPTER ONE: BACKGROUND AND PROCESS

1. INTRODUCTION

1.1. Background to the establishment of the inquiry

1 In early 2019, a number of healthcare providers ("**providers**") and members of Solutionist Thinkers and the National Health Care Professionals Association ("**NHCPA**") made allegations that they were being treated unfairly by medical aid schemes and their administrators based on race and ethnicity.[1]

2 The Council for Medical Schemes ("**CMS**") launched an investigation into these allegations in terms of its regulatory mandate.[2] This led to the establishment of an independent investigation to conduct an inquiry into these allegations. The inquiry became known as the Section 59 Inquiry ("**the Inquiry**"). A Panel, known as the Section 59 Investigation Panel ("**the Panel**"), was set up to run the investigation. The Panel members are Advocate Tembeka Ngcukaitobi SC (chair); Advocate Adila Hassim; and Advocate Kerry Williams.

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[1] The complaints were made public in May 2019, when a group of medical practitioners approached SABC's Morning Live television programme, alleging that medical schemes refused to pay them on the basis of their race. On Wednesday 15 May 2019, the Chief Executive and Registrar of the CMS appeared on Morning Live. The following day, on Thursday 16 May 2019, the CMS met with the aggrieved medical practitioners and the medical schemes accused of unfair treatment based on race and ethnicity.

[2] The CMS is the regulatory body established by section 2 of the Medical Schemes Act 131 of 1998 to govern, register and control certain activities of medical schemes. The provisions that are relevant to its power to establish an inquiry are sections 7(a) to (d), 8(a) and (k) and 9 of the Act.

3 The CMS developed the Panel's Terms of Reference, which were published on 25 June 2019.[3] The complaints, objective, mandate and functioning of the Panel are set out in the Terms of Reference.

4 The Terms of Reference use the term 'Black and Indian' to refer to the category of persons affected by the alleged unfair practices of the schemes. For the purposes of this report, we refer to Black and non-Black healthcare providers. We do this because, during the course of the Inquiry, it became evident that the true line of alleged differentiation was between Black and non-Black providers.

1.2. Language

5 For the purpose of this Report we also adopt some convenient labels. The allegations made by Black and Indian healthcare providers were made against schemes as well as their administrators. In this report we will either refer to schemes and their administrators as "**schemes**" (where the term is intended to cover both schemes and the administrator which may be acting on behalf of the scheme), alternatively we will use the phrase "**schemes and administrators**" to refer to them collectively. The meaning should be apparent from the context. Where we refer to individual schemes or administrators we will do so by their name, for example, the Government Employee Medical Scheme will be referred to as "**GEMS**" and Discovery Health (Pty) Ltd and Medscheme Holdings (Pty) Ltd, which are accredited

[3] CMS Circular 45 of 2019, Terms of Reference for the Section 59 Investigation Panel at para 1 ("**the Terms of Reference**"). The Terms of Reference are available at the Inquiry website: https://cmsinvestigation.org.za.

administrators will be referred to as "**Discovery**" and "**Medscheme**" respectively.

6 The Black and Indian healthcare providers who made the allegations consisted of a range of healthcare providers, including individuals for example practitioners registered in terms of the Health Professions Act 56 of 1974 ("**Health Professions Act**"), practitioners registered in terms of the Allied Health Professions Act 63 of 1982 ("**Allied Health Professions Act**"), those practitioners who practice as group practices, pharmacists (both individual pharmacists and corporate pharmacies), and hospitals which are incorporated companies and subject to provincial licensing regimes. For the purpose of this report, we will use the phrases "**healthcare provider**", "**healthcare practitioner**", "**practitioner**" or "**provider**" to refer to this group of persons. Where it is important to distinguish a particular provider, for example a psychologist or a dietician, we will do so specifically. Further where the name of the provider is relevant, we will also refer to such provider by name.

1.3. Overview of the complaints

7 The particularities of the complaints are contained in paragraph 1 of the Terms of Reference:[4]

> *"(i) targeting Black and Indian health care practitioners ("**practitioners**") in relation to conducting practice audits;*
> *(ii) forcing Black and Indian practitioners to enter into settlement agreements for the payment of large monetary amounts where alleged fraud or other illegal conduct is suspected;*

[4] Terms of Reference, para 1.

*(iii) generally engaging in racial profiling in the manner in which such medical schemes and their administrators are making use of section 59 of the Medical Schemes Act, 1998 ("**the Act**");*
(iv) illegally refusing to pay Black and Indian practitioners for services rendered to patients;
(v) causing Black and Indian owned health care practices to close down their practices, as a result of unlawfully withholding payments, and as a result reducing access to healthcare. (These are referred to as "the allegations".)"

8 The complaints related to a myriad of ways in which providers felt aggrieved by the power of medical schemes, *inter alia*, to clawback or withhold payment to providers for services rendered to the schemes' members (also known as "**beneficiaries**") in terms of section 59 of the Medical Schemes Act 131 of 1998 ("**the Act**").

9 The Act allows a scheme to clawback payments to providers in specific circumstances where broadly speaking the scheme is of the view that an improper claim was submitted by a provider. The turn of phrase used in the industry to describe the variety of improper claims is "fraud, waste or abuse" ("**FWA**").

10 During the course of the Inquiry, it became clear that the complaints fell into two broad categories.

10.1 The first category related to racial profiling. The essence of these complaints was that Black providers more likely to be targeted for investigation for committing FWA and having their practices audited than their Non-Black counterparts.

10.2 The second category of complaints related to unfairness and abuse in the way the schemes implement section 59 of the Act.

1.4. Findings

11 The Panel's findings and recommendations are contained in Part 3 of this Report.

12 The Panel emphasises that its findings are not a "one size fits all" approach.

12.1 First, the Panel was only able to properly assess the risk management systems of Discovery, GEMS and Medscheme. The findings are accordingly limited to these three schemes and administrators. Further, as is evident from the detail set out later in the Report, there is variation between these three schemes and administrators in the manner in which they conduct themselves; and

12.2 Secondly, the Panel notes that Discovery and Medscheme collectively administer over thirty (30) schemes. Discovery and Medscheme act as the agent of these schemes. Therefore, the findings indirectly implicate the schemes on whose behalf Discovery and Medscheme act.

13 In light of these findings, the Panel makes recommendations regarding the various ways in which section 59 could be better implemented. A balance must be struck between the importance of rooting out unlawful behaviour, without doing so in a way that compromises Black providers. The recommendations do not relate to a particular incident or scheme or administrator or complaint.

They are recommendations made based on the extensive evidence, oral and written, received by the Panel. The recommendations are aimed at the industry as a whole and the way in which the competing interests and concerns that gave rise to this Inquiry may be ameliorated.

14 The Panel is alive to the emotional and reputational response of a finding that there is a discriminatory outcome in the application of section 59 of the Act. It comes to that conclusion cautiously and with reference to the host of constitutional jurisprudence on the right to equality, both in the Constitution and the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 ("**Equality Act**").

2. THE PANEL'S METHODOLOGY

2.1. Guiding principles

15 In performing its mandate, the Panel was guided by the principles of transparency, fairness, natural and open justice.[5] The Panel adopted a procedure of hearing and evaluating evidence that was consistent with these principles.

16 The Panel issued the following rules and notices:

16.1 Rules of Procedure for the Section 59 Investigation Panel appointed by the Council for Medical Schemes ("**Rules of Procedure**");

[5] Terms of Reference, para 6.

16.2 Notice 1: Provisional Working Methods of the Panel, dated 22 July 2019 ("**Notice 1**");

16.3 Notice 2: Update: Provisional Working Methods of the Panel, dated 29 August 2019 ("**Notice 2**"); and

16.4 Notice 3: Update: Provisional Working Methods of the Panel, dated 23 January 2020 ("**Notice 3**").

17 The Panel was mandated to function as an inquisitorial body and not as an adjudicative body.[6] This is confirmed in its Rules of Procedure.[7] The Panel makes findings and recommendations – the findings are necessary for justifying the recommendations and the CMS is at liberty to accept or reject both the findings and recommendations.

18 Notices 1 to 3 ("**the Working Method Notices**") set out the working methods of the Panel which include that:

18.1 The Panel was conducting an inquiry not a trial and was not determining whether anyone should face criminal prosecution or be civilly liable;[8]

18.2 The Panel is an investigative body which is intended to "find the answers to certain questions put … in the terms of reference".[9] The

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6 Terms of Reference, para 6 (i) – (v).
7 Rules of Procedure, para 4.1.
8 Notice 1, para 5.
9 Van de Heever, Masson, Shulz, Van der Merwe, Report of the Commission of Inquiry into the Riots in Durban (1949) ("**The 1949 *Report on the Commission of Inquiry into the Riots in Durban***", p 2), available at http://disa.ukzn.ac.za/sites/default/files/DC%20Metadata%20Files/Gandhi-Luthuli%20Documentation%20Centre/DOC%201949/DOC%201949.pdf.

Panel was required to collect evidence, take statements from witness and test the accuracy of such evidence by inquisitorial examination;[10]

18.3 The Panel informed the parties that they should be aware that the rules of evidence (both in relation to the burden of proof and the standard of proof) as applicable to investigative panels will be applied by the Panel[11] (referencing the Marikana Commission of Inquiry: Report on matters of Public, National and International Concern arising out of the tragic incidents at the Lonmin Mine in Marikana, in the North West Province (2015) ("**Marikana Commission of Inquiry**");[12] and

18.4 The Panel's process is a public one which is intended to ensure transparency. The Panel is independent and is committed to treating all parties fairly. The Panel refused closed door engagements with those against whom allegations were made and it refused closed door engagements with the Steering Committee on Fraud, Waste and Abuse ("**Steering Committee**") as such engagements could lead to unfairness and a reasonable apprehension of bias on the part of the Panel.[13]

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[10] Notice 2, para 7. See also: The 1949 Report on the Commission of Inquiry into the Riots in Durban, p 2.
[11] Notice 2, para 8.
[12] Farlam, Hemraj SC, Tokota SC, Marikana Commission of Inquiry: Report on matters of Public, National and International concern arising out of the tragic incidents at the Lonmin Mine in Marikana, in the North West Province (2015), p 22 – 29, paras 1 – 3, available at https://www.sahrc.org.za/home/21/files/marikana-report- 1.pdf.
[13] Notice 3, paras 20, 23 and 24.

19 The Panel is not a commission of inquiry, which is typically established in accordance with the Commissions Act 8 of 1947 ("**Commissions Act**").[14] However, the Working Method Notices indicate that the standards of procedural fairness and evaluation of evidence applicable to commissions of inquiry, referred to in the Commissions Act, is the standard to follow as the Panel's function and duties are akin to such commissions.

2.2. Legal principles informing the Panel's approach

20 In the 1949 *Report of the Commission of Enquiry into Riots in Durban*,[15] Van den Heever JA discussed the proper function of a commission of inquiry as follows:

> *".. to find the answers to certain questions ... A Commission is itself responsible for the collection of evidence, for taking statements from witnesses and for testing the accuracy of such evidence by inquisitorial examination".* [16]

21 In considering the procedural principles applicable to commissions, the High Court in *S v Sparks*[17] stated:

> *"A court of law is bound by rules of evidence and the pleadings, but a Commission is not. It may inform itself of facts in any way it pleases - by hearsay evidence and from newspaper reports or even through submissions or representations or representations on submissions without sworn evidence."*

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[14] Section 1 of the Commissions Act confers the power on the President to appoint a commission of inquiry "for the purpose of investigating a matter of public concern" and to make the provisions of the Commissions Act applicable to the commission of inquiry.
[15] 1949 *Report of the Commission of Enquiry into Riots in Durban*.
[16] 1949 *Report of the Commission of Enquiry into Riots in Durban*, p 2.
[17] *S v Sparks and Another* 1980 (3) SA 952 (T), paras 961B-C.

22 Notwithstanding that the Panel was not bound by the strict processes of a trial, it was still under a duty to act fairly in particular to those parties who may be affected by representations that were made to the Panel.[18] In the case of *Du Preez v the Truth and Reconciliation Commission*,[19] the Supreme Court of Appeal cited with approval, the opinion of Lord Denning in *Re Pergamon Press Ltd*: [20]

> "*In the English case of Re Pergamon Press Ltd [1970] 3 All ER 535 (CA) the Court was also concerned with procedures in an investigative inquiry conducted in this instance by inspectors in terms of the Companies Act. The directors of the company concerned claimed that the inspectors should conduct the inquiry much as if it were a judicial inquiry in a court of law. Lord Denning MR said of this (at 539 a-f): 'It seems to me that this claim on their part went too far. This inquiry was not a court of law. It was an investigation in the public interest, in which all should surely co-operate, as they promised to do. But if the directors went too far on their side, I am afraid that counsel for the inspectors went too far on the other . . . he did suggest that in point of law, the inspectors were not bound by the rules of natural justice ... He submitted that when there was no determination or decision but only an investigation or inquiry, the rules of natural justice did not apply ... I cannot accept counsel for the inspectors' submission. It is true, of course, that the inspectors are not a court of law. Their proceedings are not judicial proceedings . . . They are not even quasi-judicial for they decide nothing; they determine nothing. They only investigate and report. They sit in private... But this should not lead us to minimise the significance of their task. They have to make a report which may have wide repercussions. They may, if they think fit, make findings of fact which are very damaging to those whom they name. They may accuse some; they may condemn others; they may ruin reputations or careers. Their report may lead to judicial proceedings. It may expose*

[18] *Du Preez and Another v Truth and Reconciliation Commission* 1997 (3) SA 204 (SCA) (***"Du Preez***"), para 37.
[19] *Du Preez*, paras 34 to 36.
[20] *Re Pergamon Press Ltd* [1970] 3 All ER 535 ("***Re Pergamon Press***").

> *persons to criminal proceedings or to civil actions . . . Seeing that their work and their report may lead to such consequences, I am clearly of opinion that the inspectors must act fairly.*"[21]

23 What fairness demands will depend on the context. In the case of *President of the Republic of South Africa v South African Rugby Football Union*, the Constitutional Court held that "[w]hat procedural fairness requires depends on the circumstances of each particular case."[22] The Constitutional Court confirmed this principle in the case of *Janse van Rensburg v Minister of Trade and Industry*,[23] where it held that–

> "*[O]ne of the enduring characteristics of procedural fairness is its flexibility. The application of procedural fairness must be considered with regard to the facts and circumstances of each case.*"[24]

24 Many of these cases are moored in the English case of *Doody v Secretary of State for the Home Department*, where Lord Mustill stated that the "standards of fairness are not immutable."[25]

25 The Constitutional Court has also considered the nature of inquiries conducted under the Companies Act,[26] where persons are summoned by a Master or a Court to give evidence as to the state of affairs of a company in

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[21] *Du Preez*, paras 34 to 36.
[22] *President of the Republic of South Africa and Others v South African Rugby Football Union and Others* 2000 (1) SA 1, para 219.
[23] *Janse van Rensburg and Another v Minister of Trade and Industry and Another* 2001 (1) SA 29 ("***Janse van Rensburg***").
[24] *Janse van Rensburg*, para 24. See also: *Premier, Province of Mpumalanga and Another v Executive Committee of the Association of Governing Bodies of State Aided Schools: Eastern Transvaal* 1999 (2) SA 91, para 39:
"*It is well established in our legal system and in others that what will constitute fairness in a particular case will depend on the circumstances of the case*."
[25] *Doody v Secretary of State for the Home Department* (1993) 3 All ER 92 HL, para 106 D-H.
[26] Section 417 and 18 of the Companies Act 61 of 1973.

the context of a winding-up.[27] In *Bernstein v Bester*, [28] the Constitutional Court found that the power to summon a person in this context to be of public importance:

> *". . . [e]xposure [of dishonest conduct] cannot… take place unless the affairs of the companies which fails are thoroughly investigated and reconstructed, an objective which is difficult, and often impossible, to achieve without the full co-operation of the directors, office bearers and auditors of the company who are, after all the brains, eyes and ears of the company."*

26 However, this had to be balanced against the rights of examinees before the Inquiry. An inquiry may not be conducted in a manner that is oppressive, vexatious or unfair. This would, at least, include the injunction that an examinee cannot be compelled to provide information or answer questions that result in an unjustified infringement of his or her fundamental rights.[29]

27 What is clear is that fairness will depend on context and considerations of natural justice are to be borne in mind throughout the proceedings of the inquiry. This is always going to be a flexible process. In *Re Pergamon Press Ltd*, the English Court recognised the importance of flexibility in determining fairness:

> "*In the application of the concept of fair play, there must be real flexibility, so that very different situations may be met without producing procedures unsuitable to the object in hand ...*

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[27] *Bernstein and Others v Bester NO and Others* 1996 (2) SA 751 (CC) ("***Bernstein***"). See also: *Ferreira v Levin No and Others, Vryenhoek and Others v Powell and Others* 1996 (1) SA 984 (CC).
[28] *Bernstein*, para 50.
[29] *Bernstein*, para 17 and 60. See also: *Chairman: Board on Tariffs and Trade v Brenco Inc and Others* [2001] ZASCA 67, para 29.

> *It is only too easy to frame a precise set of rules which may appear impeccable on paper and which may yet unduly hamper, lengthen and, indeed, perhaps even frustrate ... the activities of those engaged in investigating or otherwise dealing with matters that fall within their proper sphere. In each case careful regard must be had to the scope of the proceeding, the source of its jurisdiction (statutory in the present case), the way in which it normally falls to be conducted and its objective."*[30]

28 The Panel functioned based on these principles.

2.3. Evidence

29 The Panel obtained evidence in different phases.

30 Phase One: receipt of written complaints and allegations and submissions from parties alleging racial bias by medical schemes and administrators. Throughout the investigation, evidence from the complainants was provided to the schemes and administrators so that they could respond in writing and/or orally during the hearings.[31]

31 Phase Two: public hearings focusing on testimony by complainants and by regulatory bodies.[32]

32 Phase Three: public hearings focusing on expert evidence. The Panel received expert testimony regarding the legal framework for determining unfair

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[30] *Re Pergamon Press Ltd*, para 403 D-G.
[31] Terms of Reference, p 1. See also: The Rules of Procedure and the Working Method Notices.
[32] Notice 2, para 18. See also: Transcripts of the hearings are available on the Inquiry website at https://cmsinvestigation.org.za/index.php/transcriptions/.

discrimination, the theory of implicit racial bias and the outcome of a statistical analysis of racial impact of the FWA systems employed by administrators.[33]

33 Phase Four: public hearings focusing on submissions and evidence by the schemes. The schemes supplemented their oral presentations with further written submissions.[34]

34 In keeping with the commitment to transparency: public hearings were open and live-streamed; the Working Method Notices and Rules of Procedure were published on the CMS investigation website; and presentations were made available on the website as were the transcripts of each day of hearing. [35]

2.4. Inquisitorial process

35 The Inquiry was conducted by the Panel itself. The function of the Panel was fact-finding rather than judicial. The Panel was not assisted by evidence leaders.

36 The Panel did not adjudicate individual complaints. The Panel therefore does not make findings of 'guilt' or liability in the manner that a judicial body would in the context of a *lis* between parties. The evidence presented by complainants was important for the Panel's Inquiry regarding how the schemes and administrators risk management systems worked in practice.

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[33] Notice 2, para 19.
[34] Notice 2, paras 21 – 22.
[35] Presentations and submissions relating to the hearings are available on the Inquiry website at https://cmsinvestigation.org.za/index.php/hearings-2/presentations/.

37 The Panel makes findings in respect of the evidence with reference to structural and systemic problems with the risk management systems that appear to have given rise to the complaints.

2.5. Independent experts

38 Commissions of inquiry are not limited to assessing the evidence brought before it by participating parties. It may also seek out and obtain information that would aid it in the determination of the facts.

39 Given the gravity of the allegations and their serious implications for both the complainants and the schemes, the Panel sought independent expert evidence to test the allegations and responses thereto. The Panel benefited from the assistance of three independent experts.

39.1 Dr Zaid Kimmie, an independent expert who specialising in statistics, statistical modelling, mathematical modelling and the analysis of data particularly survey data, who conducted an empirical analysis of the risk management systems employed by the three administrators who were the subject of most of the allegations (GEMS, Medscheme and Discovery). In this way the Panel was able to rise above merely the receipt of individual complaints and the response to those complaints by the schemes and administrators;

39.2 Advocate Wim Trengove SC, a leading constitutional and public law senior counsel with expertise in constitutional law and specifically the legal framework regarding unfair discrimination; and

39.3 Professor Melissa Steyn, the South African National Research Chair in Critical Diversity Studies an expert in critical race theory and principles of implicit bias.

40 Dr Kimmie worked closely with the Panel in its investigation. At the outset of the investigation, the Panel with the assistance of Dr Kimmie sent out extensive information and data requests to Discovery, GEMS and Medscheme. Further Dr Kimmie conducted interviews with each of Discovery, Medscheme and GEMS so as to understand their risk management systems in more detail. Discovery, GEMS and Medscheme provided the requested information and data – which formed the underlying basis for Dr Kimmie's analysis of whether there was explicit or implicit bias in their risk management systems. More detail regarding Dr Kimmie's methodology is set out in later chapters as well as his reports issued to the Panel and to GEMS, Medscheme and Discovery.

41 The experts gave oral testimony between July and November 2019. The public, and the schemes and administrators in particular, were given an opportunity to respond to the expert evidence and challenge the experts' views. Unfortunately, the schemes and administrators did not commission an analysis of the allegations of discrimination until after – and in response to – the evidence presented by Dr Kimmie. The Panel obtained written and oral evidence from the expert witnesses in the presence of the schemes and administrators, all of which were provided with an opportunity to rebut their findings in written through to oral evidence. Often the Panel was provided with the schemes' and administrators' written responses to Dr Kimmie's report in

particular on the eve of the date on which the scheme or administrator was to present orally to the Panel. Given the importance of this information, all submissions were accepted and read prior to the hearings, irrespective of when they were received.

42 The Panel therefore did not satisfy itself with the complaints and submissions of individual stakeholders, whether on the side of the healthcare provider or the schemes and administrators. The evidence provided by its independent experts gave the Panel some objective standards against which to test all the submissions presented to it.

2.6. Evaluation of evidence and standard of proof

43 The power of the Panel does not extend beyond making recommendations to the CMS based on its findings. The recommendations are not binding. In the circumstances, the Panel has followed the approach adopted by the Marikana Commission of Inquiry regarding the evidentiary threshold for making findings and recommendations.[36] That is, that the Panel must be satisfied that there is sufficient evidence to establish a *prima facie* basis for its findings and recommendations. This is based on the fact that a commission of inquiry, as is the case with the Panel, is not designed to make a judgment about a dispute between parties but rather, it is an investigation into a set of facts and, as such, the rules of evidence may be relaxed.

[36] Farlam, Hemraj and Tokota, 'Marikana Commission of Inquiry: Report on Matters of Public, National and International Concern Arising Out of The Tragic Incidents at The Lonmin Mine In Marikana, in The North West Province', 13 March 2015 at at para 6.6 ("the Marikana Report") (available at https://www.sahrc.org.za/home/21/files/marikana-report-1.pdf).

44 It is well established that a commission of inquiry is a fact-finding body.[37] It is not a court of law and therefore the processes and evidentiary standards are different from typical judicial processes. The Panel proceeded on the basis that no one entity had the onus of proving or disproving unfair discrimination by schemes and administrators. Rather, the Panel has taken into account all the information and evidence that was placed before it.

45 The Panel's decision was based on a proper evaluation of the evidence presented to it. The Panel bound itself to the principle of rationality, basing its recommendations on accurate findings of fact and a correct application of the law,[38] while being alive to the Constitutional Court's requirement that there must be a "situation-sensitive approach" which is responsive to "shifting patterns of hurtful discrimination and stereotypical response in our evolving democratic society."[39]

46 In keeping with the consideration of balance in approaching the problems that gave rise to the Inquiry, the Panel considers, in the next chapters: (i) the seriousness of the problem of FWA that the schemes are trying to address in the interests of their members; (ii) the concerns of the complainants about the manner in which the schemes are addressing FWA; and (iii) the response of the schemes and administrators to these allegations. In the final chapters we (i) discuss, analyse and provide our findings regarding unfair discrimination;

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37 *Bell v Van Rensburg NO* 1971(3) SA 693 (C), para 719.
38 *Chairman, State Tender Board v Digital Voice Processing (Pty) Ltd* 2012 (2) SA 16 (SCA), para 41.
39 *Minister of Finance and Other v Van Heerden* 2004 (6) SA 121 (CC), para 27.

(ii) discuss, analyse and provide our findings regarding unfair procedure adopted by the schemes; and (iii) provide our findings and recommendations.

CHAPTER TWO: THE PROBLEM OF FRAUD, WASTE AND ABUSE

3. THE LEGISLATIVE FRAMEWORK

47 In order to understand the nature and context of the Inquiry, it is necessary to explain the legislative framework that governs the relationship between schemes and providers.

48 This relationship is regulated primarily by the Act. The Act stipulates when and how schemes should pay beneficiaries / members of schemes and providers of healthcare services.

49 Of particular relevance to the inquiry is section 59 of the Act, which in part provides as follows:

> "*(1) A supplier of a service who has rendered any service to a beneficiary in terms of which an account has been rendered, shall, notwithstanding the provisions of any other law, furnish to the member concerned an account or statement reflecting such particulars as may be prescribed.*
> *(2) A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme*." (our emphasis)

50 The section therefore envisages that payment may be made (i) to a member who has paid the provider and is claiming the money back from the scheme; or (ii) the provider invoices the scheme directly and is paid by the scheme. Either way, the scheme must pay the member or the provider within 30 days of receiving the account.

51 Section 59 of the Act goes on to provide for situations where, for a number of reasons, a member or provider should *not* have been paid. This is contained in section 59(3) which provides as follows:

> *"(3) Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of—*
>
> *(a) any amount which has been paid bone fide in accordance with the provisions of this Act to which a member or a supplier of health service is not entitled to; or*
>
> *(b) any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme,*
>
> *deduct such amount from any benefit payable to such a member or supplier of health service."*

4. THE MEANING OF FWA

4.1. The lack of clear definitions

52 The evidence indicated that there were no clear definitions of FWA.[40] This is so notwithstanding the "Definitions" document produced following the 2019

[40] Mr Kolver (Transcript 1 of 2, 30 July 2019, p 28, line 45 – p 29, line 20). See also: Medscheme power point presentation, 30 January 2020, slides 131-132; Dr Broomberg (Transcript, 29 January 2020, p. 14, line 19 – p 18, line 10 and p 56, lines 16 – 24); Dr Moloabi and Ms Geater (Transcript, 28

CMS FWA Summit.[41] Some terms are based in legislation; others are industry terms of art.

53 Section 59(3) of the Act refers to "theft, fraud, negligence or any misconduct" and "*bona fide* payment" to which a provider or member is "not entitled". Regulation 6(2) of the Regulations made in terms of the Act[42] ("**the Regulations**") uses the language of claims that are "erroneous or unacceptable for payment".

54 In addition to the legislative language, the industry has developed the phrase "fraud, waste and abuse" or "FWA".[43] FWA is not a statutory concept and has no formal definition. The CMS, however, has defined the concepts as follows:

54.1 "Healthcare fraud" is defined as knowingly submitting false claims, or the misrepresentation of the facts in order to get payment of a benefit to which one is not entitled; and

54.2 "Waste and abuse" are defined as claiming for healthcare treatment and services that are not absolutely medically necessary.[44]

4.2. Why the lack of definitions is a problem

55 This variety of terminology is problematic for several reasons.

January 2020, p 37, line 15 – p 38, line 15 and p 50, line 2 - p 51, line 18) and Mr Makanda and Mr Callakoppen (Transcript, 27 January 2020, p 104, line 12 and p 113, line 16).

41 The "Definitions" document can be found on the CMS website at https://fwasummit.co.za.

42 Government Gazette, Notice GNR.1262 of 20 October 1999.

43 In 2019 the CMS held a Fraud, Waste and Abuse Summit to address FWA. The report of the summit is available at http://fwasummit.co.za/wp/wp-content/uploads/2019/11/FWA-Summit-Rapporteur-Report_.pdf ("**the FWA Summit Report**").

44 The FWA Summit Report, p 43.

56 The first is that it allows for a conflation of concepts under one umbrella, which results in a 'one size fits all' approach to addressing irregular claims. For example, the word "fraud" is often used as shorthand for wasteful or abusive claims. Fraud is different from waste, which in turn is different from abuse. Fraud is a crime; waste and abuse are unlikely to rise to the level of criminal conduct. The legislation includes language of "negligence" and "any misconduct" – notions of fault and breaches of professional duties – and the Regulations use the terms "erroneous" or "unacceptable for payment" – notions of mistake.

57 The second problem with the definitional vagueness is that it creates uncertainty amongst providers, schemes and administrators. Given the seriousness of the problem for schemes, on the one hand, and the allegations of unfairness and discrimination by providers on the other, there must be certainty and clarity about the different forms of conduct. Certainty is a fundamental principle of law: it ensures that persons know what is required of them. It also legitimises the actions of schemes and administrators when implementing their risk management systems set up to identify FWA.

5. THE TYPES OF FWA

58 FWA manifests in a variety of ways. The scale and type of FWA practices vary. Some of the irregular claims were minor infractions or the result of unknowing error. Others were organised and sophisticated fraudulent operations, usually involving a number of practices and service providers.

59 The Panel received dozens of examples of FWA. These include:

5.1. Inflating claims

60 A common form of fraud occurs where a provider prescribes and dispenses one unit of medication to a member but claims, for example, the cost of six units. The provider fraudulently inflates the claim it makes on the scheme.[45]

61 Inflated claims occur where more expensive medicines are claimed than those actually dispensed to the patient.[46]

5.2. Card farming

62 Card farming occurs where several individuals use a single member's medical scheme card. The provider will treat these patients, who are *not* members of the scheme, and claim the cost from the scheme for the services provided to the card holder or scheme member / dependant.[47]

5.3. Claiming for services not rendered or goods not provided

63 The Panel received evidence of providers claiming for services that had not been rendered.[48] For example, an audiologist may bill a scheme for a hearing

[45] Discovery submission, "Report on the investigation into allegations pertaining to racially discriminatory processes of conduct in the forensic department of Discovery Health (Pty) Ltd" by Harris, Nupen and Molebatsi ("**Harris Nupen Molebatsi Report**") (Discovery bundle, p 65, para 6.2).

[46] Discovery submission, 18 July 2019, (Discovery bundle, p 33, para 11.3.1).

[47] Discovery submission, 18 July 2019, Harris, Nupen and Molebatsi Report (Discovery bundle, p 65, para 6.2).

[48] Discovery submission, 18 July 2019, Harris, Nupen and Molebatsi Report (Discovery bundle, p 65, para 6.2). See also: Medscheme submission,18 July 2019, "Whistleblower reports" (*confidential*) (Medscheme bundle, p 85).

aid, using the correct codes. The scheme then discovers from a whistleblower that a hearing aid was actually never supplied.[49]

5.4. Coding Irregularities

64 Billing codes refer to the codes that signify the services which were provided. These include, for example, codes for a consultation, a procedure, a therapy session, post-operative visit, or an investigation or test.[50] Billing codes are accompanied by descriptors, which describe the activity. There are also codes for medical devices and medication. Sometimes these are included in the cost of the service, but this is uncommon.[51]

65 ICD10 codes are different from the billing codes. The ICD10 codes signify the diagnosis. Where a patient has co-morbidities, there may be complexities regarding the use of the correct ICD10 code, which are identified as "primary" and which as "secondary".[52] There may also be a provisional ICD10 code which may change as diagnostic tests become available.[53]

66 Schemes reimburse members and providers in accordance with the billing codes. The evidence suggests that there is lack of certainty about which billing codes should be used for many healthcare services. The providers generally submitted that there was misinformation and inconsistency regarding the utilisation of billing codes. The schemes and administrators

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49 Mr Midlane (Transcript, 30 January 2020, p 49, lines 5 -7).
50 Elsabe Klinck and Associates (Pty) Ltd submission, undated ("**Klinck submission**"), p 1, para 5.1.
51 Klinck submission, undated, p 1, para 5.2.
52 Klinck submission, undated, p 1, para 5.3.
53 *Ibid*.

contested this. However, it was clear that there are no longer standard industry billing codes. Different schemes will make use of different billing codes.

67 Some witnesses indicated that providers were flagged, investigated and sanctioned for FWA where they unintentionally or innocently used the incorrect code.[54] One of the administrators accepted that coding errors could be as a result of mistake or fraud.[55]

68 The following are some of the examples provided to the Panel of coding irregularities:

68.1 Applying fraudulent modifiers to billing codes;[56]

68.2 Up-coding, which involves billing for a more expensive service than the one actually provided,[57] and other forms of overcharging through code abuse;[58] and

68.3 Using codes that fall outside the scope of the provider's practice area or specialisation.[59]

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54 Klinck submission, undated, p 1 - 2.
55 Dr Pratt (Transcript, 30 January 2020, p 48, lines 10 -13).
56 Discovery submission, 18 July 2019, Harris, Nupen and Molebatsi Report (Discovery bundle, p 65, para 6.2).
57 Medscheme power point presentation, 30 January 2020, slide 30.
58 Medscheme power point presentation, 30 January 2020, slides. 26 - 29. See also: GEMS power point presentation, 28 January 2020, slide 64.
59 GEMS power point presentation, 28 January 2020, slide 66.

5.5. Claiming for Non-claimable Items

69 Pharmacies or dispensing general practitioners were found to have submitted claims for items that are non-claimable, for example, cosmetics.[60]

5.6. Waste

70 Examples of waste include waste in the prescription of medical supplies;[61] excessive testing;[62] and unnecessary hospitalisation.

6. WHO COMMITS FWA?

71 There are a range of providers who are responsible for FWA.

72 According to GEMS, it experienced its highest number of claims in 2016, which it attributes to "irregular activities".[63]

73 According to Discovery FWA arises from the activities of numerous stakeholders including health providers, crime syndicates, individual members, brokers and hospitals.[64] Discovery's evidence indicated that 29% of proven FWA were attributable to providers in 2018.[65]

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60 Discovery submission,18 July 2019 (Discovery bundle, p 33, para 11.3.1).
61 Medscheme power point presentation, 30 January 2020, slide 32.
62 Medscheme power point presentation, 30 January 2020, slide 33.
63 GEMS power point presentation, 28 January 2020, slide 9.
64 Discovery power point presentation, 29 January 2020, slide 14.
65 *Ibid*.

74 Medscheme attributes FWA to a range of activities by providers including over-servicing, over-charging, supplier induced demand and opportunity. Conditions that enable FWA are member apathy and coding complexity.[66]

7. THE IMPACT OF FWA ON SCHEMES AND THEIR MEMBERS

7.1. The extent of the problem

75 The loss sustained by schemes due to irregular claims is significant. There is no certainty as to the actual monetary loss and estimates vary considerably. The evidence indicates that between 1-15% of healthcare expenditure is lost to FWA each year.[67] In terms of monetary loss, the Panel received evidence that a scheme may pay approximately R22-28 billion in fraudulent claims on an annual basis (equivalent to approximately 25% of all premiums paid by South Africa's 8.8 million medical aid members).[68] Unfortunately, the Panel received inconsistent messaging about the percentage and quantum of loss occasioned by fraud.

76 The lack of precise figures notwithstanding, the Panel accepts that the impact of this problem is serious.[69] According to Dr Modupe, Senior Manager: Clinical Unit Council for Medical Schemes:

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66 Medscheme power point presentation, 30 January 2020, slide 55.

67 Discovery submission, 18 July 2019 (Discovery bundle, p 131, para 12), where Discovery testified that it estimates 10% to 20% of all medical aid claims in South Africa are fraudulent. See also: Dr Nyati and Mr Midlane (Transcript, 30 January 2020, p 19, line 2 – p 22, line 17) as well as the Medscheme power point presentation, 30 January 2020, slide 12, where Medscheme clarified that the FWA cases were closer to 1% than 3%.

68 Discovery submission, 18 July 2019 (Discovery bundle, p 47, para 1.6).

69 The schemes emphasised that FWA is a global phenomenon. See for example Discovery power point presentation, 29 January 2020, slide 15.

> *"Unethical billing is a worldwide problem and poses a significant challenge to the future of healthcare funding and sustainability of the private healthcare sector in South Africa."*[70]

77 The report emanating from the 2019 CMS Summit ("**the FWA Summit Report**") provides the following information:[71]

> "*A 2017 annual report demonstrated that claims that were paid out amounted to R172 billion, those that were rejected were around R29 billion. If it is true that 15% of all claims are associated with fraud, waste and abuse, this amounts to R29 billion. These are funds intended to provide essential healthcare services to scheme members; and yet these funds are being rerouted out of the system to line the pockets of fraudulent and corrupt people.*" [72]

78 Clearly FWA is a problem that needs to be addressed and there must be a mechanism to attenuate the harm.

7.2. Threat to the Schemes' Financial Wellbeing

79 The money that is lost to FWA has a direct impact on the members of the schemes. The Panel received evidence about the various ways in which FWA negatively impacts the schemes' financial viability and the knock-on effect on the cost of members' fees. This in turn has an impact on the ability of people with lower incomes to access medical insurance.[73]

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[70] The FWA Summit Report, p 37.
[71] *Ibid*.
[72] The FWA Summit Report, p 7, para (a).
[73] This was a point made many times by Medscheme, for example: Medscheme power point presentation, 30 January 2020, slide 12.

7.3. Increase in Premiums

80 The Panel received evidence that, if FWA is not addressed, there will be an increase in premiums for members. Premiums paid by members on an annual basis are expected to cover medical scheme expenses and claims for the year. FWA leads to an increase of the cost of claims. This increase is unanticipated and burdens the fund in an unpredictable manner. In this event, it may be necessary to increase premiums to cover the loss caused by the increase in claims.[74]

8. THE RISK MANAGEMENT SYSTEMS INTENDED TO ADDRESS FWA

81 There is no standard approach to addressing FWA. The general processes described in this chapter is based on the evidence and submissions provided to the Panel. There are essentially three phases in the investigation of FWA. These are: (i) detecting cases of potential FWA; (ii) investigating cases; and (iii) sanctioning providers who have committed FWA.

8.1. Detection

82 Each scheme has different mechanisms to detect cases that need to be investigated for FWA. On the whole there are two ways in which providers are flagged as possible cases of FWA that should be investigated. The first is a system that allows for tip-offs, such as hotlines.

[74] Discovery submission, 18 July 2019 (Discovery bundle, p 47, para 1.2). See also: Medscheme power point presentation, 30 January 2020, slide 12.

83 The second method is through the utilisation of algorithms or mechanised systems that detect possible FWA. These systems use statistical analyses to identify practices that, in comparison with other providers, fall outside the norm of comparable providers. Such providers are identified as outliers and may be subject to further investigation (depending on the policies of the scheme and the decisions made by those who select cases for investigation).

8.2. Investigation

84 The second phase is the actual investigation. Once a case has been flagged as possible FWA, the administrators tend to use a variety of methods to rank the risk and seriousness of the potential FWA. Depending on the variables selected by a scheme, certain cases will then be selected for investigation.

85 The investigation usually begins with a letter to the provider who has been flagged, requesting information about the billing anomaly. Some administrators use “probes”, or “moles” or investigators who go to the provider’s practice under the guise of a patient to determine whether there is indeed FWA.

86 When a scheme engages the provider directly, it will usually request a series of documentary evidence from the provider to verify the provider’s claims. The evidence will include, for example: diary entries, to prove that the provider had a consultation on a particular date; consultation or diagnostic notes; or an explanation of the use of a particular code.

87 If the information is provided, the scheme will determine whether or not the requested information validates the anomalous billing. If it is does not, the scheme will then move to the next stage, which, depending on the scheme's policy, may include sanctioning the provider.

88 Where a provider does not, is unable to, or refuses to provide the information requested by the scheme, the scheme may take the position that the claim is invalid. It will then move to the next stage, which, depending on the scheme's policy, may include sanctioning the provider.

8.3. Sanctions

89 There are several different sanctions that the schemes employ if there is a finding of FWA.

90 Very often, the scheme will place a hold on the claims of a provider under investigation. If the investigation results in a finding of FWA, the scheme will stipulate the amount that it has calculated as having been overpaid to the provider. In some instances, the scheme and the provider will enter into a settlement agreement, often in the form of an acknowledgement of debt ("**AOD**"). The scheme may also impose a "claw back" on the future amounts owed to the provider as a way of off-setting the amount owed. The quantum of the deduction is determined by the administrators in different ways.

91 The scheme may decide to blacklist the provider. This means that the administrator will no longer pay that provider, and will advise its members that such provider is blacklisted. Where providers are in direct payment

arrangements with schemes, the administrator may suspend or end the direct payment relationship.

92 In some circumstances, the scheme or administrator reports the provider to one of the relevant regulatory bodies.

CHAPTER THREE: THE COMPLAINTS

93 There were two broad categories of complaints. The first relates to the allegations that the schemes and administrators unfairly discriminated against Black providers and use racial profiling in their implementation of section 59 of the Act. The second category of complaints relates to the unfair manner in which the schemes and administrators implemented their risk managements systems and in particular section 59(3) of the Act.

94 In order to describe the complaints, and for convenience, we have divided them into those which relate to racial discrimination and those which relate to unfairness.

9. RACIAL DISCRIMINATION

95 The purpose of the Inquiry was to address the myriad of complaints regarding racism in the way in which schemes approach FWA. The evidence presented to the Panel spans thousands of pages. The point of departure is the claim that the majority of the complainants are Black providers, leading to the allegation of racial profiling.[75]

[75] NHCPA submissions, undated, p 27, para 97.

96 According to the NHCPA:

> "*Allegations of racial profiling and racism have been repeatedly denied by the schemes but we submit that trends and the profile of the racial demographic of where forensic audits are most prevalent suggests otherwise.*"[76]

97 Emblematic of the allegation of racial profiling was the notorious "Black list", which was a list, published by GEMS, of providers that patients should no longer consult.[77] The list contains a breakdown of the categories of specialisations investigated for FWA and the percentage of persons in such categories who are Black. The findings are stark: for example, 94% of general practitioners and 100% of social workers blacklisted by GEMS were Black.[78]

98 The NHCPA made use of information provided by the Health Professions Council of South Africa ("**HPCSA**") and argued that:

> *"102. According the [HPCSA] statistics for the period May & June 2019 numbers support our assertion of practice of racial profiling by the medical schemes in the following*
> *102.1. The number fraud cases lodged by the public against black doctors is 5, while it is 11 against white doctors.*
> *102.2. The number of fraud case lodged by the medical schemes against black doctors is 25, while it is 1 against white doctors.*
> *103. The questions that arise here are the following:*
> *103.1. What is the reason that the number of the medical practitioners reported to the HPCSA by medical schemes is totally inverted in comparison to the number reported by the public.*

[76] NHCPA submissions, undated, p 28, para 98.
[77] NHCPA submissions, undated, p 28, para 99.
[78] *Ibid*.

104. No other conclusion or inference can be drawn from the above numbers except one of racial profiling."[79]

99 According to the Independent Practitioners Association Foundation of South Africa ("**IPAF**"):[80]

"*Service providers are profiled based on obscure criteria which no forensic unit will reveal even when requested to do so formally, so there is no way to exclude racial profiling or any other grounds for that matter as they refuse to disclose their profiling criteria.*"[81]

100 The schemes' audit process was described as:

"...racially discriminatory in nature, based on how the information demanded from Blacks, and Indian healthcare practitioners is completely different compared to the information demanded from their White counterparts

...

when it comes to a Black and Indian healthcare practitioners, when the audits, or letters, are sent the letters will be demanding clinical notes, confidential information of the patients, details of what is happening within the consultation rooms. However, when we compare with our White counterparts, their information that is needed from them, often when they approach the office, or they're going for interviews, they will be coming back to tell us they only needed diaries, and no clinical notes."[82]

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[79] NHCPA submissions, undated, p 29, paras 102 – 104.

[80] The Independent Practitioners Association Foundation of South Africa submission, 18 July 2019 ("**IPAF submission**") (Discovery bundle, p 3221, para 1), which provides that:

"(IPAF) is a national network of Family Practitioners that comprises of the South African Medical and Dental Practitioners (SAMDP) Network (SP Net), the Alliance of South African Independent Practitioners (ASAIPA), NIMPA Health Care (NHC), and the South African Medical Contracted Community (SAMCC)."

[81] IPAF submission, 18 July 2019 (Discovery bundle, p 3226).

[82] Dr Gatsheni (Transcript 1 of 3, 29 July 2019, p 10, line 24 - p 11, line 16).

101 The Panel was informed that, based on discussions between Black and Non-Black providers, while Black and Non-Black providers would receive the same formulated letter, the information requested at the audit meetings, was different.[83]

102 The HPCSA made submissions in support of Black healthcare providers. It explained to the Panel that mechanisms used by the schemes to address FWA in fact only affect Black providers because "[t]hey are dependent on payment directly from medical aids."[84] Therefore, if a scheme refuses to pay an invoice or decides to withhold payment of future invoices (described in further detail below), the Black providers:

> "*They are the ones that get victimised. Now, the people from affluent communities are not affected by this issues. They have, you know, tap machines, swipe machines. You pay before you are seen, or you pay before you leave. They don't have creditors. They don't send accounts. And they are not impacted by this behaviour of medical aids...*
> *Now if you are an affluent provider that does not take payment from them, but takes it directly, they can't access that information. So, this is where, the racial profiling is basically about the demographics of the Country, about the history and about the situation of people. So, whether you call it racial profiling or not, but what they do will affect Black providers in general and Black patients in particular.*"[85]

103 A key distinction, therefore, is between providers that are contracted into a scheme and therefore dependent on direct payment (i.e. the provider invoices

[83] Dr Gatsheni and Dr Chabalala (Transcript 1 of 3, 29 July 2019, p 11, lines 8 – 16, p 32, lines 19 – 23 and p 75, lines 16 – 25).
[84] Dr Letlape (Transcript 1 of 2, 31 July 2019, p 41, lines 12 – 14).
[85] Dr Letlape (Transcript 1 of 2, 31 July 2019, p 41, line 13 – p 42, line 8).

the scheme for their services and not the patient) and those that are contracted out. According to the HPCSA:

> "*99% of the providers that are contracted in, that are dependent on direct payment, would be people that have Black practices and largely Black providers. And those that are contracted out, would largely be White providers with White patient basis (sic), and the affluent societies. So you don't need to have a racial matrix to get the racial information. Because the natural settings of South Africa will do the demographic profiling for you. Just like we say, you know, poverty is general, but its face is black. It's by the same token. A poverty doesn't do, a racial register doesn't say are you African or are you Indian. But we know what the face of poverty looks like. So they can come and rightfully tell you, we're neutral, it's practice numbers.*"[86]

104 The HPCSA further submitted that the historical economic divide created by apartheid persists, with the result that Black providers often service Black patients, many of whom live in townships or do not have disposable income to be able to pay the provider and then reclaim later from the scheme. The HPCSA went on to suggest that such providers are dependent on payment from the schemes, and described it as being "salaried by the medical aids."[87]

10. GENERAL UNFAIRNESS

10.1. Limited differentiation when responding to FWA

105 Providers complained of a 'one size fits all' approach to addressing irregular claims and that there is limited differentiation in the way the FWA processes operate. On the whole, providers complained the process of addressing FWA

[86] Dr Letlape (Transcript 1 of 2, 31 July 2019, p 56, line 24 – p 57, line 11).
[87] Dr Letlape (Transcript 1 of 2, 31 July 2019, p 59, line 17 – p 60, line 5).

is not nuanced enough to respond to the multiplicity of ways that a billing concern might arise.[88] This results in innocent cases being harnessed in the wide and uniform net cast by the schemes to hold providers accountable for FWA. This 'net' tends to assume that all cases flagged for FWA are fraudulent or intentional. A 'one size fits all' approach is used, irrespective of whether the investigation involves a provider in a rural area operating in meagre circumstances, or whether it there is a syndicate of sophisticated providers under investigation.

106 The tone of many of the letters sent to the providers gives the impression of a 'one size fits all' approach. For example, an under resourced provider may be unable to provide the evidence required by the administrator or scheme during an investigation into the provider's billing. The scheme or administrator may then take the view that the provider under investigation has failed to prove that their claims are valid. In the absence of verification, a scheme may then conclude that the provider must have committed FWA. The result is that, according to one testimony, that the scheme's letter –

> "*says give us your patient files, not for the past month or for the time that you claimed from the start when you started seeing this patient. You miss one page of the patient files where there is a consultation dating back you are committing fraud.*"[89]

[88] There may be a difference in notifying the flagged provider before or after investigation, see for example Discovery submission, 18 July 2019, Knowles Hussain Lindsay Inc Report (Discovery bundle, p 131 -134).

[89] Adv Buthelezi (Transcript 2 of 2, 31 July 2019, p 44, lines 2 - 6).

10.2. Threatening communication and bullying

107 The complainants raised concerns about the aggressive, impersonal and threatening nature of communications from schemes regarding FWA allegations.[90] For example, a complainant read an extract from a letter from an administrator saying that:

> "*If we cannot finalise or resolve our concern within 30 days we reserve the right to implement the appropriate measures to minimise the scheme's risk until this matter has been finalised.*"[91]

108 Complainants testified that the tone of the schemes' correspondence was aggressive and amounted to a presumption of wrong-doing or guilt.[92]

109 Providers spoke about feeling bullied by schemes in the process of the FWA audit. One provider described her experience as follows:

> "*They don't care and I did feel bullied in that moment. I actually used the word that I feel bullied now, because for me I have no problem with releasing the files.*"[93]

And later:

> "*I think that's the day I really, really felt so overwhelmed because that guy was literally just bullying me.*"[94]

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90 Mr Kohloffel (Transcript, 29 August 2019, p 59, line 11 - p 65, line 25). See also: Mr Venter (Transcript, 21 August 2019, p 131, lines 17 - 23).
91 Mr Kohloffel (Transcript, 29 August 2019, p. 59, lines 12 - 24).
92 Klinck submission, undated, p 3. See also: Mr Boloka (Transcript, 23 August 2019, p 32, lines 18 - 25).
93 Dr Zwane (Transcript 1 of 3, 29 July 2019, p 42, lines 21 – 22).
94 Dr Zwane (Transcript 1 of 3, 29 July 2019, p 51, lines 20 – 22).

110 One provider described her experience as intimidating (even though she had her attorney present):

> "*What happens with this process is that... You go – you get into the room; you are confined into this small room and it's four men, in my case, twice, with Discovery, four men, very short lady like me confronted – you...you're encountering those tall guys. It was very intimidating; they interrogate you.*"[95]

111 The South African Medical Association ("**SAMA**") indicated that this was a common complaint from their members:

> "*Oftentimes we find that after the fact our members tell us about the fact that they felt they experience the meetings as coercive...members tell us, well, I was steamrollered during the meeting...Certainly we have attended meetings that we felt were very aggressive... absolutely the meetings can be quite antagonistic and intimidating to the doctors and there is sometimes, it feels like it's a witch hunt, and a decision has already been made.*"[96]

112 The Panel heard evidence of "ex-policemen extracting information" at the settlement or engagement meetings.[97] One provider spoke about a feeling of being blackmailed.[98]

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95 Ms Ramasolo (Transcript 2 of 3, 29 July 2019, p 2, lines 7 – 12).

96 Ms Verwey (Transcript, 1 August 2019, p 44, lines 5 - 19).

97 Dr Gatsheni (Transcript 1 of 3, 29 July 2019, p 32, lines 2 – 4). See also: Discovery supplementary submission, 15 August 2019, "Affidavit in response to *viva voce* evidence by N Gatsheni" (*confidential*) (Discovery bundle, p 549 – 595), where Discovery provided a response to the complaints of Dr Gatsheni.

98 Dr Chabalala (Transcript 1of 3, 29 July 2019, p 73, lines 1 - 3), where Dr Chabalala stated:

> *"…they are the ones who are promoting fraud where it is not there because to me that is fraud or it is, it is a me, it's blackmailing, they are blackmailing me".*

See also: Discovery supplementary submission, 15 August 2019, "Affidavit in respect of KC Chabalala" (*confidential*) (Discovery bundle, p 406 – 451), where Discovery provided a response to the complaints of Dr Chabalala.

113 The evidence painted a picture of a combination of implicit threats and heavy-handedness leading to a feeling of coercion, particularly in signing AODs:

> "*So we are very confused on how one, how the AOD is calculated and how people are coerced in signing it. They are not necessarily pushing you to sign it but however, because you know pressures is around money, you will end up deciding that let me sign so that I can have food on my table. For some of us who refuse to sign, then you are blocked, you can't practice, you can't even see patients...*
>
> *I was forced to sign and AOD because I refused with my notes. Then I signed the AOD. Then I had to pay.*"[99]

114 The threat of being reported to the provider's regulatory bodies was raised as a component of intimidation:

> "*An example is the unlawful agreement ... which is entered or is reached with a condition that a medical, a particular medical scheme or a particular medical aid administrator will not report you as a practitioner to any law enforcement agents or your regulatory board, to your regulatory body if you agree to their terms and conditions. So that is unlawful and that is what is happening time and again. Although the medical aids, the medical aids themselves may exercise their choice in terms of reporting unprofessional conduct to the Health Professional Council or any regulatory body. If it is a pharmacy, it's the Pharmacy Council. If it is nursing, it's Nursing Council. They have a duty in terms of common law and Section 66 of the Medical Schemes Act to report practitioners to, to the regulatory body if they feel they have done something wrong. So by not doing that because their main aim to ask is just to make sure that they extort as much money as possible from the practitioners.*"[100]

[99] Dr Gatsheni (Transcript 1 of 3, 29 July 2019, p 34, lines 19 – 35; line 13).
[100] Dr Chabalala (Transcript 1 of 3, 29 July 2019, p 74, lines 2 - 17).

10.3. Limited explanation from schemes about the reason for the audit

115 The Panel heard allegations that during the investigation and auditing process, there would be little or opaque communication.[101] Providers are often informed that they are being investigated or audited but there will be no further information about the reason for the investigation.[102] This left providers in a position where they were being asked for information without any context or explanation about what it was the scheme was seeking to verify.[103] This vagueness made it difficult for the providers to respond.

10.4. Excessive requests for information verifying claims

116 Practitioners reported being asked to provide information for a significant number of patients, with very short turn-around periods.[104] In one instance, a provider was informed that he was being audited following a preliminary investigation. The scheme requested information about 69 patients, including copies of clinical notes, appointment diaries and validation of the time spent with the member.[105] The provider was required to provide this information without any knowledge of the basis for the investigation.

[101] Ms Matseke (Transcript, 21 August 2019, p 47, lines 13 - 18 and p 56, lines 9 - 21). See also: Ms Sikhakhane (Transcript, 30 January 2020, p 100, line 19 – p 101, line 15).
[102] Dr Zwane (Transcript 1 of 3, 29 July 2019, p 56, lines 7 - 17). See also: Dr Talatala (Transcript, 29 August 2019, p 25, line 20 – p 26, line 7); Mr Rosen (Transcript, 23 August 2019, p 43, lines 5 - 21) and Ms Naidoo (Transcript, 21 July 2019, p 29, line 15 – p 32, line 5).
[103] Mr Kohloffel (Transcript, 29 August 2019, p 58, lines 2 - 24).
[104] Ms Klinck (Transcript, 21 August 2019, p 22, lines 11 - 25).
[105] Ms Matseke (Transcript, 21 August 2019, p 47, line 22 – p 48, line 1).

117 That lack of specificity about the reason for the investigation, coupled with the request by the scheme for information about specific clients, leads to a sense of schemes being on a "fishing expedition".[106]

118 The nature of the correspondence from the schemes creates a continuum of engagement which providers claim is threatening and intimidating. This correspondence was described as "symptomatic of the next bullying tactic that may come down the line."[107]

10.5. Conflation of waste and overcharging

119 There appeared to be a conflation of excessive charging, which is a deliberate inflation of the invoice, with unnecessary waste.

120 Providers reported that schemes would use the same forensic teams to investigate both types of billing anomalies. Providers further submitted that because forensic investigators often do not have a medical qualification, it would not be possible for them to understand the medical decision being made. The investigators would know only that the provider had been flagged as an outlier. They would not have the medical training to know whether there was a medical justification for the non-conforming services.[108]

[106] Klinck submission, undated, p 6, para 3.2.2.
[107] Mr Kohloffel (Transcript, 29 August 2019, p 83, lines 15 - 16).
[108] This became clear from the engagement with GEMS in its presentation to the Panel, see Mr Mogapi, Ms Geater and Dr Moloabi (Transcript, 28 January 2020. p 50, line 12 - p 59, line 21).

10.6. Periods which are reviewed during an investigation

(i) *The position of the complainants*

121 The Panel received complaints about the period that would be subject to an audit. In some instances, providers were asked to provide patient information dating back over three years:

> "*But we had a problem where you find that they can come and query a claim as late as three years, which we disagree that where is the, where is the good faith. If you say you want to validate a claim after three years, and you want to go and apply the section which is talking about 30 days, there is a huge disparage in that regard (sic).*"[109]

122 Depending on the period of the review, some providers simply would no longer have the documentation requested by the scheme. The schemes' position was that the failure to provide the records probably constituted evidence of FWA. There does not appear to be an engagement with the provider as to why the provider had not released their records.[110]

123 Practitioners described various impediments that made it impossible for them to retain patient information beyond a certain period of time. Complainants indicated that often they would not have the material at all, or would not be able to access it easily. For example, providers may not keep their consultation diaries for past years. If that provider is asked to prove that they actually consulted with a patient in a prior year, they may not have that information.

[109] Dr Chabalala (Transcript 1 of 3, 29 July 2019, p 23, lines 18 - 23).
[110] Dr Zwane (Transcript 1 of 3, 29 July 2019, p 41, line 23 – p 57, line 5).

124 Complainants indicated that they would be asked for information about patients dating back three years, but the request would be framed in terms of Regulation 6, which is limited to 30 days. There was a sense, therefore, that the schemes were manipulating the provisions of the Act and the Regulations.[111]

125 Many providers do not have large practices with the ability to keep patient information and files for an extended period of time. Black providers in particular confirmed this position.

126 Sometimes the information is in hospital archiving. Some hospitals will charge significant fees (in one case such fees were tens of thousands of Rands) to access these records.[112] Some hospitals may refuse to provide the information at all, citing patient confidentiality.[113] This means that the provider is unable to provide verification of the consultation or prescription of medication (or whatever the basis was for the claim anomaly).[114]

(ii) *The position of the schemes*

127 The position of the schemes is summarised as follows.

128 There are thousands of claims that have to be processed every day and paid within the statutorily prescribed period of 30 days of receipt of the invoice.[115]

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[111] Dr Chabalala (Transcript 1 of 3, 29 July 2019, p 23, lines 14 - 23).
[112] Klinck submission, undated, p 7, para 3.2.2.
[113] *Ibid*.
[114] Dr Chabalala (Transcript 1 of 3, 29 July 2019, p 58, line 14 – p 59, line 1).
[115] Discovery submission, 18 July 2019 (Discovery submission, p 38), which provides that Discovery processes 275 000 claims a day. See also: Ms Mohamed (Transcript, 27 January 2020, p 112, lines 15 – 19 and p 116, lines 15 - 24).

The schemes do not have the operational capacity to verify the enormous volume of claims within 30 days and are forced to accept the vast majority of claims at face value.[116]

129 This means that there is not enough time to detect anomalies or markers that would trigger a concern about an individual provider. It is only as a result of the various detection methodologies that a provider may be flagged over a period of time, long after they have in fact been paid.[117]

130 The 30 day payment period therefore creates a risk for schemes. The schemes argue that the obligation to pay accounts within 30 days must be balanced against the need to verify claims which have been submitted and paid erroneously. Section 59(3) of the Act, according to the schemes, provides for this balance and authorises them to investigate claims that were paid in prior years.

131 This is exacerbated by the system of direct payments by the scheme to the provider. Where the provider bills the scheme directly, the member usually will not see the invoice and may not be concerned with the transaction once they leave the provider's practice. They are therefore not able to verify whether the invoice of the provider is correct. This creates a blind spot for the

[116] Discovery submission, 18 July 2019 (Discovery bundle, p 38). See also: Ms du Toit (Transcript, 28 January 2020, p 148, lines 10 - 17).

[117] Medscheme power point presentation, 30 January 2020, slide 79. See also: GEMS power point presentation, 28 January 2020, slide 77, where GEMS provides that it is of the view, that "should providers require that all claims should be fully adjudicated to prevent future investigations, schemes should be afforded at least 90 days to adjudicate all claims."

schemes and justifies the interrogation of claims paid over a period of a number of years.[118]

132 The schemes also maintain that the HPCSA requires doctors to keep records for six years and the Pharmacy Council requires record keeping for five years. The scheme is not asking providers to remember what happened six years ago but to keep their records so that those can be audited by regulators or schemes when necessary.[119]

10.7. Duration of the investigation

133 There is no law governing how an FWA investigation is conducted let alone its duration.

134 A number of providers complained about investigations taking long periods of time to be completed.

135 According to one provider, the CMS has indicated that it is unfair to prolong audits, unless the provider has not cooperated.[120]

10.8. Suspension of direct payment

136 There are two ways in which a provider might be paid for their services. The one is where the provider charges the patient directly. This is also known as "contracting out" and, typically, providers who are contracted out have patients

[118] Discovery submission, 18 July 2019 (Discovery bundle, p 40, para 12.15).
[119] Dr Broomberg (Transcript, 29 January 2020, p 143, lines 1 - 4).
[120] Ms Phaswane (Transcript 1 of 2, 30 July 2019, p 50, line 16 - p 52, line 29).

with disposable income who are able to pay the fees up front. The second is where the provider bills the scheme and not the patient. The scheme then pays the provider directly. This is also known as direct payment and providers who are on direct payment arrangements may have contracts with the schemes (in the form of preferred provider agreements, network agreements or designated service provider agreements) or they may not.

137 Where a scheme is concerned about possible FWA, it may stop making direct payments to a provider pending the completion of an investigation.

138 The practice of suspending direct payments to providers has two overriding consequences of relevance to the Inquiry. These are:

138.1 The provider has to charge their patients directly. If the provider's patients are not accustomed to this or fall into a socio-economic bracket where they are unable to pay immediately, the provider is unlikely to be paid. If the provider insists on payment from the patient, which of course they are entitled to do, and the patient is unable to find the funds to pay upfront, the patient will forsake the service or go to another provider who is prepared to claim directly from the scheme. The reality is that providers who are placed on indirect payment run the real risk of losing their patients and their income.[121]

138.2 The second problem is that it seems this practice is likely to affect Black providers disproportionately:

[121] Dr Chabalala (Transcript 1 of 3, 29 July 2019, p 72, lines 6 - 7).

> "*One, we understand the demographics of black people or black patients because once they rely on a medical aid, it is very difficult in their circumstances to can say they will go and get cash somewhere to come and pay you. That is the first thing. Second thing is, some of the patients which we have, we had this patient before they joined the medical aid, so when they decide to join the medical aid, they have seen that as a means to can look after their health rather than to can say I will go into my pocket and pay. That is the second thing. Thirdly, yes, the patient will move or change the providers if you go and tell them that you need to pay me, then I can pay you, then your medical aid will refund you. It is very inconvenient to most patient to say, when I come I need the treatment. I didn't have money. And even if I go and pay you and wait for the money, I'm not going to go to the scheme, and they give me that money today. It is going to take a week or two depending on the processes which the particular schemes follows.*"[122]

139 In some instances, a provider may provide the service without charging the patient:

> "***ADV WILLIAMS**: But did, is it because your patients are not able to pay you directly, I am trying to under why are using the practice reserves?*
> ***DR SEECO**: They can't because when I try to introduce that then I realise that they will be in a posit-, they will leave me, they will leave the practice because they wouldn't actually afford to come to my practice if I will want cash from them. So in the light of that challenge I then said okay let me just sacrifice, have them, look after them whilst in the meantime pursuing this, this, this case.*"[123]

140 The general view is that being placed on indirect payment means that "you are literally saying to the doctors, they must close business..."[124] The Panel

[122] Dr Chabalala (Transcript 1 of 3, 29 July 2019, p 59, lines 6 – 18).
[123] Dr Seeco (Transcript 1 of 3, 29 July 2019, p 89, lines 6 - 14).
[124] Mr Sithole (Transcript 2 of 3, 29 July 2019, p 43, line 12 - 13).

was informed that the withholding of payment "affects the doctors' income and cash flow. It has led to providers losing their practices and other assets. It is alleged that it has led to some of the doctors committing suicide."[125]

141 In addition to the prejudicial consequences of indirect payment, providers also raised concerns about the process leading up to the suspension of direct payments.

141.1 In one instance, the scheme had requested confidential patient information, which the provider refused to provide. The provider then approached the HPCSA for advice about how to handle the request. The HPCSA suggested that she write a brief report for each patient rather than submitting the treatment records. She submitted these reports, together with affidavits from some of her patients who refused to sign the consent form. In response, Medscheme placed her on indirect payment.[126]

141.2 Providers complained that they were informed about the suspension of payments to them at the same time as they were told they were being investigated or audited. There was a sense of being found guilty and punished without an opportunity of being heard. This also gave providers little time to prepare for the financial impact that this would have.[127] The Panel was informed as follows:

[125] IPAF submission, 18 July 2019 (Discovery bundle, p 3222).

[126] Dr Zwane (Transcript 1 of 3, 29 July 2019, p 43, lines 20 – 23). See also: Unnamed speaker (Transcript 1 of 3, 29 July 2019, p 57, lines 15 – 19) and Unnamed speaker (Transcript 2 of 3, 29 July 2019, p 46, lines 11 – 14).

[127] Dr Kalanda (Transcript, 29 September 2019, p 3, lines 10 – 14), where Dr Kalanda describes himself as the "owner of first Black owned Radiology Practice in Limpopo Province". See also: Medscheme third supplementary submission, 26 August 2019, letter from Medscheme to Dr Kalanda

> "*Many HCPs simply cannot require of patients to pay them directly and claim then back from their schemes. The very reason why people have medical scheme cover is to assist with the payment that would not ordinarily be possible for people to make out of pocket. Changing one's way of practice in a few weeks are also extremely difficult -- patients may be used to not having to pay cash at that practice. Also, whilst this may be possible for consultation fees, very few patients can cover the cost of procedures out of pocket.*"[128]

142 The Panel heard evidence that providers were asked for extensive information, much of which would not readily be available to a provider, the scheme would suspend the payment of claims directly to the provider.[129]

143 In one instance, a provider informed the Panel about the circumstances leading to the suspension of direct payments.[130] In May 2019 Dr Thokoane received a letter from Medscheme informing her that:

> "*an analysis had been performed in respect of my practice with preliminary findings to the effect that: (a) I am state employed; (b) claims submitted are extremely high for someone in a different province to my location; and (c) that an extremely high volume of claims are submitted on Sundays.*"[131]

144 Medscheme asked Dr Thokoane to provide it with:

> "'*comprehensive' patient records in order to verify services for the period beginning May 2017 to May 2018, proof of my permission to*

(Medscheme bundle, p 3200 - 3201), in which letter Medscheme, on behalf of Bonitas, informs the practitioner of the commencement of the audit process as well as the almost immediate suspension of direct payments.

[128] Klinck submission, undated, p 4, para 3.1

[129] Ms Phaswane (Transcript 1 of 2, 30 July 2019, p 42, line 10 - p 43, line 22).

[130] South African Medical Association ("**SAMA**") submission, 12 July 2019, affidavit of Dr Thokoane, p 1115 - 1119, paras 5 - 9.

[131] SAMA submission, 12 July 2019, Affidavit of Dr Thokoane, p 1115 - 1117, para 5.

work outside of the public sector and various purchase orders. Medscheme alleged that it is entitled to patient records by virtue of Regulation I SJ(2)(c) of the Medical Schemes Act, which your Committee will no doubt knows only applies in the case of a managed health care organisation or a health care provider in terms of a contract entered into pursuant to Regulation 15A, i.e. a managed health care arrangement. I was furthermore advised that should I fail to furnish the information within 10 days, a decision to offset the amount reportedly owed would be made in my absence."

145 Dr Thokoane did not respond to the request, apparently in part due to concerns about patient confidentiality. Dr Thokoane argued that "[i]n this regard, Regulation 15J(2)(c) does not apply to me, as I am not a managed healthcare provider."[132]

146 Medscheme followed up with Dr Thokoane on 7 June 2019, informing her that–

"*…as a result of my failure to furnish them with the documentation within 10 days of receipt of their letter, Medscheme has concluded that I owe them an amount of R3 475 898.00. Furthermore, I was advised that direct payment to my practice would be suspended during the period of recovery.*

Medscheme thus concluded their investigation without ever consulting me or granting me an adequate opportunity to respond to the allegations. Furthermore, the letter is silent on precisely how the amount allegedly owed was calculated. I thus contacted Medscheme to inquire as to the basis of their allegations, but received no substantive evidence of allegedly erroneous claims other than: (a) a spreadsheet of claims with a column marked "Gauteng" as proof that my practice is located in Gauteng; (b) an unsigned official document with several errors pertaining to my residential address, but no proof

[132] SAMA submission, 12 July 2019, Affidavit of Dr Thokoane, p 1117, para 7.

regarding the physical address of my practice; and (c) a section marked "Employment -- GOV as proof that I am state employed.
Your Committee will no doubt appreciate that the aforementioned documents in no way constitute proof of Medscheme's allegations or their quantification. Had Medscheme allowed me an opportunity to respond, I would have advised them that: (a) I am not in the employ of the state, nor was I at the time of the review period; (b) my practice is located in the Free State Province and has been for the last 20 years; (c) Medscheme cannot simply conclude that a high volume of claims on Sundays is conclusive evidence of any irregularity; and (d) I am not a managed health care provider and would thus be ethically and legally obligated to obtain written informed consent from my patients to the disclosure of their records. I have since addressed a letter to Medscheme to this effect and obtained the assistance from the South African Medical Association going forward. I am still waiting for a response from Medscheme to my letter."[133]

147 According to Elsabe Klinck and Associates (Pty) Ltd ("**Klink**" or "**Elsabe Klinck and Associates**"), the suspension of direct payment is one of the most serious threats to the providers, with the result that:

"*...the very simple financial question any practice, guilty or not, faces is: "can I survive without being paid at all in a month, or for 1 week, 2 weeks...In today's depressed economic times, the answer mostly is: "no, I cannot go without that payment". They then make a simple calculation: "if I give up, let's say 20% of my weekly income from this funder by 'repaying' them, I will still have 80%, which is way better than having nothing". It is in these circumstances where many clients sign AODs, or agree to claw-backs.*"[134]

[133] SAMA submission, 12 July 2019, Affidavit of Dr Thokoane, p 1117 – 1119, paras 7 - 9.
[134] Klinck submission, undated, p 3, para 3.1.

10.9. Disclosure of confidential patient information

148 As part of a FWA audit, schemes request information about a patient in order to verify the provider's claims. A common request, for time-based disciplines and sometimes others, appears to be that of a patient's clinical notes – which obviously contain confidential health information. It appears that the schemes use the patient's clinical notes to:

148.1 determine if a service was provided at all;

148.2 determine if the length of the service was justified;

148.3 determine if a particular medicine was dispensed; and

148.4 determine if the diagnosis matches the treatment claimed.

149 Providers maintain that the requested information may be confidential, and, in such circumstances, they are precluded by law from releasing such information.[135]

150 The providers argued that (i) they are prohibited from releasing their patients' confidential information and (ii) they are not parties to the contract between the scheme and the patient, with the result that the consent given by the patient to the scheme, cannot be said to be consent given by the patient to the provider.

[135] Adv Bhuka (Transcript, 27 January 2020, p 59, line 27 – p 60, line 5).

151 The Panel received evidence of providers' concerns that releasing confidential information is a breach of their ethical and legal obligations. Their non-compliance with this obligation would be a breach that could trigger sanctions both by the patient and their regulatory body.

152 While the providers are entitled to release the information with the patient's consent, there is reluctance to do this. This is so partly because of the concerns raised about the relationship of trust between the provider and the patient (which, as we discuss below, is particularly important in the context of mental health specialists). The providers also maintain that it is not their responsibility to obtain this consent from the patient. It is the duty of the scheme to obtain such consent.[136]

153 The ultimate difficulty is that, even if the provider agrees to seek the patient's consent to release their confidential treatment records, if the patient refuses such consent, the provider cannot prove their claim.

10.10. Investigations triggered by coding issues

154 Administrators and schemes may use patterns of incorrect or anomalous billing codes as a basis on which to investigate a provider.

155 The difficulty with the requirements placed on practitioners regarding identifying and using the correct codes is that there "is no standard approach to the coding of treatment/interventions and codes that do exist have not been

[136] *Ibid*.

updated which allows for the unilateral introduction of new codes, changes in coding behaviour and, in some cases, misuse of codes."[137]

156 The confusion regarding coding is a longstanding issue in the industry. The history of the problem is described in detail in the report of the Health Market Inquiry conducted by the Competition Commission in 2019.[138] We do not traverse that history but note that today there is a multiplicity of ways in which codes – and their associated prices – may be determined.[139] Coding is integrally linked to prices; each activity performed by a practitioner has to be labelled. This is the process of coding:

> "*Clinical coding translates medical information of a patient's interaction with healthcare providers into alphanumeric codes. It provides a form of standard communication that identifies which procedures, diagnoses or services have been delivered. Codes form the basis on which prices are determined.*"[140]

157 Codes represent the complexity or time inherent in a service, among other factors. Based on these factors, a price is attached to the code. A code thus:

> "*[T]ranslates medical information of patient's interaction with health care providers into alpha numeric codes. It provides a form of stand (sic) communication that identifies which procedures, diagnosis or services have been delivered. So, codes form the basis in which tariffs are determined.*"[141]

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[137] The Competition Commission's Health Market Inquiry "Final Findings and Recommendations Report", September 2019, Chapter 6: Competition Analysis for Practitioners ("**Health Market Inquiry**"), p 134, para 5.4, available at http://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf.
[138] Health Market Inquiry, p 144, paras 56 - 57.
[139] Health Market Inquiry, p 144, paras 56 – 58.
[140] Health Market Inquiry, p 144 - 145, para 59.
[141] Ms Ramokgopa (Transcript 3 of 3, 29 July 2019, p 21, lines 14 - 18). See also: Ms Phaswane (Transcript 1 of 2, 30 July 2019, p 57, line 22 - p 59, line 15).

158 In every invoice submitted to a scheme, the provider will include the relevant code. The *status quo* regarding codes, however, is far from clear:

> "*New interventions have not been given standardised codes, old interventions still carry sometimes outdated RVUs, codes have been unilaterally suggested and accepted or not by funders and practitioners and some associations have unilaterally redefined codes.*"[142]

159 This ambiguity creates difficulties for providers. The Panel heard evidence that providers would use a code that they thought was correct and in good faith but which the schemes flagged as inappropriate billing. In other instances, a provider may not know how to allocate a code to a particular service or where there is more than one specialist.[143] According to the complainants, while this could be rectified through a discussion and explanation of the therapeutic service and the reasons therefore, the schemes would take an undifferentiated heavy handed approach during an investigation or audit.[144]

10.11. Probes / entrapment

160 Some schemes will send probes or undercover forensic agents into a provider's practice to determine whether there is FWA. Complainants provided evidence that in the cases concerning probes (i.e. agents of funders entering practices or facilities as fake patients), there was a tendency to entrap the

[142] Health Market Inquiry, p 145, para 62.
[143] Dr Zwane (Transcript 1 of 3, 29 July 2019, p 49, line 22 - p 50, line 15).
[144] Klinck submission, undated, p 4 - 6.

provider, persisting until they are successful.[145] The encounters would be recorded secretly.

161 Probes would, *inter alia*, ask providers to (a) write sick certificates, (b) dispense medication; or (c) allow a member's family to be treated on their medical scheme membership where the family were not members or dependents.

162 The probes are allegedly "quite skilled" in getting the providers to comply with their illicit requests.[146] The result was that providers had a sense of being set up and then threatened with reporting to the relevant regulatory body:

> "*In one matter, where out of six probes two were successful in getting the doctor to provide sick certificates, and although the evidence proves no loss to the scheme, and, at most, proves a contravention of the HPCSA Ethical Rules, the funder wanted at least 20% of all claims submitted to it over a three year period, to be paid back. They threaten to report to HCP to the HPCSA, unless a substantial offer is made. Out of fear for what such an investigation could mean, the HCP agreed to pay back 20% of all claims. This also happens where the HCP him/herself did not see the probes, but locums did.*
> *These are good examples of the Reid methodology, the assumption is that where a person has committed a wrong they would necessarily be guilty of much more.*"[147]

[145] Klinck submission, undated, p 7, para 3.2.3.
[146] Klinck submission, undated, p 8, para 3.2.3.
[147] *Ibid*.

CHAPTER FOUR: THE RESPONSE FROM SCHEMES AND ADMINISTRATORS

11. INTRODUCTION

163 The response of GEMS, Discovery and Medscheme are summarised, like the complaints, in two parts: first is the response to the allegations of racial discrimination; and secondly the responses to the complaints of unfairness.

164 We note that other than the three aforementioned entities, the Panel also received written submissions and oral evidence from The South African Police Service Medical Scheme ("**Polmed**") and Bonitas Medical Scheme ("**Bonitas**"). We also touch on Polmed and Bonitas's evidence where relevant. However, we note that both of these schemes are administered by Medscheme and accordingly Medscheme's evidence is relevant to the position of these two schemes as well.

165 The schemes provided comprehensive responses to many of the complaints. In many of these responses, it is clear that there was a sufficient basis on which to initiate investigations. At other times, the responses from the schemes acknowledged or evidenced the content of the complaints. As the Panel was not mandated to make findings in respect of individual complaints, we do not detail the complaints and responses. However, we note the importance of these explanations, which paint a clear picture of the problems facing the industry.

166 It is clear that FWA is profoundly serious, has a decidedly negative impact on members and schemes, and there is a constant need to address it. That, however, is not the only issue with which we are concerned. We accordingly focus our summary of the schemes and administrators' responses on how their risk management systems work internally and are implemented. We also focus on their responses to the unfair discrimination / racial profiling claims as well as the claims of general unfairness in the implementation of section 59(3) of the Act.

12. RACIAL DISCRIMINATION

12.1. Discovery's response to allegations of race discrimination

167 Discovery, like Medscheme and GEMS, at first responded to the allegations of racial discrimination by explaining that their risk management system is "race blind" and therefore it is not possible for Discovery to engage racial discrimination.[148] It explained that:

> *"At no stage does DH ever use race, or any other demographic factors in identifying potential fraud cases. The statistical analysis used to identify high risk practices relies on a series of objective factors seen in the claims submitted by the practice. None of these factors are either directly or indirectly related to race. Once a practice is highlighted for potential investigation, it is identified using the industry standard practice number (the practice code numbering system*

[148] Discovery submission, 18 July 2019 (Discovery bundle, p 4), where Discovery claimed that there is no evidence of any claims of complaints against them. However, there were several allegations made about Discovery in particular, See for example: Dr Zwane (Transcript 1 of 3, 29 July 2019, p 41, lines 8 - 13; p 44, lines 13 - 14; p 48, lines 3 - 21; p 53, line 16 – p 55, line 5 and p 56, lines 12 – 18). See also: Dr Chabalala (Transcript 1 of 3, 29 July 2019, p 70, line 11 - p 71, line 11), Dr Seeco (Transcript 1 of 3, 29 July 2019, p 86, line 15), Ms Ramasolo (Transcript 2 of 3, 29 July 2019, p 2, lines 9 - p 3, line 9; p 6,line 20 – p 7, line 7; p 9, lines 20 – 23 and p 13, line 1 -p 14, line 6) and Dr Diale (Transcript 2 of 3, 29 July 2019, p 21, lines 5 – 22), Mr Maebane (Transcript 2 of 3, 29 July 2019, p 28, line 25 - p 33, line 7, p 36, line 11 -p 37, line 16); and Unnamed speaker (Transcript 2 of 3, 29 July 2019, p 47, lines 14 - 19; p 49, lines 4 - 8 and p 54, line 23 – p 55, line 1).

("PCNS"), administered by the Board of Healthcare Funders). The PCNS system contains no race or other demographic identifiers for any practice. DH has no race information on its administration system".[149]

168 Discovery commissioned a law firm to –

"assess the integrity of its forensic processes and systems used in practice audits, in light of the allegation that medical schemes are guilty of racial profiling by targeting black and Indian medical practitioners in fraud investigations involving the submission of claims for payment."[150]

169 The law firm concluded that:

169.1 For the purpose of the statistical analysis of claim patterns, all practitioners are only identified by their PCNS number which are race and gender neutral. In other words, the database to which the Discovery Risk Rating Tool ("**RRT**"), this being a statistical tool which we described in more detail below, is applied does not racially classify practitioners;

169.2 There is no evidence that there is racial profiling when the RRT is applied;

169.3 There is no evidence of racial profiling as a result of complaints received through tip-offs; and

[149] Discovery submission, 18 July 2019 (Discovery bundle, p 6, para xvi).
[150] Discovery submission, 18 July 2019, Harris Nupen Molebatsi Report (Discovery bundle, p 46).

169.4 Bias in the investigation process is detectable and disincentivised – it is therefore "unlikely that racial profiling, even if inadvertent, occurs in these investigations".[151]

170 Discovery attended the oral hearings and made submission in response to the allegations made against it at such hearings. The allegation that Discovery engaged in forms of racial discrimination was common and Discovery maintained that this allegation was untrue.[152] It generally denied the claim and called into question the method on which such a claim was based. For example:

170.1 When SAOA submitted that the overwhelming majority of practitioners who came forward for assistance in the FWA investigations were Black and Indian, Discovery pointed out that SAOA had only been involved in eight investigations and therefore caution should be exercised in interpreting small samples that may not be representative;[153]

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[151] Discovery submission,18 July 2019 (Discovery bundle, p 7). See also: Discovery submission, 18 July 2019, Harris Nupen Molebatsi Report (Discovery bundle, p 84, para 12.27), where Harris Nupen Molebatsi reason that an investigator would know the race of the person he or she is investigating and reason as follows:

> "*… if an investigator sought to racially profile the healthcare provider he or she was investigating, this would be detected. Firstly, if an investigator is avoiding certain cases, this will be reflected in the age analysis of that case. Secondly, if an investigator was being particularly lenient on one racial group of healthcare provider for example, by closing cases without adequately investigating them, he or she would have an anomalous 'valid to invalid' case ratio when compared to his/her peers which will negatively impact their performance incentive. Thirdly, although cases are assigned to individual investigators, the investigators are supervised and work in a team with / of other investigators, it is reasonable to assume that, as such, it would be difficult to conceal a consistently biased approach to investigating*."

[152] See for example: Discovery submission, 18 July 2019, (Discovery bundle, p 6, para xvi).

[153] Discovery third supplementary submission, September 2019, "Responses to points raised during the session of the public hearings of the Section 59 Investigation (20 August 2019 - 29 August 2019)" (Discovery bundle, p 2722, para 6.2).

170.2 When Elsabe Klinck and Associates alleged there was unfair targeting of black practitioners in conducting on-site visits and calling for meetings with forensic investigators, Discovery responded by stating that this allegation was false, and their investigators follow "company policy and guidelines";[154]

170.3 When Solutionist Thinkers alleged that Discovery engaged in racial profiling in its fraud investigation process, Discovery denied that this was true and maintained that Solutionist Thinkers had "provided no evidence to substantiate this allegation";[155] and

170.4 When IPAF alleged that three quarters of doctors investigated are Black, Discovery denied that, maintaining that "IPAF have provided no evidence in support of this statement."[156]

12.2. GEMS' response to race discrimination

171 GEMS, as with Discovery and Medscheme, submitted that its risk management system was race blind. GEMS's first submission to the Panel was that:

171.1 Its claims data which is subjected to analytics does not include the race or other demographic information of healthcare practitioners; and

[154] Discovery third supplementary submission, September 2019, "Responses to points raised during the session of the public hearings of the Section 59 Investigation (20 August 2019 - 29 August 2019)" (Discovery bundle, p 2720, para 3.1).
[155] Discovery second supplementary submission, August 2019, "Response points raised during the sessions of the public hearings of the Section 59 Investigation (29 July 2019 to 2 August 2019)" (Discovery bundle, p 2682, para 1.1).
[156] Discovery second supplementary submission, August 2019, "Response points raised during the sessions of the public hearings of the Section 59 Investigation (29 July 2019 to 2 August 2019)" (Discovery bundle, p 2700, para 8.1).

171.2 The PCNS numbers for healthcare providers do not record race.[157]

172 GEMS further submitted that it is a scheme with beneficiaries who are overwhelmingly Black; its employees are overwhelmingly Black; and it is a transformative organisation which pays careful attention to ensuring it procures from suppliers who have high broad-based Black economic empowerment scores.[158] GEMS did not say as much but it appeared troubled by the possibility, and therefore unwilling to accept, that an organisation which prides itself on protecting and promoting Black people could simultaneously be engaged in racially discriminatory conduct. When the Panel put to one of the GEMS witnesses a version of this issue the following exchange occurred:

> *"**ADV TEMBEKA NGCUKAITOBI**: ...If GEMS are right in its claim that it is at the forefront of transformation, what I am not saying this is an accusation. But I am just saying any reasonable person would have expected the organisation that embraces transformation to be at the forefront of investigating and dealing with the racial discrimination allegations.*
>
> ***DR GUNVANT GOOLAB**: Ja.*
>
> ***ADV TEMBEKA NGCUKAITOBI**: Now why do I not find anywhere where you say, look these things came up. This is what we did. We asked the people that we work with. Deal with this, give it priority.*
>
> ***DR GUNVANT GOOLAB**: Ja.*
>
> ***ADV TEMBEKA NGCUKAITOBI**: I take it there are meetings obviously but I just do not see any tangible steps that you have taken over the years. What I see is a lot of rebuttal that there is no racism but the fact that you have investigated this only after the CMS investigated it. It is really a problem for me.*

[157] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 90, para 11.14.1).
[158] GEMS power point presentation, 28 January 2020, slide 12.

> ***DR GUNVANT GOOLAB**: Ja. No and we accept the point. Chairperson the best way I can attempt to articulate it is that our position is that if you speak to all of the leadership of all of these organisations including the ones, we have recently raised the matter. They will communicate to you that GEMS engage in a very fair and progressive manner and the accusation is less against GEMS."*[159]

12.3. Medscheme's response to race discrimination

173 Medscheme, as with the other schemes, denied the allegation of racial profiling:

> *"From the outset Medscheme would like to categorically deny that we perform any form of racial profiling when assessing or auditing healthcare claims. We do not collect or store any information on the racial demographics of medial scheme members or of the healthcare providers and facilities we pay on their behalf."*[160]

174 Medscheme submitted that practitioners are identified by their practice numbers, which practice numbers Medscheme uses for the purposes of assisting in detecting or preventing fraud.[161] These practice numbers do not contain racial demographics:

> "*We do not have the racial demographics of the suppliers of health services that we pay on behalf of members as there would be no reason for us to keep such information. It is totally irrelevant for purposes of processing or paying a healthcare claim. There is also no legal obligation to do so.*"[162]

175 Rather, Medscheme argues, the practice number provides Medscheme with:

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[159] Dr Goolab (Transcript, 28 January 2020, p 17, lines 4 - 27).
[160] Medscheme submission, 18 July 2019 (Medscheme bundle, p 6, para 2).
[161] Medscheme submission, 18 July 2019 (Medscheme bundle, p 14).
[162] Medscheme submission, 18 July 2019 (Medscheme bundle, p 6, para 2).

"*the name geographic location, discipline and other relevant information of the entity claiming. It does not, however, inform us of the racial identity of the persons behind the practice.*"[163]

176 A number of complaints, approximately 67, were levelled against Medscheme by practitioners.[164] Some complaints levelled against Medscheme pertained to issues of racial discrimination, these complaints have been met with the following responses:

176.1 A general practitioner, who was working alongside white colleagues, complained that the practitioner was the only person subject to "claw backs" and that the practitioner's white counterparts did not face similar scrutiny from Medscheme.[165] Medscheme as well as Bonitas, who is administered by Medscheme, denied that the said practitioner was targeted based on race and reasoned that the practitioner has been detected as a result of a high [redacted]) score, which forms part of Medscheme's forensic analysis toolkit.[166]

176.2 A hospital group alleged that Medscheme had targeted the hospital group because it was black-owned.[167] Medscheme denied the allegations and stated that, amongst others, the hospital was a juristic

[163] Medscheme submission, 18 July 2019 (Medscheme bundle, 18, para 5).
[164] Medscheme third supplementary submission, 26 August 2019, Complaints from practitioners (Medscheme bundle, p 1085 – 3941).
[165] Medscheme third supplementary submission, 26 August 2019, Complaints from practitioners (Medscheme bundle, p 2914 – 2921).
[166] Medscheme third supplementary submission, 26 August 2019 (Medscheme bundle, p 1106 - 1107). See also: Bonitas submission, 27 September 2019, Annexure S (Bonitas bundle, p 610 – 617 and 811 - 812).
[167] Medscheme third supplementary submission, 26 August 2019, Complaints from practitioners (Medscheme bundle, p 2025 – 2245 and p 2671 – 2678). See also: Vishnu Rampartab and Mr Sunny Govender (Transcript, 25 September 2019, p 66, line 2 – p 144, line 18).

entity and could therefore not be assigned a race.[168] Bonitas responded that the matter was, at that time, subject to litigation.[169]

177 In addition, Medscheme has raised a number of queries in relation to Dr Kimmie's report, which is dealt with in Part 2 of this Report. Suffice it to say that Medscheme throughout its submissions denies that their processes, including their practice number identification process, result in any form of racial discrimination, to this end:

"*Medscheme does not racially profile practitioners*" [170]

13. GENERAL UNFAIRNESS

13.1. Discovery response to allegations of general unfairness

(i) *Overview of Discovery's risk management system*

178 Discovery administers 19 medical schemes, including Discovery Medical Scheme. Discovery receives and processes approximately 275 000 claims per day, with 94% of these claims being processed immediately and paid within 4 - 5 working days.[171] The standard approach is to pay claims based on automatic rules and then investigate potential FWA retrospectively.[172]

[168] Medscheme third supplementary submission, 26 August 2019, Complaints from practitioners (Medscheme bundle, p 1088 - 1089).
[169] Bonitas submission, 27 September 2019, Annexure G (Bonitas bundle, p 531 – 571 and p 784).
[170] Medscheme submission, 18 July 2019 (Medscheme bundle, p 22, para 5).
[171] Discovery submission, 18 July 2019 (Discovery bundle. p 5, para ix and p 16, para 4.2).
[172] Discovery submission, 18 July 2019 (Discovery bundle, p 5, para xi).

179 Discovery's Fraud and Forensic Unit (also referred to as "Group Forensics") employs 44 professionals to investigate FWA, and more than 55 additional employees are indirectly employed in support of Discovery's FWA activities.[173]

180 Potential FWA cases are identified through a combination of tip-offs from members, practitioners, employees and other stakeholders, and an application of what Discovery referred to in its written submission as its "statistical algorithms and risk rating tools".[174] Simply put the two methods that Discovery uses to detect FWA are tip-offs and using its statistical analytical tool called the RRT.[175] The RRT is an algorithm (or algorithms), which Discovery developed and now owns. The tip-off mechanism and RRT will be explained in more detail below – where Discovery's system of detection is described.

181 Once cases are identified through the tip-off system or the RRT, they are placed on the Discovery's case management system called [redacted]. According to Discovery cases on the [redacted] system are:

> *"prioritised for investigation using objective criteria that have no relation to the race or other identifying factor of the practitioner. The primary prioritisation factor is the source of the complaint, with member complaints being accorded highest priority. The secondary prioritisation factor is the potential size of the fraud and is impact on client schemes."*[176]

[173] Discovery submission, 18 July 2019 (Discovery bundle, p16, para 4.5).
[174] Discovery submission, 18 July 2019 (Discovery bundle, p18, para 5.2).
[175] Discovery submission, 18 July 2019, Harris Nupen Molebatsi Report (Discovery bundle, p 65, para 6.3).
[176] Discovery submission, 18 July 2019 (Discovery bundle, p 19, para 5.5).

182 Cases are allocated to individual investigators based on the investigator's expertise and workload. Investigators will not always engage with practitioners during the investigation at the same stage of an investigation - the stage at which a practitioner gets engaged depends on the specific facts of the matter.[177] A practitioner may be engaged early on in the investigation to obtain specific information for verification purposes and in other instances the practitioner is engaged when the investigation has largely been completed.[178]

183 Discovery's investigators are required to comply with "Discovery Group Forensic Services Policies and Procedures Health Investigations" policy ("**the Discovery Investigation Policy**").[179] The Investigation Policy requires all investigations to be reasonable "to ensure that innocent individuals are not investigated".[180] It also requires investigations to be completed "in as short a period as possible" and states that "it is not acceptable to suspend payment to a practice as a result of an investigation and then let it drag on for months without informing the practice what the investigation is about"[181]. Further, it provides that investigators "should never question a health care provider's clinical judgment but limit all questions to the issue at hand i.e. the payment of benefits to a specific service provider".[182] The Discovery Investigation Policy also allows for the investigators to go undercover or to act as "probes"

[177] Discovery submission, 18 July 2019 (Discovery bundle, p 21 - 22, para 8).
[178] *Ibid*.
[179] Discovery submission, 18 July 2019, the Discovery Investigation Policy (Discovery bundle, p 115).
[180] Discovery submission, 18 July 2019, the Discovery Investigation Policy (Discovery bundle, p 116, para 1).
[181] Discovery submission, 18 July 2019, the Discovery Investigation Policy (Discovery bundle, p 117, para 2).
[182] Discovery submission, 18 July 2019, the Discovery Investigation Policy (Discovery bundle, p 118, para 2).

[183] – in this regard the Policy states that the "purpose of the probe is simply a tool to confirm allegations. It must be clearly understood that the use of a probe by medical schemes (*sic*) may be controversial and all caution must be taken not to be over-enthusiastic to avoid having charges instituted against the medical scheme/administrator."[184]

184 Where Discovery finds an irregularity following from an investigation then Discovery engages with the practitioner in order to reach an "agreed resolution of the issues at hand"[185]. Discovery indicated in its July 2019 submission that in the "majority of cases, a settlement agreement is reached in terms of which the practitioner/practice is afforded the opportunity to repay the amount of irregular claims to which a practice was not entitled but had already paid out."[186] This statement is not entirely accurate as it appears from the remainder of the submission and oral evidence by complainants and the Discovery CEO that the settlement process is a negotiation between Discovery and the practitioner and Discovery's negotiating position on the

[183] Discovery submission, 18 July 2019 (Discovery bundle p 24, para 10.4), which describes the essential elements of the undercover investigations as follows:

"10.4.3. The undercover investigator ("probe") is a DH employee, who is instructed to present him or herself at a particular practice for a medical consultation, or some or other service from the practice;
10.4.4. The investigator is instructed to complain of some or other symptom, or medical condition, and to receive services from the practitioner in question. It is important to note that the probes do not really suffer from the symptom or disease in question – they are instructed to dissemble in this regard. They are also instructed not to ingest any medication dispensed to them, and to place any evidence obtained in evidence bags provided to them;
10.4.3. In appropriate cases, the investigators are equipped with recording devices and make video or audio recordings of their interactions with the practitioner in question;
10.4.4.The investigators are instructed to retain appropriate evidence and provide the same to DH."

[184] Discovery submission, 18 July 2019, Discovery Investigation Policy (Discovery bundle, p 118, para 2).
[185] Discovery submission, 18 July 2019 (Discovery bundle, p 23, para 8.7).
[186] *Ibid*.

amount it claims is based on an estimate[187] of claims that may have amounted to similar FWA claims (making use of the practitioner's 3 year historic claim records).

185 The settlement agreement is structured as an AOD where the practitioner pays back an agreed amount over a period of time without interest.[188]

186 Discovery estimates that as a result of its anti-fraud and forensic activities it has recovered approximately R [redacted] in the past 7 years for Discovery Medical Scheme and approximately R [redacted] for all their client schemes.[189] Discovery's data shows that approximately 33% of "proven fraud and billing abuse incidents are attributable to health professionals, across all disciplines".[190] During 2018, Discovery recovered approximately R[redacted] – of this "R[redacted] was recovered from health professionals" and this "indicates that recoveries from health professionals presently account for almost 30% of total recoveries on an annual basis".[191]

187 Discovery also submits that there is a so-called "halo effect" of their risk management system – those who may be contemplating FWA choose not to do so in reaction to the visible action taken by Discovery.[192] In this regard, Discovery submits that there is an annual savings of approximately R [redacted]

[187] Discovery submission, 18 July 2019 (Discovery bundle, p 32, para 11.1).
[188] Discovery submission, 18 July 2019 (Discovery bundle, p 23 – 24, para 8.8.2).
[189] Discovery submission, 18 July 2019 (Discovery bundle, p 5, para vii).
[190] Discovery submission, 18 July 2019 (Discovery bundle, p 12, para 2.6).
[191] Discovery submission, 18 July 2019, (Discovery bundle, p 12, para 2.9).
[192] Discovery submission, 18 July 2019 (Discovery bundle, p 12 – 13, para 2.10).

[redacted] attributable to the halo effect and argues that there is a "wider economic benefit of reducing fraudulent activity".[193]

(ii) *Discovery's approach to detection*

188 As explained above Discovery identifies FWA cases for investigation through two methods: the first is as a result of a tip-off and the second is through retrospective statistical analysis of claims data.[194]

189 In relation to tips offs, Discovery has several avenues available to any person, including employees, who are able to lodge an anonymous complaint against a practitioner. There are multiple sources of reporting, from a variety of stakeholders, through the use of a designated hotline – directly to Discovery in person, via telephone or in writing alternatively through the Medical Forensics Information Sharing Initiative or following a link on a member's electronic statement.[195]

190 An administrator within Group Forensics registers the complaints received, via any of the tip-off options, on the [redacted] system. Where a tip-off does not relate to a possible FWA practice by an HCP the matter is referred to another department within Discovery.[196] Discovery guarantees that all cases reported

[193] *Ibid*.
[194] Discovery power point presentation, 29 January 2020, slide 31.
[195] Discovery submission, 18 July 2019, Harris Nupen Molebatsi Report (Discovery bundle, p 70 – 71, para 8.1).
[196] Discovery submission, 18 July 2019, Harris Nupen Molebatsi Report (Discovery bundle, p 71, para 8.3).

through tip-offs will be investigated and feedback will be given to known complainants. This is in order to encourage people to report possible FWA.[197]

191 In relation to the retrospective statistical analysis, Discovery explained that it makes use of retrospective (or historic) data analytics, including the use of algorithms developed for each health professional practice type. The algorithmic approach seeks to identify statistical 'outliers' and irregularities in claim trends.[198] The risk score for each HCP is based on up to 30 (the exact number varies by practice type) risk metrics which do not include the HCPs race or geographic location.[199]

192 The RRT applies the algorithms to identify high risk practices. The RRT does not prove FWA but flags high risk practices or patterns. The RRT generates certain risk scores and a report knowns as the "Provider Risk Report" ("**Risk Report**").[200] The purpose of the RRT is to identify outliers. There are two

[197] Discovery submission, 18 July 2019, Harris Nupen Molebatsi Report (Discovery bundle, p 17, para 8.4).

[198] Discovery power point presentation, 29 January 2020, slide 31.

[199] Email correspondence from Discovery, 08 November 2019, "Description of the Risk Rating Tool Metrics as at 12 November 2019" (*confidential*) (Discovery bundle, p 3484 - 3494, para 1 – 30), which provides [redacted]

[200] Discovery power point presentation, 29 January 2020, slide 32. See also: Discovery submission, 18 July 2019, Harris Nupen Molebatsi Report (Discovery bundle, p 69, para 7.7). According to the Harris Nupen Molebatsi Report, a Risk Report can be generated for any provider at any time and includes the risk score associated with each metric, the payment distribution per month for a three year period, the top 25 procedural codes applied by the provider as compared to his or her peers, and other statistical information presented in graphs. The Risk Report contains the providers initials and surname as well as their discipline/practice group and their geographic location.

types of outliers – those HCPs with very high (relative to the national average for their discipline) risk scores; and secondly those HCPs whose score is very high (again relative to the national average for their discipline) on a particular metric (for example, the sick note on a Monday metric).[201]

193 As explained practitioners who are identified as outliers by the RRT are placed on the [redacted] system for investigation.[202] The [redacted] system contains approximately 3500 cases at any time (being cases identified for investigation by a number of methods but not all of which have been allocated to an investigator).[203]

194 Cases are manually transferred from the RRT to the [redacted] system – in other words it is not automated. The evidence demonstrated that it is in fact manually done by a manager reporting to Mr Marius Smit, Head of Forensics at Discovery.[204] The manager who transfers the cases is not aware of the name of the practitioner – all that is visible to such manager is the PCNS number (practice number), the discipline and the RRT score.[205] The factors which are used to determine if a case is transferred onto the [redacted] system are as follows:

194.1 The practitioners risk scores;

[201] Discovery submission, 18 July 2019, Harris Nupen Molebatsi Report (Discovery bundle, p 69, para 7.6).
[202] For any new anomalies, clinical and coding reviews are conducted. If these cases are still suspicious after this review, they are also loaded onto the [redacted] system (Discovery power point presentation, 29 January 2020, slide 34).
[203] Dr Kimmie's report, "Racial Discrimination in Identifying Fraud, Waste and Abuse: A Review of Processes and Outcomes", 18 November 2019, "Interview with Discovery Health", p 123. See also: Discovery submission, Dr Kimmie's report, "Interview with Discovery Health" (Discovery bundle, p 3394).
[204] Mr Smit (Transcript, 28 January 2020, p 90, lines 10 – 16).
[205] Mr Smit (Transcript, 28 January 2020, p 90, lines 20 – 25).

194.2 The space available on the [redacted] system;

194.3 Areas of interest (either clinical or financial practices) that may be identified by clinical or actuarial specialists;

194.4 The need to spread cases across the various disciplines; and

194.5 Areas of interests based on collective past experience of the forensic team.[206]

195 Discovery submitted that potential FWA cases are prioritised for selection and allocation on the [redacted] system using so-called "objective criteria" without reference to race or any identity factor of the practitioner.[207] Discovery explained that there was a "primary and a secondary prioritisation factor" – the primary prioritisation factor was the source of the complaint where member complaints are accorded the highest priority. The secondary prioritisation was the potential value involved and the impact on the schemes which were being served.[208]

196 Dr Broomberg, in his evidence to the Panel, explained that when it came to choosing which cases from the RRT (which generates the risk scores) should be placed on the [redacted] system (which may result in an investigation), the

[206] Dr Kimmie's report, 18 November 2019, "Interview with Discovery Health", p 126. See also: Discovery Bundle, p 3397.
[207] Discovery power point presentation, 29 January 2020, slide 34.
[208] *Ibid*.

process was not automated but rather involved an element of human judgement.[209]

197 During Discovery's oral testimony further nuance emerged regarding the manner in which Discovery use the RRT and the scores it generates. First Dr Broomberg explained that there are:

> "*ad hoc situations, so the regular channels are the two that I just described. From time to time, there will, you know somewhere in our system, either because there have been several tip offs, or several types of one practice, say in this instance social work, have been flagged, or for some other reason that has emerged from certain analysis, the senior team in the forensic unit will say, we should pro-actively study certain patterns among social workers in this instance.*"[210]

198 Later in Dr Broomberg's evidence he said that the above explanation was not "an accurate explanation of our process"[211]. He explained that the investigations relating to specific disciplines are not *ad hoc* but rather:

> "*I think another important criteria that is brought to bear in deciding which disciplines is [investigated] is, I said firstly the number of flags arising monthly, a second is that the senior leadership of the forensic division is monitoring from time to time, are we getting out of balance in investigating one or two or three disciplines? And so they are trying to also ensure balance so they would also say, social work has been a focus for three or four or five months or whatever, we should actually*

[209] Mr Mogapi (Transcript, 28 January 2020, p 50, lines 14-17). See also: Dr Kimmie's report, 18 November 2019, "Interview with Discovery Health", p 132 and Discovery bundle, p 3399, where Discovery explains that this "step is manual and includes an element of human judgement".
[210] Dr Broomberg (Transcript, 29 January 2020, p 74, line 25 – p 75, line 6).
[211] Dr Broomberg (Transcript, 29 January 2020, p 76, line 8).

make sure we are applying diligence to other as well so that would be another criteria."[212]

199 Bearing in mind Dr Broomberg's equivocal stance on this issue, Mr Smit was asked whether it was untrue that specific disciplines were given priority because of patterns observed by Group Forensics. In response he stated as follows:

"*I won't say it's untrue, you know so if you're looking at social workers we know through experience that what you will find in social workers is abuse of time code, so the pattern might be claiming more hours than what is in the particular –but that is –that is why a particular metric will apply to that discipline.*"[213]

200 Mr Smit later in his evidence confirmed that there may have been a focus on social work, physiotherapy and psychology in the past due to particular abuses within these disciplines that may have been familiar to Group Forensics.[214] He offered to make further information available to the Panel.

201 Discovery duly provided further information in a submission made after their oral evidence. In this submission, Discovery stated that "there is no targeting or profiling of any specific disciplines".[215] Discovery also provided an analysis of investigations per clinical discipline for 2012 to June 2019 and argued such analysis supported its statement that there was no targeting of particular disciplines.

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[212] Dr Broomberg (Transcript, 29 January 2020, p 78, lines 10 – 18).
[213] Mr Smit (Transcript, 28 January 2020, p 92, lines 15 - 20).
[214] Mr Smit (Transcript, 28 January 2020, p 90, line 12 – p 95, line 19). We note that we accept that only practitioners with high risk score in these disciplines would be added to the [redacted] system and investigated.
[215] Discovery fifth supplementary submission, 7 February 2020, p 5, para 6.

202 However, the data Discovery provided tells a different story. In our view it demonstrates that there was a focus on particular disciplines at particular times, as was explained in the oral evidence – albeit with some degree of defensiveness.

203 This view that there was a focus on particular disciplines at particular times is supported by the following: for general practitioners (the largest discipline) their figures show that about 13% of all general practitioners were investigated each year, with very little variation (high of 17, low of 11.6). In contrast to the lack of variation in the percentages of GPs who were investigated:

203.1 for physiotherapists the proportion of practitioners investigated is very stable from 2012 to 2016 (about 3.5%) but in 2017 the proportion increases to 5.8% and in 2018 increases to 11.9%. This is a 300% increase (from 2012-2016) to 2018;

203.2 for psychologists the proportion of practitioners investigated is at 2.5% from 2012 to 2014, but between 2015 to 2018 the proportion increases 4.2%. This is an increase of 70%;

203.3 for social workers the proportion of practitioners investigated is just under 2% from 2012 to 2015, but in 2016 the proportion increases to 4.8%, and then to 17% between 2016 to 2017. There is a clear and directed focus on social workers in the 2016-2017 period; and

203.4 for dieticians the average proportion of practitioners investigated from 2012 to 2017 is below 5%, but in 2018 this proportion increases to 10.6% (i.e. it more than doubles) in 2018.

204 We note that Discovery was often at pains to emphasise its so-called objectivity in using its RRT system, but during the oral testimony the strength of this assertion weakened and its appears that there was and is a fair amount of employee interaction with the RRT and the scores its generates, which introduces subjectivity, in order to give direction to which cases may or may not be investigated.

205 To be fair to Discovery it made this very concession in its answers to Dr Kimmie's questions, before it gave oral evidence, and it was probably not necessary in some of its written submissions to over-emphasise the "objectivity" of its systems. Discovery explained that "registering cases on the [redacted] that are found to be invalid are a waste of resources for the forensics team. Discovery therefore engages in ongoing refinements to ensure that only cases with a high probability of valid FWA are registered on the [redacted] system".[216] This confirms that Discovery uses its human capacity, by actively engaging with the data, to select cases that are most likely to be found to have committed FWA. This is an effective use of resources.

(iii) *Discovery's approach to investigation*

206 Once a case is prioritised using the method described above, it is automatically allocated by the [redacted] system to individual investigators. Allocation criteria include type of case and the workload of the particular

[216] Dr Kimmie's report, 18 November 2019, "Interview with Discovery Health", p 128. See also: Discovery bundle, p 3399.

investigator.[217] Once an investigator has been allocated a case, he or she knows the practitioners name and the associated details.[218]

207 The mode of investigation is determined by the nature of the potential FWA. Most investigations involve direct engagement with the provider to obtain further information and to review Discovery's findings.[219] Undercover investigations, in other words the use of probes, are reserved for small numbers of serious cases where Discovery believes this is the only method of confirming or excluding fraud.[220]

208 Discovery explains that information is requested from practitioners as part of its investigative process. It states that "administrative data" is requested, such as appointment records and purchase orders. Where clinical information is required, Discovery states that "the absolute minimum of such information necessary for the investigation is requested" and further that "the practitioner can always redact any information (s)he believes is sensitive."[221]

209 Discovery's assertion that practitioners can always redact information that they believe to be sensitive was not based on the evidence before the Panel. The Panel had seen copies of numerous letters that Discovery sent to practitioners where no such offer was made. During Discovery's oral evidence, Dr Broomberg was only able to point us to one letter where the

[217] Discovery power point presentation, 29 January 2020, slide 35.
[218] Mr Smit (Transcript, 28 January 2020, p 98, lines 10-15).
[219] Discovery power point presentation, 29 January 2020, slide 36.
[220] *Ibid*.
[221] Discovery power point presentation, 29 January 2020, slide 37.

express offer was made to a practitioner to redact patient information.[222] Dr Broomberg correctly explained that "there is no point in trying to *not* acknowledge that prior letters did *not* make the offer [to redact] explicit"[223] and that "in my view it should be done consistently … it should be done in every single letter. I would imagine that as of now it is being done in every single letter."[224] Dr Broomberg later in his testimony summed up Discovery's position as follows: "I think we've acknowledged that some of the information requested is not necessary. We have acknowledged that we should always pro-actively tell practitioners that they are free to redact and I think I have made the other points on that."[225] It appears that during the course of 2019 Discovery corrected its practices to make sure that only the necessary clinical information was requested and further that practitioners were always given the option of redacting patient information that they considered confidential or sensitive.

210 Further, Discovery appears to be suspicious of providers who resist providing confidential patient information. Dr Broomberg explained that "if I can be frank, we believe they [the HCPs] are using patient confidentiality as an excuse for not supplying information that will confirm the activities which we suspect are untoward. That is our view."[226]

[222] Dr Broomberg (Transcript, 29 January 2020, p 66, lines 11 - 12).
[223] Dr Broomberg (Transcript, 29 January 2020, p 67, lines 1 - 2).
[224] Dr Broomberg (Transcript, 29 January 2020, p 66, lines 15 - 19).
[225] Dr Broomberg (Transcript, 29 January 2020, p 142, lines 19 - 22).
[226] Dr Broomberg (Transcript, 28 January 2020, p 68, lines 2 - 8).

211 In relation to Discovery's use of undercover investigations, an investigator will pose as a patient and visit a practice in order to obtain information which either verifies or excludes the suspected fraud. Discovery has had its undercover investigation processes reviewed by Senior and Junior Counsel who have confirmed their legality.[227] Further, Discovery ensures that the undercover investigations are conducted in accordance with the applicable legislation including the Criminal Procedure Act 51 of 1977.[228]

(iv) *Discovery's approach to settlement and sanction*

212 Once Discovery has decided if an practitioner is guilty of FWA then it proceeds to follow one or more of the following routes: administrative, professional, criminal or civil action.[229] Broadly speaking the administrative route is where a settlement is reached between Discovery and the practitioner, the professional route is where the matter gets reported to the relevant statutory body such as the HPCSA, criminal action is where a criminal case is opened with the South African Police Service ("**SAPS**"), and civil action is where a civil case is opened in order to recovery losses (the latter route is uncommon as "civil action is generally quite expensive and likelihood or recovery should be considered carefully").[230] Further, Discovery's approach is that "unless there is a legal obligation to do so it may not be appropriate to routinely report cases to the SAPS and/or a statutory body, and it might be more appropriate to deal

[227] Discovery power point presentation, 29 January 2020, slide 38.
[228] *Ibid*.
[229] Discovery submission, 18 July 2019, "Discovery Group Forensic Services, Policies and Procedure: Health Investigations" ("**The Discovery Investigation Policy**") (Discovery bundle, p 120).
[230] *Ibid*.

with these cases on an administrative level. This also ties in with the philosophy of rehabilitation."[231]

213 When the administrative route is followed a meeting is convened with the practitioner. At such meeting, the practitioner is afforded the opportunity of having a representative of his or her choice.[232] Most of the evidence from practitioners related to them being subject to the so-called administrative route. From the above, it is also clear that this route is preferable for Discovery as it is both cost-effective and encourages behavioural change.

214 Discovery's experience of such meetings is very different to the experience of practitioners. Discovery submits that "DH engages with the relevant practice/practitioner in order to reach an agreed resolution of the issues at hand. In this regard, meetings are held with the relevant practice/practitioners and their representatives. In the majority of cases, a settlement agreement is reached in terms of which the practitioner/practice is afforded the opportunity to repay the amount of irregular claims to which a practice was not entitled but had already paid out."[233] Practitioners alleged that they are intimidated in such meetings as they are called into Discovery's offices and are outnumbered and ambushed with information about their billing practices which is difficult to address in the meeting.[234] Further, they allege they are coerced into signing

[231] Discovery submission, 18 July 2019, The Discovery Investigation Policy (Discovery bundle, p 120).
[232] *Ibid*.
[233] Discovery submission, 18 July 2019 (Discovery bundle, p 23, para 8.7).
[234] *Supra*. See also: Discovery second supplementary submission, August 2019, "Responses to points raised during the sessions of the public hearings of the Section 59 Investigation (29 July 2019 to 2 August 2019)" (Discovery bundle, p 2654, para 1.2), where Solutionist Thinkers alleged that the investigation process was akin to extortion. See further: Discovery second supplementary submission, August 2019, "Responses to points raised during the sessions of the public hearings of the Section 59 Investigation" (Discovery bundle, p 2671, para 7.2; p 2716, para 1.2; p 2718, para

settlement agreements as if they do not they will lose a source of income.[235] Discovery denies this. Discovery submits that "health professionals invited to meetings with the Discovery Forensic Unit are always invited to bring appropriate representation, including legal representation, with them to the meeting, and many people do so. We reiterate that we have never coerced a healthcare professional into signing an agreement to repay funds inappropriately claimed. We believe it is misguided to categorise highly trained healthcare professionals as unsophisticated or easily manipulated".[236] Dr Broomberg testified that "I am assured by my colleagues, I have never been personally present in a meeting and so what I am telling you now is in good faith to the best of my knowledge. I am assured by my colleagues that there is never a meeting where we use duress to force a practitioner to sign an acknowledgement of debt. We do record these meetings. We film them. We take careful note. We always encourage practitioners to bring representation, some many (*sic*) do, some do not".[237]

215 Discovery retains a discretion as to how to manage the administrative process with a practitioner. Discovery explained that: "the process followed under

2.1 and p 2720, para 3.3. – 3.5), as well as Discovery third supplementary submission, September 2019, "Responses to points raised during the sessions of the public hearings of the section 59 Investigating (20 August 2019 to 29 August 2019)" (Discovery bundle, p 2664, para 2.8 – 2.9 and p 2720, para 3.3. – 3.5).

[235] *Supra*. See also: Discovery second supplementary submission, August 2019, "Responses to points raised during the sessions of the public hearings of the Section 59 Investigation (29 July 2019 to 2 August 2019)" (Discovery bundle, p 2652, para 1.2; p 2654, para 1.5 and p 662, para 3.7).

[236] Discovery third supplementary submission, September 2019, "Responses to points raised during the sessions of the public hearings of the Section 59 Investigation (20 August 2019 to 29 August 2019)" (Discovery bundle, p 2720). See also: Discovery submission, 18 July 2019 (Discovery bundle, p 26, para 9.3.2), where Discovery explained that:

> "*the DH investigators will always adjourn a meeting at any stage if the practitioners feels unable to respond to the concerns raised, and/or if the practitioner requests additional time to investigate the issues prior to meeting with DH*".

[237] Dr Broomberg (Transcript, 29 January 2020, p 68, lines 12 - 20).

each investigation will be determined by the specifics of each case as well as the response by the provider to the requests for information and to address anomalies identified. The type and extent of information requested, as well as the decisions on how much should be repaid and whether or not claims payment should be suspended or blocked depends on the specifics of each case."[238]

216 In relation to settlement agreements, Discovery "estimates the quantum of fraudulent claims from a practice by analysing all claims submitted by the practice over the prior 3 years, thus using an extensive sample of claims to ensure an accurate and fair estimate of the quantum of claims inappropriately paid to the practice."[239] The settlement agreement is usually structured as an AOD where the practitioner pays an agreed amount back to Discovery over a period of time, without interest.[240] Discovery submits that the use of AODs to recover "fraudulent payments" has been determined lawful by the Supreme Court of Appeal ("**SCA**") in *Medscheme Holdings (Pty) Ltd and another v Bhamjee*[241] ("***Bhamjee***"). Once an AOD is agreed the HCP may continue to submit claims to Discovery and will be paid for such claims. Discovery estimates that in 2018, 90% of cases were settled by way of AODs.[242]

217 The manner in which Discovery calculates the re-payment set out in the AOD has also been controversial. Practitioners and even the CMS have alleged

[238] Discovery third supplementary submission, September 2019, "Responses to points raised during the sessions of the public hearings of the Section 59 Investigation (20 August 2019 to 29 August 2019)" (Discovery bundle, p 2720 - 2721).
[239] Discovery submission, 18 July 2019 (Discovery bundle, p 23, para 8.8.1).
[240] Discovery submission, 18 July 20219 (Discovery bundle, p 23 - 24, para 8.8.1)
[241] [2005] 4 All SA 16 (SCA).
[242] Discovery submission, 18 July 2019 (Discovery bundle, p 24, para 8.8.1).

that the amount is a "thumb suck".[243] This allegation is denied by Discovery and it explained" each calculation is based on the specifics of each case and that the general principle is to determine the approximate extent of the FWA and then to apply it to all claims over a prior period (determined depending on the case) to get to a fair settlement amount.[244]

218 Discovery further submitted that there is both a typical methodology and an alternative methodology, depending on the type of FWA (pharmacy/dispensing GP, claiming for non-scheme members, purchase record audits and audits for time-based coding).[245] These methodologies were not set out in any of the Discovery policies made available to the Panel and were described, in this level of detail and as a typical and alternative methodology, for the first time during Discovery's oral evidence.

219 The Panel's expert, Dr Kimmie, also investigated how repayment was calculated and Discovery commented on this findings. In sum, it was agreed between Dr Kimmie and Discovery that repayment calculations were done as follows:

> *"- In some cases (eg where the behaviour can be systematically tracked, as in the use of incorrect codes) the calculation of the amount to be repaid to each of the medical schemes is fairly straightforward.*
> *- In other cases the DH team will ask for a "reasonable sample" of documentation (either invoices or medical records) in order to assess the amount to be repaid.*

[243] Ms Phaswane (Transcript 1 of 2, 30 July 2019, p 60, lines 8 – 9).
[244] Discovery power point presentation, 29 January 2020, slide 40.
[245] Discovery power point presentation, 29 January 2020, slides 41 - 42.

- In general this sample will be used to extrapolate the behaviour of the provider over a period of three years. However, in some cases a longer period may be used if the data exists and the behaviour can be clearly identified. [Discovery correction: "The period over which the behaviour of the provider is assessed will depend on the specifics of the investigation and will be determined in consultation with the provider and based on the evidence collected. In some cases, the data available may support a longer period, however we seldom go back longer than 3 years"]

- The precise meaning of reasonable sample is not clear. It is, however, not based on any statistical calculation that would support the validity of the extrapolation. [Discovery addition: "The size of the sample of claims information that can be supplied by the provider will be determined by what is feasible for the provider to provide. This will be reviewed in conjunction with the RRT analysis which covers a rolling 3 year period of claims. The affidavits submitted on individual cases provider details on calculation processes that have been followed."]

- It appears that in most cases the sample required is decided upon through a process of negotiation between the provider and the forensics team, and the provider is not dissuaded from providing additional data.

- Where the estimate does produce of range of values for repayment the DH approach is to select the bottom end of the range as a starting point for negotiation. This amount may then be further reduced based on the ability of the provider to make the required payments.

- DH does not have data that would allow an estimate of the amount that is repaid directly to medical scheme members and the amount paid to the schemes themselves as part of the repayment process. [Discovery correction: "No recoveries are paid directly to medical scheme members. All allocated recovery payments happen via medical scheme. Where claims are specifically identified that can be reversed, the benefits available to individual members (where benefit limits apply) will be replenished or where claims were paid from a medical savings account, this will be replenished. Where amounts cannot be associated with individual claims, the amount is allocated

to the risk pool which benefits all members through reduced contribution increases"]"[246]

220 Discovery also explained that during investigations there are instances (albeit rare) when payments to practitioners are suspended or permanently blocked.

221 Where a practitioner is not cooperating with the investigators and/or where ongoing payments to a practice are deemed to pose material risk to the schemes, Discovery will temporarily suspend payments to the practice until the matter is resolved.[247] In relation to temporary suspensions, they are reviewed periodically and are lifted when a practitioner indicates that he or she is willing to engage with DH in order to address or resolve the concerns that Discovery has identified.[248]

222 Discovery submitted that in a small minority of cases (less than 1% of investigated cases) payments to a provider or practice are permanently blocked.[249] Blocking is reserved for HCPs who refuse to engage with Discovery, practitioners who have engaged in very material fraud and practitioners who repeatedly commit fraud.[250]

223 Discovery submits that suspension is justified on the basis that a medical scheme has no obligation to pay an practitioners directly. The medical

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[246] Dr Kimmie's report, 18 November 2019, "Interview with Discovery Health", p 124. See also: Discovery bundle, p 3395, para 6 as read with p 3481).
[247] Discovery power point presentation, 29 January 2020, slide 47.
[248] Discovery submission, 18 July 2019 (Discovery bundle, p 24 - 25, para 8.10). See also: Dr Broomberg (Transcript, 29 January 2020, p 168, lines 1-9).
[249] Discovery submission, 18 July 2019 (Discovery bundle, p 24, para 8.10).
[250] Discovery submission, 18 July 2019 (Discovery bundle, p 24, para 8.10). See also: Discovery power point presentation, 29 January 2020, slide 48.

scheme has an obligation to pay the member. Where a practitioner has the benefit of receiving direct payment it is because the practitioner has entered into a voluntary arrangement with the scheme to do so.[251] Discovery argues that medical scheme rules permit the suspension of direct payments to practitioners.[252] The Panel has not had sight of all the scheme Rules which allegedly permit the suspension of direct payments to practitioners. However, during the course of the investigation the Panel sought a copy of Discovery Medical Schemes Rules to understand Discovery's submission. Unfortunately the Discovery Medical Scheme Rule 14.7 on which Discovery relies in part for this submission has not been approved and registered by the CMS since 2012 and it appears that Discovery Medical Scheme and the CMS hold different views on the legality of this Rule.[253] Bearing in mind the complexity underlying

[251] Dr Broomberg (Transcript, 29 January 2020, p 147, lines 5 - 15).
[252] Discovery power point presentation, 29 January 2020, slide 47.
[253] Rule 14.7 as registered and approved by the CMS in 2012 provides as follows:

> "*The Scheme may at its discretion and based on justifiable reason, shall reject all claims in respect of services obtained from a provider where it can be shown on probably cause that such provider has placed the Scheme at risk. For purposes of giving effect to this rule –*
> *14.7.1 The Scheme shall notify the provider in writing of such decision and the reason thereof. The provider is entitled to dispute the decision. The provision of Rule 27.8 to 27.11 shall apply to the resolution of such disputes;*
> *14.7.2 In respect of all provider who have received a notice in terms of Rule 14.7.1, the Scheme shall –*
> *14.7.2.1 inform its members hereof by publishing the names of all such providers on its website; and*
> *14.7.2.2 inform all members who received services from such providers in the 12 month period preceding such notice, of its decision to stop payment*".

See also: Email correspondence from Discovery to the Panel's secretariat, 11 September 2020,when Discovery was asked about whether this Rule was in force it explained as follows:

> "*Please note that Rule 14.7 was registered by the Registrar in 2012, and remains in force as a rule of the Scheme. DHMS had proposed certain amendments to Rule 14.7 after 2012, which amendments were rejected by the Registrar leading up to a hearing before the Appeal Committee of the Council for Medical Schemes in July 2018. This appeal did not proceed, as it was not viewed as necessary by the parties: DHMS, the Registrar and the CMS settled this appeal on the basis that DHMS was prepared to withdraw the appeal and to rely upon Rule 14.7 as registered in 2012, to which the Registrar and the CMS agreed. The CMS and Registrar agreed that there had been no power to strike out Rule 14.7, and that the Rule registered in 2012 remained registered. Since that time, the Registrar has been called upon to stamp a copy of Rule 14.7 but has to date failed to do so, without providing any reasons for this failure*."

the legality of this Rule, we do not express a view thereon. We do note, however, that the reliance by Discovery on the Rules of the schemes to refuse to make direct payments to practitioners (where such practitioner has placed the Scheme at risk) is not without controversy and is an issue that the CMS should urgently resolve so as to remove the uncertainty relating to this issue.

(v) *Discovery's approach to codes: coding errors versus coding abuse*

224 Another area of controversy during the investigation related to practitioners use of diagnostic and procedural codes and more particularly where such use was found to constitute a form of FWA.

225 Discovery explained that it accepts the SAMA's Billing Manual as setting out the correct approach to codes for practitioners. Discovery explained that the vast majority of historic codes are accepted by Discovery and further that each year new codes are added and then the medical schemes will decide if they will pay for such codes.[254] Any coding confusion may come from this latter step where a code is added by SAMA but not accepted for repayment by the medical scheme. However, Discovery was at pains to explain that when this sort of confusion arises this will never lead to an FWA investigation but would only lead to a claim being rejected.[255]

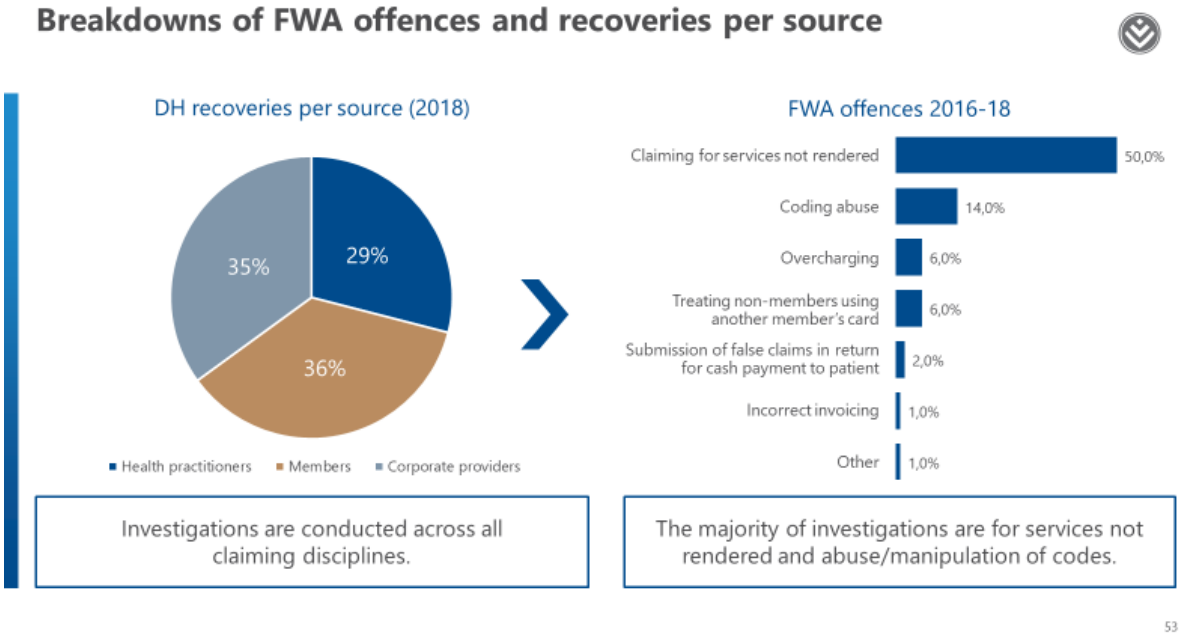
226 It is noteworthy that Discovery appears to have a more sophisticated system than, for example, GEMS – whose system is discussed in more detail below, which allows it to identify coding errors quickly and to reject a claim rather than

[254] Dr Broomberg (Transcript, 29 January 2020, p 144, line 10 - p 145, line 2).
[255] Dr Broomberg (Transcript, 29 January 2020, p 145, lines 3 - 10).

mistakenly pay for a claim where an incorrect code was used for a particular discipline (for example if a physiotherapist used a code ordinarily used by a surgeon). Discovery's automated claims system immediately picks up if the incorrect code is used and then rejects the claim.[256] Discovery has the ability to pick up and rectify these types of coding errors within the 30 day period required by Regulations 5 and 6. It was Discovery's submission that because of this ability, their RRT algorithms only pick up so-called "abuse of codes" rather than coding errors.[257] We understood that what Discovery understood as a "abuse of codes" would be for example if a practitioner consistently used a time code for a long consultation (for example more than 55 minutes) rather than a short consultation (for example less than 55 minutes); or if most physiotherapists charged for a particular device for 10% of the time but a particular physiotherapist charged for the use of this device 90% of the time. This type of coding abuse would not be noticed immediately but the pattern would be picked up by the RRT over time.

227 Discovery submitted that coding abuse (as opposed to coding errors) was the second highest category of FWA offence between 2016 – 2018 and provided the following figure in support of this submission:[258]

[256] Dr Broomberg (Transcript, 29 January 2020, p 55, lines 2 – 18).
[257] *Ibid*.
[258] Discovery power point presentation, 29 January 2019, slide 53.



13.2. GEMS response to procedural fairness

(i) *Overview of GEM's and its approach to cost containment*

228 GEMS is a restricted medical scheme, which commenced operations as an insurer of public sector employees in 2006. It is the second largest medical scheme in South Africa with over 1.8 million beneficiaries and 726 621 principal members.[259] GEMS submitted that it "seeks to ensure that public service employees and their families get the best healthcare at affordable rates"[260] and "in excess of 1 million GEMS beneficiaries did not previously belong to a medical scheme."[261]

229 GEMS submitted that 91% of its beneficiaries are "Black."[262] The exact racial composition of GEMS's beneficiaries is unknown to GEMS as not all members disclose their race, or that of their beneficiaries, when applying to be a member

[259] GEMS power point presentation, 28 January 2020, slide 7.
[260] *Ibid*.
[261] GEMS power point presentation, 28 January 2020, slide 8.
[262] GEMS power point presentation, 28 January 2020, slide 12.

of GEMS.[263] However, GEMS surmises that the racial composition of its membership is similar to that of the racial composition of the public sector. In GEMS's second Supplementary Submission its suggested that as of 31 January 2020 its membership was as follows:[264]

Race distribution in the Public Service

as on 31 January 2020

Race	Number	%
White	87 140	7.09
Asian	30 466	2.48
Coloured	105 992	8.63
African	1 005 040	81.80
Total	**1 228 638**	**100.00**

Data source: PERSAL

Compiled by the DPSA

Excluding Defence and State Security Agency

Excluding Abnormal and Periodical appointments

230 GEMS membership is therefore probably at least about 82 - 85% Black.

231 GEMS submitted that it is a "transformative organisation", for a range of reasons, including that it adopts a preferential procurement promotion strategy; it leverages GEMS's position as a strategic purchaser of health care services; and its employees are 95% Black.[265]

[263] Dr Goolab (Transcript, 28 January 2020, p 20, lines 20-25).
[264] GEMS fifth supplementary submission, 12 February 2020 (GEMS second supplementary bundle, p 9 - 10, para 7.2.5 – 7.2.6).
[265] GEMS power point presentation, 28 January 2020, slide 12.

232 GEMS receives approximately 268 000 claims daily and 8.1 million claims monthly.[266] 95.7% of claims are paid within 30 days; the remaining 4.3% are not paid within 30 days because they are identified as being fraudulent or the claims submission is not in accordance with the Act or the GEMS Rules.[267]

233 GEMS risk management has been heavily influenced by events in 2016 where it experienced unusually high claims and irregular activities.[268] The claims in this year were so high that GEMS's reserves were below the statutory requirement of 25%. According to Mr Moloabi, the Principal Officer of GEMS, "there was a lot of panic amongst our members, they were not sure if the scheme is sustainable."[269] GEMS accepted that the low reserves in 2016 were as a result of a number of factors, one of which was FWA. GEMS proceeded to put a number of strategies in place to rectify the situation, including establishing the GEMS Claims Management Forum ("**CMF**") which addressed amongst other things, FWA.[270] Mr Moloabi testified that:

> " *… in 2016 there were media reports and I'm not going to go into the details. There was a lot of public discourse of about the fact that GEMS is set to be financially unsustainable because of the low reserve ratio and at that stage the claims management forum was established and the claims management forum is going to talk to those interventions including Fraud Waste and Abuse.*"[271]

[266] Dr Moloabi (Transcript, 28 January 2020, p 25, lines 20 - 27).
[267] Dr Moloabi (Transcript, 28 January 2020, p 26, lines 1 - 6).
[268] GEMS power point presentation, 28 January 2020, slide 9.
[269] Dr Moloabi (Transcript, 28 January 2020, p 28, lines 16 - 22).
[270] Dr Moloabi (Transcript, 28 January 2020, p 29, lines 10 - 15) and GEMS power point presentation, 28 January 2020, slides 10 - 11. See also: GEMS power point presentation, 28 January 2020, slide 31 and GEMS fifth supplementary submission, 12 February 2020 (GEMS second supplementary bundle, p 3 – 4, para 2.2), where it is stated that other cost savings initiatives introduced by the CMF were: underwriting, protocol reviews, in-hospital case reviews, MPL savings and the introduction of the benefit option known as the emerald value option.
[271] Dr Moloabi (Transcript, 28 January 2020, p 31, lines 19 - 24).

234 GEMS submitted that 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 Administrators of the scheme to identify potential outliers."[272] GEMS submitted that the introduction of the CMF reduced the scheme's projected financial losses which resulted in better financial performance for the 2017 – 2019 financial years.[273] For example, the CMF "identified the KZN region as a specific outlier when compared to the rest of the country" and "this led to the scheme implementing onsite case managers at specific hospitals identified as outliers and also using forensic investigators to follow up on potential FWA in the region."[274]

235 GEMS outsources a number of its functions aimed at managing the risk associated with FWA. It contracts with Metropolitan Health ("**Metropolitan**") for "Member and Claim Services" and with Medscheme for "Contributions and Debt Collection."[275] The former relationship is relevant to FWA detection, investigation and sanction (the latter is not).

236 When GEMS gave evidence, it relied on a Fraud Policy and Prevention Approach policy document ("**Fraud Policy**"), dated May 2015 as the policy document which guided its internal approach to FWA. Surprisingly the Fraud Policy only contains a definition of fraud and abuse, it does not contain a definition of waste.[276] Subsequent to GEMS's oral evidence it has made a

[272] GEMS power point presentation, 28 January 2020, slide 28.
[273] *Ibid*.
[274] GEMS power point presentation, 28 January 2020, slide 29.
[275] GEMS supplementary submission, 12 August 2019 (GEMS bundle, p 31, para 10.6.7).
[276] Mr Mogapi (Transcript, 28 January 2020, p 58, lines 3 - 6).

further policy document available to the Panel: the Fraud, Waste and Abuse Policy (version 1), dated 2019 ("**recent FWA Policy**").[277] It appears that the recent FWA Policy, defines fraud, waste and abuse and is what "GEMS currently follows and applies."[278] Having said this, GEMS made a number of submissions based on the Fraud Policy, dated May 2015, including submissions that Annexure D of this document, entitled "Medical Aid Abuse and Fraud Sanctions" ("**the Sanctions Policy**"), governs the sanctions that may be imposed on practitioners guilty of FWA.[279]

(ii) *GEMS's approach to detection*

237 GEMS explained that it uses at least the following mechanisms to detect FWA:[280]

237.1 First, tip-offs which are received through the Vuvuzela Hotline. GEMS explained that it "receives tip-offs from its members and/or other parties disputing the validity of claims or complaining about practitioners conduct. GEMS received 792 tip-offs during 2018 of which 148 resulted in actual investigations";[281]

237.2 Secondly, tip-offs which are received through the BHF Health Forensics Management Unit ("**HFMU**"). GEMS explained that it is an

[277] GEMS fifth supplementary submission, 12 February 2020 (GEMS second supplementary bundle, p 5, para 3.3). See also: GEMS supplementary submission, 12 February 2020, Annexure B: "Fraud, Waste and Abuse Policy" (GEMS second supplementary bundle, unpaginated).
[278] GEMS fifth supplementary submission, 12 February 2020 (GEMS second supplementary bundle, p 5, para 3.3).
[279] GEMS fifth supplementary submission, 12 February 2020, Annexure D: "Sanctions Policy" (GEMS second supplementary bundle, unpaginated, clause 13.3).
[280] GEMS power point presentation, 28 January 2020, slide 43, where GEMS lists the following sources of FWA: hotline, analytics, service provider networks (SPNs), regulatory bodies, industry bodies and scheme).
[281] GEMS fourth supplementary submission, 23 January 2019, Annexure 1: "GEMS Submission to Section 59 Investigation Panel" (GEMS supplementary bundle, p 121 - 122, para 4).

"active participant" in the HFMU and that it "receives alerts via this unit and other medical schemes regarding possible fraud, waste and abuse. GEMS received 77 industry tip-offs of which 33 resulted in actual investigations";[282]

237.2.1 The HFMU lists the members as follows:[283]

NAME OF ENTITY	ENTITY	*YEAR JOINED
Agility Global Health Solution [formerly Resolution Health Medical Scheme]	Medical aid	2013
Bestmed Medical Scheme	Medical aid	2013
Bonitas Medical Fund	Medical aid	2013
Charted Accountant Medical Aid Fund (CAMAF)	Medical aid	2019
Compensation Fund	Bureau	2019
De Beers Benefit Society	Medical aid	2013
DENIS	MHC	2013
Government Employee Medical Scheme (GEMS)	Medical aid	2016
Health 360 [formerly SECHABA]	Administrator	2013
Hosmed Medical Aid Scheme	Medical aid	2013
ISO LESO	Administrator	2013
Keyhealth	Medical aid	2013
Liberty	Medical aid	2013
Medihelp	Medical aid	2013
MEDSCHEME HOLDINGS	Administrator	2013
METROPOLITAN HEALTH GROUP	Administrator	2013
MOMENTUM HEALTH	Medical aid	2013
MOMENTUM TYB	Administrator	2013
OPMED	Medical aid	2013
PRIVATE HEALTH ADMINISTRATORS	Administrator	2013
POLMED	Medical aid	2013
PPN	MHC	2013
PPS	Insurance	2013
PROFMED	Medical aid	2013
PROVIDENCE	MHC	2013
QHUBEKA	Forensic investigators	2013
Rand Water Medical Scheme	Medical aid	2013
SAMWUMed	Medical aid	2013
Selfmed Medical Scheme	Medical aid	2013
Standard Bank Forensic Services	Banking & Forensics	2013
UNIVERSAL HEALTHCARE	Administrator	2013
Veripath/Verirad	MHC	2013

237.2.2 The purpose of the HFMU is to advise medical schemes and administrators of possible FWA cases, which information is contributed by members of the

[282] *Ibid*.
[283] Response from the BHF titled "Section 59 Investigation into Allegations of Racial Profiling Lodged by the National Health Care Professionals Association (NHCPA)", 17 September 2019, p 6.

HFMU and circulated via, amongst others, emails to its members.[284]

237.2.3 This is a very limited forensic analysis and causes some concern as the portal that ought to only include the confirmed FWA cases, however it also appears to list ongoing investigations as well. This is confirmed by Medscheme, who alludes to HFMU database as a system of "Information sharing and industry initiatives".[285]

237.2.4 The risk in the system is that if a practitioner is on the HFMU database, the other medical schemes or their administrators are likely to investigate these practitioners.[286] BHF does "not assess the veracity of any information uploaded into the HFMU Portal save for validating the practice number of the relevant healthcare service provider."[287] There is further risk in the system as there is no means of

[284] Dr Kimmie's report, 18 November 2019, Letter titled "Board of Healthcare Funders – Information Request", p 78. See also: Dr Kimmie's report, 18 November 2019, Letter from the BHF titled "Section 59 Investigation into Allegations of Racial Profiling Lodged by The National Health Care Professionals Association (NHCPA)", p 83.

[285] Medscheme submission, 18 July 2019 (Medscheme bundle, p 15, para 4.2.4), where Medscheme stated that medical schemes would report suspicious activity in respect of other medical schemes, for the purposes of network distribution.

[286] Dr Kimmie's report, 18 November 2019, Letter titled "Board of Healthcare Funders – Information Request", p 78. See also: Dr Kimmie's report, 18 November 2019, Letter from the BHF titled "Section 59 Investigation into Allegations of Racial Profiling Lodged by The National Health Care Professionals Association (NHCPA)", p 83.

[287] *Ibid*.

removing a practitioner if an investigation is proved to be unfounded.

237.3 Thirdly, computer analytics are used to identify possible FWA using the following claims data: discipline, tariff code, condition (ICD 10 code), links to previously sanctioned practices and geographic location (the latter according to GEMS is "also sometimes considered."[288] However, this was contradicted by the information which GEMS and Metropolitan provided to Dr Kimmie which was that the geographic functionality is not in use.[289] GEMS explained that Metropolitan uses a "global software product which has built in algorithms"[290] and also uses other "early warning analytics reports identify practitioners based on exceeding time based thresholds and a significant increase in claims."[291]

238 GEMS explained that the Vuvuzela Hotline is contracted to GEMS.[292] However, the information which is gathered through the Vuvuzela Hotline is given to both GEMS and Metropolitan.[293]

239 In relation to GEMS' reliance on computer analytics, this function is completely outsourced to Metropolitan. Metropolitan has a Health Investigation Unit ("**HIU**") which is responsible for detection and investigation. The HIU consists

[288] GEMS fourth supplementary submission, 23 January 2020, Annexure 1: "GEMS Submission to Section 59 Investigation Panel" (GEMS supplementary bundle, p 122, para 4).
[289] Dr Kimmie's report, 18 November 2019, "Notes: GEMS/Metropolitan Health Interview", p 130.
[290] GEMS fourth supplementary submission, 23 January 2020, Annexure 1: "GEMS Submission to Section 59 Investigation Panel" (GEMS supplementary bundle, p 122, para 4).
[291] *Ibid*.
[292] Mr Mogapi (Transcript, 28 January 2020, p 63, lines 4 - 10).
[293] Mr Mogapi (Transcript, 28 January 2020, p 64, lines 18 - 20).

of 6 managers and senior technical specialists, 2 senior specialists, 2 data analysts and 17 investigators.[294]

240 The independent expert conducted an interview with GEMS and Metropolitan on 8 October 2019 in order to understand the details of how Metropolitan and its analytical systems work. In sum, Metropolitan uses a system known as [redacted].[295] GEMS describe [redacted] as follows:

> "[redacted] *is a true big data analytical solution, which applies statistical scoring to assess peer groups of healthcare practices and, by comparing like with like, assist with the identification of anomalous behaviour and outliers (which may be indicative of fraud, waste, abuse or error).*"[296]

241 GEMS explained that "Metropolitan is driving the investigation process, they identify the outliers and then come to" GEMS.[297] We note that this is contradicted by the contents of the interview with the independent expert where GEMS and Metropolitan explained that the Metropolitan computer analytics has the capacity to identify outliers but "its main use is directed by tip-offs and the [GEMS] independent business and clinical processes" (which we understand is an auditing or financing function within GEMS).[298]

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[294] Mr Mogapi (Transcript, 28 January 2020, p 71, lines 15 - 25).
[295] Dr Kimmie's report, 18 November 2019, "Notes: GEMS/Metropolitan Health Interview", p 130 – 131.
[296] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 82, para 11.9.2).
[297] Mr Mogapi (Transcript, 28 January 2020, p 70, lines 3 - 10).
[298] Dr Kimmie's report, 18 November 2019. "Notes: GEMS/Metropolitan Health Interview", p 131, para 4.1 and para 4.3, where GEMS and Metropolitan explained that:

[redacted]

242 [redacted] ranks practices in relation to peers within specialties and sub-specialties and can rank practices in relation to its peers within specific geographic regions (although it appears that Metropolitan has not applied this function yet). Results are displayed in a variety of graphical formats that readily identify practices that fall outside the norm (these are referred to as "outliers"). [redacted] supports further investigation by enabling investigators to drill down into detailed information on practices' clinical and claims profiles.[299] The foundation of the [redacted] is peer group profiling. The norms of the peer group as a whole are used to evaluate each practice within the peer group. Metropolitan developed the peer groups based on the discipline and sub-discipline under which the practice is registered with BHF.[300]

243 Each model that [redacted] uses contains a number of questions asked of the claims data. [redacted] produces an overall score and ranks practice within the relevant peer group.[301] When doing this, Metropolitan only uses GEMS' claims line data going back for a period of one year. [redacted] conducts the analysis mainly using built in rules, but there is the possibility of developing bespoke rules.[302]

244 Metropolitan started using the [redacted] system for general practitioners in 2015 and thereafter numerous other disciplines were introduced:[303]

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[299] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 83, para 11.9.6).
[300] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 83, para 11.9.8).
[301] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 85, para 11.9.15).
[302] Dr Kimmie's report, 18 November 2019, "Notes: GEMS/Metropolitan Health Interview" (*confidential*), 29 November 2019, p 130 – 131, para 3.
[303] *Ibid*.

Discipline	Date of implementation
General Practitioners	Aug-15
Pharmacy	Aug-15
Psychologist	Apr-16
Registered Counselor	Apr-16
Clinical Technologist	May-16
Physiotherapist	May-16
Psychiatry	May-16
Social work	May-16
Medical Technologist	Feb-17
Radiographer	Feb-17
Radiology	Feb-17
Anaesthetist	Mar-17
Gynaecologist	Mar-17
Pathology	Mar-17
Orthopedic Surgeon	Jun-17
Surgeon	Jun-17
Physician	Feb-18
Cardiology	Feb-18

245 GEMS and Metropolitan were not able to share the statistical workings and algorithms that [redacted] applied as according to IBM (who owns [redacted]) it is proprietary.[304] This is in contrast to Discovery who developed its own algorithms and has provided the descriptions of the factors used in the algorithm to the Panel.

246 Although the [redacted] can be independently used to identify outliers for further investigation, Metropolitan also uses it to investigate health care practitioners or practices which are the reported via tip-offs from GEMS

[304] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 85, para 11.9.16).

(Vuvuzela) or other independent business and clinical processes.[305] Dr Kimmie explained that:

"[redacted]"[306]

247 The decision as to which providers to investigate is made by the forensics team at Metropolitan and presented for approval to GEMS at the monthly CMF meeting.[307] It appears that the approval by GEMS is a formality as GEMS explained in its oral testimony that it plays no role in the investigation of providers and that it only begins to play a role when the both the detection and investigation phase is over and when decisions are to be made about sanction.[308]

[305] Dr Kimmie's report, 18 November 2019, "Notes: GEMS/Metropolitan Health Interview", p 131, para 4.1 - 4.3.
[306] Dr Kimmie's report, 18 November 2019, "Notes: GEMS/Metropolitan Health Interview", p 131. para 4.3.
[307] Dr Kimmie's report, 18 November 2019, "Notes: GEMS/Metropolitan Health Interview", p 131, para 4.6 and 4.8.
[308] Mr Mogapi (Transcript, 28 January 2020, p 73, lines 10 - 23).

(iii) *GEMS and Metropolitan's approach to investigation*

248 GEMS explained in its oral submissions that investigations by Metropolitan usually take place "within 60 days … but may require additional time on complex cases and where providers require additional time to respond."[309] In its first Supplementary Submission GEMS put up a graph which indicated rather that investigations can take up to 125 days.[310]

249 GEMS further explained that Metropolitan receives input during such investigations from medical advisors and service provider networks ("**SPNs**") and Metropolitan considers GEM's financial risk when making a decision whether to suspend payment during such an investigation.[311]

250 GEMS submitted that the investigation process includes the following stages:

250.1 A case is allocated to an investigator on the case management system and the investigator familiarises him/herself with the matter;

250.2 The investigator formulates an investigation plan;

250.3 The investigator conducts background searches to determine if the practice is linked to another sanctioned practice or if the practitioner is employed by the State or another institution;

250.4 The investigator has an initial engagement (usually telephonic) with the practitioner;

[309] GEMS power point presentation, 28 January 2020, slide 43.
[310] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 87, para 11.11.2).
[311] GEMS power point presentation, 28 January 2020, slide 43.

250.5 Data analytics are performed using the [redacted] Early Warning System ("**EWS**")[312] and Velocity reports[313] to identify areas of concern GEMS and Metropolitan have an arrangement with "other medical schemes to receive data … that is included in the analytics performed";

250.6 The investigator has a further engagement with the provider (either telephonically or by letter) wherein *inter alia* a response to the allegation is requested and a range of information is requested including documentary evidence such as "prescriptions/invoices/proof of equipment." The provider is allowed between 7-14 days to respond and extensions are granted where voluminous information is requested;

250.7 The information received from the provider is validated;

250.8 The investigator obtains clinical input from GEMS's medical advisor, the relevant SPN[314] or a subject matter expert who may be a practising or retired medical specialist;

250.9 Claim and service verification is done with members;

250.10 The investigator sends an anomaly letter requesting an explanation for the anomalies identified and providers are requested to supply

[312] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 86, para 11.10.3), where GEMS states that an Early Warning Systems ("**EWS**") report uses multiple measures to identify providers who have an increase in benefit spend above 10% compared to the previous year.

[313] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 86, para 11.10.1), were GEMS provides that a Velocity Report is an exception report which was developed by Metropolitan and identifies practices that exceed 11 hours of work per day.

[314] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 79), which provides that GEMS's SPNs include a dental network manager, and optical network manager, a pharmacies network manager, a chronic medicine network manager, an emergency or ambulance network manager and an in-hospital network manager.

evidence to substantiate their claims. Once again providers are given 7-14 days to respond and reasonable requests for extensions will be granted;

250.11 The provider's response is assessed and where it is unsatisfactory the investigator engages the provider again; and

250.12 The investigation is finalised and a case report is prepared and saved on the case management system.[315]

251 GEMS also appointed a separate service provider to conduct more in-depth field investigations of practitioners and practices (referred to as "**field investigators**"):

251.1 As regards probes, GEMS explained that "GEMS forensic investigators are not mandated to use or perform 'probes' on health care practitioners' practices";[316]

251.2 As regards AODs, GEMS explained that they:

> "*[D]o not coerce providers into signing AODs, nor do they set traps and/or send in probes to trap providers into committing fraud and they do not have a scheme mandate to do so … part of their responsibilities/duties include the validation of the findings of the desktop investigation by obtaining further records from a provider and to interview members in respect of alleged irregularities*";[317]

[315] GEMS's supplementary submission, 23 January 2020 (GEMS bundle, p 74 – 82, para 11.8).
[316] GEMS fourth supplementary submission, 23 January 2020, Annexure 1: "GEMS Submission to Section 59 Investigation Panel" (GEMS supplementary bundle, p 127, para 4(a)).
[317] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 96, para 11.16.1 – 11.16.2).

251.3 Field investigators are independent parties who assist GEMS with further investigation of a matter by:

> "*interviewing numerous members, visit[ing] the relevant locations and attempt engagement with the complainants … our field investigators are not mandated to act in an aggressive manner and/or to coerce any party to conduct him/herself in a certain way. The purpose is to find additional facts and to report to GEMS.*"[318]

252 The GEMS Assessment Process – Standard Operating Procedure ("**GEMS SOP**") sets out the standard process which the Metropolitan HIU should follow when deciding to allocate a case for further investigation.[319] During oral evidence GEMS submitted 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." [320]

253 In sum, it appears that the Metropolitan HIU has some discretion to determine which cases are investigated based on both quantitative criteria (including the degree of financial exposure the alleged activities gives rise to) and qualitative criteria (including whether there was a request from GEMS to investigate).[321]

[318] GEMS fourth supplementary submission, 12 August 2019, GEMS's response to complaints (GEMS bundle, p 17, para 10.7.4).
[319] GEMS fourth supplementary submission, 23 January 2020, "GEMS Fraud Forum Charter" (GEMS supplementary bundle, p 559).
[320] GEMS power point presentation, 28 January 2020, slide 45.
[321] *Ibid*.

(iv) *GEMS and Metropolitan's approach to sanction*

254 GEM's Sanctions Policy, which is explained as an Annexure to its Fraud Policy, dated May 2015, provides for a range of possible sanctions which may be imposed on practitioners where evidence of FWA has been found. These sanctions include: reversal of all irregular claims, issuing a final warning, terminating direct payment, monitoring claim submission, imposing a longer claim payment cycle, reporting providers to the relevant regulatory body, and recovering losses through civil litigation or a negotiated settlement.[322]

255 The Sanctions Policy specifically provides the sanctions for three categories of transgressions: irregular behaviour (including unacceptable human error); abuse; and fraud (as mentioned above neither the Fraud Policy nor the Annexure constituting the Sanctions Policy mention 'waste').[323] Noticeably, for all categories of transgression GEMS indicate that an appropriate sanction would be to:

255.1 "reverse the irregular claim";

255.2 "quantify the financial loss suffered and recover such loss from provider through settlement"; and

255.3 "terminate direct payment in respect of any claims submitted from date of notice."[324]

[322] GEMS power point presentation, 28 January 2020, slide 49. See also: GEMS fourth supplementary submission, 23 January 2020, "Sanctions against Members" (GEMS supplementary bundle, p 555).
[323] *Ibid*.
[324] GEMS fourth supplementary submission, 23 January 2020, "Sanctions against Members" (GEMS supplementary bundle, p 557- 559, clause 9.1, 9.2 and 9.3).

a. Reversal of claims

256 GEMS explained that prior to 2017 it 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.*"[325]

257 GEMS further explained that in 2015 and 2016 the claims that it reversed were exceptionally high due to (presumably) deemed FWA activity by group practices, physicians, clinical psychologists and counsellors.[326] GEMS reversed amounts of approximately R[redacted] and R[redacted] in 2015 and 2016 respectively.[327] GEMS's explanation of these large reversals was that it was due to them uncovering two "group[s] of service providers who submitted [claims amounting to FWA] regularly" in KwaZulu-Natal.[328]

258 When questioned by the Panel regarding the circumstances in which GEMS reverses payments, GEMS began by indicating it would happen when there was fraud. When the Panel pointed out to GEMS that the Sanctions Policy allows for reversal in a wide range of circumstances including human error, GEMS accepted that reversal would happen in all these circumstances but argued that this was done to protect members.[329] GEMS further confirmed that reversal of claims was simply an accounting tool – it was similar to entering a debt.[330]

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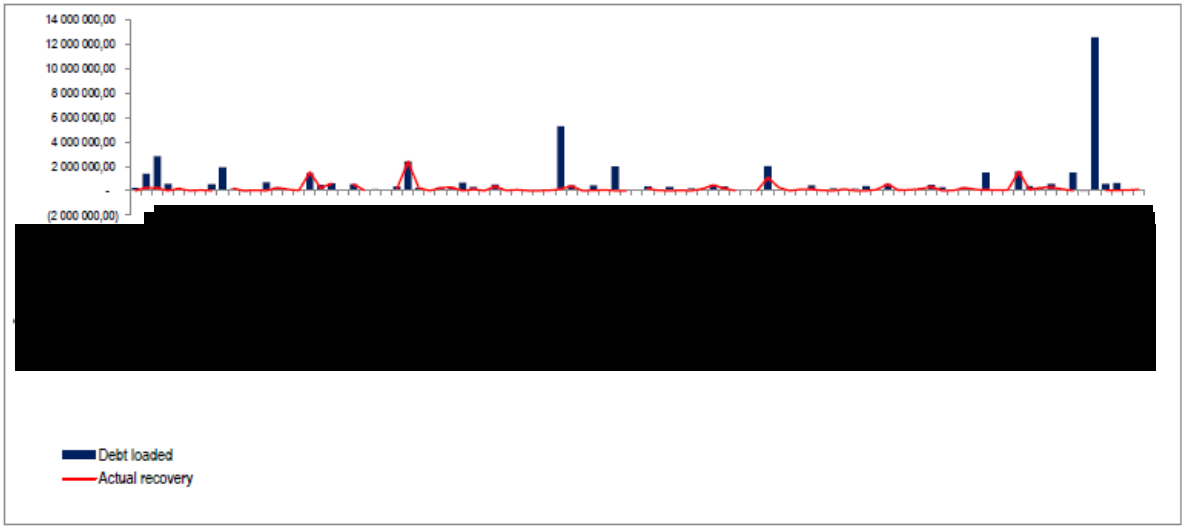
[325] GEMS power point presentation, 28 January 2020, slide 52.
[326] *Ibid*.
[327] *Ibid*.
[328] Mr Mogapi (Transcript, 28 January 2020, p 93, lines 20 - 25 and p 94, lines 15 - 20).
[329] Dr Moloabi (Transcript, 28 January 2020, p 84, line 20 – p 85, line 1).
[330] Mr Mogapi (Transcript, 28 January 2020, p 99, lines 7 -14).

259 However, the reversals lead to GEMS pursuing a recovery (whether it be through a settlement agreement/AOD or through civil litigation).[331] GEMS provided the following graph showing the relationship between debts loaded and actual recoveries in 2018:[332]



260 GEMS was reluctant to accept that a reversal of payment due to human error was a severe punishment for the practitioner who might depend on GEMS for practice income.[333]

b. Recovering funds through settlement agreements or AODs

261 GEMS and Metropolitan enter into settlement agreements with practitioners through AODs. It appears that in 2016 the field investigators would negotiate and conclude the AODs with practitioners; whereas from 2017 to 2018 the

[331] Mr Mogapi (Transcript, 28 January 2020, p 94, line 19 - p 95, line 10). See also: GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle p 102, para 11.8).
[332] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 105).
[333] Dr Moloabi (Transcript, 28 January 2020, p 84, lines 4 – 15).

AODs would be negotiated by GEMS; currently the AODs are being negotiated by Metropolitan's HIU with practitioners[334] - although the SOP provided to the Panel still indicates that either the field investigators or the HIU may request a practitioner to sign an AOD.[335]

262 The Panel has not been provided with information as to how the field investigators or GEMS historically calculated the amounts that are agreed in the AODs. In 2019, however, Metropolitan's HIU used the GEMS claims line data to determine the amount that it will agree to in the AOD. Bearing in mind the investigation focuses on an amount under investigation (based on the claims line data), the practitioner is asked to submit corrected claims and the difference between the actual amounts claimed and the corrected claims are then quantified.[336] The time period covered in the calculation of repayment varies – the standard is to work with the current year to date and the previous year.[337]

263 GEMS does not allow an AOD settlement to be concluded for an amount which is lower than the identified anomalies unless GEMS's sub-forum gives its authorisation.[338] Further the SOP records that:

> "*The Scheme reserves the right to negotiate the following payment arrangements:*

[334] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 102-103, para 11.8.5).
[335] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 609).
[336] Dr Kimmie's report, 18 November 2019, "Notes: GEMS/Metropolitan Health Interview", p 132, para 8.
[337] Dr Kimmie's report, 18 November 2019, "Notes: GEMS/Metropolitan Health Interview", p 132, para 10.
[338] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 103, para 11.18.9).

- *A lump sum payment;*
- *Arrangements to repay over a period of 6,12 and/or 24 months; and*
- *Set-off against future claims*
    - *o If set-off is applied the Scheme has the discretion to set-off the amount negotiated against future claims due to the service provider; and*
    - *o The accepted claims to be reviewed prior to each claims run to determine that sufficient claims have been submitted to apply set-off."*[339]

264 Finally, GEMS also submitted that in 2019 it changed its approach of reversing all irregular transactions to:

> "*loading of debt based on a negotiated AOD … to ensure that debt processed onto the provider's debt system had a high degree of recoverability. This process is also more favourable to the specific provider, in that certain instalments and/or other terms are negotiated with the provider to enable him/her to still continue to practice, whilst repaying the debt. If all irregular transactions were to be reversed at once, all claims submitted by the provider would automatically set-off against the debt, which would result in the provider not receiving any funds.*"[340]

265 GEMS submitted that in the past it has incentivised recoveries by its service providers. It explained that "for a brief period in 2016 and a portion of 2017 GEMS incentivised recoveries on the basis that the relevant service provider who facilitated the recovery of a specified amount would be entitled to a

[339] GEMS fourth supplementary submission, 23 January 2020, "GEMS Employees Medical Scheme (GEMS) – Medical and Fraud, Waste and Abuse Recoveries Standard Operating Procedure (SOP)" (GEMS supplementary bundle, p 603).
[340] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 103, para 11.18.7).

commission of 10% of that amount."[341] GEMS further submitted that by 2018 there was not any incentivisation of service providers involved in recoveries.[342]

c. Suspending payment of claims and terminating direct payment arrangements

266 GEMS submitted that it temporarily suspends the payment of claims to practitioners where an investigation was underway. However, it was contended elsewhere that payments have been suspended before an investigation[343] or at the same time the anomalies letter is sent to the practitioner.[344]

267 It justified its approach with reference to the GEMS Rules which provide that the:

> "*Scheme shall suspend the payment of a claim or a request for reimbursement to a provider in the event of an investigation pertaining*

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[341] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 102, para 11.18.3).

[342] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 102, para 11.18.4).

[343] Klinck submission, undated, p 2, para 2.

[344] Ms Klinck (Transcript, 21 August 2019, p 15, lines 6 – 12). See also: Ms Klinck (Transcript, 21 August 2019, p 31, line 23 – p 32, line 5), where it was stated that:

> "*So in this very particular case by the time the client received this letter his claims were already suspended and when we attended the meeting it was one of the first questions that I asked, if there was a suspension on the claim of the client and – because the client was not informed but he could pick up from claims that he submitted that he was not getting paid and it was at the meeting that was disclosed that the client was already under suspension even though we had not had an opportunity to meet yet to get the outcome of the enquiry*."

See also: Dr Talatala (Transcript, 29 August 2019, p 19, lines 12 - 14), where Dr Talatala stated that:

> "*But at some stage, there was a time where some of the schemes and I didn't bring that – they would suspend even before they tell you that they are investigating you.*"

See further: Ms Sikhakhane (Transcript, 30 January 2020, p 107, lines 24 - 25), where Ms Sikhakhane stated:

> "…*actually Doctor Ngombela learnt for the first time when she got the first letter that she had been suspended."*

> *to alleged fraud or irregular activity … except where to do so in particular circumstances would not be in the best interests of the Scheme, in the absolute discretion of the Board.*"[345]

268 GEMS submitted that this part of its Rules and section 59(2) of the Act places an obligation on GEMS to act to prevent further losses.[346]

269 GEMS further submitted that in addition to the temporary suspension of payments of claims to practitioners it also permanently removes practitioners from direct payment arrangements (with an option of later applying to be placed back on a direct payment arrangement). GEMS also justified this approach based on its Rules which provide that:

> "*Scheme may in accordance with Rule 17.5 make payment of the full amount of a claim or a request for reimbursement, or the valid portion thereof which is not under such investigation, directly to the member to whom services were rendered.*"[347]

270 Rule 17.5 of the GEMS Rules provides that the "Scheme has the right to pay any benefit directly to the members concerned" notwithstanding the provisions which make allowance for the payment of providers.

271 GEMS submitted that "where the Scheme becomes aware of <u>possible</u> irregular claims, it has an obligation to act in terms of its policies and prevent

[345] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 32, para 10.7.1), which quotes Rule 15.6.
[346] *Ibid*.
[347] *Ibid*.

further loss, which it does by terminating direct payment to the provider concerned."[348] (our emphasis)

272 GEMS informs practitioners that they have been removed from direct payment arrangements. GEMS provided the Panel with the standard wording that is used for such notice.[349]

273 GEMS gives practitioners an opportunity to apply to be re-instated on direct payment. The practitioner is required to complete an application which will only be considered once either the civil, professional or criminal processes against the practitioner are complete; or after the expiry of a 24 month period calculated from the date on which the practitioner was removed from a direct payment arrangement.[350]

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[348] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 32, para 10.7.2).

[349] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 39, para 10.8.2), the wording is as follows:

> *"As provided for in Section 59 of the MSA, GEMS members will receive direct payment from the Scheme for the procurement of healthcare products and services rendered by you. This means that your claims will not be considered and you will be required to recover such costs from members directly. The GEMS member concerned will be responsible for submitting the claim for the services rendered with a valid proof of payment and in line with the Scheme Rules. We encourage that you support members in providing them with all the relevant documentation they would* require in submitting claims to the Scheme to pay them. For ease of reference, this is detailed below.
> *The claim submission must include proof of payment in the form of:*
> *• A valid stamped receipt from the healthcare provider with the corresponding detail; and*
> *• Proof of payment in the form of an electronic fund transfer (EFT) slip or credit card payment voucher with provider details corresponding to the claim reference; or*
> *• Proof of payment in the form of a bank deposit slip with provider details corresponding to the claim reference."*

See also: GEMS supplementary submission, 12 August 2019 (GEMS bundle, p 30, para 13.9). See further: GEMS third supplementary submission, 30 September 2020 (GEMS bundle, p 202, para 9.8; p 239, para 7.2; para 240, para 10; p 260, para 12.2.1), for examples where GEMS confirms that, in some instances, direct payment to practitioners is suspended pending the finalisation of an investigation.

[350] GEMS power point presentation, 28 January 2020, slide 54.

(v) GEMS' approach to coding errors

274 In GEMS' written submissions it indicated that the 2006 NHRPL is the official published tariff guide for health care professionals in South Africa. It further indicated that GEMS uses the 2006 NHRPL has the basis for billing and tariff management. It noted that it has recently conducted a comprehensive "GAP analysis" between the "GEMS tariff file" and the "industry tariff files" of various professional associations. It robustly then submitted that:

> "*The GEMS tariff file for 2020 is thus the most updated version representative of industry tariff files. The interpretation thereof (whilst it is actually simple to use) is a common excuse given by providers when irregular claims are submitted.*"[351]

275 In GEMS's oral evidence it submitted that where a practitioner makes what it considers to be a coding error this could result in a reversal and a recovery.[352] GEMS ultimately adopted a less robust approach in the oral evidence and accepted that there was confusion regarding which codes should be used on invoices and further suggested that the whole industry, including practitioners, needed education about which codes to use.[353]

(vi) GEMS approach to confidential information

276 GEMS addressed the Panel in relation to its practice of requesting confidential information about patients from practitioners. GEMS submitted that it does not

[351] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 109 - 110, para 12.7.11 – 12.7.15).
[352] Dr Moloabi (Transcript, 28 January 2020, p 82, lines 8 – 14).
[353] Dr Moloabi (Transcript, 28 January 2020, p 82, line 20 - p 83, line 10).

request “detailed records” but rather that it seeks patient’s clinical notes or patient files in order to simply “validate services.”[354]

277 GEMS argued that it was entitled to do this for a number of reasons including that when members apply for GEMS membership they consent to their private information being made available to the scheme or administrator.[355] GEMS’s membership application form provides as follows:

> “*11. If I am accepted as a member, I must, both now and in future, give GEMS all such information and evidence as it may require from time-to-time for the purpose of my dependants and my membership of GEMS. For this purpose, I authorise GEMS and/or its agents to obtain from any person any information that they may require concerning me or my dependants for any purpose which directly relates to our medical scheme membership or which is authorised in terms of the Act, the Rules or any other legislation. I direct that person to provide GEMS and/or its agents with such information on request.*
>
> *12. I hereby authorise any medical doctor or other health care provider who has attended to me or my dependants in the past or who will attend to me or my dependants in the future, to provide GEMS and/or its agents with such information as it may require. I expressly grant GEMS the right to access my information and that of my dependants as and when it is necessary.*” [356] (Our emphasis)

[354] Ms Geater (Transcript, 28 January 2020, p 170, line 19 – p 172, line 4).
[355] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 47, para 10.22.3.2).
[356] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 48, para 10.23.1).

278 GEMS submitted that the above clause of its membership contract "obliges a provider" to provide any information which GEMS requests on condition that the request is not arbitrary.[357]

279 GEMS submitted further that private clinical information is in any event furnished to the scheme when a claim is submitted, such as the ICD10 code, which reveals the diagnosis and that the scheme cannot pay without this private information.[358]

280 In the event that a practitioner refuses to provide a patient's clinical notes or patient files on the basis that it is confidential, GEMS explained that it will engage with the practitioner. However, the nature of the engagement and the process which is followed depends on the anomalies identified and specific irregularities.[359] Similar to the approach adopted by Discovery, GEMS submitted that if a practitioner refuses to provide his or her clinical notes (and presumably as his or her patient files) GEMS regards the practitioner's behaviour as suspicious.[360]

281 It is the view of the Panel that the schemes on the whole failed properly to engage with the practitioner's concerns regarding confidential patient information. Discovery did concede this concern, indicating that forthwith they

[357] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 49, para 10.23.2 – 10.23. 3).
[358] Ms du Toit (Transcript, 28 January 2020, p 171, lines 10-17).
[359] Ms Geater (Transcript, 28 January 2020, p 170, line 19 – p 171, line 8).
[360] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 49, para 10.23.5).

would ensure that practitioners would be informed that patient files and notes could be redacted.[361]

13.3. Medscheme's response to procedural fairness

(i) *Overview of Medscheme's risk management system*

282 Medscheme is a health care administrator, established in 1970 and is accredited to perform administration and managed care services for 13 medical schemes as well as forensic services for 11 medical schemes.[362] Bonitas, Fedhealth, Sasolmed, Polmed and Medshield are amongst the 5 biggest medical schemes administered by Medscheme.[363]

283 Medscheme is duly remunerated for its services and receives a bonus incentive for the detection of FWA cases, as more fully set out below.

284 On a day-to-day, Medscheme "administers approximately 1.9 million lives and processes roughly 200 000 claims per day (6 million per month)."[364] All such claims are paid up front, in good faith, which it describes as the "cornerstone of private healthcare funding and why retrospective forensic analysis is crucial to detecting, investigating and preventing fraudulent or abusive billing and claiming."[365]

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[361] Dr Broomberg (Transcript, 29 January 2020, p 65, line 20 – p 66, line 2).
[362] Medscheme power point presentation, 30 January 2020, slides 1 – 7. See also: Dr Nyati (Transcript, 30 January 2020, p 8, lines 2 – 7) and Dr Ndlovu (Transcript, 30 January 2020, p 37, line 22 – p 38, line 12).
[363] Letter from Medscheme to CMS titled "Information requested during Presentation on 30 January 2020", 20 February 2020, para 2 (*confidential*), which provided the membership application forms of Bonitas, Fedhealth, Sasolmed, Polmed and Medshield.
[364] Medscheme submission, 18 July 2019 (Medscheme bundle, p 9, para 1).
[365] Medscheme submission, 18 July 2019 (Medscheme bundle, p 9, para 1).

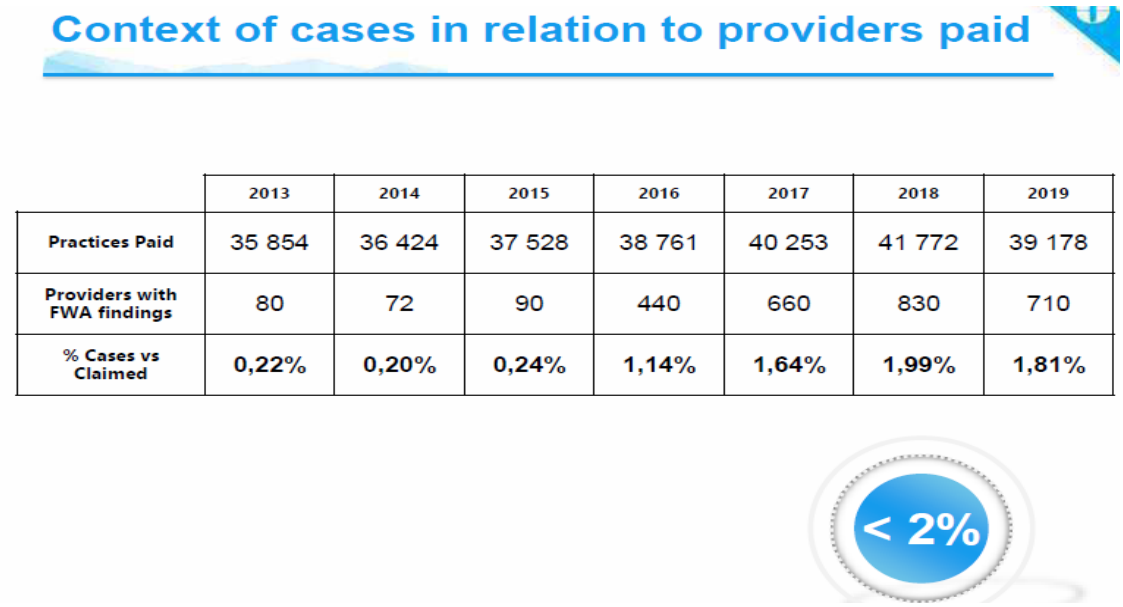
285 For the purposes of determining whether complaints are deemed to be detected as FWA, Medscheme utilises the following definitions:

285.1 Fraud is where a practitioner intentional and "knowingly submitting, or causing to be submitted, false claims or an international misrepresentation of the facts in order to access payment of a benefit to which you would otherwise not have been entitled."[366]

285.2 Waste and Abuse is where the practitioner is "claiming for healthcare treatment and services that are not absolutely necessary, including any form or over-servicing or over-charging a patient, and that may objectively be considered as not adding clinical value to the patient and/or as unethical or unconscionable or contrary to best practice and/or evidence-based medicine principles."[367]

286 Medscheme provided that its findings of FWA cases were high and, on the increase, as per the following slide:[368]

[366] Medscheme power point presentation, 30 January 2020, slides 51 - 60.
[367] *Ibid*.
[368] Medscheme power point presentation, 30 January 2020, slide 61.



287 Medscheme has emphasised that it has implemented a robust risk management system for the purposes of minimising FWA cases. The forensic process is divided into three divisions/stages, namely: (i) detection; (ii) investigation; and, lastly (iii) settlement.[369] This forensic process can then be further subdivided into its various parts:

287.1 Five mechanisms are utilised for the purposes of detecting FWA cases, which include tip-off processes, healthcare provider vetting processes, analytical process, operational and financial controls, information sharing through industry initiatives and general media monitoring, which is discussed more fully hereunder.[370]

287.2 Once a FWA matter has been detected, it is investigated by way of data analysis and verification of services.[371]

[369] Medscheme submission, 18 July 2019, Medscheme's NHCPA presentation (Medscheme bundle, p 280, para 3).
[370] Medscheme submission, 18 July 2019 (Medscheme bundle, p 12 - 15).
[371] Medscheme submission, 18 July 2019 (Medscheme bundle, p 15 para 4.3). See also: Medscheme supplementary submission, 08 August 2019, Annexure "E4": "External Investigation Process" (Medscheme bundle, p 1071 – 1081, para 3).

287.3 Subsequent to investigation Medscheme enters into the settlement stage, which consists of quantification and sanctioning, recovery of payments and other sanctions.[372]

288 Medscheme submits that its FWA processes are unpopular, however that it is integral to the proper functioning of a proper medical aid scheme:

> "*In a perfect world all claims would be paid irrespective of the cost. The provider would be happy; the member would be happy. This is just not possible. One of the most important controls is protecting these very limited financial resources is strong FWA risk management, It Is not a popular function, but it is critical in safeguarding funds to keep contributions lower and benefits richer. Without it private healthcare would be substantially more expensive for everyone.*"[373]

289 The detection and analysis of the FWA cases are managed by Medscheme's Healthcare Forensic Unit in its operations, made up of 53 employees, whom have varying qualifications and are from diverse backgrounds.[374]

290 The Panel questioned Dr Nomalungelo Nyati of Medscheme, and queried whether the employees making up the Healthcare Forensic Unit were medical professionals. Dr Nyati stated that professionals are employed for the purposes of assessing cases regarding authorisation.[375]

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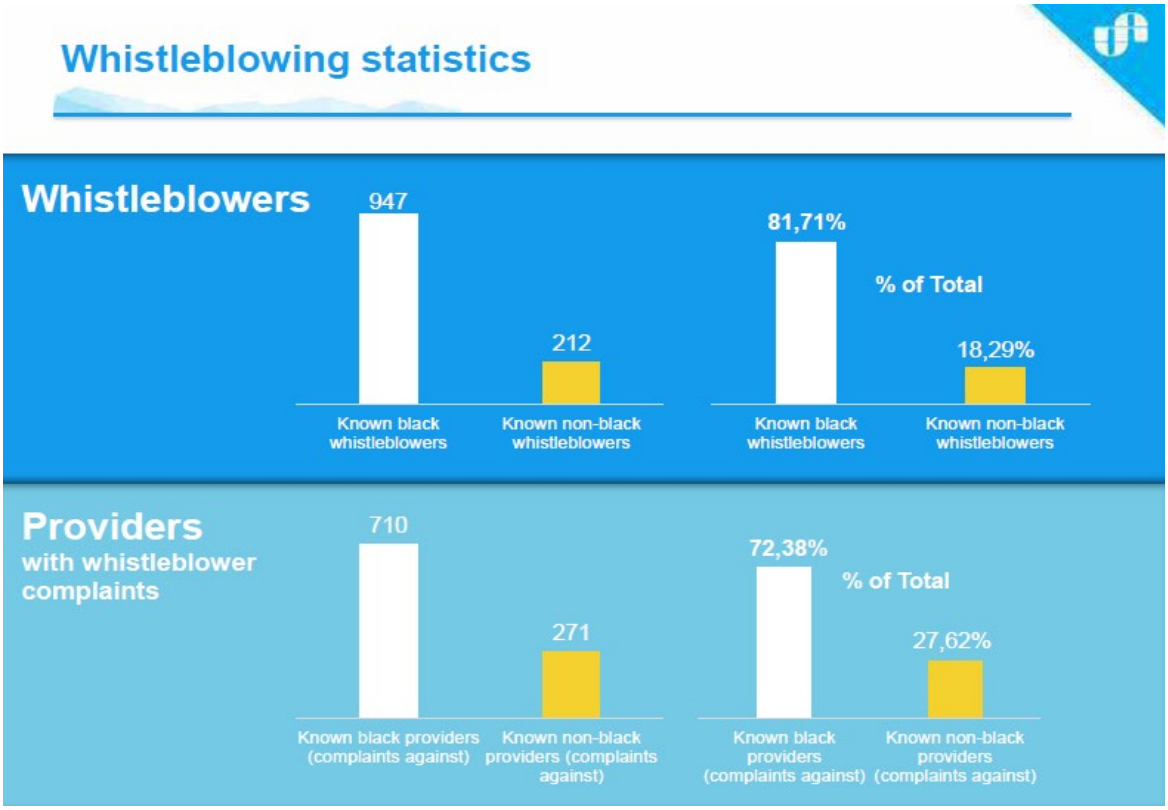
[372] Medscheme submission, 18 July 2019 (Medscheme bundle, p 17 – 20, paras 4.3.3 – 4.3.5).
[373] Medscheme submission, 18 July 2019 (Medscheme bundle, p 23 – 24, paras 4.3.3 – 4.3.5).
[374] Medscheme submission, 18 July 2019 (Medscheme bundle, p 10, para 2).
[375] Dr Nyati (Transcript, 30 January 2020, p 11, lines 13 – 25):
"...So, some cases authorisation. So, a member needs to go into hospital, they request an authorisation. Some of those authorisations are easy to make a decision on whether to authorise or not to authorise. But some of them require more in-depth information where the clinical expertise is required to be able to understand the information that is provided to be able to do an authorisation. And some are queries so they are not necessarily assessing claims, they are dealing with member queries from providers or from 20 members or from the Council

(ii) *Medscheme's approach to detection*

291 As set out above, Medscheme has 5 sources of detection of FWA, tip-off/ whistleblowers being the first mode.[376] Medscheme has a fraud hotline in terms of which any member of the public can report an irregularity and, according to Medscheme, they receive 150 to 200 reports monthly. Medscheme provide the following graphic, which depicts reporting by way of known race:[377]



and we have clinical people to deal with those queries. Because sometimes there is new information that gets provided at the time of the query and they have to assess those and see if anything has to change in our process."

[376] Medscheme submission, 18 July 2019, "Whistleblower reports" (*confidential*) and "*Tip Off Process*" (Medscheme bundle, p 13, 15, 61 – 157) and Medscheme supplementary submission, 08 August 2019, Annexure "E1": "Tip off process" (Medscheme bundle, p 1027 - 1038) . See also: Mr Midlane (Transcript, 30 January 2020, p 158, line 10 – p 160, line 20).

[377] Medscheme power point presentation, 30 January 2020, slide 68.

292 It is noteworthy that the quantification of whistleblowers and providers identified by whistleblowers are identified by race, in this regard, 72.38% of total identified practitioners are "Known black providers". Another significant statistic is the number of practitioners that are flagged in relation to the various methods utilised by Medscheme – this was clarified at the hearing of the matter:

> *"**ADV ADILA HASSIM:** Before you move on can you just say what percentage of your-those that are flagged or whatever is identified claims-service providers that is identified. What percentage comes through the [redacted] and what from the other means? Because there are several methods that-*
> ***MR PAUL MIDLANE:** Correct.*
> ***ADV ADILA HASSIM:** You employ in order to identify-*
> ***MR PAUL MIDLANE:** Yes.*
> ***ADV ADILA HASSIM:** Which claim for investigation.*
> ***MR PAUL MIDLANE:** Thank you Advocate Hassim. When we deal with the Dr Kimmie report the stat is 53 47 which I mean believe it or not it is the name status yesterday but it is completely independent result. It just is what it is.*
> ***ADV ADILA HASSIM:** 53 come from?*
> ***MR PAUL MIDLANE:** 53 from tip-offs, 47 from analytical."*[378]

293 The Analytical Process consists of (i) a rule-based analytical system that functions by way of the systematic development of 'flags' over time, this equates to the identification of outliers within a dataset based on pre-defined rules; and (ii) predictive analytics, which is the employment of mathematical algorithms to identify outliers within a particular dataset. [379]

[378] Mr Midlane (Transcript, 30 January 2020, p 140, lines 1 - 15).
[379] Medscheme submission, 18 July 2019, "Analytical Process" (Medscheme bundle, p 13 – 14) and Medscheme supplementary submission, 08 August 2019, Annexure "E3": "Analytical Process" (Medscheme bundle, p 1049 - 1070).

294 The Analytical Process is managed by Medscheme through the [redacted] ([redacted]) as from 2015.[380] Medscheme licensed the analytical system from [redacted] in April 2015, and the "Medical Professional Model into production in October 2015, the Pharmacy Model in October 2016; and the Facility Model on February 2017."[381]

295 The [redacted] makes use of an algorithm that scores every single claim. There are four scoring models licensed by Medscheme, namely (i) Medical Professionals which is utilised for the purposes of general practitioners, specialists, auxiliary, optometry, pathology, etc; (ii) Pharmaceutical which it utilised for pharmacies and medicines; (iii) Facility which is utilised, amongst others, for hospitals, step-downs and rehabs; and lastly (iv) Dental. [382]

296 The [redacted]l does "not confirm FWA….it highlights outliers that require further analytical scrutiny." Medscheme further stated that they "have not assessed whether there are any real or potential biases with cases identified by the [redacted]", further that the algorithm has in "no way" been altered.[383]

297 Prior thereto, Medscheme did not use an automated system, they relied solely whistleblower tip-offs and leads generated internally from business units and

[380] Mr Midlane (Transcript, 30 January 2020, p 135, line 22 – 138, line 18).
[381] Medscheme submission, 18 July 2019, Response to Request for Information" ("**Response to Request for Information**") (Medscheme bundle, p 289).
[382] Medscheme supplementary submission, 08 August 2019 (Medscheme bundle, p 289, paras 2(a) and (b)).
[383] *Ibid.*

the broader industry.[384] After the introduction of the [redacted], the amounts recovered from FWA process grew dramatically:

297.1 In 2015, FWA cases to the value of R [redacted] were recovered;

297.2 In 2016, FWA cases to the value ofR [redacted] were recovered;

297.3 In 2017, FWA cases to the value of R [redacted] were recovered

297.4 In 2018, FWA cases to the value of R [redacted] were recovered; and

297.5 In 2019, FWA cases to the value of R [redacted] were recovered.[385]

298 Another manner of detection is Medscheme's Operational and Financial Controls, which are described as inherent controls including exception limit reports, onsite case management, provider network departments, managed care reporting, internal and external audits, financial reporting and statements, claims assessing and benefit rules[386] These inherent controls assist in identifying suspicious billing or claiming.

[384] Medscheme supplementary submission, 08 August 2019 (Medscheme bundle, p 289, paras 2(a) and (b)). See also: Medscheme supplementary submission, 08 August 2019, annexure "B1": "Explanation Behind [redacted] Predictive Models" (Medscheme bundle, p 835), which provides that medical predictive models use the following variables including claim ID, claim line number, provider ID, member ID, procedure code modifiers, units, allowed amount, paid amount, claim begin date, claim end date, diagnoses codes, place of service, type of services, provider speciality, provider practice (whether the provider is an individual or a group, members date of birth and member gender).

[385] Medscheme supplementary submission, 08 August 2019 (Medscheme bundle, p 291).

[386] Medscheme submission, 18 July 2019 (Medscheme bundle, p 14 - 15).

299 The penultimate manner of detection is termed as 'Information sharing and industry initiatives' by Medscheme. [387] This involves the reporting of fraudulent or suspicious activity in respective of other medical schemes, which information is circulated to other medical schemes.

300 Lastly, Medscheme utilises general public, formal media and social media as a mode of detecting FWA matters.[388] This essentially entails monitoring comments in newspapers, online articles and platforms such as Facebook.

(iii) *Medscheme's approach to investigation*

301 Pursuant to either a whistleblowing report, an outlier being identified by means of the [redacted] or any of the other methods of detection as specified above, a forensic analyst is appointed for the purpose of applying the relevant legal, financial, clinical or institutional principles to the facts as they are presented.[389] The application of these principles is described as the 'data analysis' process, which is the first tier of the investigative process.[390]

302 According to Medscheme, the analyst then conducts an exercise to verify services, which forms the second tier of the investigative process.[391] This can consist of a desktop analysis, which would be a suitable in the event that the

[387] *Ibid*.
[388] *Ibid*.
[389] Medscheme submission, 18 July 2019 (Medscheme bundle, p 15; para 4.3). See also: Mr Midlane (Transcript, 30 January 2020, p142, line 12 - p 143, line 22).
[390] Medscheme submission, 18 July 2019 (Medscheme bundle, p 15, paras 4.3).
[391] Medscheme supplementary submission, 08 August 2019, Annexure "E4": "*External Investigation Process*" (Medscheme bundle, p 1071 – 1081).

complaint related to a pure incorrect coding issue or a licensing query; or a physical verification of services that require an onsite inspection. [392]

303 The onsite inspections are often unannounced, for the purpose of avoiding practitioners "window dressing." Medscheme stated that they do, however, "identify themselves upfront and obtain the consent of the practitioners, pharmacy owner of facility manager to inspect the premises and records." However, if the practitioner does not allow the unannounced inspection or "refuses to cooperate" with the requests as outlined in a desktop audit, the medical schemes cannot continue honouring claims from that practice.[393]

(iv) *Medscheme's approach to settlement and sanction*

304 The consequences of a finding by Medscheme are similar to other schemes. Subsequent to having investigated complaints and having reached a finding, Medscheme will quantify the FWA claim and sanction the practitioner, thereafter seek to recover overpayments and will, where necessary, ensure other sanctions are also given effect. These other sanctions include (i) placing the practitioner on indirect payment; (ii) termination of membership; (iii) the cancellation of contractual relationship; (iv) referral of the matter to the HPCSA if the conduct is grossly unethical or dishonest; or (v) lodges a criminal case with the SAPS in the event that there is clear criminal intent.[394]

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[392] *Ibid*.
[393] *Ibid*.
[394] Medscheme submission, 18 July 2019 (Medscheme bundle, p 18 – 20, paras 4.3.4 – 4.3.5). See also: Medscheme power point presentation, 30 January 2020, slide 5 and Mr Midlane (Transcript, 30 January 2020, p 160, line 12 – p 165, line 7).

305 Medscheme contended that the only real recourse for FWA cases was to "deduct such amount from any benefit payable to such a member or supplier of health services" in terms of section 59 of the Act.[395]

306 The process of quantification and sanctioning requires the quantification of financial loss based on the findings, whereafter Medscheme attends to inform the practitioner, who is provided with an opportunity to make further representations.[396]

307 The Panel queried the manner in which the amounts owed were formulated and whether these amounts were properly formulated.[397] One answer was that a 5% extrapolation over a period of time was used to determine recoveries.[398]

308 The administrator places the burden on the practitioner to refute this by producing records. If the provider cannot explain the anomaly, then the scheme imposes the amount: "And if you can't [explain the anomaly] then we do estimate the loss."[399]

> *"And then you say a total of 5% from your total claims will be recovered. So, you don't explain the quantification you to say a total of 5% over that period of time of your retrospective analysis. And you say it's resulted in a financial impact to the schemes and you see there R65,000, more than R65,000. And if you go to page 2394 on the very*

[395] Medscheme submission, 18 July 2019, Annexure "S": "Healthcare Fraud, Waste and Abuse presentation to the NHCPA" (Medscheme bundle, p 272 - 291).
[396] Medscheme submission, 18 July 2019 (Medscheme bundle, p 17 – 18, para 4.3.3). See also: Medscheme power point presentation, 30 January 2020, slide 55 and Mr Midlane (Transcript, 30 January 2020, p 160, line 12 – p 165, line 7).
[397] Mr Midlane (Transcript, 30 January 2020, p 71, line 17 – p 72, line 7).
[398] Mr Midlane (Transcript 30 January 2020, p 73, line 15 – p 74, line 25).
[399] Mr Midlane (Transcript, 30 January 2020, p 74, lines 11 – 25).

same day, Dr Ngumbela receives a letter from you on behalf of Bonita's for exactly the same problem, exactly the same issues in the exact same wording for the total of 5% of claims for more than 44,000. Is this typo as well?
MR PAUL MIDLANE: The typo is that Bonita's is referred to in both letters and it does appear to be a quality assurance problem. We do have controls in place for quality assurance but it should not be in two letters. And we must definitely address that..."[400]

309 When considering the correspondence provided to the Panel it was evident that Medscheme does not use a consistent methodology to calculate amounts to be recovered. Instead, Medscheme adopts a case by case approach. There are therefore real concerns about both Medscheme's identification of FWA *and* the quantification of any amounts owing. Further, there appears to be no independent process or arbiter, and there seems to be a clear lack of quality control.

310 Medscheme relies on the legal opinion of Loxton SC to justify their approach. This opinion, however, clearly shows that administrators must "act reasonably and in good faith before making deductions", to ensure that there is a fair process and that the finding and quantification are substantively reasonable.[401]

311 Thereafter, a practitioner can either agree to a payment arrangement by way of entering into an AOD, repay the quantified amount directly or by way of set off. That is to say Medscheme takes the approach that "a medical scheme can

[400] Mr Midlane (Transcript, 30 January 2020, p 68, line 19 - p 69, line 15).
[401] Medscheme submission, 18 July 2019, Annexure "P": advisory opinion of Adv C Loxton SC titled "Interpretation of section 59" ("**Adv Loxton SC's opinion**") (Medscheme bundle, p 250, para 19).

invoke a set-off from future claims as provided for in Section 59(3)(a) and (b)" of the Act.[402]

312 Where a practitioner "is repetitively found to have displayed abusive billing practices … they may be placed on "Indirect Payment" status. This means that claims will be refunded to the members and the duty will be on the practice to charge cash or to recover unpaid accounts from their patients. This is a last resort when a medical scheme cannot trust the practice to submit valid claims that do not require further scrutiny. The member must then submit the claim to the scheme or administrator for reimbursement, and provide proof that the account has been settled with the practice. This shifts the onus onto the member to verify the service before the claim is paid."[403]

313 The Panel was provided with standard form contracts entered into between Medscheme and schemes for identifying and investigating FWA and recovering amounts. According to these contracts between Medscheme and various schemes, Medscheme obtains an incentive bonus and is remunerated as follows:

313.1 [redacted]

[redacted]

[402] Medscheme submission, 18 July 2019 (Medscheme bundle, p 18 – 19, para 4.3.4).
[403] Medscheme submission, 18 July 2019 (Medscheme bundle, p 19 – 20, para 4.3.5).

[redacted]

313.2 [redacted]

[redacted][407]

314 Medscheme thus receives substantial remuneration for their administration and forensic services fees.

(v) <u>Medscheme's approach to codes: coding errors and coding abuses</u>

315 As set out above, Medscheme estimates that around 50% of FWA cases are as a result of coding issues.[408] When investigating coding anomalies, Medscheme has regard to the Relative Value Units, appropriateness, aim,

[404] Bonitas supplementary submission, 12 February 2020, Annexure D: "Value Add Report 2017 – 2019" ("**Value Add Report**") (Bonitas supplementary submission bundle, p 52 – 53).
[405] Letter from Medscheme to CMS titled "Information requested during Presentation on 30 January 2020", 20 February 2020, where the Panel with copies of their forensic service agreements (*confidential*).
[406] Bonitas supplementary submission, 12 February 2020, Value Add Report (Bonitas supplementary submission bundle, p 52 - 53).
[407] Letter from Medscheme to CMS titled "Information requested during Presentation on 30 January 2020", 20 February 2020, where the Panel with copies of their forensic service (*confidential*).
[408] Dr Pratt (Transcript, 30 January 2020, p 48, lines 10 -11).

billing *versus* funding rules, consistency and code irregularities (up-coding, unbundling, padding, manipulation and over-charging).[409]

316 During the course of the hearing Medscheme submitted, amongst others, that it accepts the vast majority of coding but not all:

> *"**ADV ADILA HASSIM:** And do you accept all the let's say procedural and diagnostic descriptors for wants of a better word, does Medscheme accept all the procedural and diagnostic ...[intervenes].*
> ***DR GREGORY PRATT:** I would say the vast majority. It is an evolving document, each year new codes get added. Schemes then have the option to either accept the code as a descriptor level to either accept the code as a descriptor level, or in terms of the relative value units that has been given.*
> ***ADV ADILA HASSIM:** On behalf of your scheme do you accept all the descriptors and procedural codes as they evolve?*
> ***DR GREGORY PRATT:** Not every single on.*
> *…*
> ***ADV ADILA HASSIM:** Leave aside the tariffs for the moment. I accept there is a difference. I am just talking about the procedural and diagnostic codes.*
> ***DR CLAUDE SIMPHIWE NDLOVU:** The point is, there is going to be a large variety amongst even the schemes you represent as to what they are reimbursed for.*
> ***DR CLAUDE SIMPHIWE NDLOVU:** Yes you are right. You are right. Yes.*
> ***ADV ADILA HASSIM:** Am I right to say a larger variety?*
> ***DR CLAUDE SIMPHIWE NDLOVU:** Not large variety. No-no. So, because it depends on the number of number of codes that gets introduced on ANO basis, and also when we do the review, we do the review of the entire coding chapter, and the recommendation we base on all of that and the same recommendation goes to all the schemes.*

[409] Medscheme power point presentation, 30 January 2020, slides 2- 34. See also: Dr Pratt and Dr Nyati (Transcript, 30 January 2020, p 49, line 3 – p 69, line 1).

ADV ADILA HASSIM: *Would it be correct to say that it does create a complex billing system for health care providers?*

DR CLAUDE SIMPHIWE NDLOVU: *Yes, completely, completely.*

…

ADV ADILA HASSIM: *Then if there are irregularities on the doctor's claims, the coding irregularities does that go into a Fraud Waste and Abuse investigation?*

DR NOMALUNGELO NYATI: *It goes into an investigation of different kinds, so some of those you engage with the provider societies, because you are seeing, sometimes you see an irregularity at much bigger levels, sometimes then you have the conversation with the provider in question themselves and some of those then are explainable and you deal with it. And you close the case and life moves up.*

But it does show up as an irregularity, depending on the nature of the issue.

…

ADV TEMBEKA NGCUKAITOBI: *As an irregularity. But in the Discovery system it picks it up within that Regulation 5 and Regulation 6 process. What about your system?*

DR GREGORY PRATT: *So there are many code rules in a system that will pick up, for example if you have a code linked to a female condition, it will reject on male beneficiary. Yes that will happen.*

Where certain codes have rules you cannot use this code with that code, that will pick up in our system. But where you can have codes used in the same health care event, depending on the actual circumstances it would not pick up that a code is invalid or not invalid. We need to find out the actual context of that event to determine that. For example, if you get a person who is billing a laparotomy, doing an operation on a person, closing the wound up again afterwards is included in the operation fee. But if you charge an extra code for suturing a wound, it would only be valid if there was a separate wound that was sutured. And it was not used to suture the primary surgery wound.

So you cannot tell that from a claim. It would come later through context

…

> ***ADV TEMBEKA NGCUKAITOBI:*** *And in relation to those it misses you and then you do a post payment investigation?*
> ***DR GREGORY PRATT:*** *So that is the type of thing that would be picked up on retrospective analyses that are done at a forensic level.*
> ***ADV TEMBEKA NGCUKAITOBI:*** *And do you have sense of the proportion of coding irregularities that are picked up prior to payment, this are those that are only discovered subsequent to payment?*
> ***DR GREGORY PRATT:*** *I could not tell you a proportion."*[410]

317 Medscheme conceded, however, that there is a complex billing system for practitioners[411] and that there should be unified coding standards.

318 Medscheme submitted that they promote the standardization of coding – in terms of their participation in the Fraud, Waste and Abuse summit held by CMS in February 2019 and the formation of a charter, which provides for the unification of coding standards by *inter alia* removing complexity, enabling "code unbundling", "up coding" and "code farming." [412]

(vi) *Medscheme's approach to confidential information*

319 Medscheme is of the view that there is no issue with the investigative team requesting access to treatment records such as patient files and patient notes. Medscheme submitted that "the onus is on the provider to get member consent if he wishes to submit claim directly to medical scheme for payment.[413] This contention is based on Section 15(1) of the National Health Act and Regulation 15J(2)(c) of the Regulations:

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[410] Dr Pratt (Transcript, 30 January 2020, p 42, line 11 – p 47, line 18).
[411] *Ibid*.
[412] Medscheme submission, 18 July 2019 (Medscheme bundle, p 12).
[413] Medscheme submission, 18 July 2019, Annexure "S": "Healthcare Fraud, Waste and Abuse presentation to the NHCPA" (Medscheme bundle, p 285).

319.1 Section 15(1) provides that a “health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, healthcare provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interest of the user”; and

319.2 Regulation 15J(2)(c) of the Medical Scheme Regulations provides that “subject to the provisions of any other legislation, medical scheme is entitled to access any health record held by a managed health care provider and other information pertaining to the diagnosis, treatment and health status of the beneficiary in terms of a contract entered into pursuant to regulation 15A, but such information may not be disclosed to any other person without the express consent of the beneficiary”.

320 This concludes the overview of the schemes’ responses to the complaints, both in respect of unfair discrimination and in respect of the fairness of the FWA processes.

321 In the next two chapters, the Panel provides its views and analysis of the two distinct areas of concern, namely, unfair discrimination and procedural fairness.

PART 2(A): UNFAIR DISCRIMINATION

PART 2(A) : TABLE OF CONTENTS

PART 2(A)

CHAPTER ONE: UNFAIR DISCRIMINATION

14. INTRODUCTION

14.1. The Allegations

322 This chapter addresses the allegation that medical schemes and their administrators unfairly discriminate against Black[414] practitioners in:

> "*that they were being unfairly treated and their claims withheld by medical schemes based on race and ethnicity.*"[415]

323 The allegations of racial discrimination, as per the Terms of Reference, are as follows:

> "*(i) targeting Black and health care practitioners ("practitioners") in relation to conducting practice audits;*
> *(ii) forcing Black and Indian practitioners to enter into settlement agreements for the payment of large monetary amounts where alleged fraud or other illegal conduct is suspected;*
> *(iii) generally engaging in racial profiling in the manner in which such medical schemes and their administrators are making use of section 59 of the Medical Schemes Act, 1998 ("the Act");*

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[414] As set out in Part 1 of this Report, the Terms of Reference refer to "Black and Indian practitioners". We use the term 'Black' in both its generally understood form (referring to people who would, under the Apartheid system, have been classified as non-White) and in the more limited form in the classification scheme developed by Dr Kimmie (people whose surnames are linked to particular African or South-East Asian ethnic groups). The second Black group (that picked out by Dr. Kimmie's classification) is clearly contained in, but not equal to, the first Black group. The second use of the term "Black" is limited to those instances where we explicitly discuss the results of Dr. Kimmie's analysis and the responses to that analysis. We will, based on the outcome of that analysis, make inferences in respect of Black people (in its first use – i.e. classified by the Apartheid system as non-White). So, when we ask questions about racially biased outcomes ("are Black practitioners more likely to be identified as having committed FWA?") we are using Black in the first form. When we answer that question using the data and analysis presented to the Panel we use Black in its second restricted form, and when we make findings we once more extrapolate from the statistical analysis to the second broader category of Black people.

[415] Terms of Reference, p 1.

(iv) illegally refusing to pay Black and Indian practitioners for services rendered to patients;
(v) causing Black and Indian owned health care practices to close down their practices, as a result of unlawfully withholding payments, and as a result reducing access to healthcare. (These are referred to as "the allegations".)"

324 Racial profiling is a term which developed in the context of law enforcement and anti-terrorism law. The phrase is used to describe the targeting of a group of people through

> "*the systematic association of sets of physical, behavioural or psychological characteristics with particular offences and their use as a basis for making law enforcement decisions.*"[416]

325 Racial profiling can be both implicit and explicit and is one method by which racial discrimination may occur.

326 The allegations are extremely serious and the Panel is aware that its conclusions and recommendations may impact schemes, their administrators and the complainants. For this reason, the Panel has gone to great lengths to provide a comprehensive analysis of anti-discrimination law. It has also obtained expert evidence on the social manifestation of discrimination. Too often, legal analyses of equality are removed from the sociology of how discrimination affects people's lives and the Panel sought to attenuate this divide.

[416] United Nations, Counter-Terrorism Implementation Task Force Working Group on Protecting Human Rights while Countering Terrorism, Basic Human Rights Reference Guide: The Stopping and Searching of Persons in the Context of Countering Terrorism, updated 2nd ed.(New York, March 2014), p 12.

14.2. The Panel's Mandate

327 The Panel does not (and was not mandated to) make findings in respect of the individual complaints of racial discrimination. Rather, the Panel was mandated to investigate whether there was racial discrimination in the manner in which schemes and their administrators were implementing section 59 of the Act in general. As the investigation proceeded it became apparent to the Panel that to answer the aforementioned question, two prior questions needed to be investigated and answered:

327.1 Is there an explicit racial bias in the algorithms and methods that the administrators and schemes use to identify FWA?

327.2 Are the outcomes of the administrators and schemes' FWA processes racially biased? In particular, were Black providers identified as having committed FWA at a disproportionately higher rate than non-Black providers.

328 We note that the administrators and schemes appeared to have unduly emphasised one of the meanings of the word "bias", being purposeful bias - often the evidence given was aimed at persuading the Panel that there was no *intentional* bias. As we explained during the oral hearings, on a number of occasions,[417] we were concerned with investigating racial discrimination and more particularly whether the outcomes of the FWA detection and

[417] Dr Moloabi (Transcript, 28 January 2020, p 141, line 11 - p 142, line 11; p 205, lines 2 - 13). See also: Mr Callakoppen (Transcript, 27 January 2020, p 135, lines 2 - 18).

investigation process were racially discriminatory. We were concerned with unconscious rather than conscious bias.

329 As stated by the Constitutional Court in *City Council of Pretoria v Walker*,[418] the purpose of the prohibition of discrimination

> *"is to protect persons against treatment which amounts to unfair discrimination; it is not to punish those responsible for such treatment."*[419]

330 This is the primary purpose of the Inquiry.

331 The point of departure adopted by the Panel is that any allegation of racism in South Africa must be addressed with a communal and shared insistence that we work to eradicate unfair discrimination and racism. All the schemes and administrators, some earlier in the investigation than others, ultimately made a commitment to address the allegations in their individual capacities to the extent that their FWA investigations may lead to a differential impact on Black and non-Black practitioners.[420] Having said that, the schemes and administrators all denied that they engaged in conduct which produced racially discriminatory outcomes. In the view of the Panel this is a pity as the first step in properly addressing the allegations is taking responsibility for the conduct

[418] *City Council of Pretoria v Walker* 1998 (2) SA 363 ("***Walker***"), para 43.
[419] *Walker,* para 43.
[420] See for example: Dr J Broomberg (Transcript, 29 January 2020, p 5, lines 18 - 21), where Dr Broomberg, on behalf of Discovery, welcomes advice from the Panel on how to improve their FWA processes. See also: evidence on behalf of GEMS by Dr Moloabi (Transcript, 28 January 2020, p 158, line 24 - p 159, line 12) and the evidence on behalf of Medscheme by of Dr Nyati (Transcript, 30 January 2020, p 186, line 14 - p 194, line 5).

which produced skewed outcomes – even where such conduct was not intentional.

332 In its analysis, the Panel does not adopt a 'one size fits all' approach. Different schemes adopt different measures. On the whole, however, there are standard steps that the industry appears to follow in addressing FWA. The Panel approaches the question of discrimination in respect of these common steps. Similarly, its recommendations speak to best practices that can be adopted by schemes, administrators and practitioners.

14.3. The Evidence before the Panel

333 The Panel received an abundance of information relating to the question of discrimination, including legal, statistical and experiential information. The Panel is indebted to all participants for their comprehensive oral and written submissions.

334 The Panel was presented with an array of facts, data and opinions from the following sources:

334.1 Schemes and administrators: Information provided by Discovery; GEMS; Medscheme; Polmed; and Bonitas;

334.2 Individual complainants: the Panel received hundreds of complaints from individual practitioners and practices, describing their personal experience of treatment by the various schemes and administrators over a number of years. This ranged from individuals practicing in almost every province in the country to group practices and large

corporates such as Clinpath Laboratories; Joint Medical Holdings Pty (Ltd) ("**JMH**"); and the NHCPA;

334.3 Consultants to practitioners: Healthman (Pty) Ltd ("**Healthman**"); Elsabé Klink and Associates and Adv Hasina Cassim;

334.4 Industry organisations: Solutionist Thinkers Groups; NHCPA; South African Medical and Dental Practitioners Association ("**SAMDP**"); Health Funders Association ("**HFA**"); Independent Community Pharmacy Association ("**ICPA**"); South African Private Practitioners Forum ("**SAPPF**"); Faculty of Consulting Physicians of South Africa ("**FCPSA**"); SAMA; Board of Healthcare Funder ("**BHF**") and the Health Forensic Management Unit ("**HFMU**") and South African Society of Psychiatrists ("**SASOP**").

334.5 Regulators and government departments: The Competition Commission; the CMS; the HPCSA and the Department of Health ("**Department**").

335 The quality of the evidence varied significantly and as a result the Panel decided it would be prudent to engage experts who could perform particular tasks and who could advise it on some of the more difficult issues. It accordingly appointed and heard from the following three experts: Dr Kimmie, Professor Steyn and Advocate Trengove SC, as set out in Part 1.

336 Dr Kimmie provided the Panel with a draft report on 18 November 2019.[421] A redacted version of this report is attached as annexure "**A**" ("**Dr Kimmie's Report**").[422] Dr Kimmie presented evidence to the Panel on the 19th of November 2019.[423] The schemes then had an opportunity to respond to Dr Kimmie's report.[424] Dr Kimmie has since produced a further report to respond to the issues raised by the administrators and scheme. The further report of Dr Kimmie is attached as annexure "**B**" ("**the final report**").

14.4. Evidence of Discriminatory Outcome

337 Based on an assessment of the evidence, together with the application of anti-discrimination law, the Panel is of the view that the outcome of the FWA investigations, conducted by Discovery, GEMS and Medscheme, on the whole have the effect of unfairly discriminating against Black practitioners.

338 The reasons for this view are discussed in detail below.

15. THE POSITION OF THE SCHEMES

339 Before we proceed with our analysis, we provide a detailed overview of the position of the schemes in response to the allegations of racial profiling and racism in the FWA process.

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[421] Dr Kimmie, 18 November 2019, "Racial Discrimination in Identifying Fraud, Waste and Abuse: A Review of Processes and Outcomes".
[422] The redactions in the report are as a result of GEMS, Medscheme and Discovery indicating that some of the data they provided Dr Kimmie was confidential.
[423] Dr Kimmie (Transcript, 19 November 2019, p 2, line 2 – p 86, line 2).
[424] The schemes and administrators presented evidence to the Panel from Monday the 27th of January 2020 to Thursday the 30th of February 2020. The Panel has received a series of reports and responses from the schemes and their administrators, which are available on the CMS website: https://cmsinvestigation.org.za.

15.1. Discovery

340 Dr Broomberg in his oral evidence explained that Discovery's approach to answering the allegations of racial discrimination changed when the independent expert, Dr Kimmie, presented his findings.[425]

341 First, Discovery conducted its own surname-based analysis of its FWA findings, which was reviewed by Deloitte. Discovery, like Dr Kimmie, used a name-based methodology in order to determine the probable race of the practitioners. The database consisted of all fraud cases for individual practices that were closed between January 2015 and June 2019 (7493 practitioner investigations were analysed). Discovery also constructed a comparable dataset on total billing practice paid by Discovery for use as the denominator.[426] The results of Discovery's analysis was:

341.1 Of the total FWA identified and investigated cases, 55.7% were Black (as compared to 44.3% being non-Black);

341.2 Those FWA cases identified as a result of tip offs were 49.5% Black and 50.5% non-Black;

341.3 The disproportionate number of Black practitioners identified was produced by the RRT which identified 61.5% Black practitioners and 38.5% non-Black practitioners.[427]

[425] Dr Broomberg (Transcript, 29 January 2020, p 111, lines 11 - 16).
[426] Discovery power point presentation, 29 January 2020, slides 65 - 67.
[427] Discovery power point presentation, 29 January 2020, slide 67.

342 Discovery explained that the factors are not linked to the demographics of practitioners and maintained that there was "no implicit or explicit bias in these factors".[428] Discovery further asserted that there was no "evidence of racial bias in the Discovery FWA investigation processes once initiated."[429] Instead, Discovery submitted, because Dr Kimmie acknowledged that his results only demonstrate a correlation between race and the FWA finding, there is no proof that race is the cause of the FWA finding, and instead there must be a confounding factor which explains the correlation.[430]

343 Discovery then "extended Dr Kimmie's analysis to include some potential confounding factors for which [it did] have data". Discovery argued that the four confounding factors (year, direct payment, RRT and tip-offs in the prior year) reduce the overall risk ratio of Black practitioners being targeted for FWA from 1.36 to 1.09.[431] Additionally Discovery argued that there "could well be additional confounding and environmental factors that explain the remaining difference."[432]

344 Discovery concludes with the submission that Dr Kimmie's findings are not supported by the evidence and the evidence only suggests that the differential outcomes based on race are not caused by race bias but are rather due to confounding factors which Dr Kimmie did not investigate.[433] Discovery stated

[428] Discovery power point presentation, 29 January 2020, slide 69.
[429] *Ibid*.
[430] Discovery power point presentation, 29 January 2020, slide 70.
[431] Discovery power point presentation, 29 January 2020, slide 72.
[432] *Ibid*.
[433] Discovery power point presentation, 29 January 2020, slide 74.

that “[n]either Dr Kimmie nor any other party has provided the Panel with firm evidence of either implicit or explicit bias in any of DH’s FWA processes.”[434]

345 When the Panel questioned Mr Smit of Discovery about whether in his personal experience the majority of doctors investigated by Discovery were Black or non-Black, he at first answered that he thought Discovery investigated an equal amount of Black and non-Black doctors. However, when challenged the following exchange occurred:

> “***ADV TEMBEKA NGCUKAITOBI****: ... What I am trying to really get to is now that you know the facts around the 35 000 and you know the split there and you are the person at the [coal] face of the investigation. What is your honest answer to this Panel about the disproportionality? Are you saying that there is a disproportional impact on Black doctors or are you saying there is no such disproportional impact?*
> ***MR MARIUS MEYER SMIT****: Chair, we are dealing with that later in our presentation and the stats show that there is a disproportionate impact.*
> ***ADV TEMBEKA NGCUKAITOBI****: Yes, but you are the right person to answer us you see because you are the Head of Forensics so that is why . . . (intervenes)*
> ***MR MARIUS MEYER SMIT****: Absolutely.*
> ***ADV TEMBEKA NGCUKAITOBI****: I am putting this question to you.*
> ***MR MARIUS MEYER SMIT****: There is a - based on the statistics that we now have it is clear that there is a disproportionate impact on Black practitioners as opposed to White practitioners.*”[435]

[434] *Ibid*.
[435] Mr Smit (Transcript, 29 January 2020, p 101, line 15 - p 102, line 6).

15.2. GEMS

346 When GEMS was given an opportunity to respond to Dr Kimmie's findings, GEMS engaged Insight Actuaries and Consultants and Professor Paul Fatti (referred to collectively as the "**GEMS experts**") to review Dr Kimmie's findings. The GEMS experts submitted that their review was independent:[436] they used the data provided by CMS; they did not request any additional data from GEMS;[437] they provided only a critique of Dr Kimmie's report;[438] and they did not independently investigate whether or not GEMS engaged in racially biased practices.[439]

347 In sum, GEMS argued that the Kimmie Report failed to prove that GEMS's FWA systems produce racially biased results.[440] They argued that the Kimmie Report materially overstated the extent to which Black practitioners are more likely to be identified by GEMS as guilty of FWA.[441]

348 GEMS's experts' critique of Dr Kimmie's findings were as follows:

348.1 Dr Kimmie failed to make adjustments for the fact that GEMS' beneficiaries exhibit a far greater propensity to interact with Black healthcare providers than non-Black healthcare providers (the GEMS experts refer to this as a "failure to adjust for exposure"). The GEMS experts argued that the Kimmie Report could be improved through the

[436] Dr Getz (Transcript, 28 January 2020, p 176, line 22).
[437] Dr Getz (Transcript, 28 January 2020, p 177, line 24 – p 178, line 6).
[438] Prof Fatti (Transcript, 28 January 2020, p 178, line 25 – p 179, line 1).
[439] Prof Fatti (Transcript, 28 January 2020, p 179, lines 2 - 13).
[440] Insight Actuaries and Consultants Report titled "A review of the Expert Report Prepared for the Section 29 Investigation panel" ("**Insight Report**"), January 2020, p 3, para 1.
[441] Insight Report, January 2020, p 4, para 3.

use of the proportion of Black practitioners found guilty of FWA, expressed as a proportion of the number of interactions with Black healthcare practitioners; and through the use of the proportion of non-Black practitioners found guilty of FWA, expressed as a proportion of the number of interactions with non-Black healthcare practitioners (whereas Dr Kimmie rather expressed the proportion as a percentage of total number of Black practitioners and a total number of non-Black practitioners respectively);[442]

348.2 Dr Kimmie included corporatised or state practices in his analysis and mistakenly classified these practices as non-Black. Instead Dr Kimmie should have excluded corporatised or state practices (and suggested the disciplines that are predominantly made up of corporatised or state practices should have been excluded);[443] and

348.3 Dr Kimmie included group practices in his analysis and mistakenly classified these practices as non-Black. Instead Dr Kimmie should have excluded group practices from his analysis.[444]

349 The GEMS experts then proceeded to "test the accuracy" of Dr Kimmie's race classification methodology (which manifested in the use of an algorithm) manually by conducting a desktop audit of "the 800 most prominent non-Black practices." Such desktop audit found that 104 of the 800 practices were

[442] Insight Report, January 2020, p 5, para 3.1.
[443] Insight Report, January 2020, p 6 - 7, para 3.2.
[444] Insight Report, January 2020, p 8, para 3.3.

"believed to be incorrectly classified".[445] They argued that as a result Dr Kimmie's methodology "could not be relied upon."[446]

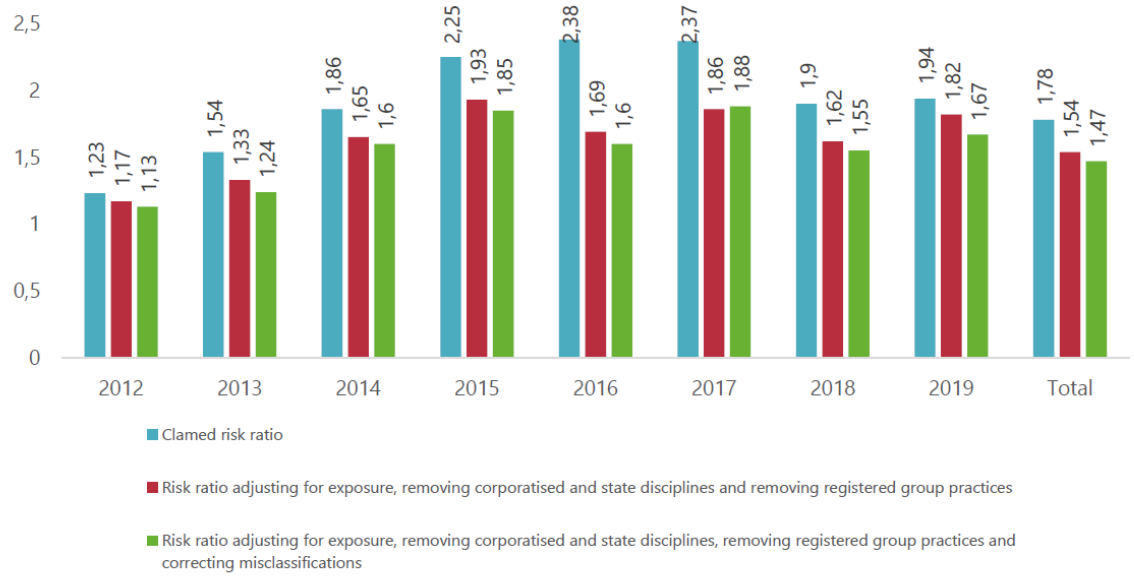
350 Finally, the GEMS experts presented "revised results", based on the above alleged shortcomings that they identified in the Kimmie Report. According to the GEMS experts, the revised results demonstrated the following:

> *"The risk ratio reduced to 1.47. This suggests that Black healthcare practitioners are 47% more likely to be flagged as possibly guilty of fraud, waste and abuse than non-Black practitioners. This is far less than the 78% presented by the experts appointed by the Section 59 Investigation Panel. This may decrease further and substantially should the required verification of racial classifications be performed."*[447]

351 The revised risk ratios that the GEMS experts presented for 2012 to 2017 were depicted as follows:[448]

[445] Insight Report, January 2020, p 8, para 3.4.
[446] We note that Discovery reached the exact opposite conclusion – with such conclusion being confirmed by Deloitte.
[447] Insight Report, January 2020, p 11, para 4.,
[448] Insight Report, January 2020, Figure 5: "Revised results", p 11.

Figure 5: Revised results



352 When the Panel asked the GEMS expert if we should accept that they too find that Black practitioners are more likely to be found guilty of FWA than non-Black practitioners the following exchange occurred:

> "***ADV TEMBEKA NGCUKAITOBI***: *Professor, can you just explain, maybe you can help us here. Should we rely on this 47% yes or no?*
> ***PROF PAUL FATTI***: *I would rely on it, that it's an upper bound, it's an upper –it could be lower, it could be …[intervenes]*
> ***ADV TEMBEKA NGCUKAITOBI***: *Because, I mean, we have to make a decision at the end of the day, we have a 78% that's been identified by our expert. The GEMS' expert is pointing to 47%.*
> ***PROF PAUL FATTI***: *Ja.*
> ***ADV TEMBEKA NGCUKAITOBI***: *So we have options to make. What do you suggest as the expert view? Should we rely on this?*
> ***PROF PAUL FATTI***: *My suggestion is that we consider it as an upper bound, as it could be smaller and I think what comes out in the rest of the report will possibly …[intervenes]*
> ***ADV TEMBEKA NGCUKAITOBI***: *So if we accept it, whether as an upper bound or not, if we accept that, it still shows that on GEMS' own*

–your analysis of GEMS' practices still shows a disproportionate impact on Black practitioners, whether it's intentional or not.
***PROF PAUL FATTI**: That is correct and that's in fact the conclusion we come to.*
***ADV TEMBEKA NGCUKAITOBI**: I see, alright. Thank you.*"[449]

353 Finally, the GEMS experts submitted that Black practitioners are 45% more likely to be flagged as possibly guilty of FWA than non-Black practitioners via the Vuvuzela hotline. Because this is almost precisely the same as the revised risk ratio of 47% it implies that GEMS FWA processes arising from their analytics and investigations are not racially biased.[450]

15.3. Medscheme

354 Medscheme responded to the two primary issues raised in Dr Kimmie's report, namely:

354.1 Whether there is explicit racial bias in the algorithms and methods used by Medscheme to identify FWA ("**Question 1**");[451] and

354.2 Whether the outcomes of the FWA process are racially biased? In particular, were Black providers identified as having committed FWA at a higher rate that their non-Black counterparts ("**Question 2**").[452]

355 Medscheme's point of departure is that the percentage of providers found guilty of FWA, is less than 2% of overall claims paid.[453]

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[449] Dr Fatti (Transcript, 28 January 2020, p 200, line 10 - p 201, line 20).
[450] Insight Report, January 2020, p12, para 5.
[451] Medscheme power point presentation, 30 January 2020, slide 62.
[452] *Ibid*.
[453] Medscheme power point presentation, 30 January 2020, slide 84. See also: Dr Nyati (Transcript, 30 January 2020, p 186, lines 20 - 24).

356 As regards Question 1, Medscheme understood racial profiling to mean:

> *"the act of suspecting or targeting a person of a certain race on the basis of observed or assumed characteristics or behavior of a racial or ethnic group, rather than on individual suspicion."*[454]

357 Medscheme's understanding of bias was:

> *"Disproportionate weight in favour of or against an idea or thing, usually in a way that is closed-minded, prejudicial or unfair."*[455]

358 Medscheme submitted that bias is subjective to an institution or an individual and that it can be either explicit (intentional / conscious) or implicit (unintentional / unconscious).[456]

359 Based on these understandings of racial profiling and bias, Medscheme concluded as follows:

> *"Medscheme is satisfied with the analysis performed in interrogating whether our forensic processes and systems contain any form of racial profiling or explicit racial bias in their design or implementation."*[457]

360 This, according to Medscheme, aligned with Dr Kimmie's finding in respect of Question 1, i.e. that there is no evidence of *explicit* racial profiling in the design or implementation of systems used to identify potential FWA cases by Medscheme.

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[454] Medscheme power point presentation, 30 January 2020, slide 63.
[455] *Ibid*.
[456] *Ibid*.
[457] Medscheme power point presentation, 30 January 2020, slide 64.

361 With regards to Question 2, as opposed to Question 1, Medscheme did not agree with Dr Kimmie's findings. Medscheme interpreted bias in the statistical sense i.e. a:

> *"feature of a statistical technique or of its results whereby the expected value of the results differs from the true underlying quantitate parameter being estimated."*[458]

362 Based on this understanding, Medscheme refuted Dr Kimmie's finding that there is evidence of racial bias in the *outcome* of Medscheme's FWA processes. Their explanation was that the methodology used by Dr Kimmie "is insufficient for purposes of reaching factually accurate conclusions for purposes of this investigation…"[459] Their conclusion was based on the following principles:

362.1 It is difficult to assign race to private healthcare practices (which, according to Medscheme, was acknowledged in Dr Kimmie's report);[460]

362.2 Using surnames as a proxy for race appears to be the only logical way of attempting to reach some form of indication;[461]

362.3 Over half of the cases where there is a forensic finding of FWA originated from sources over which Medscheme had no influence or

[458] Medscheme power point presentation, 30 January 2020, slide 63.
[459] Medscheme power point presentation, 30 January 2020, slide 65, where Medscheme seems to infer that the methodology is insufficient because the data includes juristic entities, which do not have a racial identity, and labels juristic entities as "*non-Black*". Medscheme states that this would significantly dilute the underlying baseline population against which the racial allocation of FWA cases is compared. Medscheme are of the view that juristic entities should have been excluded.
[460] Medscheme power point presentation, 30 January 2020, slide 4.
[461] *Ibid*.

control (we understood this to refer to whistleblowers). Therefore, according to Medscheme, there is no possibility of implicit racial profiling by Medscheme in these cases;[462] and

362.4 Medscheme also raised the point that 81.7% of their whistle-blowers are Black and 18.29% are known as non-Black.[463] It is unclear why this point was made: the race of the whistle-blower does not negate the fact that there may be structural issues leading to indirect discrimination.

363 Medscheme further critiqued the Kimmie Report as follows:[464]

363.1 Statistical racial bias is proportionately higher in the compulsory FWA cases over which Medscheme has no explicit or implicit influence;[465]

363.2 Medscheme, when removing the FWA investigation cases, reduced the risk ratio from 3.29 to 2.99;[466]

363.3 Medscheme, when running only the FWA investigation cases, increased the risk ration from 3.29 to 3.74.

363.4 Medscheme went further to conclude that on the inherent neutrality of the compulsory cases, one can factually conclude that the cases identified proactively through data analysis display no empirical

[462] Medscheme power point presentation, 30 January 2020, slide 67.
[463] Medscheme power point presentation, 30 January 2020, slide 68.
[464] Mr Midlane and Dr Nyati (Transcript, 30 January 2020, p 175, line 13 - p 180, line 17).
[465] Medscheme power point presentation, 30 January 2020, slide 69.
[466] *Ibid*.

evidence of disproportionality based on race when compared to the independent baseline.

363.5 The independent expert commissioned by Medscheme further noted that after removing juristic entities and cases originating from tip-offs, and adjusting the method of calculation to account for claim lines rather than individual cases, that the risk ratio is reduced to 1.35.[467]

363.6 Finally, the independent expert that this risk ratio would be further reduced to 1.02 by removing auxiliary providers, non-network providers and those on indirect payment.[468]

364 In addition to the aforementioned factors, Medscheme raised the following points in supporting their contestation of the findings in Dr Kimmie's report:

364.1 Medscheme has a Level 1 B-BBEE status;

364.2 The forensic team is racially diverse (over 72% of the 51 employees are Black);

364.3 Medscheme uses predictive analytics software developed outside of South Africa and therefore it does not exercise any influence or control over the risk scoring outputs.[469]

[467] Medscheme appointed Dr Mike Bergh of OLSPS Analytics, OLSPS Solutions for the purposes of providing an expert report on the findings of Dr Kimmie, titled "Adjustments to Medscheme's risk ratio using additional variables, and [redacted] trends of relevant variables" ("**Dr Bergh report**"), 7 February 2020, p 2, para 1.

[468] *Ibid*.

[469] Medscheme power point presentation, 30 January 2020, slide 70.

365 Finally, Medscheme took issue with the proportionality of Dr Kimmie's findings. Medscheme maintained that Dr Kimmie's analysis was incomplete and lacked certain critical data that would yield a more accurate result.[470] The objective criteria for "proportionality" were not established, as the quantitative parameter must be clearly defined. Without the application of risk adjustment factors, applicable to the specific baseline population under review, one cannot deduce whether the results indeed indicate statistical bias. Costs and utilization are key factors when assessing risk exposure.[471]

366 Furthermore, according to Medscheme, there is a strong possibility that the number of Black providers who actually claimed from Medscheme in the data set is higher and therefore there would be more Black practitioners investigated for FWA. In addition, FWA outcomes are based on specific conduct of the individual or entity under investigation.[472]

367 As a result, Medscheme argued it is not possible for Dr Kimmie to conclude that FWA processes have a disproportionate outcome. This conclusion, according to Medscheme, was not the type of indirect discrimination outlined by Advocate Wim Trengove SC. According to his testimony, for discrimination to exist, the outcomes of an administrative action or process must disproportionately impact one race or ethnic group over another. Because of the faults in Dr Kimmie's analysis, argued Medscheme, there could be no

[470] Dr Nyati and Mr Midlane (Transcript, 30 January 2020, p 180, line 9 - p 181, line 11).
[471] Medscheme power point presentation, 30 January 2020, slide 74.
[472] Medscheme additional submission, affidavit deposed to by Mr Midlane titled "Response to the findings of Dr Kimmie" ("**Mr Midlane affidavit**"), 7 February 2020, p 4, para 2.2; p 16.

statistical finding of a differential and therefore, no finding of indirect discrimination.

368 Medscheme concluded its analysis by stating that the Dr Kimmie's Report:

> *"Is neither correct nor incorrect, but merely incomplete...It will take a much deeper and more thorough analysis to properly determine whether the outcomes of FWA cases disproportionately impact one race of healthcare practitioners more than another."*[473]

369 During the hearings, however, Medscheme was challenged for its failure to respond to allegations of race discrimination in the past. It was put to Medscheme that:

> *"**ADV TEMBEKA NGCUKAITOBI**: You see part of the problem of this is that there is a sense in which schemes are just indifferent to racism and this is one of those instances. Somebody tells you that my colleagues are not treated the same way that I am. What you should do that is what she is expecting you to do not imposing that is to go and speak to those colleagues. That is the most logical thing to do but you do not and you do not have an explanation why you did not. **MR PAUL MIDLANE**: In a complaint that was said, we do not have evidence that that was happening. We looked at all practices that were using that code and we audited them. So that is- but I am happy to take the point Chair. I mean if that becomes a recommendation of a type of investigation that must be done, it is fair comment. **ADV ADILA HASSIM**: It is not about a recommendation. It is about a practice. And you see a lot of the complaints that were made at the outset have in fact and we are going to come to that at some point I imagine in your submission. Regardless of the merits of each individual complaint there have been borne out by the statistical analysis that Black practitioners are more likely to get- significantly*

[473] Medscheme power point presentation, 30 January 2020, slides 81 – 82. See also: Mr Midlane (Transcript, 30 January 2020, p 185, lines 18 - 22).

more likely to get identified for FWA than White practitioners. And it is in that context that I am putting the question to you.

...

***ADV TEMBEKA NGCUKAITOBI**: It is how you responded in real time to allegations of racism and that is the point of the indifference of the*

***DR NOMALUNGELO NYATI**: No, I understand Chair, your point is very well noted. What I would like to do is for us to actually investigate this particular case and be able to give written feedback as to what-as is actually in the case notes.*"[474]

370 The same point arose later in the proceedings:

"***ADV TEMBEKA NGCUKAITOBI**: You see the problem Mr Midlane is that your excuse that you only learned today or this week about Dr Ngumbela has to be rejected. Dr Ngumbela gave evidence. She brought about 10 patients. She repeated these allegations in these letters. You were present at the hearing. Well, someone from your team must have been present or at least you were invited and it was a public hearing. It is completely unacceptable for you to tell us that you only learned about this, this week. It's just false.*"[475]

371 Before delving into the analysis of the evidence presented to the Panel, it is necessary to understand the importance of equality in South Africa particularly.

16. THE MEANING OF DISCRIMINATION

16.1. The history of discrimination in South Africa

372 In *South African Police Service v Solidarity obo Barnard*, [476] Moseneke ACJ (as he then was) described the historical backdrop to the equality clause:

[474] Mr Midlane and Dr Nyati (Transcript, 30 January 2020, p 76, line 16 - p 78, line 14).
[475] Mr Midlane (Transcript, 30 January 2020, p 70, lines 18 - 25).
[476] *South African Police Service v Solidarity obo Barnard* [2014] ZACC 23 ("***Barnard***").

> *"At the point of transition, two decades ago, our society was divided and unequal along the adamant lines of race, gender and class. Beyond these plain strictures there were indeed other markers of exclusion and oppression, some of which our Constitution lists. So plainly it has a transformative mission. It hopes to have us re-imagine power relations within society. In so many words, it enjoins us to take active steps to achieve substantive equality, particularly for those who were disadvantaged by past unfair discrimination. This was and continues to be necessary because, whilst our society has done well to equalise opportunities for social progress, past disadvantage still abounds."*[477]

373 The diminution of a person based on their race and ethnicity is both undignified and painful. Equality is inextricably linked to dignity. Both values are central to the democracy South Africans scripted through the Constitution. There is no person in this country that is not tainted by discrimination as a result of the three hundred years of colonialism and apartheid. These structures are not easily overcome. They were entrenched through war, law and a belief in white superiority. It is therefore incumbent on the Panel:

> "*to scrutinise… the situation of the complainants in society; their history and vulnerability; the history, nature and purpose of the discriminatory practice and whether it ameliorates or adds to group disadvantage in real life context…".*[478]

374 It is with this past in mind that the Panel sought to understand the claims of discrimination. The Panel therefore took careful consideration of the emotional consequences of discrimination. The Panel heard extensive evidence from complainants about their experiences of discrimination, which included

[477] *Barnard*, para 29.
[478] *Minister of Finance and Other v Van Heerden* 2004 (6) SA 121 (CC) ("***Van Heerden***"), para 27.

emotional, mental and financial harm.[479] Such evidence should not be ignored or undervalued. The human experience of pain is at the heart of the constitutional prohibition against unfair discrimination.

375 As noted above, the schemes denied, on the whole, that there was any form of discrimination, explicit, implicit or otherwise. The fact that the independent statistical evidence, produced by Dr Kimmie on behalf of the Panel, confirmed the concerns raised by the complainants, demonstrates the importance of listening to and taking seriously personal accounts of discrimination. Frankly, as explained, Medscheme, GEMS and Discovery admitted that the outcomes of their FWA investigations have a disproportionate impact on Black practitioners (the debate was, and remains, the extent of the disproportionate outcomes, and in the case of Discovery, the factors that may have contributed to the outcome).[480]

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[479] As set out in Part 1 of this Report, *supra*.

[480] In respect of GEMS, see: Prof Fatti (Transcript, 28 January 2020, p 187, line 22 - p 188, line 8):

> *"ADV TEMBEKA NGCUKAITOBI: But we know for sure from GEMS it is 90 percent fraud by blacks.*
> *PROF LIBERO PAUL FATTI: Yes. So, so certainly even if we do revise the results we do see an increased propensity for black practitioners to be flagged as possibly guilty of Fraud Waste and Abuse as opposed to nonblack practitioners. What does change is the extent of the difference.*
> *ADV TEMBEKA NGCUKAITOBI: I understand ... even if you use your own or you use his own figures, what you find is that there is a disproportioned exposure or disproportionate effect when it comes to the investigation or the instances."*

See also: Mr Getz (Transcript, 28 January 2020, p 196, line 14, p 197, line 6):

> *"MR CRAIG GETZ: So our view the report shows that there is a difference between black and non-black practitioners. The difference though doesn't immediately point to racial bias...*
> *ADV TEMBEKA NGCUKAITOBI: Sorry, I mean before we get to the extenuating reasons, I think let's just get to the hard facts, let's not shy away from them. I mean, on your own, once you start with that 60/40 that you drew at the beginning, on your own findings, a 47% is a disproportionate number.*
> *MR CRAIG GETZ: On our own findings we find a difference but that finding is subject to the caveat that there needs to be full review or at least a more comprehensive review of the surname classification."*

See further: Prof Fatti (Transcript, 28 January 2020, p 200, line 23 - p 201, line 2):

> *"ADV TEMBEKA NGCUKAITOBI: So if we accept it, whether as an upper bound or not, if we accept that, it still shows that on GEMS' own – your analysis of GEMS' practices still shows a*

376 The Panel hopes that the industry takes proactive steps to ensure that going forward industry stakeholders, such as practitioners, are able to alert administrators and schemes to concerns of discrimination, knowing that such concerns will be taken seriously.

16.2. Differentiation Based on Race

377 Discrimination is understood as conduct that differentiates between people or groups of people based, *inter alia*, on their race. Usually discrimination "causes or perpetuates systemic disadvantage".[481]

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disproportionate impact on black practitioners, whether it's intentional or not. PROF PAUL FATTI: That is correct and that's in fact the conclusion we come to."

See further: Prof Fatti (Transcript, 28 January 2020, p 205, lines 15 - 16):

"PROF PAUL FATTI: ... what we find is yes, there's a difference, it's beyond our expertise to be able to explain why it is."

In respect of Discovery, Dr Broomberg (Transcript. 29 January 2020, p 104, lines 19 - 24)*:*

"DR JONATHAN BROOMBERG: Mr Chair, if I can answer for my colleague. I think the facts are the facts so we are not here to content (sic) against the proportionality including to the degrees that are part of our own evidence. But the question before you are not whether there is disproportion, it is whether the disproportion arises from race bias or possibly from other factors."

See also: Dr Broomberg (Transcript, 29 January 2020, p 114, lines 4 - 6):

"ADV TEMBEKA NGCUKAITOBI: What we can agree on is that blacks are more likely to be investigated as an objective fact than whites. DR JONATHAN BROOMBERG: Correct."

In respect of Medscheme, see: Mr Midlane (Transcript, 30 January 2020, p 169, line 20 – p 170, line 1):

"*ADV ADILA HASSIM: And more than that. On your own analysis, there is greater likelihood of black practitioners being identified for an investigation through the tipoffs than through your proactive analysis.*

MR PAUL MIDLANE: Correct. And that is the point. That is what we are trying to demonstrate. And we have the stats here. That more black practitioners identified through the tipoff line than through our proactive analytics."

See further: Dr Nyati (Transcript, 30 January 2020, p 180, lines 9 - 12):

"DR NOMALUNGELO NYATI: Chair, our report and our slide do answer your question. And it shows that the ratio does change but the risk ratio does show that it is more than- there is more- there is a higher likelihood that Blacks will be identified than Non-Blacks..."

See further: Dr Nyati (Transcript, 30 January 2020, p 187, lines 6 - 9):

"DR NOMALUNGELO NYATI: We do note has been discussed in detail right now that their outcomes show that there is a higher proportion of providers who are Black than Non-Black in terms of our outcomes and we do believe that there is a need for additional research why that is."

[481] Section 1 of the Equality Act.

378 In South Africa, differentiation based on race has resulted in Black and non-Black people being positioned differently.[482] This differential positionality manifests by and large geographically and in terms of socio-economic status.

379 Because Black and non-Black people are positioned differently in South Africa, a seemingly non-racist law, policy or procedure may impact Black and non-Black people differently.

16.3. Implicit v explicit bias

380 Discrimination is not always explicit. It is possible that a person may be biased against a group of people without being aware of it. While implicit bias is very different from explicit bias, the outcome is the same; both result in one group of people experiencing discrimination.

381 One of the ways in which implicit bias operates is through a blindness to the fact that a seemingly equal *status quo* has racist premises inscribed into it.[483]

382 During the inquiry, the example was given of a group of Black and non-Black children having to write an exam.[484] The policy is that those with 50% will pass and those who do not get 50% will fail. Given the alignment of race and poverty as a result of apartheid, many of the Black children may not have eaten before the exam. Because it is more difficult to concentrate when one is hungry, people who have not eaten before writing the exam tend to fail. The

[482] Prof Steyn (Transcript, 18 October 2019, p 6, lines 12 - 13).
[483] Prof Steyn (Transcript, 18 October 2019, p 11, lines 19 - 24).
[484] Prof Steyn (Transcript, 18 October 2019, p 12, line 19 - p 13, line 11).

majority of people who fail the exam, therefore, are people living in poverty. Because the majority of people living in poverty in South Africa are Black, the majority of children who fail the exam are Black. Therefore, the outcome of applying a seemingly neutral pass policy is a lower pass rate among Black children.

383 In this example, neutrality results in discriminatory outcomes. There has been an assumption that all students coming to write the exam will be equally positioned i.e. all students will have eaten before the exam. The policy makers have an implicit bias that all students are equally positioned to write the exam, without considering that social structures in South Africa are predicated on racial inequality. In order to create a truly equal examination process, it would be necessary to make sure that nobody writes an exam when they are hungry.

384 The Constitution and the Equality Act prohibit both direct and indirect discrimination. Indirect discrimination occurs where the primary purpose of a policy may not be discriminatory, but it has a discriminatory effect. The classic example of indirect discrimination is a policy that requires airplane pilots to be of a certain height. Typically, women are shorter than men and are rarely as tall as the height required by the policy. The result is that women are precluded from becoming pilots. The policy, although facially neutral as to gender, has the effect of discriminating against women.

385 The inclusion of both direct and indirect discrimination within the ambit of section 9 of the Constitution “evinces a concern for the consequences rather

than the form of conduct."[485] In order to determine differentiation, one looks at the impact of a policy and not its language.[486] This is because impugned conduct may appear to be neutral but it results in a disproportionate impact on some people rather than others on the basis of a prohibited ground. Such conduct therefore results in discrimination. As the Court put it in *Harksen v Lane*:[487]

> *"The test of unfairness focuses primarily on the impact of the discrimination on the complainant and others in his or her situation."*[488]

386 The Panel heard evidence from Professor Steyn, a critical race theorist who is the founding director for the WITS Centre for Diversity Studies and is the South African National Chair in Critical Diversity Studies. Professor Steyn explained that critical diversity studies:

> *"is the study of how difference gets positioned within unequal power relations and how it gets constructed with in unequal power relations in such a way that you end up having different outcomes for different people."*[489]

387 She explained 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 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."*[490]

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[485] *Harksen v Lane, NO and Others* 1997 (11) BCLR 1489 ("***Harksen***"), para 31.
[486] *Walker,* para 31.
[487] *Supra.*
[488] *Harksen*, para 54.
[489] Prof Steyn (Transcript, 18 October 2019, p 3, lines 1 - 6).
[490] Prof Steyn (Transcript, 18 October 2019, p 3, lines 7 - 12).

388 The evidence of Professor Steyn provides an important insight into the analysis of unfair discrimination. It explains and reinforces why outcomes are not incidental but are as a result of what Professor Steyn names "naïve indifference" or "deliberate blindness".

389 Importantly she drew an analogy between the policing sector and the administrators of medical schemes (and the schemes themselves), and reminds us that the latter are similar to the policing sector as they perform a policing role in their FWA activities. She explained the international literature on racial profiling describes police officers as not being aware of their biases and "falling back on their unconscious assumptions" and the literature speaks about:

> *"a well- meaning person who might think that their biases are gone, have been socialised to ignore race and … the work of implicit bias specifically indicates how bias is actually present in everything we do".*[491]

390 She explained that implicit bias is:

> *"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."*[492]

391 Critical race theory starts with the assumption that race is a social fact:

> *"That in terms of our history it's a socio historic reality that is in our societies and informs every aspect of our societies that race in in fact constitutive in shaping our societies through the period of modernity.*

[491] Prof Steyn (Transcript, 18 October 2019, p 4, lines 21 -; p 5, lines 3).
[492] Prof Steyn (Transcript, 18 October 2019, p 5, lines 4 - 6).

And this means people have been positioned very differently in relation to each other."[493]

392 She explains that if we are to ignore race in our thinking, in our planning and even in our implementation it is at best naïve but probably indifferent or even deliberately blind to have different people or people who are effected differently as a result of the same process.[494]

393 In explaining how ignoring race or not factoring it into one's thinking can lead to unequal outcomes, she gave the example of a Mayor of a town who prohibits anybody from sleeping under bridges, irrespective of one's financial status:

"Formerly that is completely fair but it doesn't take in to 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 conscious of the way in which we are positioned differently in society given our history is to trivialise and to delegitimize the plight of those who are either in the system."[495]

394 Professor Steyn also explained what the effects of a what a claim of colour-blindness (race-blindness) might be. The difficulty with these claims is that:

"…it represses the kinds of discussion exactly around what we are talking about. With colour blindness usually the person who names race seems to be the racist … So it actually represses the kinds of discussions that the complainants I think are bringing to the Panel, it represses exactly those kinds of conversations and ironically it allows for processes of implicit bias to operate without being able to name or

493 Prof Steyn (Transcript, 18 October 2019, p 6, lines 8 - 13).
494 Prof Steyn (Transcript, 18 October 2019, p 6, lines 20 - 24).
495 Prof Steyn (Transcript, 18 October 2019, p 9, lines 17 - 22).

examine or work to change how different race groups are being impacted."[496]

395 Conduct that is considered neutral or race-blind is often not:

"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 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 in formed. We can't escape that."[497]

396 Professor Steyn also explained the importance of taking the complainants seriously. She said that in order to understand how a normative system creates unfair consequences, you have to consider the position of the people who are telling you it is not working for them. This is because "the power relations operate from the position that is established as the norm and so it operates for the comfort and benefit of the powerful norm. And it works not only to establish privilege but maintain privilege and prevent privilege from being eroded".[498] She continued:

"in formulating policies it is important for people in these dominant positions to seek out the perspectives of others and critically assume there is racial bias in their system. Not to start with the assumption that somehow you have been able to … 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 wrongdoing … but actively to take steps to ensure that one is thinking through how these things may be operating within

[496] Prof Steyn (Transcript, 18 October 2019, p 10, lines 3 - 12).
[497] Prof Steyn (Transcript, 18 October 2019, p 11, lines 7 - 14).
[498] Prof Steyn (Transcript, 18 October 2019, p 15, lines 18 - 23).

ecosystems. … even though it is important to anonymise data bases, at the same time we also have to reintroduce race and keep race very clear in our thinking as we formulate policies, as we formulate implementations, as we look at how things play out".[499]

397 With this understanding of the social realities of race and race discrimination in South Africa, we turn to consider the legal position *vis-a-vis* unfair discrimination.

17. ANTI-DISCRIMINATION LAW

17.1. The Applicable Sources of Law

398 The law governing equality and discrimination is found in the Constitution of South Africa ("**the Constitution**"), the Equality Act, and jurisprudence of the Constitutional Court of South Africa. The panel uses all these sources in analysing the allegations.

399 It was suggested by Discovery that the allegations of racial discrimination must be considered under the Equality Act and not in terms of the Constitution.[500] This raised an important consideration regarding the source of law on which the Panel relied in coming to its conclusions.

400 The suggestion of Discovery is based on the holding by the Constitutional Court in *MEC for Education, Kwazulu-Natal v Pillay*[501] which states as follows:

"*[T]hat claims brought under the Equality Act must be considered within the four corners of that Act. This Court has held in the context*

[499] Prof Steyn (Transcript, 18 October 2019, p 16, line 19 – p 17, line 8).
[500] Discovery sixth supplementary submission, 14 February 2020, p 4 - 5, para 9.
[501] *MEC for Education, Kwazulu-Natal v Pillay* 2008 (1) SA 474 (CC) ("***Pillay***").

of both administrative and labour law that a litigant cannot circumvent legislation enacted to give effect to a constitutional right by attempting to rely directly on the constitutional right. To do so would be to "fail to recognise the important task conferred upon the legislature by the Constitution to respect, protect, promote and fulfil the rights in the Bill of Rights." The same principle applies to the Equality Act. Absent a direct challenge to the Act, courts must assume that the Equality Act is consistent with the Constitution and claims must be decided within its margins." [502]

401 The holding in this case applies to 'litigants'. *Litigants* may not rely on the Constitution when there is a legislative provision on which they can bring their claim. This principle is relevant to proceedings where these is a *lis* between parties. The case does not, however, say that investigative bodies may not rely on the Constitution in investigating disputes and making recommendations. This is underscored by section 39 of the Constitution which mandates a court, tribunal or forum, when interpreting legislation, to promote the spirit, purport and objects of the Bill of Rights. The Panel's Terms of Reference also require that it acts "in accordance with the Constitution" and the Equality Act.

402 The Panel therefore is of the view that equality is "not only a guaranteed and justiciable right in our Bill of Rights but also a core and foundational value...".[503] As such it considers the complaints against the provisions of the Equality Act *and* through the lens of the Constitution. However, the Panel notes that even if it were to analyse the allegations from the point of view only of the Equality Act, and without reference to the Constitution, it would come to

[502] *Pillay*, para 40.
[503] *Van Heerden*, para 22.

the same conclusions. Indeed, the Equality Act requires a complainant only to make out a *prima facie* case of discrimination and not prove discrimination.[504]

403 In this regard, the Equality Act mirrors the provisions of section 9(5) of the Constitution, which provides that "discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair."

17.2. The Constitution

404 There are three provisions relevant to the right to equality in the Constitution. These are sections 1(a) and (b); section 8(2); and section 9.

405 Section 1 of the Constitution: Equality as a founding value

405.1 Section 1 of the Constitution identifies the values on which democratic South Africa is based. Subsections 1(a) and (b) provide that:

> *"The Republic of South Africa is one, sovereign democratic state founded on the following values:*
> *(a) Human dignity, the achievement of equality and the advancement of human rights and freedoms.*
> *(b) Non-racialism and non-sexism."*

405.2 These subsections elevate equality to the status of a founding value that underpins the entire Constitution and governance of South Africa. The assessment of unfair discrimination must therefore take place

[504] Section 16 of the Equality Act.

with due regard to the backdrop of the elevated importance of equality in the Constitution and in the society that it envisions.

406 Section 8(2) of the Constitution: Application of the Bill of Rights to juristic persons

406.1 Section 8 of the Constitution identifies the entities that are bound by the Bill of Rights. The Constitution binds "all law… the legislature, the executive, the judiciary and all organs of state." [505] In addition, Section 8(2) provides that:

> *"A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right."*

406.2 This subsection makes it clear that the Bill of Rights is of horizontal application. This means that natural and juristic persons (non-state actors), such as medical schemes and their administrators, may be responsible for both the protection and advancement and unjustifiable infringements of rights in the Bill of Rights.[506]

406.3 The Act itself contains an anti-discrimination provision. Section 24 sets out registration pre-conditions for schemes. One of them is that the Council for Medical Schemes should be satisfied that "the medical scheme does not or will not unfairly discriminate directly or indirectly

[505] Section 8(1) of the Constitution.
[506] B Meyersfeld, The South African Constitution and the Human-Rights Obligations of Juristic Persons, South African Law Journal, Volume 137 Number 3 (Sep 2020), p 439 – 478.

against any person on one or more arbitrary grounds including race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health." While this is a registration requirement, it is also an ongoing requirement.

407 Section 9: The Equality Clause

407.1 The third relevant provision is section 9 of the Constitution, known as the equality clause. Section 9 provides as follows:

> "*(1) Everyone is equal before the law and has the right to equal protection and benefit of the law.*
> *(2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.*
> *(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.*
> *(4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.*
> *(5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.*" (our emphasis)

407.2 Section 9 confirms the following principles:

407.2.1 'Persons' such as medical schemes and their administrators, have a constitutional duty not to discriminate;

407.2.2 Only unfair discrimination is prohibited;

407.2.3 Discrimination is deemed to be unfair unless the contrary is proven;

407.2.4 Both direct and indirect discrimination are prohibited; and

407.2.5 The objective of section 9 is to achieve substantive equality and not just formal equality.

407.3 These principles are elaborated upon below.

17.3. The Equality Act

408 The Equality Act defines discrimination as:

> *"any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly-*
> *(a) imposes burdens, obligations or disadvantage on; or*
> *(b) withholds benefits, opportunities or advantages from,*
> *any person on one or more of the prohibited grounds."*[507]

409 Equality is defined as:

[507] Section 1 of the Equality Act.

"the full and equal enjoyment of rights and freedoms as contemplated in the Constitution and includes de jure and de facto equality and also equality in terms of outcomes."[508]

410 According to section 6 of the Equality Act, the prohibition of unfair discrimination applies to persons and not just state actors:

"Neither the State nor any person may unfairly discriminate against any person."

411 Section 7 deals with racial discrimination in particular. Section 7(e) of the Equality Act provides that it is unfair discrimination where there is a "denial of access to opportunities, including access to services or contractual opportunities for the rendering of services for consideration".

412 Read together with section 6 it is clear that no person, including private entities and individual non-state actors, such as medical schemes and their administrators, may discriminate against another person on the basis of race.

413 Chapter 3 of the Equality Act deals with the burden of proof and the determination of whether discrimination is fair or unfair.

413.1 The point of departure is that a complainant must make out a *prima facie* case of discrimination.[509]

413.2 If the complainant successfully makes out a *prima facie* case of discrimination, then:

[508] Section 1 of the Equality Act.
[509] Section 13(1) of the Equality Act.

413.2.1 The respondent must prove, on the facts, that the discrimination did not take place as alleged;[510] or

413.2.2 The respondent must prove that the conduct is not based on any of the prohibited grounds.[511]

413.2.3 If there is discrimination based on a prohibited ground, such as race, then it is automatically deemed to be unfair. The onus would then shift to the respondent to prove that the discrimination was in fact fair.[512]

413.2.4 It is also possible that the discrimination may be based on grounds that are not specifically prohibited but that cause or perpetuate systemic disadvantage; undermine human dignity; or adversely affect the equal enjoyment of a person's rights and freedoms in a serious manner that is comparable to discrimination on a prohibited ground.[513] If discrimination on one of these grounds is established, then it too will constitute unfair discrimination unless the respondent proves that the discrimination is fair.[514]

[510] Section 13(1)(a) of the Equality Act.
[511] Section 13(1)(b) of the Equality Act.
[512] Section 13(2)(a) of the Equality Act.
[513] See the definition of 'prohibited grounds' in Section 1 of the Equality Act.
[514] Section 13(2)(b) of the Equality Act. There is therefore not a closed list of prohibited grounds. See also: Adv Trengove SC (Transcript, 23 August 2019, p 77, lines 3 - 21) and *Harksen*, para 46.

413.2.5 How does one determine whether discrimination is fair? This is addressed in section 14 of the Equality Act. There are several factors that must be taken into account when determining whether a respondent has proved that discrimination is fair. These are:

413.2.6 Context;[515]

413.2.7 Whether the discrimination reasonably and justifiably differentiates between persons according to objectively determinable criteria, intrinsic to the activity concerned;[516]

413.2.8 The additional factors:[517]

(a) Whether the discrimination impairs or is likely to impair human dignity;

(b) the impact or likely impact of the discrimination on the complainant;

(c) the position of the complainant in society and whether he or she suffers from patterns of disadvantage or belongs to a group that suffers from such patterns of disadvantage;

(d) the nature and extent of the discrimination;

[515] Section 14(2)(a) of the Equality Act.
[516] Section 14(2)(c) of the Equality Act.
[517] Section 14(3) of the Equality Act.

(e) whether the discrimination is systemic in nature;

(f) whether the discrimination has a legitimate purpose;

(g) whether and to what extent the discrimination achieves its purpose;

(h) whether there are less restrictive and less disadvantageous means to achieve the purpose;

(i) whether and to what extent the respondent has taken such steps as being reasonable in the circumstances to-

(i) address the disadvantage which arises from or is related to one or more of the prohibited grounds; or

(ii) accommodate diversity.

17.4. Summary of Anti-Discrimination Law

414 The aforementioned law confirms the following principles.

415 Substantive equality:

415.1 The law demands substantive equality and not only formal equality. Substantive equality, as opposed to formal equality, looks at the impact of a particular policy or practice.

415.2 Therefore, if facially neutral conduct (and of course law or policy) has a disproportionately negative impact on a specific racial group, such

conduct would amount to unfair discrimination, unless it is shown that it is fair.

416 Every person: Anti-discrimination law binds all persons, and not just the state. This includes private entities and individual non-state actors, such as medical schemes and their administrators.

417 Prohibited grounds: There is not a closed list of prohibited grounds of discrimination. The Equality Act makes it clear that conduct will be discriminatory where it: (i) causes or perpetuates systemic disadvantage; (ii) undermines human dignity; or (iii) adversely affects the equal enjoyment of a person's rights and freedoms in a serious manner that is comparable to discrimination on the ground of race.

418 Presumption of unfairness: Discrimination on a specific ground is presumed to be unfair unless it is proved otherwise. The discriminating party has the onus of proving that the discrimination is fair or that the discrimination is not on a prohibited ground.[518]

419 This legal analysis provided the Panel with the roadmap to determine whether or not there was racial discrimination in the outcomes of the FWA detection and investigation processes.

[518] Section 9(5) of the Constitution. See also: Adv Trengove SC (Transcript, 23 August 2019, p77, lines 3 - 21).

18. THE LEGAL TEST TO DETERMINE DISCRIMINATION

420 In *Harksen*, the Constitutional Court developed the test to determine whether there has been a breach of the equality clause. The Constitutional Court held that:

> *"The test of unfairness focuses primarily on the impact of the discrimination on the complainant and others in his or her situation."*[519]

421 This test can be broken down into three stages: (i) is there differentiation; if so, (ii) is there unfair discrimination; and if so, (iii) can the presumption of unfairness be rebutted?

18.1. Stage One: Differentiation

422 The first question is whether a policy differentiates between people or categories of people. The question is not merely about the words or the content of a policy or practice. It is the result that triggers the provisions of section 9. This is a factual question and must be answered by an analysis of the facts.[520]

423 If the answer to this factual question is a negative one, then there can be no finding of discrimination and the allegation falls away.[521] However, if the answer is in the affirmative, then it is necessary to proceed to the second stage of the analysis and determine whether the discrimination is "unfair". In the case

[519] *Harksen,* para 50(b)(ii).
[520] *Harksen*, para 50(b)(ii).
[521] *Harksen*, para 47.

of discrimination on a specified ground, the unfairness of the discrimination is presumed, but the contrary may still be established.[522]

18.2. Stage Two: Unfair Discrimination

424 If there is differentiation, the second question is whether such differentiation amounts to unfair discrimination. The second question can be broken down into a two-stage analysis:

424.1 Does the differentiation amount to discrimination in that it is based on a prohibited ground, such as race?

424.2 If the differentiation amounts to discrimination, does it amount to unfair discrimination. The answer is that all discrimination on prohibited grounds will be presumed to be unfair, unless it is proved otherwise. There is therefore a presumption of unfairness. The presumption is not conclusive and the discriminating party has the onus of proving that the discriminatory conduct is fair and/or justifiable.

18.3. Stage Three: Can the Presumption of Unfairness be Rebutted?

425 To determine unfairness, the Constitutional Court in *President of the Republic of South Africa v Hugo*,[523] held that it is necessary to look at:

> *"the nature of the power in terms of which the discrimination was effected and, also at the nature of the interests which have been affected by the discrimination."*[524]

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[522] *Ibid.*
[523] *President of the Republic of South Africa and Another v Hugo* 1997 (6) BCLR 708 ("***Hugo***").
[524] *Hugo*, para 43.

426 The Court identified the following factors relevant to determining fairness:[525]

426.1 The position of the complainants in society and whether they have suffered in the past from patterns of disadvantage, irrespective of whether or not the discrimination is on a prohibited ground;[526]

426.2 The nature of the power and the purpose sought to be achieved by it. If its purpose is not directed at impairing the complainants' right to equality, "but is aimed at achieving a worthy and important societal goal" this will have a bearing on whether the complainants have suffered the impairment in question;[527] and

426.3 The extent to which the discrimination has affected the rights or interests of complainants and whether it has led to an impairment of their human dignity or an impairment of a comparably serious nature.[528]

427 In addition to the factors considered by the Court, it is apposite to consider Section 7(e) of the Equality Act at this stage of the determination of unfairness. This section provides that it is unfair discrimination where there is a "denial of access to opportunities, including access to services or contractual opportunities for the rendering of services for consideration". This explicit articulation is apposite in the circumstances where practitioners are suspended/placed on indirect payment or blacklisted. In such circumstances

[525] *Hugo*, para 50.
[526] *Hugo*, para 50(a).
[527] *Hugo*, para 50(b).
[528] *Hugo,* para 50(c).

they are denied the opportunity to contract with the schemes directly for the reimbursement of the costs of services to patients.

428 It bears repeating that what is absent from the test for unfair discrimination is intention. The role of intention was addressed squarely in *Walker*:

> *"In many cases, particularly those in which indirect discrimination is alleged, the protective purpose would be defeated if the persons complaining of discrimination had to prove not only that they were unfairly discriminated against but also that the unfair discrimination was intentional. This problem would be particularly acute in cases of indirect discrimination where there is almost always some purpose other than a discriminatory purpose involved in the conduct or action to which objection is taken. There is nothing in the language of section 8(2) which necessarily calls for the section to be interpreted as requiring proof of intention to discriminate as a threshold requirement for either direct or indirect discrimination. Consistent with the purposive approach that this Court has adopted to the interpretation of provisions of the Bill of Rights, I would hold that proof of such intention is not required in order to establish that the conduct complained of infringes section 8(2). Both elements, discrimination and unfairness, must be determined objectively in the light of the facts of each particular case. This seems to me to be consistent not only with the language of the section, but also with the equality jurisprudence as it has been developed by this Court."*[529]

429 Advocate Trengove SC provided the example of the law that criminalises robbery.[530] If one assumes that 99% of people caught and prosecuted and jailed for robbery are men, then you would have a differentiation on the grounds of gender. This is an enumerated ground, and for that reason it

[529] *Walker*, para 43.
[530] Adv Trengove SC (Transcript, 23 August 2019, p 79, line 24 – p 80, line 8).

constitutes discrimination and it is presumed to be unfair. But the unfairness enquiry will immediately tell you that there is nothing unfair about the differentiation; men commit robbery more often than women and it is not because the law is biased. It is simply as a result of a social phenomenon that men commit robbery more often than women.

430 The entire question of discrimination and unfairness is ultimately a value judgment.[531] However, it is one which is made within the scaffolding of clear considerations, which we use in the application of anti-discrimination law to the outcomes of the FWA detection and investigations processes that Discovery, Medscheme and GEMS have put in place.[532]

19. APPLICATION OF LEGAL TEST TO THE FWA PROCESSES

431 In light of the above, the Panel asks whether, the FWA outcomes have a differential impact on Black healthcare practitioners. Put differently, we were required to determine whether the administrators and scheme's FWA findings have an unfair racially discriminatory *outcome*.

[531] Adv Trengove SC (23 August 2019, p 90, lines 4 - 6).
[532] *Hugo*, para 41, where the Constitutional Court held that:
"*At the heart of the prohibition of unfair discrimination lies a recognition that the purpose of our new constitutional and democratic order is the establishment of a society in which all human beings will be accorded equal dignity and respect regardless of their membership of particular groups. The achievement of such a society in the context of our deeply inegalitarian past will not be easy, but that that is the goal of the Constitution should not be forgotten or overlooked.*"

19.1. Stage One: Is There a Differential Outcome in the FWA Findings?

432 The first step is to determine whether Black healthcare providers were more likely to be found by the schemes to have committed FWA than non-Black providers.

433 The Panel received hundreds of complaints of discrimination. The number of complaints does not prove differential treatment or racial profiling. While they provide evidence both of the experience of possible discrimination (through for example, feeling racially profiled or targeted) and its concomitant harm, it is not alone conclusive evidence of racial discrimination, and more particularly that Black practitioners are targeted more than their non-Black counterparts.

434 For this reason, the Panel requested the assistance of Dr Kimmie, an expert in statistics, statistical modelling, mathematical modelling and the analyst of data, particularly survey data.[533]

435 The Panel ultimately asked Dr Kimmie to address two main questions:

435.1 Was there explicit racial bias in the algorithms and methods used by Discovery Health, GEMS and Medscheme to identify potential instances of FWA? and

435.2 Were the outcomes of the FWA process racially biased?

[533] Dr Kimmie (Transcript, 19 November 2019, p 6, lines 5 - 6). See also; Kimmie Report, 18 November 2019, p 34 – 39, which provides that Dr Kimmie has a PhD in mathematics (UCT); a Master's in public health (Harvard School of Public Health), focusing on biostatistics, epidemiology and the design and analysis of experimental data. Dr Kimmie worked as a statistician at the Council for Scientific and Industrial Research, focusing on the analysis of quantitative data.

436 As set out above, Dr Kimmie provided the Panel with two reports – the first in November 2019 and the second in October 2020 (redacted versions attached as Annexures A and B).[534] Dr Kimmie presented evidence to the Panel on the 19th of November 2019. The schemes and administrators responded to Dr Kimmie's evidence and his first report.

437 The methodology employed by Dr Kimmie consisted of:

437.1 A review of the initial submissions made to the Panel, by Discovery, GEMS and Medscheme;

437.2 The production of an overview of the methodological questions and data sources that would need to be analysed in order to satisfactorily address the question of whether the outcomes of FWA processes were racially biased. This document was submitted to the Panel on 7 August 2019. Based on this document the Panel directed Dr Kimmie to focus on the two questions set out above.

437.3 On-site interviews with the forensics teams of Medscheme (19 September 2019), Discovery Health (27 September 2019), and GEMS (8 October 2019). At these sessions, the various teams demonstrated the implementation of their forensics systems.

437.4 The acquisition of the primary data required to determine whether FWA outcomes were racially biased. This data consisted of the PCNS database (which contained the PCNS number, discipline, name and

[534] The redactions in the report are as a result of GEMS, Medscheme and Discovery indicating that some of the data they provided Dr Kimmie was confidential.

surname of all practitioners interacting with medical schemes), and the PCNS numbers and FWA status (whether or not they had been identified as committing FWA) of all practitioners delivering services to each of Discovery, Medscheme and GEMS.

437.5 The classification of all practitioners on the PCNS list as Black or Non-Black based on their surname. This method has been widely used in other contexts but had not been previously applied in a South African context. The surname-based race classification provided a useful proxy through which the racial discrimination in FWA outcomes could be examined.

437.6 The final step consisted of a statistical analysis of FWA outcomes in order to determine whether or not a racial bias existed. The measure used to determine whether a bias existed is the risk ratio, which is defined as the proportion of Black practitioners who have been identified as having committed FWA divided by the proportion of Non-Black practitioners who have been identified as having committed FWA. A risk ratio of 1.5 can therefore be interpreted (in this instance) as Black practitioners being 50% more likely to be identified as having committed FWA than non-Black practitioners. Standard statistical techniques were used to determine whether the calculated risk ratios were likely to have occurred by chance or whether they reflected real differences in the population.

438 Dr Kimmie's Report provided a detailed description of the methodology he used in examining the data and coming to his conclusions.[535] Based on this methodology, Dr Kimmie concluded that:

438.1 There is a substantial difference in FWA outcomes between Black and non-Black practitioners over the period January 2012 to June 2019.[536]

438.2 The findings with respect to racial bias were based on the racial classification method used in the analysis, and that the inference that this represents a meaningful actual difference was based on an analysis of the scale of the bias (measured by the risk ratio), the probability that the associations were the result of chance events, and an examination of the robustness of the result with respect to the racial classification method. He further noted that the racial bias simply represents a correlation between the race classifier and FWA status, and that it may be the case that the relationship is clarified by some intermediate confounding variable, and that the causal relationship is between that variable and the outcome.

438.3 Over this period Black practitioners were 1.4 times more likely to be classified as having committed FWA than those identified as not Black.[537]

[535] Dr Kimmie's report, 18 November 2019, Chapter 3: "Methodology", p 7 - 15.
[536] Dr Kimmie's report, 18 November 2019, Chapter 5: "Racial Bias in FWA Outcomes", p 22.
[537] *Ibid*.

438.4 The probability that this distribution occurred by chance (i.e. that there is no correlation between racial status and FWA outcomes) is for all practical purposes 0 (zero).[538]

438.5 The scale of the deviation increased steadily from 2013 to 2017, at which point Black providers were almost twice as likely to have been identified as committing FWA than non-Black providers;[539]

438.6 The starkest differentials are evident amongst the following:[540]

438.6.1 Black general practitioners are 1.5 times more likely to be identified as FWA cases than their non-Black counterparts;

438.6.2 The rate at which Black physiotherapists are identified as FWA cases is almost double (1.87) that of their non-Black counterparts;

438.6.3 Black psychologists are three times more likely to be identified as FWA cases;

438.6.4 Black registered counsellors and social workers are also three times more likely to identified as FWA cases. More than 50 percent of Black registered counsellors *have* been identified as FWA cases – this

[538] *Ibid*.
[539] Dr Kimmie's report, 18 November 2019, Chapter 5: "Racial Bias in FWA Outcomes", p 24.
[540] Dr Kimmie also analysed the differentiation in FWA outcomes by various disciplines within healthcare practitioners, see Dr Kimmie's report, 18 November 2019, Chapter 5: "Racial Bias in FWA Outcomes", p 25.

is the highest rate among the disciplines analysed; and

438.6.5 Black dieticians are 2.5 times more likely to be identified as FWA cases compared to their not Black counterparts.

438.7 The results are robust in the sense that the scale of the effect of racial bias is not materially affected by changes in the racial classification schema. This provides assurance that the results presented are not an artefact of the particular racial classification method adopted.

438.8 The results are also conservative, in the sense that the effect estimate is likely an under-estimate of the true effect. This is a direct consequence of the use of a conservative approach to the racial classification method where the default classification is non-Black.[541]

438.9 The FWA outcomes for the three administrators and schemes exhibit clear racial bias, with Black providers significantly more likely to be identified as FWA cases. The scale of the bias, however, varies quite dramatically, with risk ratios varying from 1.35 to 3.31.[542]

438.10 There are clear differences in the scale of racial discrimination between the three administrators and the schemes – Discovery was 35% more likely to identify Black providers as having committed FWA,

[541] Dr Kimmie's report, 18 November 2019, Chapter 5: "Racial Bias in FWA Outcomes", p 23; Chapter 6: "Conclusions", p 31 and Annexure D: "Conceptual Framework for determining FWA cases", p 69.

[542] Dr Kimmie's report, 18 November 2019, Chapter 5: "Racial Bias in FWA Outcomes", p 26 - 27. For a discussion of the statistics applicable to individual schemes, see also: Dr Kimmie's report, 18 November 2019, Chapter 5: "Racial Bias in FWA Outcomes", p 27 – 30.

GEMS was 80% more likely, and Medscheme was 330% more likely to identify Black providers as guilty of FWA.[543]

438.11 Dr Kimmie also compiled detailed reports for each of the schemes and administrators, such reports being made available to them before the oral hearings.

439 The results when broken down per scheme and administrators were:

439.1 Discovery: the pattern of racial bias first manifests in 2014 (with a risk ratio of 1.25) and then becomes steadily stronger in subsequent years (rising to 1.61 in 2017). The bias in 2018, while still significant, reverted to the 2014 level. Although data for 2019 is limited to the first six months it appears the risk ratio this period is not significantly different from 1, i.e. no bias appears to exist for this period.

439.2 GEMS: the pattern of racial bias is clear from 2013 onwards. The relative risk increases substantially over this period, from 1.5 in 2013 through to 2.5 in 2017.

439.3 Medscheme: the Medscheme data showed the most variation. This is a result of the relatively small numbers of FWA cases identified before 2016 (only about 70 cases a year). From 2016 onwards the risk ratios are high (approximately 4.0 for 2016 and 2017) implying that Black providers were being identified as FWA cases at four times the rate of Non-Black providers.

[543] Dr Kimmie's report, 18 November 2019, Chapter 5: "Racial Bias in FWA Outcomes", Table 5.4, p 26.

440 The results when broken down per discipline were:

440.1 General practitioners: there was a clear racial bias in the identification of FWA cases, with the bias being significantly higher (risk ratios greater than 2 compared to 1.4 for Discovery) among GEMS and Medscheme.

440.2 Pharmacies: there was no evidence of racial discrimination within the Discovery and GEMS data. A large proportion of pharmacies have not been racially classified in Dr Kimmie's classification scheme. However, even with these restrictions the Medscheme data showed significant racial bias (a risk ratio of close to 3).

440.3 Optometrists: the only evidence of racial bias exists within the GEMS data (a risk ratio of 2).

440.4 Physiotherapists: there is clear evidence of racial bias among all three entities. The risk ratios within the Medscheme (>12) and GEMS (>6) are particularly high. For example, within Medscheme the risk of physiotherapists being identified as FWA cases is 12 times higher than the risk for Non-Black physiotherapists.

440.5 Social workers and dieticians: the pattern of racial bias exists across all three entities.

441 While it was not part of our mandate to consider whether there was a discriminatory outcome regarding gender, it became clear to the Panel that professions that contained more Black women evinced particularly high levels

of bias. It would further appear that there is worrying variation by race within gender categories: Black men are 50% more likely to be the subject of FWA cases than non-Black men; Black women are 250% more likely to be the subject of FWA cases than non-Black women.[544]

442 Returning to racial discrimination, the first part of the test therefore is answered in the affirmative: the FWA processes do have a differential impact between Black and non-Black practitioners.

19.2. Stage Two: Does the Differential Outcome Constitute Discrimination?

443 The next question is whether the differential outcomes constitutes discrimination.

444 Race is a prohibited ground of discrimination within section 9 of the Constitution. Therefore, according to the Equality Act, there is a presumption that the FWA processes result in unfair discrimination.

445 This presumption, however, can be rebutted. The onus is on GEMS, Discovery and Medscheme to show that the discriminatory outcome is *not* unfair (or is fair).[545]

[544] We do not delve further into this, but we note that, when the schemes review their FWA processes, they do so not only in respect of racial discrimination but also in respect of the disproportionate impact on Black women.
[545] Adv Trengove SC (Transcript, 23 August 2019, p 80, line 23 - 81, line 23).

19.3. Stage Three: Rebut the presumption of unfair discrimination

446 None of the schemes made a serious attempt to argue that the disproportionate effects on Black practitioners were fair (although we will say more about fairness or rather the unfairness of the disproportionate effect on Black practitioners below). Rather, the schemes' focus was on critiquing Dr Kimmie's report and arguing that his evidence of racially biased effects should not be accepted.

447 The schemes clearly did not rebut the presumption that their risk management systems produced unfairly discriminatory results. In the next section we discuss the schemes' responses to Dr Kimmie's report.

20. THE SCHEMES' RESPONSE TO DR KIMMIE'S REPORT

448 Medscheme in its oral submission maintained the position that "the methodology used however is insufficient for purposes of reaching factually accurate conclusions for purposes of this investigation."[546] In the supplementary submission by its expert, Dr Mike Bergh of OLSPS Analytics and OLSPS Solutions, it elaborated on this submission where the expert argued that "the effect of sequentially sub-setting risk ratios using the variables described above shows that Dr Kimmie's risk ratio cannot be interpreted as is"[547] and rather the expert argues "the risk ratio is reduced in some cases to close or below 1."[548]

[546] Medscheme power point presentation, 30 January 2020, slide 65.
[547] Dr Bergh report, 7 February 2020, p 2, para 1.
[548] Dr Bergh report, 7 February 2020, p 13, para 5.

449 Discovery, like Medscheme and GEMS, also argued in its oral submission that the Dr Kimmie's risk ratios were wrong. The critique that Discovery offers is that Dr Kimmie failed to take into account possible confounding factors which may explain why Discovery's risk management systems result in Black practitioners being 36% more likely to be found guilty of FWA.[549] Discovery explained that it "extended Dr Kimmie's analysis to include some potential confounding factors for which we do have the data" and that this "analysis confirms that the identified confounding factors reduce the differences in FWA outcomes by race by more than 75% - from a risk ratio of 1.36 to a risk ratio of 1.09."[550]

450 Discovery, after the oral hearings conducted its own analysis of FWA outcomes by race (a part of which was confirmed by Deloitte & Touche[551]) to confirm and elaborate on the arguments it made in the oral hearings.[552] Discovery further engaged its legal advisors to make legal submissions on its behalf.[553] These two documents argued *inter alia* that:

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[549] Discovery power point presentation, 29 January 2020, slide 72.

[550] *Ibid*.

[551] Discovery appointed Deloitte for the purposes of evaluating the classification methodology of Discovery titled "Data Classification methodology Evaluation" ("**the Deloitte report**"), January 2020, p 2, where Deloitte explains that:

"Discovery have determined and implemented a classification methodology to classify health practitioners by race. Deloitte has evaluated and tested the classification methodology and performed further analysis thereon".

See also: the Deloitte report, January 2020, p 7, where Deloitte finds that*:*

"Deloitte has evaluated the classification methodology used by Discovery and does not find it to be inappropriate."

[552] Discovery's fourth supplementary submission titled: "Analysis of fraud, waste and abuse outcomes by race" ("**Discovery FWA outcomes report**"), 27 January 2020; accompanied by the Deloitte Report dated January 2020.

[553] Discovery's sixth supplementary follow-up legal submission, titled "Follow up submission to the Section 59 Investigation Panel", 14 February 2020 ("**Discovery's legal submission**").

450.1 On Discovery's own analysis there is a disproportion in FWA outcomes for Black practitioners arising from investigations.[554] Discovery further explains that the RRT identifies a higher proportion of black practitioners than those identified by tip-offs – albeit that there is still a disproportionate number of Black practitioners identified by tip-offs.[555] Discovery therefore concedes that both their analysis and Dr Kimmie's analysis demonstrated "disproportionate outcomes by race" but they argued that they "believe that the difference in the proportions of practitioners investigated can be explained by factors other than racial bias". Discovery then identifies 5 alleged confounding factors (discipline, year, direct payment, RRT and tip-offs) which they argue reduces the risk ratio of 1.36 to 1.09.[556] Discovery concludes with the submission that their "analysis shows that once a small set of confounding factors are taken into account, the unexplained difference in FWA outcomes by race is far smaller than initially identified and is below 10%."[557];

450.2 Discovery submits that "on the facts presented to the Panel by Discovery and by its own expert, there is not even *prima facie* evidence of discrimination."[558] Discovery accordingly appears to be of the view that it does not have to rebut the presumption that its FWA outcomes give rise to unfair discrimination. It further submits that the reduced risk ratio of 9% (or in Discovery's submission of 8%) "does

[554] Discovery FWA outcomes report, 27 January 2020, p 7, para 2.3.
[555] *Ibid*.
[556] Discovery FWA outcomes report, 27 January 2020, p 11, para 4.2.
[557] Discovery FWA outcomes report, 27 January 2020, p 12, para 4.3.
[558] Discovery's legal submission, 14 February 2020, p 15, para 31.

not amount to discrimination" and "no question of unfairness arises". It then hedges its position and submits that:

> *"if the Panel disagrees, then Discovery seeks an opportunity to investigate additional confounding factors and also the number of black practitioners in the PCNS database"*[559]

450.3 Discovery submits that the Panel would be acting unfairly if it were "to find that Discovery has failed to discharge an "onus" to show that there has been no racial discrimination, without being afforded a proper opportunity to do so."[560]

451 The responses of the three administrators and schemes to Dr Kimmie's findings can be classified into the following four categories:

451.1 Arguments that the racial classification methodology could be improved;

451.2 Arguments that the claim in Dr Kimmie's report that the estimates produced by his methodology are not in fact conservative;

451.3 Arguments that there are specific confounding factors which provide alternative explanations of the cause of the racially biased outcomes; and

451.4 Suggestions that the basis on which the analysis was conducted could be improved, in particular arguments that adjusting for utilisation (the

[559] Discovery's legal submissions, 14 February 2020, p 22, para 40.
[560] Discovery legal submissions, 14 February 2020, p 11, para 20.

level of interaction with the scheme) would provide a more accurate measure of effects.

452 Discovery, GEMS and Medscheme did not contest the fact that Black practitioners were more likely to be found to have committed FWA than non-Black practitioners.[561] Rather, in the main, they critiqued Dr Kimmie's approach and contested whether his findings were the result of explicit or intentional racial bias or whether the racial bias was due to other, possibly environmental, factors.

453 Importantly, however, none of Discovery, GEMS or Medscheme demonstrated that there were not disproportionate effects on Black practitioners. They failed to rebut the presumption of unfairness – and we explain in detail why we find this to be the case below.

20.1. The racial classification methodology could be improved

454 Both Medscheme and GEMS suggested that the racial classification of certain types or disciplines of practitioners, in particular those in which the majority of practitioners are corporate, group or public entities, was not legitimate and those practices should be excluded from the analysis.[562] Neither of the experts consulted by Medscheme or GEMS demonstrated the immediate

[561] In respect of GEMS, see: Prof Fatti and Dr Getz (Transcript 28 January 2020, p 187, line 2 – p 188, line 14; p 196, line 12 -197, line 6; p 200,lines 10 - 26; p 205, lines 5 - 18). See also, in respect of Discovery: Mr Smit and Dr Broomberg (Transcript, 29 January 2020, p 104, lines 1 - 19; p 114, lines 3 – 9) and, in respect of Medscheme, Mr Midlane and Dr Nyati (Transcript 30, January 2020, p 169, line 20 – p 170, line 1; p 180, lines 9 – 22 and p 187, line 11 - p 188, line 24).

[562] Insight Report, January 2020, p 6, para 3.2 – p 8, para 3.3. See also: Dr Bergh report, 7 February 2020, p 4, para 3.1.

result of such exclusions on the risk ratio, instead conflating this intervention with other, unrelated, interventions.

455 Dr Kimmie reviewed these claims and accepted that in some instances the analysis could be improved by removing certain disciplines of medical practitioners. The results presented by the GEMS experts, even though it conflated number of interventions, found that the effect of this removal resulted in a reduction of the risk ratio (for practitioners interacting with GEMS) from 1.78 to 1.47. The effect due solely to the removal of certain types of practices does not materially affect the finding that the outcomes of FWA processes are racially biased as Black practitioners are 47% more likely to be found guilty of FWA as compared to the non-Black counterparts.

456 The analysis presented by Medscheme's experts is illogical and/or unreasonable since the expert first removes all cases of FWA derived from whistle-blower complaints.[563] This is an unfortunate misinterpretation of the relevant question. The relevant question is FWA outcomes – are findings of FWA disproportionately being made against a certain group of practitioners – not whether the set of investigations exhibits such a bias, nor whether or not any explicit intent was involved.

[563] Dr Bergh report, 7 February 2020, p 5, para 3.2.

20.2. Dr Kimmie's estimates are not conservative

457 Each of the schemes claim in their submissions that correcting errors in the classification process will result in a lowering of the risk ratio.[564] In some instances the schemes claim to have produced examples to demonstrate their position, thus invalidating the claim made by Dr Kimmie that his estimates are conservative.

458 Dr Kimmie reviewed this claim and maintains that his original statement holds true. His original statement was:

> *"the racial classification has been conservative, with the default classification being Not Black. This will, on the assumption that the classification is independent of the outcome (as is the case here), tend to increase the risk rate among the non-Black group, thus reducing the risk ratio."*[565]

459 In slightly different terms, non-differential classification will bias the estimate towards the null, i.e. produce an estimate lower than the true effect. Dr Kimmie noted in his report that this is a mathematical truth, and one that is firmly established in the epidemiological literature.[566] It is not an issue over which there appears to be disagreement.

460 The racial classification used by Dr Kimmie is non-differential with respect to the outcome since each name was assigned a race without any information

[564] Discovery's legal submission, 14 February 2020, p 16, para 33.1. See also: Discovery FWA outcomes report, 27 January 2020, p 12, para 4.4. Medscheme additional submission, Mr Midlane affidavit, 7 February 2020, p 5, para 3 and Insight Report, January 2020, p 8 – 10, para 3.4.
[565] Dr Kimmie's report, 18 November 2019, p 23, para 5.2.1.
[566] Dr Kimmie's report, 18 November 2019, p 1, para 3.3.

about the FWA status of practitioners with that name. The independent classification exercise conducted by Discovery, which was independently audited by Deloitte, did not substantively differ from that produced by Dr Kimmie, and there is therefore no reason to doubt the integrity of the initial process.

20.3. Racial bias is the result of confounding factors

461 Discovery claims that, when taking into account the role of certain confounding factors (in particular the year in which the finding of FWA was made, whether or not the practitioner was on direct payment, and whether or not the practitioner was the subject of a tip-off) the risk ratio is substantially reduced (from 1.36 to 1.09). Discovery also claim that this ratio could be further reduced by dint of other confounding factors that have not yet taken into account, or which may not have been measured.

462 The GEMS experts make a similar, though slightly less robust argument. In order to explain the residual risk ratio of 1.47 (after reclassifying some practitioners, removing certain categories of practices and adjusting for exposure) the GEMS expert notes that this is very close to the risk ratio when only considering cases reported through the whistle-blower mechanism. The claim is then that the whistle-blower mechanism is therefore responsible for the residual risk ratio, and thus that race is not a meaningful predictor of FWA status.

463 Dr Kimmie notes that no formal definition of a confounder is ever provided by Discovery, and that this oversight materially undermines their analysis. In particular the Discovery analysis appears to rely on the erroneous assumption that confounding can be determined simply by examining the effect of including such a variable on the risk ratio.[567]

464 Dr Kimmie notes that the formal definition (as given in a standard epidemiological textbook as well as in the general literature) explicitly disallows consideration of a variable as a confounder if it is affected by the exposure variable (race in this case) or the outcome variable (FWA status in this case). In particular a variable cannot be a confounder if it lies on the causal path between exposure and the outcome. In such a case "adjusting" for the confounder would artificially lower the size of the effect.[568]

465 Direct payments (whether or not the practitioner is on direct payment, i.e. the practitioner is paid directly by the scheme rather than by the patient) is clearly a consequence of race. Black practitioners are, given the socio-economic circumstances of their patients, more likely to be paid directly by the medical scheme. This was explicitly conceded by Dr Broomberg in his oral evidence.[569]

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[567] See for example the comments by Dr Broomberg (Transcript, 29 January 2020, p 129, lines 10 - 24).

[568] Dr Kimmie's report, the final report, 29 October 2020, p 14, para 5.3.

[569] Dr Broomberg (Transcript, 29 January 2020, p 134, lines 12 - 17):

"But I think what drives a doctor to be on a payment arrangement, all other things being equal, is what is the balance between earning more by being off it and can my patients afford the co-payments and will they still come and see me? So there are parts of, you know, I think that is really, that's the point here.".

See also: Dr Broomberg (Transcript, 29 January 2020, p 135, lines 11 – 13):

466 Dr Kimmie notes that the analysis by Discovery (as reflected in the submission of 27 January 2020) contains no indication that the authors are aware of the formal definition of a confounder or of the dangers of incorrectly adjusting for a variable that is not a confounder. The commentary by their independent expert (who confirms that the analysis was done correctly) uses a simplistic definition of a confounder extracted from a website that "explains" confounding without any formal definitions.[570] The verbal evidence presented by Dr Broomberg similarly reveals a flawed understanding of confounding. When questioned by the Panel about the link between race and direct payment (which would therefore exclude the use of this factor as a confounder) Dr Broomberg incorrectly continues to insist that the aforementioned linkage is of no concern.[571]

467 Dr Kimmie further notes that the best practice guidance (in a communication by 47 editors of medical journals for the control of confounding factors specifically rejects methods that rely on whether or not a measure (such as a

"You have to accept that my hypothesis that one of the main reasons why people accept payment arrangements is that they have on balance, lower socio-economic status patients. That may or may not be true."

[570] Discovery's legal submission, 27 January 2020, p 8, para 2.4, footnote 5.

[571] Dr Broomberg (Transcript, 29 January 2020, p 136, lines 11 - p 137, line 2):

> *"DR JONATHAN BROOMBERG: No, I disagree strongly with that with respect Mr Chair because the history of severe discrimination against Black people in our country has led to tremendous poverty impacting the Black population of this country. These people are patients, they are the members of the medical scheme. That can never excuse fraud by a doctor regardless of her or his skin colour. And what I am saying to you is that we are very cognisant of the plight of our members. The majority of the members of Discovery Health Medical Scheme are Black. Our duty is to them and the exercise of that duty is being very diligent about fraud, waste and abuse and we practise no race discrimination implicit or explicit when we investigate and when we identify for investigation and so it does turn out that participating in direct payment arrangements is a confounding factor, it undermines what you said is such strong correlation that you must suspect causation. This undermines your allegation, sorry your contention and it is a confounder. It may be linked to race. That does not mean that Discovery's racial bias is leading to the outcomes. It is a very important distinction."*

risk ratio) changes significantly.[572] In particular hunting for variables that change the outcome and then *post facto* declaring that they are confounders amounts to nothing more than a fishing expedition. The guidance by the editors referred to is to identify potential confounders based on the state of existing knowledge and causal relationships. The danger of fishing for variables that affect the outcome measure is that once such a variable is found and identified as a "confounder" the search for a post-hoc explanation then commences. The lack of a theoretical framework in which valid causal relationships can be investigated leads inevitably to incoherent causal explanations. If, for example, one were to find that the hair colour confounded the relationship between smoking and lung cancer (because controlling for hair colour changed the risk ratio) one would be tempted to imagine all sorts of superficially reasonable sounding causal explanations for a phenomenon with no physical manifestation.[573]

468 This sort of difficulty is adequately demonstrated by Dr Broomberg's attempts to explain why the year in which FWA occurred is a potential confounder.[574]

469 The final factor posited as a potential confounder is whether or not the practitioner was the subject of a tip-off. The question of what the causal mechanism by which the confounding occurs is not addressed in the written submissions and was also not covered in the verbal evidence.

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[572] Dr Kimmie, the final report, 29 October 2020, p 15, para 5.3.
[573] Dr Kimmie, the final report, 29 October 2020, p 14 - 15, para 5.3.
[574] Dr Broomberg (Transcript, 29 January 2020, p 129, line 22 - 24), where Dr Broomberg stated that:
"*Beyond that I am afraid to say I can't think of a reason why a year would be a confounding factor here save to say that it is the confounding factor.*"

470 Dr Kimmie concludes that the existence of potential confounders cannot be dismissed, but that the attempts to investigate confounding by Discovery do not meet the basic technical standards required of such an analysis.[575]

20.4. Adjusting for utilisation would more accurately reflect results

471 The Medscheme and GEMS's experts suggested that taking into account the level of exposure (i.e. the extent of the interaction between the practitioner and the scheme) would be the more appropriate measure to use when investigating racial bias.

472 GEMS's expert suggested using the number of consultations claimed for by the practitioner and proceeded to conduct the analysis on this basis. As indicated above this modification, together with some other adjustments, reduced the risk ratio from 1.78 to 1.47.[576]

473 This reduction is not meaningful and is not sufficient to invalidate the conclusion about racial bias reached in the Dr Kimmie's original report.[577]

474 The experts retained by Medscheme suggested adjusting by the number of claim lines. It is not clear why claim lines rather than number of consultations were chosen – the expert report does not mention whether any investigation of adjusting by consultations was considered, and if so, why it was rejected.[578] The number of claim lines appears to be significantly higher than the number

[575] Dr Kimmie, the final report, 29 October 2020, p 16, para 5.4.
[576] Dr Kimmie, the final report, 29 October 2020, p 11, para 4.5.
[577] Dr Kimmie, the final report, 29 October 2020, p 11, para 4.6.
[578] Dr Kimmie, the final report, 29 October 2020, p 17 – 18, para 6.3.

of consultations, and this may introduce unnecessary volatility into the measurement, as discussed below.[579]

475 Unfortunately, the Medscheme experts only presented results after conflating three distinct steps – adjusting for exposure, removing certain types of practices and removing all cases generated by whistle-blowers. The fallacy of the last step has been addressed above.[580] There is thus no basis on which to examine the effect of the adjustment for exposure. Nevertheless Dr Bergh's report concludes that the risk ratio after all of these efforts is 1.35[581] – this would even by this flawed methodology be a significantly disproportionate effect on Black practitioners as they would be 35% more likely to be found guilty of FWA than their non-Black counterparts.[582]

20.5. Summation

476 In light of the above, GEMS, Medscheme and Discovery have failed to persuade us that the disproportionate effects that their risk management systems produce for Black practitioners does not amount to unfair discrimination.

477 The evidence before us indicates that Black practitioners are significantly more likely to be identified as FWA cases than non-Black practitioners – the racial differentiation is evident regardless of whether the FWA case is identified by Medscheme, GEMS or Discovery.

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[579] *Ibid*.
[580] Dr Kimmie, the final report, 29 October 2020, p 18 - 19, para 6.6.
[581] Dr Bergh report, 7 February 2020, p 2, para 2.
[582] Dr Kimmie, the final report, 29 October 2020, p 5, para 2.2.

478 The degree of the race differentiation differs significantly with the risk ratios varying from:

478.1 1.35 with Discovery, to;

478.2 1.8 with GEMS, to; and

478.3 3.31 with Medscheme.[583]

479 In other words, Black practitioners are 35% more likely than non-Black to be flagged as committing FWA by Discovery; Black practitioners are 80% more likely than non-Black to be flagged as committing FWA by GEMS; and Black practitioners are 331% more likely than non-Black to be flagged as committing FWA by Medscheme.[584]

480 Whilst GEMS, Discovery and Medscheme may dispute the exact risk ratios, it is accepted by Medscheme, Discovery and GEMS that the risk ratios are different for Black and non-Black practitioners and therefore, Black practitioners are more likely to have been identified as committing FWA than non-Black practitioners. On their own versions the risk ratios for Black practitioners are as follows:

480.1 Medscheme: 1.35 (In relation to Medscheme's its expert argues for other reasons that the risk ratio reduces to 1.02, 1.01 and then 0.88.[585]

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[583] Dr Kimmie's report, 18 November 2019, Chapter 5: "Racial Bias in FWA Outcomes", Table 5.4, p 26.

[584] Dr Kimmie's report, 18 November 2019, Chapter 5: "Racial Bias in FWA Outcomes", p 26 - 27.

[585] Dr Bergh report, 7 February 2020, p 2, para 1:

"Three other areas that play a role in earmarking providers for investigations are whether they are auxiliary providers, whether they are on or off network, and whether payment is direct or indirect. The average [redacted] score for 'Black' auxiliary providers that are off network is 53% higher

We cannot accept this evidence as accurate in any way – the first outcome is observed after implementing a sequence of decisions, at least one of which is clearly erroneous. Subsequent calculations merely serve to perpetuate these initial errors and therefore cannot be considered;[586]

480.2 Discovery: 1.09 (In relation to Discovery it argues that its new risk ratio of 1.09 is not enough to sustain a finding of unfair discrimination, for the reasons explained above, we do not accept that Discovery has identified any confounding factors – and therefore we reject Discovery's new risk ratio as it is simply wrong); and

480.3 GEMS: 1.47. After implementing their own adjustments GEMS ended with a risk ratio of 1.47, and argued that since it was almost identical to the risk ratio for complaints through the whistle-blower system it could not be a result of unfair discrimination – the assumption being that this difference was due to factors beyond their control, possibly the result of unspecified "extenuating factors which differentiate between black and non-black practitioners".[587] As with Discovery, the onus is on GEMS to demonstrate what these factors are and hence we reject the assertion that no unfair discrimination has occurred.

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than for 'Not Black' providers, and this naturally draws more investigative attention. A risk ratio calculated on the basis of non-auxiliary providers only, reduces the risk ratio of 1.35 to 1.02. When this analysis is further restricted to providers on-network then the corresponding risk ratio value is 0.88, and then restricting it to direct payment only the risk ratio is 1.01."

[586] Dr Bergh report, 07 February 2020, p 2, para 1 and p 11, Table 6.

[587] Insight report, January 2020, p 12, para 5.

21. THE FAIRNESS ASSESSMENT

481 Essentially fairness requires a value judgement, where one considers the relevant factors set out in the Equality Act and by the Constitutional Court, and weighs up:

481.1 The purpose of a policy, in this case the attempt to root out FWA by healthcare providers; against

481.2 The discriminatory impact on Black healthcare practitioners, particularly the effect this has on Black people's dignity.[588]

482 We consider it prudent to assess the fairness of the disproportionate effects on Black practitioners. The reason for this is first for completeness; second, because GEMS, Discovery and Medscheme did not make detailed submissions on fairness; and third because Discovery has reserved their position in relation to making full submissions on fairness.

483 First, Discovery, GEMS and Medscheme emphasised the seriousness and extent of FWA.[589] They submitted that the impact of FWA is extremely dire, on both the scheme and its members.

484 Discovery in particular entreated the Panel:

> "*not to generalise from a tiny number of complainants in the context of you know 35,000 practitioners submitting millions of claims every*

[588] Adv Trengove SC (Transcript, 23 August 2019, p 90, lines 4 - 12).

[589] See for example: Dr Broomberg (Transcript, 29 January 2020, p 13, line 13 - p 14, line 18). See also: GEMS power point presentation, 28 January 2020, slide 45; Discovery power point presentation, 29 January 2020, slides 14 – 16 and Medscheme power point presentation, 30 January 2020, slide 12.

year not to generalize from those. And thereby weaken an entire system that is providing great protection to the members of medical schemes."[590]

485 We agree that efforts to reduce FWA is a "worthy and important societal goal".[591] This is particularly so as FWA is ultimately experienced by members of medical schemes – as the schemes hold members' monies in trust and both administrators and schemes are obliged to take steps to prevent FWA.[592] It is important that schemes, either themselves or through their administrators, manage their financial risk appropriately and this includes having systems for the detection and prevention of FWA.

486 We accept the importance of eradicating FWA and more particularly the importance of having effective risk management systems in place, despite the difficulties with the evidence that was adduced about the cost of FWA.[593] However, such evidence at times appeared exaggerated and overstated. For example, Medscheme initially suggested that the impact of FWA could range between 3% - 15%, with some people claiming it could be as high as 23%.[594] Medscheme conceded, however, that the figure applicable to Medscheme is 3%.[595] Also, where for example, GEMS, in its own policy documents did not

[590] Dr Broomberg (Transcript, 29 January 2020, p 167, lines 2 - 6).
[591] *Harksen*, para 51.
[592] The CMS has issued new rules for Administrators requiring them to have mechanisms to detect and prevent FWA. See 'Requirements For Administration Of Medical Schemes', April 2020, available at https://www.medicalschemes.com/files/Administrators/Requirements_for_Administration_of_Medical_Schemes_Final_Apr_2020.pdf.
[593] Discovery submission, 18 July 2019 (Discovery bundle, p 11, para 2.3), where Discovery stated: "*At the 2019 FWA Summit, the CMS went on to state that FWA claims may account for up to 15% of all claims paid out by medical schemes in South Africa, suggesting that as much as R22 billion to R28 billion of medical scheme members' money may be lost to fraudulent claims each year.*"
[594] Mr Midlane (Transcript, 30 January 2020, p 15, lines 1 - 23).
[595] See Medscheme's evidence regarding the impact of FWA: Dr Nyati (Transcript, 30 January 2020, p 16, lines 2 - 7):

define “waste” but only defined fraud and abuse, it is difficult to accept that GEMS’s calculations of the cost of at least “waste” was accurate.

487 Having accepted the importance of eradicating FWA, the measures and systems used should not do so at the expense of Black people’s dignity and the principles of equality. It is to be expected that risk management systems will not be perfect – in other words they cannot be required to produce a risk ratio of 1 (where Black and Non-Black practitioners are perfectly equally treated). However, the extent of the risk ratios (and hence unfair and unequal treatment) that were evident in the years under consideration are significant (and in the case of Medscheme we would say extreme) and have clearly had a disproportionate impact on Black people and affected their quality of life and dignity. It is exactly this disproportionate impact and effects that led to the associations representing Black doctors to take action and ensure that the CMS initiated an investigation through the Panel. The disproportionate impact was also palpable in the evidence before the Panel where we heard experiences of loss and severe emotional distress.[596]

“ADV TEMBEKA NGCUKAITOBI: So, these figures that you give here about global utilisation of 26%, 30%, 33- are really irrelevant if we are talking about 3%. DR NOMALUNGELO NYATI: The relevance really is just to see what happens in different countries. They are not relevant to this specific discussion, no.”

[596] Ms Ramasolo (Transcript 2 of 3, 29 July 2019, p 6, lines 1 – 8):

“The common responses to such devastation include – sorry – anxiety, depression, which suicidal ideation or psychotic features, PTSD, alcohol abuse or drug abuse, nightmares, panic attacks, over...overwhelming - or levels of stress characterized by loss of feelings of security and adequacy, confusion, feelings of detachment, inability to sleep and other physical and mental symptoms of stress and depression. I’ve had a colleague; she was my office maid; she killed herself. It’s very sad.”

See also: Ms Ramasolo (Transcript 2 of 3, 29 July 2019, p 5, line 16 – p 17, line 1):

“This economic hard...hardship and financial dis...distress can have devastating effects on families. In tough economic times like when your...your money is withheld, many families lose their homes, their cars, their retirement accounts, belongings, health insurance and more. And families often struggle just to meet their basic needs. The shift from having something even moderate means to having nothing is devastating. When families are faced with the grief of losing everything and the fear of never being able to recover, these uncontrollable

488 It is also noteworthy that the risk ratios were significant in almost every respect – when they were considered as an average over the 6 year period for each of GEMS, Discovery and Medscheme and when they were looked at from a discipline perspective (where it was evident that certain disciplines were investigated more than others). There were accordingly not isolated incidents of unfair discrimination which may be attributed to occasional error, but there has rather been systemic discrimination perpetrated over a number of years. It is also noteworthy that the risk ratios of at least Discovery began to decrease in 2019 when a spotlight was shone on the inner workings of the risk management systems – suggesting that there was something that needed correction.[597]

489 We are therefore of the view that the disproportionate effects on Black practitioners is unfair and amounts to unfair discrimination perpetrated by GEMS, Discovery, and Medscheme over the period under investigation.

22. CONCLUSION

490 We find that Black healthcare providers are more likely to be targeted than their non-Black counterparts. Black healthcare providers have been unfairly

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circumstances have a drastic impact on families as a whole, marriages and on husbands and wives as well as children."

See further: Dr Diale (Transcript 2 of 3, 29 July 2019, p 26, line 20 – p 27, line 2):

"One moment they are paying me, one moment they are not paying me. One moment they are paying the patients. So, it's a confusion and that's the state that I'm in...I'm in at the moment and had to close my practice because of financial constraints you know and you get to be heavily indebted, have to sell your property at a loss because you are trying to make up to...to sustain your practice for a false accusation which are levelled against you."

[597] Dr Kimmie, the final report, 29 October 2020, p 13, para 5.1. See also: Dr Broomberg (Transcript, 29 January 2020, p 140, line 11 – p 141, line 4).

discriminated against by Medscheme, GEMS and Discovery during the years investigated.

491 This discriminatory outcome is important for a range of legal reasons, which we have explained above. However, it is also necessary to consider the emotional, financial and human consequences of discrimination.

492 We note that all business enterprises in South Africa have an obligation to address systemic discrimination. Systemic discrimination by its very nature discriminates day in and day out against all the members of the disadvantaged class.[598] It is therefore incumbent on businesses to ensure that a facially neutral policy does not entrench the unfairness and segregation that characterised our past.

[598] Adv Trengove SC (Transcript, 23 August 2019, p. 90, line 22 - p 91, line 4).

PART 2(B):

PROCEDURAL FAIRNESS IN THE IMPLEMENTATION OF SECTION 59(3) OF THE ACT

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PART 2(B)

PROCEDURAL FAIRNESS IN THE IMPLEMENTATION OF SECTION 59(3) OF THE ACT

CHAPTER TWO: PROCEDURAL FAIRNESS

23. INTRODUCTION

23.1. The complainants' submissions on unfairness

493 This section considers the obligations of schemes to comply with procedural fairness and reasonableness when exercising rights in terms of section 59(3) of the Act. By "procedural fairness", we refer to the obligations flowing from the provisions of section 33 of the Constitution as codified by the Promotion of Administrative Justice Act 3 of 2000 ("**PAJA**"). We also consider the obligations on schemes to act in accordance with the rule of law as per section 1(c) of the Constitution and more particularly not to engage in "self-help" in breach of the principle of the rule of law when schemes make decisions to place providers on indirect payment or claw back monies from future benefits.

494 The complainants submitted they were unfairly treated by being harassed and intimidated by schemes during the implementation of their FWA processes. Providers reported that administrators and schemes would impose a heavy burden on them to prove their claims, often in a brief period of time. If the provider was not able to obtain the information requested, they would be placed on indirect payment i.e. they would have to get paid directly from the patient (we refer to this as being "**placed on indirect payment**" or "**direct**

payment being suspended"). Sometimes the scheme would place a provider on indirect payment at the start of their investigation, before the provider had an opportunity to respond. This would place practices at risk and, in some instances, led to practitioners having to close down as a result of the cash flow issues which arise from not receiving direct payment.

495 The providers' position is that the schemes' approach to FWA is inconsistent with the Act and the Regulations in that, in particular, the schemes are not entitled to place providers on indirect payment. When the schemes alleged that a provider had been paid erroneously, there is no apparent methodology in the calculation of the amount allegedly owing. This notwithstanding, providers would sign AODs as a result of coercion and in some cases bullying and harassment by the schemes and administrators.

496 Providers also reported that schemes would insist on being provided with confidential patient information. Providers stated that they are prohibited by the Act and the rules of the relevant regulatory bodies from releasing such information to a third party without the patient's consent. If a provider refused to provide the confidential patient information, they would be placed on indirect payment.

497 Overall, there was a sense that the scheme and administrators' FWA / risk management processes were quick to find providers guilty of FWA and impose sanctions that could cripple providers financially where there was no wrongdoing.

23.2. The administrators and schemes' response

498 The administrators and schemes maintain that they are entitled to conduct an investigation in keeping with their fiduciary duty to address FWA. The overall position of the administrators and schemes was that the steps they take in respect of FWA detection, investigation and sanctioning, is consistent with the Act, the Regulations and the relevant schemes' rules. The administrators and schemes refuted the argument that they are required as a matter of law to pay the provider directly.

499 Further, the administrators and schemes pointed to the fact that some providers are in contractual relationships with the schemes and that these contracts allow the schemes to place the providers on indirect payment.

500 The administrators and schemes indicated that there are internal protocols in place which govern how their FWA function operates. These protocols ensure that providers are given an opportunity to explain any billing irregularity and that the process for recovery of funds in general is free of coercion, bullying and harassment.

501 Most importantly, the administrators and schemes argued that the procedures they use are indispensable to addressing FWA and that they are under a legal duty to protect the members' funds. The administrators and schemes justify this practice on the grounds that they want to mitigate risk of paying further fraudulent claims which will deplete the scheme's funds. Further they are obliged to do so because of their duty to protect the funds of the scheme,

particularly in terms of section 57 of the Act. If they did not suspend payments directly to practitioners, the scheme might incur further losses.

23.3. The issues identified by the Panel

502 It appears there are four main issues arising from evidence:

502.1 Issue one: The meaning of section 59(3) of the Act including its interaction with Regulation 6 of the Regulations ("**The meaning of section 59(3) of the Act"**);

502.2 Issue two: Are schemes entitled to place practitioners on indirect payment or suspend direct payment to the practitioners? If so, what are they required to do before taking this decision? ("**Suspending direct payment**");

502.3 Issue three: How should amounts owed in terms of section 59(3) of the Act be calculated? ("**Calculation of claw back amounts in terms of section 59(3)"**); and

502.4 Issue four: Issues arising out of the negotiation and conclusion of settlement agreements, commonly known as AODs. (**Constraints applicable to negotiating a settlement agreement**).

503 We accordingly turn to address each of these issues separately. Where there is more to say about the evidence before us because of the complexity of the particular issue discussed we do so.

24. THE MEANING OF SECTION 59(3) OF THE ACT

24.1. Section 59 in general

504 Section 59 of the Act regulates how suppliers charge for services (subsection 1); how and when schemes pay for such services (subsection 2); and the circumstances in which a scheme may deduct amounts owing to a provider or member from future benefits payable (subsection 3).

505 Before we discuss section 59, we note that all these sections and the Regulations must be read in the context of the following provisions of the Act:

505.1 Section 26(1)(b) of the Act, which provides that:

> *"Any medical scheme registered under this Act shall—*
> *(b) assume liability for and guarantee the benefits offered to its members and their dependants in terms of its rules"*

505.2 Section 1 of the Act, which provides that:

> *"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; …*"

506 Therefore, the "liability the scheme undertakes may include obtaining health services, defraying expenditure in connection with health services or rendering health services."[599]

[599] *Genesis Medical Scheme v Registrar of Medical Schemes and Another* 2017 (6) SA 1 (CC), para 23.

24.2. Section 59(2)

507 Section 59(2) provides that:

> *"A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme".*

508 The point of contestation about the meaning of section 59(2) arises in the context of the implementation of section 59 as a whole. In sum, when the schemes and administrators identify that a provider may be engaged in FWA they place the provider on indirect payment. The schemes and administrators generally argue that they have the *choice* of paying either the member or the provider and because of the concern that a particular provider is engaging in FWA they choose to pay the member rather than the provider. The provider's retort is that section 59(2) of the Act does not allow such a choice and properly interpreted requires the schemes to pay them directly on demand. The providers further draw on the text of Regulation 6 of the Regulations to support their argument submitting that Regulation 6 includes an obligation to pay a provider's account within 30 days.

509 We turn to consider these arguments below.

(i) *Case law on section 59(2)*

510 A number of cases have touched on the interpretation of section 59(2). However, none of these cases is dispositive of the question raised by the

providers (i.e. that a scheme is not entitled to suspend payment to practitioners during its FWA investigation).[600]

511 The most relevant case on section 59(2) is the 2015 decision of the SCA in *Sechaba Medical Solutions Ltd v Sekete*.[601] In that case, Gen-Health Medical Scheme ("**Gen-Health**") was placed in final liquidation. Sechaba Medical Solutions (Pty) Ltd ("**Sechaba**"), originally the administrator in respect of Gen-Health, was appointed to manage members' claims against the scheme in liquidation. The third respondent, Life Healthcare Group (Pty) Ltd ("**Life Healthcare**"), representing 18 medical facilities and hospitals that had rendered services to Gen-Health's members prior to its liquidation, submitted claims against the liquidated estate. These claims were challenged by Sechaba on the basis that section 59 of the Act did not entitle a provider (Life Healthcare) to submit its account directly to the scheme (Gen-Health).

512 The key question before the SCA was whether, if a scheme gives a hospital pre-authorisation for treatment, this creates a contract between the scheme and the provider. The SCA held that, by giving pre-authorisation:

> *"What the scheme undertakes to do as against the hospital is to comply with its contractual obligation as against its member... [and] to pay the hospital in accordance with the applicable tariff, provided it is bound to do so as against its member."*[602]

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600 See for example: *Margate Clinic (Pty) Ltd v Genesis Medical Scheme* 2007 (4) SA 639 (D) ("***Margate Clinic***") at 642E and *Sechaba Medical Solutions and Others v Sekete and Others* [2015] ZASCA 8 (11 March 2015) ("***Sechaba***"). The SCA also dealt with issue of direct payments in the *Bhamjee* case, but it did not engage with section 59 of the Act or the nature of the relationship between the provider and the scheme.

601 *Supra*.

602 *Sechaba*, para 14, citing *Margate Clinic,* para 642E.

513 The statutory obligation that the scheme owed to its member is that it will take responsibility for the member's debt, i.e. it will pay the healthcare provider:

> *"The undertaking given, and statutory obligation owed, to its member is that it will pay the healthcare provider itself, not that it will reimburse the member for what the member has paid. On that argument the 'benefit' referred to in s 26(1)(b) is the act of discharging the obligation incurred by the member to the healthcare provider when receiving medical treatment."*[603]

514 In coming to this conclusion, the SCA appears to have considered Gen-Health's schedule of benefits as it explained that:

> *"A reading of Gen-Health's schedule of benefits makes it clear that the benefits it provided were not restricted to refunding the member with the amount of the benefit, leaving the member to pay the healthcare provider**. The benefits were that the scheme would itself pay the healthcare provider to the extent reflected in the schedule of benefits**. That is apparent from those items dealing with situations where the cost of the service exceeded the amount of the benefit. The schedule said that in that event the member would 'co-pay' the difference between the cost of the service and the stipulated benefit. If the scheme were not itself going to pay the service provider the reference to 'co-pay' would not make sense.*"[604] (our emphasis)

515 The SCA held, therefore, that "a benefit conferred on a member under a medical scheme [is] primarily to pay the member's health service providers for their services."[605] This obligation entails both the liability for the benefit but

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[603] *Sechaba*, para 16.
[604] *Sechaba*, para 17.
[605] *Sechaba*, para 18.

also to "guarantee the benefit."[606] The SCA explained this guarantee as follows:

> *"A guarantee is an obligation given by one party on behalf of another to discharge that other's liability to a third party. And that seems to me precisely what a medical scheme is obliged to do.* ***It is obliged to guarantee to its members that it will discharge, to the extent of the benefits set out in the schedule of benefits, their liability to the healthcare providers who render services to the members.***" (our emphasis)

516 The SCA raises an important contextual rationale for its holding. It notes that many providers in South Africa are dependent on direct payment from the schemes because their patients are not able to afford upfront payments:

> "*Construing the obligations of medical schemes in that way constrains them to function in a manner that is consonant with the social realities of this country. By far the majority of people are not in a position, after paying their medical aid subscriptions, to fund medical treatment from their other resources and seek reimbursement from their medical scheme. They are dependent for their ability to obtain such treatment on the fact that the cost will be borne by the medical scheme. And that is reinforced by the fact that the schemes enter into agreements with doctors, pharmacies, clinics and other healthcare providers to establish preferred provider networks and other systems for the provision of medical services.*"[607]

517 Further, it appears that the SCA was cognisant of the effects that Gen-Health's agreements with providers had on its obligation to pay providers directly. The SCA explained that Gen-Health had agreements in place with providers:

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[606] *Ibid*.
[607] *Sechaba*, para 20.

"*The founding affidavit described these arrangements as 'Designated Service Provider Agreements' and accepted that services rendered by services providers under such agreements would be paid for directly by Gen-Health*".[608]

518 Finally, the SCA turned to Section 59(2) of the Act, noting the following relevant points:

518.1 The Act "expressly recognises that the medical scheme may pay the service provider directly ... It is plain therefore that a benefit may be owing to the service provider…";[609] and

518.2 The language in sections 59(1), 59(2) and 26(1)(b) of the Act underscore this finding. The SCA approaches the question of schemes' obligations to the provider by examining the text of section 59. It notes that section 59(1) refers to the provider's account; section 59(2) refers to *benefit* being payable, not the account.[610] This is reinforced by the language of 26(1)(b) of the Act, which provides that the scheme assumes liability for the *benefit* and guarantees the payment therefor.[611]

519 The Court's conclusion is that "if the benefit is owing to the service provider, which is what the section says, I fail to see on what basis it can be said that the medical scheme is not obliged to pay the service provider."[612]

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608 *Sechaba*, para 20.
609 *Sechaba*, paras 23 - 24.
610 *Ibid*.
611 *Ibid*.
612 *Sechaba*, para 25.

520 *Sechaba*, however, only takes us so far.

520.1 First, it was driven by the facts of that case where the provider had received pre-authorisation for the services rendered thereby resulting in a contract between the scheme and provider. Also, the scheme's schedule of benefits made it clear that the scheme was obliged to pay providers directly when contractual arrangements were in place. This limits the applicability of the findings in the *Sechaba* judgement to those instances where there is a contract between the scheme and the provider. Where there is no contractual relationship between the scheme and the provider then the *Sechaba* judgment is of limited use; and

520.2 Secondly, the *Sechaba* judgment does not deal with instances when a scheme suspends direct payment to a provider because it suspects that such provider is engaging in FWA.

521 Another relevant case is *Tshwane Pharmacy (Pty) Ltd v Government Employees Medical Scheme*,[613] decided before *Sechaba*, but nevertheless worth mentioning. The case involved a decision by GEMS to place a provider on indirect payment for reasons which are not apparent from the judgment. The High Court rejected the argument that section 59(2) of the Act requires a scheme to pay a provider directly.[614]

[613] *Tshwane Pharmacy (Pty) Ltd v Government Employees Medical Scheme* [2011] ZAGPPHC 72 (20 May 2011) ("***Tshwane Pharmacy***").
[614] *Tshwane Pharmacy,* para 8.

522 But the decision also has limited use. First, the provider's approach in this case was unusual in that it was demanding that it be paid a certain amount where such amount had already been paid to the member.[615] In effect the provider was demanding the scheme make a double payment. Secondly, the provider pleaded that there was a tacit contract between it and the scheme which obliged the scheme to pay it directly - but the provider did not succeed in this respect because of the deficiency of its pleadings.[616]

523 We note the High Court's consideration of the schemes rules and the Court's *obiter* statements that it was inclined to reject the argument that section 59(2) of the Act did not give the scheme a discretion as to whom it wished to pay (provider or member) as such "payment is subject to the rules of the medical scheme" which, in this case, "state unambiguously that the respondent has the right to pay either the member or the supplier of the service."[617]

524 In sum, the two aforementioned cases emphasise that a scheme is required to pay a provider, rather than the member, where the provider has a contractual relationship with the scheme. This may arise out of a situation where a service has been pre-authorised by the scheme or where the scheme and provider have entered into any form of direct payment arrangements (the evidence indicated that this could be a preferred provider arrangement, a network arrangement or the designated service provider arrangement at the very least).

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615 *Tshwane Pharmacy*, para 6.
616 *Tshwane Pharmacy*, para 13.
617 *Tshwane Pharmacy*, para 10.

525 There may well be situations where a provider submits an invoice to a scheme for payment where such provider is not in a contractual relationship with the scheme but the cases referred to above make very little pronouncement on what section 59(2) of the Act means for this transaction.

(ii) *Regulation 6*

526 The providers also argued that section 59(2) of the Act should be read subject to Regulation 6.

527 Section 67(1)(d) of the Act empowers the Minister to make regulations relating to "the manner in which any payment due by a medical scheme shall be made" after consultation with the CMS. Regulation 6 provides for specifically the "manner of payment of benefits" in the following terms:

> "*6.* ***Manner of payment of benefits****.—(1) A medical scheme must not in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependant of such member is entitled, limit, exclude, retain or withhold, as the case may be, any payment to such member or supplier of service as a result of the late submission or late re-submission of an account or statement, before the end of the fourth month—*
> *(a) from the last date of the service rendered as stated on the account, statement or claim; or*
> *(b) during which such account, statement or claim was returned for correction.*
> *(2)* ***If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant health care provider within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment*** *and state the reasons for such an opinion.*

(3) After the member and the relevant health care provider have been informed as referred to in subregulation (2), ***such member and provider must be afforded an opportunity to correct and resubmit such account or statement within a period of sixty days following the date from which it was returned for correction****.*
(4) If a medical scheme fails to notify the member and the relevant health care provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of subregulation (2) or fails to provide an opportunity for correction and resubmission in terms of subregulation (3), ***the medical scheme shall bear the onus of proving that such account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute****.*
(5) If an account, statement, or claim is correct or where a corrected account, statement or claim is received, as the case may be, a medical scheme must, in addition to the payment contemplated in section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars—
(a) the name and the membership number of the member;
(b) the name of the supplier of service;
(c) the final date of service rendered by the supplier of service on the account or statement which is covered by the payment;
(d) the total amount charged for the service concerned; and
(e) the amount of the benefit awarded for such service." (our emphasis)

528 Providers argued that:

528.1 "erroneous or unacceptable" payments were equivalent to the types of payments that could be clawed back in terms of section 59(3) of the Act; and

528.2 the time periods for identifying and correcting "erroneous and unacceptable" payments were accordingly also applicable to the claw-backs of payments in terms of section 59(3) of the Act.

529 We do not agree with the providers' arguments.

530 Regulation 6 is concerned with the payment of current benefits and not with whether a scheme may claw-back amounts from future benefits (an issue which is covered by section 59(3) of the Act). Section 59(2) of the Act governs the payment of current benefits owed by the scheme.

531 Regulation 6 implements section 59(2) of the Act as both the regulation and the subsection refer to the same time period of 30 days: In section 59(2) an invoice must be paid within 30 days and in Regulation 6 a practitioner must be notified of a problem with an invoice within 30 days. Further, we note that the reference to section 59(2) of the Act in sub-regulation 5 is a further indication that Regulation 6 implements section 59(2) of the Act. Additionally, Regulation 6, like section 59(2) of the Act, is concerned with obligations which arise when paying a provider. It is not concerned with the circumstances in which, and how, a scheme may claw back amounts from future payments to providers.

532 These features indicate that section 59(2) of the Act is implemented through Regulation 6. The wording of Regulation 6 which refers to "erroneous or unacceptable" payments or accounts does not suggest it was intended to be equivalent to the type of amounts, losses or benefits referred to in section 59(3) Act. Section 59(3) of the Act makes no reference to either "erroneous" or "unacceptable" payments or accounts. Had the Minister intended Regulation 6 to implement and constrain section 59(3) of the Act one would expect the wording in Regulation 6 to mirror that of section 59(3) of the Act

and be focussed on a claw back of future benefits (arising from a loss or an amount which should not have been paid).

533 We appreciate that from the providers' perspective they might be concerned that this interpretation removes the procedural safeguards set out in Regulation 6 (in other words, they are concerned that this removes the obligation on the scheme to point out erroneous or unacceptable claims within 30 days and then give providers an opportunity to correct erroneous or unacceptable claims within a further 60 days). However, there are still a number of procedural safeguards, as we explain in more detail below.

534 Bearing in mind our view that neither the wording of section 59(2) of the Act, the case law interpreting section 59(2), nor the wording of Regulation 6 entirely resolves the question of whether the scheme has an obligation to pay the provider directly where it suspects the provider has engaged in FWA, we turn to consider the meaning of section 59(3) of the Act.

535 Notably, section 59(3) is the only subsection in the Act which is concerned with regulating the risk management systems that the schemes and administrators have put in place to detect, investigate and sanction FWA.

24.3. The meaning of section 59(3)

536 Section 59(3) provides that:

> "*(3) Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of—*

(a) any amount which has been paid bone fide in accordance with the provisions of this Act to which a member or a supplier of health service is not entitled to; or
(b) any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme,
deduct such amount from any benefit payable to such a member or supplier of health service."

537 Before analysing section 59(3), we make a few preliminary points.

537.1 The key distinction between subsections (2) and (3) is that section 59(3) is concerned with deductions of future benefits; and section 59(2) is concerned with the obligations to pay current benefits.

537.2 Section 59(3) gives the schemes significant power *vis-à-vis* providers and members – the power to deduct past payments made to providers or members from future benefits which are owed to providers or members.

537.3 Section 59(3) empowers the schemes to unilaterally make a decision regarding when and what amount is clawed back from future benefits owed to members or providers.

538 There are no Court judgments interpreting section 59(3) of the Act. We therefore must have resort to the ordinary principles of statutory interpretation.

(i) Principles of interpretation

539 In *Road Traffic Management Corporation v Waymark*, the Constitutional Court held that the process of statutory interpretation:[618]

> *[E]ntails a simultaneous consideration of—*
> *(a) the language used in the light of the ordinary rules of grammar and syntax;*
> *(b) the context in which the provision appears; and*
> *(c) the apparent purpose to which it is directed.*[619]

540 When considering the language of the text, it is necessary to consider the provision in relation to other provisions within the legislation. A linguistic approach must go in lock-step with an analysis of the context of the legislation and the purpose it seeks to achieve.

541 Therefore, our approach to the interpretation of section 59(3) is, from the outset, to consider "the context and the language together, with neither predominating over the other."[620]

542 Of course, the difficulty arises where words are capable of different meanings or interpretations. The guiding principle in such situations is described by the SCA as follows:

> *"An interpretation will not be given that leads to impractical, unbusinesslike or oppressive consequences or that will stultify the*

[618] *Road Traffic Management Corporation v Waymark (Pty) Limited* 2019 (5) SA 29 (CC), paras 29 - 32.
[619] See also *Natal Joint Municipal Pension Fund v Endumeni Municipality* 2012 (4) SA 593 (SCA) ("***Endumeni***").
[620] *Endumeni*, para 19. See also *Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs and Tourism and Others* 2004 (4) SA 490 (CC) ("***Bato Star")***, para 90.

broader operation of the legislation or contract under consideration."[621]

543 We also adopt a purposive approach to interpreting section 59(3) in keeping with the requirement that a statute must also be interpreted in a manner which "enables it to achieve its purpose."[622] The purposive approach was discussed by the Constitutional Court in the case of *Department of Land Affairs v Goedgelegen Tropical Fruits (Pty) Limited* ("***Goedgelegen***").[623] In that case, Moseneke DCJ remarked that in construing the provisions of a particular statute a "blinkered peering"[624] at the language in the legislation must be avoided. Rather:

> "*We must prefer a generous construction over a merely textual or legalistic one in order to afford claimants the fullest protection of their constitutional guarantees. In searching for the purpose, it is legitimate to seek to identify the mischief to be remedied. In part, that is why it is helpful, where appropriate, to pay due attention to the social and historical background of the legislation. We must understand the provision within the context of the grid, if any, of related provisions and of the statute as a whole, including its underlying values."*[625]

544 The Constitutional Court held in *Cool Ideas* that:[626]

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[621] *Endumeni*, para 26. This approach to interpretation of statutes was confirmed by the Constitutional Court in *Independent Institute of Education (Pty) Limited v Kwazulu-Natal Law Society and Others* 2020 (2) SA 325, para 41.

[622] *Saidi and Others v Minister of Home Affairs and Others* 2018 (4) SA 333 (CC), para 63 of Jafta J's concurring opinion.

[623] *Department of Land Affairs v Goedgelegen Tropical Fruits (Pty) Ltd* 2007 (6) SA 199 (CC) ("***Goedgelegen***").

[624] *Goedgelegen,* para 52.

[625] *Goedgelegen,* para 53. This approach has been endorsed in subsequent decisions of the Constitutional Court, for example: *Bakgatla-Ba-Kgafela Communal Property Association v Bakgatla-Ba-Kgafela Tribal Authority and Others* 2015 (6) SA 32(CC), para 35; and *Minister of Mineral Resources and Others v Sishen Iron Ore Company (Pty) Ltd and Another* 2014 (2) SA 603 (CC), para 47. The SCA also endorsed this approach in *Brown v Mbhense* 2008 (5) SA 489 (SCA), paras 23 - 25.

[626] *Cool Ideas 1186 v Hubbard* 2014 (4) SA 474 (CC) para 28. Reiterated in *Premier Foods v Manoim NO* 2016 (1) SA 445 (SCA) para 42.

" A fundamental tenet of statutory interpretation is that the words in a statute must be given their ordinary grammatical meaning, unless to do so would result in absurdity. There are three important interrelated riders to this general principle namely:

(a) that statutory provisions should always be interpreted purposively;

(b) the relevant statutory provision must be properly contextualised; and

(c) *all statutes must be construed consistently with the Constitution, that is, where reasonably possible, legislative provisions ought to be interpreted to preserve their constitutional validity."*

545 Both the concepts of purpose and context, demand that we apply the lens of the Constitution in the interpretation exercise. In *Klaase and Another v van der Merwe N.O. and Others*,[627] the Constitutional Court held that:

"In line with a purposive approach to statutory interpretation, a meaning that places the definition within constitutional bounds should be preferred."[628]

546 In terms of section 39(2) of the Constitution when interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights. This Panel is a forum as per section 39(2) of the Constitution. The Panel is duty bound to interpret the Act and, in so doing, to promote the spirit, purport and objects of the Bill of Rights.

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[627] *Klaase and Another v van der Merwe N.O. and Others* [2016] ZACC 17 ("***Klaase***").

[628] *Klaase,* para 50. See also: *Investigating Directorate: Serious Economic Offences and Others v Hyundai Motor Distributors (Pty) Ltd and Others In re Hyundai Motor Distributors (Pty) Ltd v Smit NO and Others* 2001 (1) 2001 SA 545 (CC), para 23, where the Constitutional Court explained that: "*judicial officers must prefer interpretations of legislation that fall within constitutional bounds over those that do not, provided that such an interpretation can be reasonably ascribed to the section.*"

547 These modes of interpretation guide us in the interpretation of section 59(3) of the Act. However, the task is not straightforward: the section is lengthy, situated in bulky legislation with lengthier regulations; there are no definitions of the terms used in section 59(3); there is no detail about how section 59(3) may be implemented; and it seems unlikely that, when it was drafted, it was envisaged that it would indirectly birth or justify the algorithmic FWA systems which we have heard about in the Inquiry.

548 In our view, the purpose of the provision is to protect the financial well-being of a scheme, and by implication its members who pay contributions to the scheme, from either a mistaken *bona fide* payment by the scheme or from losses which the scheme may experience through four forms of conduct: theft, fraud, negligence and (professional) misconduct.

(ii) *The nature of the schemes' powers*

549 We have explained the significant power that section 59(3) confers on schemes. Schemes can unilaterally determine when and what amounts are clawed back from future benefits payable to providers or members. This allows the schemes to 'take back' monies which they believe are rightfully owed to them – either they were paid when they should not have been or they were paid because the scheme sustained a loss as a result of fraud, negligence, theft or (professional) misconduct.

550 The question therefore arises whether the schemes' exercise of powers in terms of section 59(3) is the exercise of a private power or a public power. If it is the latter then it is permissible to construe the section as requiring the

scheme to act reasonably, rationally and procedurally fairly when a scheme makes a decision in terms of section 59(3).[629] We accordingly turn to consider the nature of the powers that medical schemes exercise in terms of section 59(3) of the Act first.

551 We acknowledge that determining if a particular power is public or private in nature is not easy.[630]

552 An early constitutional case which considered the nature of the powers exercised by a private body was *AAA Investments (Proprietary) Limited v Micro Finance Regulatory Council*.[631] The Constitutional Court held, with reference to the relatively broad definition of an organ of state in the Constitution, that if an entity

> *"performs its functions in terms of national legislation, and these functions are public in character, it is subject to the legality principle and the privacy protection. In our constitutional structure, the Council or any other entity does* ***not have to be part of government or the government itself to be bound by the Constitution as a whole****."* (our emphasis)[632]

[629] We do not suggest that the exercise of private contractual power is insulated from constitutional control on that account alone. We state that for the purposes of this investigation it is not necessary to explore that question as we come to the conclusion that the nature of the power can be characterised as public.

[630] *Chirwa v Transnet Limited & Others* 2008 (4) SA 367 (CC) ("***Chirwa***"), para 186 and *AAA Investments (Pty) Limited v Micro Finance Regulatory Council & Another* 2007 (1) SA 343 (CC), 2006 (11) BCLR 1255 (CC) ("***AAA Investments***"), para 119, where the Constitutional Court held that: "It is true that no bright line can be drawn between "public" functions and private ordering".

[631] *Supra*.

[632] *AAA Investments,* para 41.

553 In her concurring opinion, O'Regan J identified relevant criteria in deciding whether rules of the Micro Finance Regulatory Council, a private body, are of a public or a private nature:

553.1 whether the rules apply generally to the public or a section of the public;

553.2 whether they are coercive in character and effect; and

553.3 whether they are related to a clear legislative framework and purpose.[633]

554 In *Chirwa v Transnet Limited & Others*[634] the Constitutional Court explained that:

> "*Determining whether a power or function is "public" is a notoriously difficult exercise. There is no simple definition or clear test to be applied. Instead, it is a question that has to be answered with regard to all the relevant factors including: (a) the relationship of coercion or power that the actor has in its capacity as a public institution; (b) the impact of the decision on the public; (c) the source of the power; and (d) whether there is a need for the decision to be exercised in the public interest. None of these factors will necessarily be determinative; instead, a court must exercise its discretion considering their relative weight in the context.*"[635]

[633] *AAA Investments*, para 119 in the judgment of O'Regan J.
[634] *Supra*.
[635] *Chirwa,* para 186.

555 More recently in *Ndoro v South African Football Association*,[636] Unterhalter J summarised the principles emerging from the body of cases on private entities exercising public powers as follows:

555.1 First, it is not necessary for the power to be derived from statute:

> "*Private entities may discharge public functions by recourse to powers that do not have a statutory source. Powers of this kind may be characterized as public powers. So characterized, actions that issue from their exercise may constitute administrative action.*"[637]

555.2 Second, a private entity may exercise public powers:

> "*but this does not entail that all its conduct issues from the exercise of a public power or the performing of a public function – all depends on the relevant power or function.*"[638]

555.3 Finally, the key criteria is not whether the power is of great interest to the public but rather:

> "*it is the assumption of exclusive, compulsory, coercive regulatory competence to secure public goods that reach beyond mere private advancement that attract the supervisory disciplines of public law.*"[639]

556 The application of procedural fairness to private bodies is necessary to attenuate the power imbalance that such power often creates.[640] In *Klein v*

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636 *Ndoro and Another v South African Football Association and Others* 2018 (5) SA 360 ("***Ndoro***").
637 *Ndoro,* para 23.
638 *Ibid*.
639 *Ibid*.
640 See *Taylor v Kurtsag NO and Others* 2005 1 SA 362 (W) ("***Taylor***") at 382B, where the High Court found that the decisions of religious tribunals are subject to the same common law review jurisdiction as those of other voluntary organisations on the basis that churches (and trade unions) are subject to administrative law because "they are founded on principles that are applicable to the application of general rules to individual cases in all unequal relationships."

Dainfern College and Another[641] the Court noted that the application of procedural fairness to private bodies is moored in the principle of fairness and for the purpose of addressing the "*unequal bargaining position of members or employees*".[642]

557 Applying some of the aforementioned principles to the power exercised by schemes in terms of section 59(3) of the Act:

557.1 a scheme has significant power when it makes a decision to deduct an amount owed from a benefit of a provider (or member). The exercise of the power involves depriving a provider of an amount owed;

557.2 the power is coercive in that the provider is subject to the exercise of the power by the scheme – which power is in turn aimed at rectifying what is identified in the statute as a "wrong";

557.3 there is an imbalance of power between the scheme and provider in the implementation of section 59(3) of the Act. Not only is a scheme (or an administrator acting on the scheme's behalf), generally better resourced than a provider, but the power is exercised by the scheme unilaterally;

557.4 a decision made by a scheme to deduct monies from future benefits both has an immediate effect on the provider (or member) and, as the schemes were at pains to emphasise, on the whole membership of

[641] *Klein v Dainfern College and Another* [2005] ZAGPHC 102 (1 October 2005) ("***Dainfern College***"),
[642] *Dainfern College*, para 23.

the scheme as the deduction benefits the pool of members' funds. The schemes submitted that section 59(3) allowed them to act to the benefit of the broader membership of the scheme – a segment of the public;

557.5 the power to deduct amounts in terms of future benefits is sourced in the Act and of course would not exist were it not for the subsection. We note that where a scheme has a contract in place with a provider allowing for such a deduction then of course section 59(3) of the Act would be superfluous; and

557.6 the consequence of a deduction made in relation to a future benefit is that current claims are not paid until the amounts owed are paid off by way of deductions. This means there is immediate non-payment of claims submitted by providers. The providers have no choice but to accept such non-payment and have no effective recourse in relation to non-payment.[643]

558 On this basis, it is our view that the powers exercised in terms of section 59(3) of the Act are public powers and are constrained by the principles of administrative justice embodied in sections 1 and 33 of the Constitution and PAJA.

[643] Although the complaints mechanism set up by the Act provides a form of recourse, the complaint mechanism is not designed to deal with disputes arising out of the exercise of powers in terms of section 59(3). Resolution of complaints take time and are subject to a lengthy internal appeals process.

559 Even if we are incorrect in relation to the view that the powers exercised in terms of section 59(3) of the Act are public powers, the exercise of coercive private powers are also subject to the protections of administrative justice by way of the common law.[644]

(iii) *The requirement to act reasonably and procedurally fairly*

560 In *Transvaal Agricultural Union v Minister of Land Affairs and Another* ("***Transvaal Agricultural Union***"),[645] the Constitutional Court held that:

> "*The mere fact that the legislation does not specifically make provision for such a hearing does not mean that there is indeed no such right.*
> ...
> *The question whether such right has been excluded by the Act in the present case depends, therefore, upon the proper interpretation of the statute.*" [646]

561 This general principle was confirmed *Zondi v MEC for Traditional and Local Government Affairs*.[647] In that case, the Constitutional Court had to determine whether certain provisions of the Pound Ordinance (KwaZulu-Natal) ("**the Ordinance**")[648] were constitutional. One challenge was that the Ordinance did not require notice to be given to stockowners whose stock may be subject to administrative action (including, for example, impounding and killing animals belonging to stockowners).

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[644] *Turner v Jockey Club of South Africa* 1974 (3) SA 633 (A); *Theron v Ring van Wellington van die NG Sendingkerk in Suid Afrika* 1976 (2) SA 1 (A); *Taylor*; *Body Corporate of the Laguna Ridge Scheme Non 152/1987 v Dorse* 1999 (2) SA 512 (D) and *Dainfern College*.
[645] *Transvaal Agricultural Union v Minister of Land Affairs and Another* 1997 (2) SA 621 (CC) ("***Transvaal Agricultural Union***").
[646] *Transvaal Agricultural Union,* paras 25 - 26.
[647] *Zondi v MEC for Traditional and Local Government Affairs* 2005 (3) SA 589 (CC) ("***Zondi***").
[648] Pound Ordinance (KwaZulu-Natal), 32 of 1947.

562 The Court considered the question whether, by their silence, the impugned provisions "exclude a notice and a hearing".[649] Citing *Transvaal Agricultural Union*,[650] the Constitutional Court held that the impugned sections of the Ordinance were:

> "*capable of being read so as to require prior notice where the stockowner is known or where, with the exercise of reasonable diligence, the stockowner could be ascertained. Such a construction is not inconsistent with their language.*"[651]

563 The requirements of administrative justice, more particularly the requirement to act reasonably and procedurally fairly, is incorporated into legislation where such legislation does not include these requirements.

564 Section 59(3) of the Act is begging for augmentation in this way. The CMS Appeal Board ("**the Appeal Board**") has already acknowledged this to the extent that it has found that schemes should not claw back monies in terms of section 59(3) or place providers on indirect payment without first being notified of such proposal and being given an opportunity to comment.

565 In *Ekhanyeni Pharmacy and Others v Medscheme Holdings (Pty) Ltd*,[652] the Appeal Board had to determine whether Medscheme was entitled to suspend payments in respect of various claims, and to offset the claims against the

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[649] *Zondi*, para 108.
[650] *Supra*.
[651] *Zondi*, para 109.
[652] *Ekhanyeni Pharmacy and Others v Medscheme Holdings (Pty) Limited*, Case No. CMS 67765, 19 June 2019 ("***Ekhanyeni***").

payments already made.[653] As regards the right of schemes to suspend payment, the Appeal Board held *inter alia* as follows:

565.1 Providers under investigation are obliged to cooperate with the schemes and provide information that may be requested;[654] and

565.2 Schemes have the "right to suspend payment of claims to the Appellants, pending the outcome of the investigations".[655]

566 However, in the circumstances, the Appeal Board held that Medscheme was *not* entitled to suspend payments in that case because of a lack of procedural fairness. This decision was based primarily on the failure of Medscheme to (i) engage the appropriate regulatory body (in this case, the South African Pharmacy Council); (ii) have a conclusive finding of misconduct; and (iii) grant the providers a hearing prior to taking the punitive steps. It was in light of these procedural deficiencies that the Appeal Board held that "*Medscheme's act of suspending the claims and to offset claims was not on (sic) accordance with fair process*".[656] The following statement is of particular importance:

> "*It could never been (sic) envisaged that schemes could deduct amounts without conclusive findings and without furnishing the applicants an opportunity to make representations on such findings. This omission demonstrates failure to follow fair process and it gives rise to serious consequences, both financially and reputation based."*[657]

[653] *Ekhanyeni,* para 33.
[654] *Ekhanyeni,* para 17.
[655] *Ekhanyeni,* para 15.
[656] *Ekhanyeni,* para 46.
[657] *Ekhanyeni,* para 37.

567 The Panel is of the view that section 59(3) of the Act properly interpreted requires that the schemes act in a manner that is procedurally fair and reasonable before making a decision to deduct amounts from future benefits payable to providers (or members).

(iv) Reasonableness

568 The concept of reasonableness rests on the pillars of rationality and proportionality.

569 Rationality means that a decision must be supported by the evidence and information before the decision-maker as well as the reasons given for it.[658] It must also be objectively capable of furthering the purpose for which the power was given or which the decision was purportedly taken.[659] In essence, this means that there must be a rational connection between the action taken and the reasons given for it.

570 Proportionality is the notion that there must be a balance between the adverse effects of the decision and the benefits it seeks to achieve. A decision-maker is encouraged to "consider both the need for the action and the possible use of less drastic of oppressive means to accomplish the desired end."[660] In

[658] Cora Hoexter, *Administrative Law in South Africa* (Juta & Co., 2012) ("**Hoexter**"), p 340. See also: *Trinity Broadcasting (Ciskei) v Independent Communications Authority of South Africa* 2004 (3) SA 346 (SCA), paras 36, 43, 48 and 50. See further: *Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others* 2006 (2) SA 311 (CC) ("***New Clicks***"), para 108.

[659] Hoexter, p 340.

[660] Hoexter, p 344. See also: *Medirite (Pty) Limited v South African Pharmacy Council and another* [2015] JOL 33000 (SCA), para 22, where the court held that the decision-maker should "consider less drastic but surely available means to accomplish the desired result."

essence, the principle of proportionality entails balance, necessity, and suitability or appropriateness to accomplish the decision-maker's objective.[661]

571 What will constitute a reasonable decision will depend on the circumstances of each case. The Constitutional Court, in *Bato Star Fishing v Minister of Environmental Affairs and Tourism* ("***Bato Star***"),[662] identified a series of factors relevant to determining whether a decision is reasonable. These include:

> "*the nature of the decision, the identity and expertise of the decision-maker, the range of factors relevant to the decision, the reasons given for the decision, the nature of the competing interests involved and the impact of the decision on the lives and well-being of those affected.*"[663]

572 These factors give content to proportionality. At its core is that there is a rational link between the decision and the reason for such decision. Further, that the harm associated with the decision must not be disproportionate to harm that the decision was aimed at addressing.

(v) *Procedural fairness*

573 Procedural fairness has two components: (i) a fair hearing ("*audi alteram partem" or "audi"*) (ii) by an impartial decision-marker ("*nemo iudex in sua causa"*).

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[661] *Ibid*.
[662] *Supra*.
[663] *Bato Star,* para 45.

574 The *audi* component of procedural fairness is a flexible requirement in that its requirements are determined by the circumstances of the particular case. It is trite that it has variable content dependent on the circumstances. In that way it remains useful to a variety of situations.

575 Section 3 of PAJA governs procedurally fair administrative action which affects persons (as opposed to the public) and is most relevant for present purposes. Section 3(2)(a) provides that a "*fair administrative procedure depends on the circumstances of each case*". The subsection then proceeds to set out ways in which to give effect to procedural fairness. It requires a decision-maker to give:[664]

575.1 adequate notice of the nature and the purpose of the proposed administrative action;

575.2 a reasonable opportunity to make representations;

575.3 a clear statement of the administrative action;

575.4 adequate notice of the right to request reasons; and

575.5 a person who is affected by the administrative action should, where a case is serious or complex, be able to seek assistance generally or seek the assistance of a legal representative, be able to present and dispute information or arguments.[665]

[664] Section 3(2) of PAJA.
[665] Section 3(3) of PAJA.

576 In relation to the requirement of adequate notice of the nature and purpose of the proposed administrative action:

576.1 There must be sufficient information to enable a person to exercise their fair hearing rights when affected by the decision;

576.2 The charges must be formulated with sufficient particularity so that the person affected by the decision understands the charge; and

576.3 There must be sufficient time for the person affected by the administrative action to prepare their case adequately. The sufficiency of the time period depends on the degree of sophistication of the person affected by the administrative action and on the consequences of the decision.

577 In relation to the requirement of a reasonable opportunity to make representations, the persons affected by administrative action must be properly apprised of the information which underlies, and reasons for, the decision. If there is any incriminatory documentation or material, it would be unfair not to disclose it (although it is not necessary always to provide full discovery of all documentation).

578 In relation to the requirement of adequate notice of the right to request reasons, affected persons are entitled to request reasons and, at minimum, a decision-maker must provide adequate reasons for its decision.

579 The second component of procedural fairness is the rule against bias or *neo iudex in sua causa*. This is the principle that no-one should be a judge in their own matter and demands that decision-makers be impartial. While this principle applies to decision-makers in a forum deliberating a dispute, it speaks to the fact that there needs to be independence of decision-making in order that it is, and appears, fair.

580 When medical schemes exercise powers in terms of section 59(3) of the Act, whether it be *vis-à-vis* practitioners or members, they are therefore required to act reasonably and procedurally fairly in the ways described above.

581 The Panel is not alone in its view that the powers in section 59(3) of the Act must be exercised reasonably. The Panel received evidence from Medscheme that included an opinion from Advocate Loxton SC.[666] The opinion addresses a scheme's power to deduct funds from future benefits. The opinion concludes that claw backs are lawful provided that schemes:

> "*act reasonably and in good faith before making deductions. In other words, medical schemes must take reasonable steps to satisfy themselves that the payments which they seek to deduct from benefits due to members or service providers were not in fact payable.*"[667]

582 In this regard, Adv Loxton SC confirms that this type of decision must be reasonable.

[666] Medscheme submission, 18 July 2019, Adv Loxton SC's opinion (Medscheme bundle, p 238 – 250).
[667] Medscheme submission, 18 July 2019, Adv Loxton SC's opinion (Medscheme bundle, p 250, para 19).

(vi) *The rule of law constraints*

583 So far, we have considered section 33 of the Constitution and the provisions of PAJA and how they may be read into section 59(3) of the Act. We consider in this section a further constraint which is incorporated by the Act to regulate the power of the schemes, namely the rule of law in terms of section 1(c) of the Constitution.

584 One of the founding values of the Constitution is *"supremacy of the Constitution and the rule of law".* The rule of law comprises various elements: The exercise of statutory power must be authorised; any power may not be arbitrarily exercised; public powers must be rationally applied; and in appropriate cases the process by which a decision is taken should be rational. Another feature of the rule of law is the principle against self-help.

585 As we have explained above, the Panel is duty bound to interpret the Act to promote the spirit, purport and objects of the Bill of Rights. This includes interpreting the Act to promote the principle of the rule of law.

586 The power to claw back from future payments due to providers is a significant encroachment into the interests of providers. The power is also statutory in nature. This means it must be exercised consistently with the rule of law principle.

587 In *Public Servants Association obo Olufunmilayi Itunu Ubogu v Head of Department of Health, Gauteng and Others* ("***Ubogu***")[668] the Constitutional Court considered the constitutionality of section 38(2)(b)(i) of the Public Service Act, 103 of 1994 ("**the Public Service Act**') which entitled the State in its capacity as employer to deduct, *"*wrongly granted remuneration*"* from an employee's salary. The case is analogous to the situation here, as the schemes seek to exercise their entitlement to deduct from future benefits consequent to a payment which was made *bona fide* but which ought not to have been paid or where the scheme has sustained a loss sustained through fraud, theft, negligence or (professional) misconduct. We emphasise that we are aware that in the present Inquiry there was not, and could not be, a constitutional challenge to section 59(3) in the same way as there was in *Ubogu*. But the rule of law principles emerging from this judgment are helpful in interpreting section 59(3) in order to avoid unconstitutional outcomes.

588 The Constitutional Court struck down the section in *Ubogu* as "undermining a deeper principle underlying our democratic order." It noted that the salary deductions authorised by section 38(2)(b)(i) of the Public Service Act "constitute an unfettered self-help – the taking of the law by the State into its own hands and enabling it to become the judge in its own cause, in violation of section 1(c) of the Constitution."[669]

589 The Court held that the section, undermines the judicial process which requires disputes to be resolved by law in terms of section 34 of the

[668] 2018 (2) SA 365 (CC).
[669] *Ubogo*, para 66.

Constitution. Since the section enabled the employer to deduct remuneration from an employee's salary without recourse to the judicial process, the section was accordingly declared to be unconstitutional.[670]

590 The Court also held that the State as employer had an obligation to exercise its power under section 38(2)(b)(i) "reasonably and with regard to procedural fairness". Notably, notions of "fairness and justice inform public policy – which takes into account the necessity to do simple justice between individuals."

591 The rule of law may also entail fair procedures:

591.1 The Court noted that monies could not be deducted from an employee's salary without the employee, who is entitled to the salary by virtue of the services rendered, being allowed to make representations.

591.2 The amount itself, which is recoverable, could not be arbitrarily determined – the amount had to be accurate.

591.3 The dispute as to whether an amount was owed and the quantum had to be resolved by an independent and impartial forum as per the provisions of section 34 of the Constitution.

[670] The principle of a set-off was also considered. At its root the principle applies where two parties being mutually indebted to each other with *"both debts being liquidated and fully due*" the doctrine of compensation comes into operation. The one debt extinguishes the other as effectually as if payment had been made (*Ubogo*, para 70). However, the Court noted that the principle of set-off does not operate as a matter of law. It is necessary first to establish existing mutual debts. But in a case where there is a dispute about the debt and the factual circumstances arising from it, there can be no agreement that there is a liquidated debt which has become fully due. Thus, set off could not be invoked to defeat an employee's claim in relation to her salary.

592 We accept that we are in no position to declare any law as unconstitutional; nor do we seek to do so. Section 59, properly construed, requires due process. It is a principle long established that[671]:

> *"It is a fundamental principle of our law that a person may not take the law into his own hands and a statute should be so interpreted that it interferes as little as possible with this principle."*

593 This principle has since been buttressed by the constitutional injunction of interpreting statutes in a manner that is consistent with the Constitution. It is therefore our view that the Act should be interpreted consistently with section 1(c) of the Constitution and the right in section 34 of the Constitution.

594 The text of section 59 of the Act is not inconsistent with this approach. The text does not sanction unilateral action. Nor does it permit arbitrarily imposed amounts. It also does not exclude the right of a provider to make representations.

595 To the contrary, the Act embodies elements of fair dealing. Section 24(f) requires the Registrar, when registering a scheme, to ensure that they will act in the public interest. Although this is a pre-condition for registration, it is apparent that it is a continuing obligation. A scheme is always required to act in the public interest.

596 Construing the Act narrowly through the prism of private law could be inconsistent with the public interest.

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[671] *George Municipality v Vena and Another* 1989 2 SA 263 (A), at 271E.

597 Furthermore, section 57(6)(a) imposes a duty on trustees of schemes to protect the interest of beneficiaries. The schemes have argued that by terminating direct payments and making deductions in terms of section 59(3), they are protecting beneficiaries. We accept this. But it must be balanced with other beneficiary interests.

598 We heard evidence that when schemes place providers on indirect payment, the immediate impact is also experienced by patients – beneficiaries. In certain instances, patients must change doctors. Where, as in the case of Dr Ngumbela and her patients, access to medical services is difficult, for reasons of cost and geography, the impact on patients could be severe. Thus, an appropriate equilibrium should be struck between the interests of beneficiaries in taking steps to combat unlawful activity by providers and the immediate interests of patients deprived of access to medical services because their doctor has been placed on indirect payment.

599 Striking that balance requires a reading of the Act which accommodates the procedural elements of the rule of law. It is only when the material evidence has been obtained, and the provider afforded an opportunity to rebut a case against him or her that a determination can be made as to where the correct balance ought to be maintained.

600 Without a fair procedure, it is not possible to determine if a provider is unfairly being targeted, or there is in fact a legitimate concern about their conduct.

601 The policy behind the principle of a fair hearing has recently been explained by the Constitutional Court: “the first is recognising the subjects dignity and sense of worth. Second, there is a more pragmatic consideration. This is that *audi alteram partem* inherently conduces to better justice.”[672] Hence, it is no answer for schemes to argue that a hearing will not make a difference. A hearing is always necessary and it recognises a person’s dignity in doing so.

602 When applied to the present situation - if schemes can deduct amounts unilaterally and without a meaningful opportunity to make representations then this amounts to a form of self-help which is contrary to the rule of law. Similarly, where the underlying liability is in dispute, if schemes can place providers on indirect payment without a meaningful opportunity to make representations that would amount to self-help which is inconsistent with the principle of the rule of law. It follows that in order to uphold the rule of law in the Constitution section 59(3) of the Act must be interpreted to allow for procedural fairness.

603 Having established that section 59(3) entails powers of a public nature, alternatively that the rule of law constrains the exercise of section 59(3) powers, and that such powers must be exercised in accordance with the principles of procedural fairness and reasonableness, we now turn to consider the specific issues identified above, namely: whether and when a scheme may suspend direct payments to a provider; how amounts owed in terms of section

[672] *Psychological Society of South Africa v Qwelane & Others* [2016] ZACC 48 (14 December 2016), para 34.

59(3) of the Act should be calculated; and what principles governs the negotiation and conclusion of settlement agreements or AODs.

25. SUSPENDING DIRECT PAYMENT

604 Are schemes entitled to place practitioners on indirect payment? If so, what are they required to do before placing practitioners on indirect payment?

605 These questions demand a consideration of both sections 59(2) and (3) of the Act and how they interact. The reason we say this is that section 59(2), as we have explained, embodies the obligation to pay current benefits (invoices) and placing a provider on indirect payment means she is not paid her current invoices directly – rather the member is paid. Section 59(3), as we have explained, is concerned with claw backs of future benefits. The implementation of section 59(3) requires the scheme to deduct an amount from a benefit to be paid in the future. The net effect however is that a current benefit (invoice) is not paid as it is subject to a claw back of a past amount that should not have been paid by the scheme.

606 In order for the schemes to place providers on indirect payments they must either be entitled to do so as a result of their contracts with the providers or they must source their power to do so from section 59(2) and (3) of the Act. We do not say anything about the situation where a scheme may be in a contractual relationship with a provider and where the circumstances in which the provider may be placed on indirect payment are agreed in such contract.

We do, however, express our views on the situation where there are no agreed terms as to when and how a provider may be placed on indirect payment.

607 Before proceeding to explain how it is that we believe the schemes are empowered to be place a provider on indirect payment we note that there was one area in the evidence that was not clear - that is the impact that being placed on indirect payment has on the flow of money. There are two scenarios which could arise:

607.1 First, a provider who is placed on indirect payment could demand upfront payment from a member. If the member pays, she then submits the invoice with proof of payment to the scheme and the member is reimbursed. There is nothing unusual about this scenario; and

607.2 Second, a provider who is placed on indirect payment could not demand upfront payment from members. In this situation the provider does not get paid, the member does not submit an invoice to the scheme (as she could not show proof of payment), and the scheme does not pay the member or the provider. The net effect is that the member gets the service for free and the provider provides healthcare for free.

608 Should the providers, schemes and administrators wish to make further submissions on how in particular the second scenario above is managed we welcome such submissions. For example, we did not hear detailed evidence regarding how members who have obtained a service from a provider on

indirect payment claim for such services - are they exempt from submitting proof of payment and, if not, then how do the schemes and administrators justify non-payment of either the provider or the member?

25.1. Are schemes empowered to suspend direct payments?

609 Each scheme and administrator had a slightly different yet similar legal argument justifying the basis on which there were entitled to suspend direct payments to providers. We have already summarised their submissions.

610 Broadly speaking, the point of departure for most schemes is that placing a provider on indirect payment, helps ameliorate further loss while an investigation is underway. The amelioration of such losses was a requirement which flows from the Act and other legislation to safeguard members' funds. Further the schemes and administrators relied on the provisions of their Rules to justify placing providers on indirect payment.

611 One administrator explained their fiduciary duty to their members as follows:

> "*[W]e are not here to primarily protect the interest of suppliers of medical schemes. Of course, those must be treated fairly, consistently with the law, respected for the huge value they provide. But the primary duty of schemes, their trustees and their administrators are to protect the interest of members and that is our understanding.*"[673]

[673] Dr Broomberg (Transcript, 29 January 2020, p 7, lines 13 - 17).

25.2. Is there an implied power to suspend direct payments?

(i) *Sections 59(2) and 59(3)*

612 Neither section 59(2) or 59(3) of the Act expressly empower schemes to place practitioners on indirect payment.

613 We therefore are required to consider if there is an implied power in either of these sub-sections to place practitioners on indirect payment or if there is any other provision in the Act or the Regulations which empowers a scheme to do so.

614 As a general rule, in relation to entities exercising public functions or performing public powers, express statutory powers are needed for action to be taken or decision to be made.[674] In order to read in an implied power to a statute it should exist as ancillary to the express powers or "as a necessary or reasonable consequence of the express powers."[675]

615 As the Appellate Division explained:

> *"in order that such a power may be implied, it is not sufficient that its existence would be reasonably ancillary or incidental to the exercise of any express power, in the sense that it would be useful in giving effect to that power. It must be reasonably necessary for that purpose. The test is not mere usefulness or convenience, but necessity."676*

[674] Hoexter, p 43.
[675] Hoexter, p 44. See also *Lekhari v Johannesburg City Council* 1956 (1) SA 552 (A) ("***Lekhari***") at 567A.
[676] *Lekhari,* para 24.

616 Where the action in question is coercive, oppressive or is likely to have far-reaching effects, it is less likely that a court will find implied authorisation for it.[677]

617 The question therefore is whether the power to place providers on indirect payment is reasonably necessary for the exercise of either the powers in section 59(2) or 59(3) of the Act. In relation to the section 59(2) duties it does *not* seem reasonably necessary that in order to be able to exercise the duty to pay providers there must also be a power *not* to pay providers. There is nothing in the nature of the section 59(2) powers which suggests that were it not for an ability to refuse to pay providers, the schemes could not pay providers. Again, in relation to the section 59(3) powers to deduct an amount from a provider, there does not seem to be anything specific about this power which means it cannot be exercised without the power to suspend payments to providers. In fact the opposite is true – the power to deduct amounts is conferred because it is assumed that providers will be paid and therefore there needs to be a mechanism to claw back monies which should not have been paid. For these reasons it seems relatively clear that neither sections 59(2) nor 59(3) of the Act confer a power on the schemes to place provider on indirect payment.

618 Bearing in mind the coercive nature of the power to place a provider on indirect payment it also seems unlikely on this basis that an implied power can be read into section 59(2) or (3) of the Act. We are accordingly of the view that there

[677] Hoexter, p 44.

is not an implied power in either section 59(2) or (3) of the Act that enables a scheme to suspend direct payment to providers.

619 However, section 57 of the Act is also relevant to the powers and duties of the schemes when managing their risk management functions and more particularly FWA systems.

620 Section 57 deals with the governance of schemes and provides as follows:

> "*(1) Every medical scheme shall have a board of trustees consisting of persons who are fit and proper to manage the business contemplated by the medical scheme in accordance with the applicable laws and the rules of such medical scheme.*"

621 Section 57(4)(c) of the Act provides that:

> *"(4) The duties of the board of trustees shall be to— (c) ensure that proper control systems are employed by or on behalf of the medical scheme".* (our emphasis)

622 It seems to us that a proper control system would include a proper system of financial control. It further seems to us that a proper system of financial control would include systems which prevent payments being made to providers where it is reasonably certain that such providers are engaged in fraud, theft, professional misconduct or negligent behaviour which is causing the scheme loss.

623 Section 57(4)(c) of the Act requires a scheme to put proper control systems, including proper financial control systems, in place. We return to the meaning of "proper" below.

(ii) The Rules of the Scheme

624 As explained above, a number of schemes and administrators have argued that their Rules allow them to place practitioners on indirect payment.

625 Section 32 of the Act provides for the "Binding force of rules":

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

626 It is clear that the scheme, its officers and the members are bound by the Rules. It also extends to providers, who would fall into the category of a person "whose claim is derived from a person so claiming".

627 The Rules are subject to the Act and the Constitution. In other words, the schemes cannot make rules which contravene the Act or the Constitution; nor can they give themselves powers which are not conferred by the Act or the Constitution.

628 In this regard, if neither section 59(2) nor (3) of the Act empower to scheme to place providers on indirect payment it can hardly be argued that the schemes can make Rules empowering themselves to place providers on indirect payment. This would be using the Rules to subvert a constraint in the Act.

629 Further, even if the Rules may embody some aspects of the proper financial control systems that a scheme is required to have in place as a result of section 57(4)(c) of the Act, the Rules are not well suited to embody such a system of financial controls and do not seem to be the logical place where such a system of financial control should manifest.

630 The system of financial controls should be included in a scheme's internal policies.

25.3. Are the schemes also required to act reasonably and procedural fairly when suspending direct payments to providers?

631 As explained, section 57(4)(c) of the Act requires the schemes to put in place a proper system of financial control and such system may provide for a provider to be placed on indirect payment. It remains to be considered in what circumstances a scheme may decide to place a provider on indirect payment.

632 The word which determines what such systems must include is "proper". In other words, a system of financial control that a scheme puts in place must be proper.

633 What is "proper" and hence reasonable and justifiable is in many respects a value judgment,[678] but will be informed by the principles applicable to good decision making.

[678] As Moseneke J explained in *New Clicks*, para 712 - 713 in relation to the meaning of the word "appropriate" and the standard it set for the dispensing fee in dispute in this case:

634 In relation to placing providers on indirect payment it does not matter whether the schemes are exercising a public power or not – as the Act requires a system of financial control which is proper. The Act therefore introduces the standard by which a scheme will be measured when developing and implementing such systems of financial control.

635 In our view a proper system of financial control will at the very least include a system which:

635.1 treats providers procedurally fairly before they are placed on indirect payment; and

635.2 ensures that the decision to place a provider on indirect payment is reasonable.

636 As with the decision to claw back amounts which ought not have to have been paid to the provider in terms of section 59(3) of the Act, the system of financial control that a scheme puts, or has, in place should ensure that the following, before the scheme places a provider on indirect payment, that:

"*It is so that "appropriate" is not a word of precise connotation. Yet one must agree that the qualification "appropriate" must mean, as found by the SCA, a fee "specially suitable" or "proper" to the purpose of the statute. Naturally, to be appropriate the fee must be just and fair to all affected by its determination. What is or is not an appropriate fee can be objectively determined by reference to the purpose of the enabling legislation and the lawful boundaries for the exercise of the public power conferred. …*
It does not however mean that the term "appropriate" in itself lays down an absolute or immutable standard. It is correct that people well informed of the subject matter, might very well take different views on what is appropriate. The ultimate question must be whether the determination of appropriateness falls within a range of what may be reasonably regarded as proper, well-suited and fair. That determination falls to be made by balancing out the relevant but often competing factors and thereafter striking equilibrium amongst all factors. The competing factors would include the factual context, the purpose of the power, the nature of the measures impugned and its impact on affected parties and on the public interest."

636.1 the scheme notifies the provider in writing that the scheme is considering placing the provider on indirect payment. Such notice should give the provider an opportunity to meaningfully comment on the proposed decision. Meaningful comment would be enabled by giving the provider the information on which the scheme's proposed decision is based as well as a summary of the scheme's reasons for the proposed decision. Additionally, the time which a provider is given to comment will depend on the complexity of the allegations as well as the time a provider might require to consider the allegations;

636.2 the scheme should consider the providers representations before making any final decision; and

636.3 if the scheme decides to place the provider on indirect payment despite the representations made by the provider, such decision must be reasonable. In other words, it should be based on the facts and its impact on the provider should be considered, to ensure that the consequences of indirect payment are not disproportionate to the reasons the scheme believes indirect payment is necessary.

637 When considering placing a provider on indirect payment, it is also important to distinguish between an investigation into FWA that is the result of serious organised fraud, and those that relate to instances of possible errors in, for example, coding:

> "***ADV HASSIM**: Sorry. Just on indirect payment. You say to break the collusion between members and providers. So, you would use indirect payment in instances where the abuse or that was at play was of that*

nature. Would you, as opposed to for example using indirect payment as a response to a coding irregularity.

MS BAKKES *Chair, so from experience I can't say that just on a coding error you would place the service provider on indirect payment. That's why I say that we do classify them between soft, medium and hard. It would depend on the transgression whether you place them on indirect payment. So, to me it won't be just a coding error and I do think that your investigation report, you analysis report outcomes would prescribe the response strategy that you would follow...*"[679]

638 The position of the Panel in relation to a scheme's decision to suspend direct payment to providers may be summarised as follows:

638.1 schemes are required to have a proper system of financial control in place as a result of section 57(4)(c) of the Act;

638.2 in order for such a system of financial control to be proper they must treat the provider procedurally fair and any decision to place the provider on indirect payment must be reasonable; and

638.3 procedural fairness requires giving the provider a meaningful opportunity to comment on the proposed decision to place the provider on indirect payment. It further requires the schemes to ensure that the impact of the decision to place the provider on indirect payment is not disproportionate to the reasons for doing so.

[679] Ms Bakkes (Transcript 2 of 2, 30 July 2019, p 92, lines 1 – 15).

25.4. The problem of confidential patient information

639 As we have explained, one of the issues that arose repeatedly was whether schemes are entitled to insist that providers disclose confidential patient information in order to allow the scheme to verify their claims. This is a useful issue through which to consider whether the schemes implementation of section 59(3) of the Act is reasonable as well as whether it is reasonable to place a provider on indirect payment.

(i) The legislative context

640 Section 14 of the National Health Act 61 of 2003 ("**NHA**") provides as follows:

> "*All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.*
> *(2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless:*
> *(a) the user consents to that disclosure in writing;*
> *(b) a court order or any law requires that disclosure; or*
> *(c) nondisclosure of the information represents a serious threat to public health.*"[680] (Our emphasis)

641 The Health Professions Act 56 of 1974 makes provision for the making of ethical rules governing health care providers. As a result, the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act were published (in GNR 717 of 4 August 2006) ("**the Ethical Rules**"). The obligation

[680] Section 15(1) of NHA provides for the sharing of information within a team of health care professionals who may treat a particular patient. It provides that "A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user."

to protect patient confidentiality is contained in Rule 13, which provides as follows:

> *"13(1) A practitioner shall divulge verbally or in writing information regarding a patient which he or she ought to divulge only –*
> *(a) in terms of a statutory provision;*
> *(b) at the instruction of a court of law; or*
> *(c) where justified in the public interest.*
> *(2) Any information other than the information referred to in subrule (1) shall be divulged by a practitioner only –*
> *(a) with the express consent of the patient;*
> *(b) in the case of a minor under the age of 14 years, with the written consent of his or her parent or guardian; or*
> *(c) in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate."*[681]

642 The question of patient confidentiality must of course be understood against the background of the right to privacy contained in section 14 of the Constitution. Health information, including diagnosis and treatment of a patient, epitomises the type of information which would fall within the scope of personal private information which is protected by the right to privacy entrenched in the Constitution. In the case of *NM v Smith*,[682] the Constitutional Court stated that:

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[681] Because of the particularly sensitive nature of personal information, which is disclosed to psychologists, there are separate rules governing confidential information held by psychologists. Annexure 12 of the Ethical Rules, contains rules relating to the profession of psychology, and Rule 24 provides as follows:

> "*(1) A psychologist shall safeguard the confidential information obtained in the course of his or her practice, teaching, research or other professional duties, subject only to such exceptions to the requirement of confidentiality as may be determined by law or a court of law.*
> *(2) A psychologist may disclose confidential information to other persons only with the written, informed consent of the client concerned.*" (our emphasis)

[682] *NM and Others v Smith and Others* 2007 (5) SA 250 (CC) ("***NM and Others***"). *NM and Others* followed the earlier landmark case of *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (AD),para 38 where a medical practitioner had disclosed the HIV status of his patient — after

"Private facts have been defined as those matters the disclosure of which will cause mental distress and injury to anyone possessed of ordinary feelings and intelligence in the same circumstances and in respect of which there is a will to keep them private.[683]

643 The Court addressed in particular the issue of confidential medical information:

"Private and confidential medical information contains highly sensitive and personal information about individuals. The personal and intimate nature of an individual's health information, unlike other forms of documentation, reflects delicate decisions and choices relating to issues pertaining to bodily and psychological integrity and personal autonomy.[684]

644 The Court's rationale for the elevated positioning of confidential medical information was that –

"Individuals value the privacy of confidential medical information because of the vast number of people who could have access to the information and the potential harmful effects that may result from disclosure. The lack of respect for private medical information and its subsequent disclosure may result in fear jeopardising an individual's right to make certain fundamental choices that he/she has a right to make. ***There is therefore a strong privacy interest in maintaining confidentiality****.*[685](our emphasis)

645 The Court concluded that –

an explicit request by the patient to keep the information confidential — to other health practitioners during the course of a game of golf. In that case, the SCA held that "a patient has the right to expect due compliance by the practitioner with his professional ethical standards".

683 *NM and Others*, para 34, citing *National Media Ltd and Another v Jooste* 1996 (3) SA 262 (A).

684 *NM and Others*, para 40.

685 *NM and Others,* para 41.

> *As a result, it is imperative and necessary that all private and confidential medical information should receive protection against unauthorised disclosure."*[686]

646 Of particular relevant to the issues at stake is the following statement by the Court:

> *"The* ***assumption that others are allowed access to private medical information once it has left the hands of authorised physicians and other personnel involved in the facilitation of medical care, is fundamentally flawed****. It fails to take into account an individual's desire to control information about him or herself and to keep it confidential from others. It does not follow that an individual automatically consents to or expects the release of information to others outside the administration of health care."*[687] (our emphasis)

647 In addition to the legislation and case law, there are various directives from the HPCSA and booklets published by the HPCSA, which address the issue of confidential patient information. The most relevant booklet appears to be Booklet 5 entitled "*Confidentiality: Protecting and Providing Confidential Information*" and updated in September 2016 ("**Booklet 5**"). Paragraph 3 of Booklet 5 reaffirms the patient's right to confidentiality. Paragraph 8 of Booklet 5 explains how health care providers should go about seeking <u>express and informed consent</u> from patients:

> "*8.2.1 Seeking consent of patients to disclosure is part of good communication between healthcare practitioners and patients and is an essential part of respect for the autonomy and privacy of patients. The following principles should be applied:*

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[686] *NM and Others,* para 43.
[687] *NM and Others,* para 44.

8.2.2 Obtaining consent where the disclosures will have personal consequences for patients:

8.2.2.1 Healthcare practitioners must obtain express consent where patients may be personally affected by the disclosure, for example when disclosing personal information to a patient's employer or to a medical scheme for ICD-10 coding.

8.2.2.2 When seeking express consent, health care practitioners must make sure that patients are given enough information on which to base their decision, the reasons for the disclosure and the likely consequences of the disclosure.

8.2.2.3 Healthcare practitioners should also explain how much information will be disclosed and to whom it will be given.

8.2.2.4 If the patient withholds consent the healthcare practitioner should first attempt to persuade the patient to consent.

8.2.2.5 If the patient continues to refuse consent, or consent cannot be obtained, the consequences of disclosure and non-disclosure should be explained to the patient. Disclosures may be made only where they can be justified in the public interest." (our emphasis)

648 The NHA, the Ethical Rules, the case law explaining the right to privacy in the context of personal health information and the HPCSA booklets all emphasise:

648.1 The exceptionally sensitive nature of personal health information, particularly diagnoses of health conditions and treatments;

648.2 The general rule is that disclosure of personal health information is not allowed;

648.3 There is a high bar for justifying disclosure of health information:

648.3.1 it must be with the consent of the patient and such consent must be express and fully informed; alternatively

648.3.2 there must be an overriding public interest in a particular disclosure if express and fully informed consent is not obtained.

649 We note that the Regulations[688] and more recently the Protection of Personal Information Act, 4 of 2013[689] allow for the processing of some personal health information by schemes. This must be so for the running of the business of a scheme. But this is not relevant to the question of whether schemes and administrators can demand that providers hand over patient files or notes – this being the category of confidential patient information which is said to be required in order for the schemes to verify claims.

(ii) *The views of the Panel*

650 In the face of demands from the schemes to provide patient files and patient notes, the providers rightly refused to disclose this confidential patient information. Providers' concerns regarding the confidentiality of patient information are extremely important and it appears they are upholding the

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[688] Regulation 5 (f) and (h) of the Regulations requires a provider to include the following on the invoice to the member:

"*the relevant diagnostic and such other item code numbers that relate to such relevant health service;*

…

the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine…"

[689] Section 32 of the Act provides that:

"*(1) The prohibition on processing personal information concerning a data subject's health or sex life, as referred to in section 26, does not apply to the processing by*

…

(b) insurance companies, medical aid schemes, medical scheme administrators and managed healthcare organisations, if such processing is necessary for

(i) assessing the risk to be insured by the insurance company or covered by the medical scheme and the data subject has not objected to the processing;

(ii) the performance of an insurance or medical scheme agreement; or

(iii) the enforcement of any contractual rights and obligations."

requirements of the NHA, the Ethical Rules and the right to privacy in the Constitution. If a provider is unable to obtain express and informed consent from the patient to disclose their file or the provider's clinical notes, then there is little more that the provider can be obliged to do.

651 Discovery was the first to readily accept this – and in doing so indicated that Discovery would be happy for the providers to submit redacted patient files and notes where all confidential patient information is removed. This appears to be a pragmatic solution to a potential impasse. The claims of confidentially fall away if what the provider is asked to disclose are files or notes that contain no confidential information as they have been redacted.

652 It remains to be considered if the arguments put forward by GEMS and Medscheme have merit.

653 As explained GEMS's membership application form provides *inter alia* that the member authorises the provider "who has attended to me or my dependants in the past or who will attend to me or my dependants in the future, to provide GEMS and/or its agents with such information as it may require". This is an exceptionally wide consent, and it is doubtful whether when a member signs such consent, she will be aware that it may allow a provider to hand over her patient file or patient notes.

654 The clause does not appear to satisfy the requirements of being express and informed as: (i) there is a risk that many members will sign the application form without their attention being brought to the particular clause and in these

circumstances the consent is not informed (and only arguably express); (ii) prior consent to future disclosure of information does not cover the disclosure of information which may materialise after the consent is given and in these circumstances the consent is not informed nor is it express.

655 As explained, Medscheme argued that section 15(1) of the NHA and Regulation 15J(2)(c) of the Regulations entitles it to access patient files and notes from providers and the onus is on the provider to seek the necessary consent.

656 Medscheme's reliance on Regulation 15J(2)(c) of the Regulations is wrong – the regulation is designed to enable the managed healthcare function – a function with which an administrator conducting an FWA function should not be concerned. The regulation is therefore not relevant. Section 15(1) of the NHA is more relevant as it provides that:

> *"any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user".*

657 However, Medscheme fails to indicate why where a provider discloses patient files or notes it would meet the requirement of "being necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user". Such a justification for disclosure would need to take account the extremely personal

nature of the information at stake and the difficulty of meeting the requirements of disclosure being in the interests of the user (patient).

658 In sum:

658.1 The schemes should be requesting non-confidential (redacted) versions of patient files and notes if this is what is required to verify a claim submitted by a provider;

658.2 Should the schemes demand confidential information from providers and the providers refuse to provide such confidential information the scheme cannot exercised powers in terms of section 59(3) of the Act. This is not a reasonable exercise of powers; and

658.3 Similarly, a scheme cannot place a provider on indirect payment on the basis that a provider refuses to provide patient confidential information. This is improper and unreasonable.

26. CALCULATION OF CLAW BACK AMOUNTS

659 Section 59(3) of the Act identifies the circumstances in which a scheme may claw back monies erroneously paid to a provider, from future benefits payable to members or providers. These circumstances are limited to where a member or provider was not entitled to payment and to where the scheme has experienced loss (as a result of the four forms of aforementioned conduct).

660 Therefore, the conditions that must exist prior to the exercise of the powers in section 59(3) are: (i) an amount has been paid *bona fide* to which a provider

is not entitled; or (ii) loss has been sustained as a result of theft, fraud, negligence or any misconduct.

661 Both of these conditions indicate that the subsection envisages actual amounts, which can be calculated. It is only then that such an amount can be deducted from future benefits payable to the provider. The question which arises is how schemes calculate the amounts to repaid – and whether such amounts can be an estimate of loss.

662 The providers generally argued that section 59(3) of the Act did not allow the schemes and administrators to use estimates. For example, the NHCPA argued as follows:

> "53.1 *Section 59(3)(a) speaks of "an amount" that has been paid bona fide. However the schemes through their desktop audits or other audit processes work on an average and convert that average to an amount.*
> *53.2 Section 59(3)(a) does not make provision for aggregation of such amounts and the practice of aggregation thereof is a breach of this provision.*"[690]

663 The schemes and administrators argued that it was permissible to make use of estimates. We note, however, that in some of the evidence from the schemes and administrators it was not clear if their position, that they were entitled to make use of estimates, related to the calculation of AOD amounts or the calculation of the claw back amount in terms of section 59(3) of the Act, or both.

[690] NHCPA submissions, undated, p 13, paras 53.1 - 53.2.

664 For the purpose of this section we assume that the evidence, which we have already detailed in Part 1 regarding the calculation of AOD amounts, applies to the calculation of amounts which the scheme claws back in terms of section 59(3). We note that if we are incorrect on this score then when the schemes and administrators comment on this interim Report they should explain:

664.1 how the claw back amounts are calculated; and

664.2 if such calculations differ from those used to calculate the AOD amounts, then how do they justify this different approach.

665 We do not wish to repeat the schemes and administrators' evidence on the approach they took to estimating the losses experienced by the scheme, but in sum:

665.1 Discovery estimates the quantum of FWA claims from a practice by analysing all claims submitted by the practice over the prior 3 years. It will apply a different methodology depending on the type of FWA (claims from pharmacies or dispensing GPs, claim submissions for non-scheme members, purchase record audits, and audits for time-based coding). Discovery usually makes an extrapolation, based on the information it has, to calculate the amount owed by the provider. There is significant variation in the methods used, where for example in an audit on time-based coding where a provider "cannot provide suitable verification, the claims paid out are recovered in full."[691] This

[691] Discovery power point presentation, 29 January 2020, slide 42.

approach is in contrast to claim submissions for non-scheme members where a provider is "requested to indicate the extent of the irregularities" and "that information is used to calculate the approximate percentage of total claims that are irregular."[692]

665.2 GEMS, through its administrator Metropolitan, negotiates amounts owed. The amounts are determined using the claims line data for the current year to date and the previous year. The practitioner is asked to submit corrected claims and the difference between the actual amounts claimed and the corrected claims are then quantified in order to reach the amount.

665.3 Medscheme did not appear to follow a particularly rigorous or explicit methodology for the calculation of the amounts owed. Medscheme written submission simply stated that "based on the findings of our investigations, we then quantify any financial loss suffered by medical schemes and notify the practices of our findings and quantification."[693] Medscheme further emphasised that "every single forensic outcome is unique [and different cases] cannot be treated with the same veracity."[694] When the Panel queried the manner in which such amounts were formulated, in relation to one provider, Medscheme suggested that it claims 5% of the provider's total claims during the investigation period.[695] There are other instances where Medscheme

[692] Discovery power point presentation, 29 January 2020, slide 42.
[693] Medscheme submission, 18 July 2019 (Medscheme bundle, p 13, para 4.3.3).
[694] Medscheme submission, 18 July 2019 (Medscheme bundle, p14, para 4.3.3).
[695] Dr Nyati, Mr Midlane and Ms Sikhakhane (Transcript 30 January 2020, p 2, line 25 - p 73, line 9; p 96, line 17 – p 97, line 13).

has estimated losses in correspondence to providers where the method of calculation of such losses are opaque.[696]

666 Notably, the method of calculation of claw backs differs quite dramatically between GEMS, Discovery and Medscheme. GEMS appears to adopt the most conservative approach, only making use of claims data for approximately a one year period. Medscheme appears to adopt the least conservative approach – one which is not constrained by a particular methodology.

667 Discovery informed the Panel of the reasons why it could not undertake a more scientific approach to calculating amounts owing:

> "*I want to argue against your statement that we don't try and understand the extent to the losses. We are, we try to be as scientific as we can within some of the logistical constraints that I was pointing out to Advocate Williams. We, firstly on slide 40 we look at the specifics of each case. We try to estimate, you are correct that it is an estimate as accurately as we can the quantum of losses. Part of the constraint is also the burden of the work on the practitioner. We could ask to see every single record for the last five or six years and go through those. That would be a huge burden for the practitioner, but equally so for us. We would have to employ thousands of people in order to do that. We always engage with the affected practitioner on*

[696] See for example: Medscheme third supplementary submission, 26 August 2019, Complaint by Dr Kalanda (Medscheme bundle, p 3162 – 3211), for the complaint by Dr Kalanda, a radiologist, where Medscheme investigated Dr Kalanda's claims from 1 January 2017 to 30 June 2019. Medscheme explained the estimate of its losses in the following manner:

[redacted]

In relation to the first quantification the method by which an amount was reached is unclear. See also: Dr Kalanda (Transcript, 27 September 2019, p 72, lines 7 - 22).

the data. We always give the practitioner the opportunity to suggest errors in our estimate and to present their own analyses and proposals."[697]

668 We accept and understand some of the constraints under which the schemes operate. It is probably true that neither the provider nor the schemes have the resources to consider every record in order estimate loss with perfect precision.

669 That being said, we turn to consider what section 59(3) of the Act requires of schemes and the administrators acting on their behalf.

670 We have already explained that section 59(3) refers to two amounts, one described as an amount "to which a member of a supplier of health services is no entitled to" and the other being a loss sustained by the scheme through theft, fraud, negligence of (professional) misconduct. Only "such amount[s]" may be deducted from future benefits.

671 We have explained how the exercise of power in terms of section 59(3) is probably a public power and if not, is constrained by the common law principles of administrative law. Therefore, when a scheme makes a decision to deduct an amount it must do so based on at the very least a rational method of calculation and probably on a reasonable method of calculation.

[697] Dr Broomberg (Transcript, 29 January 2020, p 153, lines 3 - 16).

672 The method of calculation should therefore be justifiable, in that it should be based on the logic of mathematics and/or statistics. On this standard it seems that the methodologies put forward by GEMS and Discovery pass muster in that they are probably reasonable. As explained, Medscheme's methodologies are less clear and for this reason we do not suggest that they are always reasonable. The claiming back of 5% of Dr Ngumbela's claims (the provider referred to above) over a particular period is manifestly unreasonable as there appears to be no basis on which the 5% was reached. As Dr Ngumbela explained herself:

> *"the calculation of penalties amount to 5% of my claims … is without any rational basis. No explanation at all is given of the source of this formula."*[698]

673 Further, the methodology used to calculate losses should not have disproportionately harsh impacts on providers. It seems to us that the disproportionate impact on providers often arise out of the fact that an audit, and hence a calculation of loss, may go back as far as three years. Discovery appears to regularly conduct three year audits. It seems to us that disproportionate impacts would on the whole be avoided if the schemes and administrators limited their audits to a period of between one and one and a half years.

674 Interestingly, GEMS appears to have learnt through the application of section 59(3) of the Act that its approach can have disproportionate effects on

[698] Medscheme third supplementary submission, 26 August 2019, Complaint by Dr Ngumbela (Medscheme bundle, p 2288, para 33).

providers. It explained that in 2019 it changed its approach of reversing all irregular transactions to an approach of loading a debt on its system based on an AOD. GEMS explained that this is:

> "*more favourable to the specific provider, in that certain instalments and/or other terms are negotiated with the provider to enable him/her to still continue to practice, whilst repaying the debt. If all irregular transactions were to be reversed at once, all claims submitted by the provider would automatically set-off against the debt, which would result in the provider not receiving any funds*".[699]

675 Another difficulty that the schemes and administrators face when formulating a method of calculation which is reasonable is that a method of calculation may be fair for a provider who is guilty of FWA but unfair on a provider who is not guilty of FWA. By way of example, where an innocent provider cannot produce records to justify his services then he will be subject to the same method of quantification as a guilty provider unable to produce records to justify services. Both the innocent and the guilty party will be subject to the method of calculation. This observation underscores two important points:

675.1 First, the schemes and administrators need to move away from the assumption of guilt in relation to their engagements with providers; and

675.2 Second, the importance of giving a proper hearing to providers will do much to improve the scheme's understanding of the provider's position and hence the proper method for calculating loss.

[699] GEMS fourth supplementary submission, 23 January 2020 (GEMS supplementary bundle, p 103, para 11.18.7).

676 Although section 59(3) of the Act properly interpreted requires the schemes to adopt a reasonable method of calculating the losses which it proposes clawing back in terms of section 59(3), the evidence also suggested that this might not be enough to attenuate the power imbalance between scheme and provider nor solve some of the difficulties of determining when an approach adopted by a scheme may result in an disproportionate impact on providers.

677 We therefore are of the view that there is value in recommending that an independent mediator assist a scheme and provider in reaching a reasonable determination of the losses experienced by the scheme which may be clawed back in terms of section 59(3). We say more about this suggestion in Part 3.

678 We turn to the next procedural issue, which is the negotiation of AODs.

27. CONSTRAINTS APPLICABLE TO NEGOTIATING AN AOD

679 As explained above, the Panel received complaints that providers were intimidated and coerced into entering settlement agreements with the schemes to avoid being reported to the regulatory authority or to offset potential financial harm of being put on indirect payment or blacklisted.

27.1. Threat of economic duress

680 It is established in our law that, where a party enters into a contract as a result of duress, the contract may be challenged on the basis of a lack of true

consent. While the threat of economic duress has not been incorporated as a principle in South African law of contract,[700]

> "*'economic duress' could rather be regarded as incorporating a variety of circumstances, such as coercion, economic necessity and exploitation or abuse of circumstances, which, taken together, may amount to an untenable influence on an expressed will.*"[701]

681 At the heart of the question of economic duress – and the concerns of the providers *in casu* – is the power imbalance between contracting parties.[702] In *Barkhuizen v Napier*,[703] the Constitutional Court held that:

> "*Self-autonomy, or the ability to regulate one's own affairs, even to one's own detriment, is the very essence of freedom and a vital part of dignity. The extent to which the contract was freely and voluntarily concluded is clearly a vital factor as it will determine the weight that should be afforded to the values of freedom and dignity. The other consideration is that all persons have a right to seek judicial redress.*"[704]

682 In *BOE Bank Bpk v Van Zyl*,[705] the High Court decided that it is not necessary that the threat be by express words or deeds but may also be implied, tacit or by conduct, and may also, like extortion, consist in more subtle forms of intimidation.[706]

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[700] *Bhamjee*, para18.
[701] LF Van Huyssteen, GF Lubbe, MFB Reinecke, *Contract: General Principles* (Juta, 2016), p 117 - 118.
[702] The position of unequal power relations was discussed by the SCA in *Bredenkamp v Standard Bank* (599/09) [2010] ZASCA 75, although in that case the power disparity was found to be inapplicable and the contract was upheld.
[703] *Barkhuizen v Napier* 2007 (5) SA 323 (CC), 2007 (7) BCLR 691 (CC) ("***Barkhuizen***").
[704] *Barkhuizen*, para 57.
[705] *BOE Bank Bpk v Van Zyl* 1999 3 SA 813 (C) ("***BOE Bank***").
[706] *BOE Bank, para* 828H -829G.

683 In *Workers Life Direct (Pty) Ltd v Goodford*,[707] the High Court held that:

> *"Hard bargaining is not the equivalent of duress, even when the bargaining is the product of imbalance... the law draws a distinction between economic duress and hard (tough, rigid) bargaining. Duress involves compulsion, pressure, intimidation, force, bullying or coercion. Whilst bargaining involves negotiating and haggling for a good deal."*[708]

684 In *Bhamjee*, the SCA considered the fact that English and American law recognised that "economic pressure may, in appropriate cases, constitute duress that allows for the avoidance of a contract."[709] While that principle has yet to be authoritatively accepted in South African law, the SCA nonetheless held that:

> *"there would seem to be no principled reason why the threat of economic ruin should not, in appropriate cases, be recognised as duress [although], such cases are likely to be rare."*[710]

685 Having said that, the SCA made is clear that–

> *"it is not unlawful, in general, to cause economic harm, or even to cause economic ruin, to another, nor can it generally be unconscionable to do so in a competitive economy. In commercial bargaining the exercise of free will (if that can ever exist in any pure form of the term) is always fettered to some degree by the expectation of gain or the fear of loss."*[711]

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[707] *Workers Life Direct (Pty) Ltd v Goodford and Another* [2018] ZAGPPHC 10 ("***Workers Life Direct***").
[708] *Workers Life Direct,* para 49.
[709] *Bhamjee*, para 18.
[710] *Ibid*.
[711] *Ibid*.

686 In order for economic harm to constitute duress, “Something more... would need to exist for economic bargaining to be illegitimate or unconscionable and thus to constitute duress.”[712]

687 The question thus is whether the threat of being placed on indirect payment or being subject to a claw back in term of section 59(3) could constitute economic duress of the ilk envisaged by the courts.

688 It is worth mentioning that the personal financial circumstances of the provider and the conduct of the schemes would not be the only relevant facts to determining if in a particular case there was the type of economic duress that the SCA suggests South African law is ready to acknowledge. An important factual consideration is also the impact of the section 59(3) powers and the schemes power to place providers on indirect payments – which we have described in great detail above. Both of these powers mean that the provider will be faced with some stark choices in that should she fail to agree to the terms of an AOD with the scheme she is likely to know first that the scheme may claw back amounts from future benefits and second that the scheme could place her on indirect payment. The scheme does not have to threaten the exercise of these powers in order for these possibilities to be known.

689 There may be factual circumstances where the fear of economic ruin is real. Further, on the whole is seems clear that there is a power disparity between the providers and the schemes and it seems improbable, as Discovery

[712] *Ibid*.

submitted, that all providers are sophisticated professionals capable of protecting their commercial interests. The evidence presented to the Panel by the providers and their representatives associations suggest the exact opposite. At the very least, this power imbalance, coupled with the seriousness of the consequences of failing to conclude an AOD for providers, warrants that the schemes proceed with caution, and take extra measures to level the proverbial playing fields, when negotiating AODs with providers.

690 We emphasise that this power imbalance does not operate in the abstract. Section 59(3) gives the schemes the power to claw back. The schemes are entitled to place providers on indirect payment where the circumstances justify it. If an AOD is not agreed, the schemes will exercise one or both of these powers. This is not a situation of a person, who having incurred heavy debts, wants to sell their house; and a buyer exploits this situation by offering a cheeky purchase price. In that situation, the seller technically may be able to look for another buyer. In the case of claw backs and suspension of direct payment, the power *de facto* and *de jure* lies with the schemes. This can hardly be said to be an equal relationship with sophisticated bargaining abilities on both sides of the negotiating table.

691 We also note that in relation to Medscheme (and for a period of approximately one year, GEMS), that:

691.1 In relation to one scheme, Medscheme itself is being financially incentivised to recover as much money as possible from providers.

Medscheme is entitled to 30% of all successful financial recoveries up to a cap of R25 million; and

691.2 The GEMS investigators were incentivised on the basis that the relevant investigator would be entitled to a commission of 10%.

692 In relation to Medscheme, it is troubling that for the scheme in question and its providers, that Medscheme is being incentivised to collect in this way. The Act provides that "no payment in whatever form shall be made by a medical scheme directly or indirectly to any person as a dividend, rebate or bonus of any kind whatsoever" (our emphasis). The scheme appears to be paying Medscheme a bonus and therefore both the scheme and Medscheme appear to be breaching the Act. Further, in doing so, the scheme and Medscheme are creating a situation where Medscheme approaches the negotiations with the scheme's providers with a financial incentive to extract as much from the provider as possible. This can hardly be fair play in what is already an unequal power dynamic and we have our doubts if this arrangement accords with the *boni mores* of the time.

693 For the reasons we have given above, and leaving aside this issue of incentivisation, it is necessary that in reaching agreement on the terms of the AOD, the approach of the schemes must be fair and reasonable and must take into account their disproportionate power relations in the negotiation of AODs.

694 This position is underscored by the evidence of Professor Steyn, who noted that the forensic aspect of the schemes' approach to FWA is a form of policing.[713] Professor Steyn drew an analogy between the policing sector and the administrators of medical schemes (and the schemes themselves). She observed that the latter are similar to the policing sector as they perform a policing role in the implementation of their FWA systems. She explained that the international literature on racial profiling describes police officers as not being aware of their biases and "falling back on their unconscious assumptions" and the literature speaks about "a well- meaning person who might think that their biases are gone, have been socialised to ignore race and … the work of implicit bias specifically indicates how bias is actually present in everything we do".[714]

695 Professor Steyn explained that:

> *"difference gets positioned within unequal power relations and ... it gets constructed within unequal power relations in such a way that you end up having different outcomes for different people."*[715].

696 Given how race is likely to operate in a negotiation process as well as the unfairly discriminatory FWA outcomes, explained in great detail above, the inequality of arms in relative bargaining power and the likelihood that Black providers have been more severely affected by this cannot be gainsaid.

[713] Prof Steyn (Transcript, 18 October 2019, p 3, lines 13 - 18).
[714] Prof Steyn (Transcript, 18 October 2019, p 4, line 21 - p 5, line 6).
[715] Prof Steyn (Transcript, 18 October 2019, p3, lines 3 - 6).

697 Given the importance of ameliorating the power imbalance to make sure that, AODs are not agreed to under duress, and given the importance of correcting a wrong that has been perpetuated by Discovery, GEMS and Medscheme during the years investigated, the Panel is minded to recommend that an independent mediator is required to assist in the negotiation and conclusion of AODs. Having an independent person in the room is likely to reduce actual duress as well as allegations of duress. It is also likely to cast light on any racialised dynamics which might lead to unequal treatment and outcomes or the perception of unequal treatment and outcomes. We say more about this recommendation in Part 3 which follows.

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PART 3

FINDINGS AND RECOMMENDATIONS

28. FINDINGS

698 The complaints, submissions and evidence provided by the providers, funders, regulators and consultants to the industry reflect the broader contested landscape of private health services. The Health Market Inquiry Report has already provided insight into the sector and the perverse incentives at play – whether on the side of administrators or of providers. Concerns regarding the regulatory framework, coding and tariffs, the relationship between schemes and administrators and supplier-induced demand are all addressed in the Health Market Inquiry Report. While these issues form an important backdrop to this Inquiry, they were not the focus of the investigation by the Panel.

699 The Panel was mandated to investigate two main issues: whether there is racial discrimination by schemes against Black health care providers and whether Black providers were being treated procedurally unfairly. In order to base our findings on a firmer ground than the complaints provided, we appointed an independent expert (skilled in mathematics, statistics and data analytics) to assess the outcomes of the FWA investigation processes by the three main administrators – Discovery, Medscheme and GEMS. The Panel also appointed Adv Trengove SC and Prof Steyn to provide expert assistance to the Panel with regard to the legal framework to test unfair discrimination, and the principles of implicit racial bias. The Panel considered, reviewed and

tested the submissions and evidence of all stakeholders that presented. The foregoing chapters detail our analysis of the evidence and the basis for our findings. In this chapter, we summarise the key findings and make recommendations in respect of the two main fault lines – that is, unfair discrimination and procedural fairness in the investigation process.

28.1. FWA generally

700 FWA is serious and requires mechanisms to combat it:

700.1 The Panel does not disagree with the assertion by the schemes, administrators and the CMS, that loss due to FWA is serious and substantial. While the evidence varies regarding the amount of scheme funds which are lost to FWA, on any version it is significant. It is a problem that must be addressed.

700.2 It is also a problem for members of schemes as money that is lost to FWA has a direct impact on members' contributions and the ability of lower income earners to join schemes.

700.3 This is particularly so as FWA is ultimately experienced by members of medical schemes – as the schemes hold members' monies in trust and both administrators and schemes are obliged to take steps to prevent FWA.

700.4 FWA is committed by providers as well as members. The Inquiry only focused on FWA that was alleged to be caused by providers, either acting alone or in concert with members.

701 FWA is not properly defined and is used as a ‘catch-all’ term which often then is used as a justification for investigations and sanctions:

701.1 There is no consistent definition of the term ‘FWA’. It is not a statutory concept. Although the CMS has developed definitions, it is not applied consistently and there remains uncertainty.

701.2 The uncertainty allows for the conflation of different types of irregular claims under one umbrella. The result is that ‘fraud’ is often used as a shorthand for other irregular conduct. There is a gulf between deliberate over-servicing and excessive charging and inadvertent use of incorrect billing codes.

701.3 The seriousness of the consequences of FWA, both for schemes and practitioners, requires greater clarity regarding the different forms of conduct. Clarity will contribute to the legitimacy of the risk management systems of the schemes.

701.4 The Act uses discrete concepts when it authorises schemes to claw back amounts from providers or members which ought not to have been paid. Section 59(3) of the Act makes no mention of FWA and in contrast provides for claw backs where there has been fraud, theft, negligence, misconduct or where there has been *bona fide* payment by the scheme to which a provider or member is not entitled.

28.2. FWA investigation process

702 The sophistication of the detection and investigation systems vary across the schemes and administrators, but all use a combination of data analytics and whistleblower reports as the basis for investigation. The detection systems employed by Discovery, GEMS and Medscheme all use algorithms to flag providers as so-called 'outliers'. However, despite some automation in the operation of the algorithms, there is always an element of human intervention at some point along the chain of investigation. In other words, the systems are not fully automated and therefore the FWA outcomes are not a product of only machines or their programmers.

703 All three schemes and administrators have internal policies or protocols governing the implementation of their risk management systems. Of the administrators Medscheme exhibited the least quality control over the implementation of its internal protocols.

704 All schemes employ the sanctions of AODs, claw backs on future amounts owed to the provider, placing providers on indirect payment and, in extreme cases, blacklisting (where providers would not be paid by schemes at all).

705 The investigation of providers and the ability of providers to fend off what they consider to be unwarranted allegations falls apart at the point at which confidential patient information is requested.

705.1 All administrators request confidential patient information from providers but the justification for the request varies between administrators.

705.2 The request for patient information often spans many months and even years.

705.3 There is a wide difference of opinion on the appropriate disclosure of the patient information between the administrators and the providers.

705.4 The regulators have not provided clear and consistent advice to providers.

28.3. Unfair discrimination

706 Every scheme that was implicated in the complaints denied that there was unfair racial discrimination in their FWA investigation process. In the main the denial was based on the fact that the FWA investigations are triggered by either a) an automated system, underpinned by an algorithm, that flags outlier practices for investigation; or b) tip-offs and whistleblowers. Only practice numbers are known in the first method and there is no assignment or identification of race either explicitly or implicitly. GEMS added that it is a scheme with beneficiaries who are overwhelmingly Black and that it is a transformative organisation.

707 We find that Black practitioners are more likely to be found to have committed FWA than their Non-Black (White) counterparts, by Discovery, Medscheme

and GEMS. This means, for the reasons provided in this report, there is unfair racial discrimination.

708 We do not find evidence of explicit racial bias in the algorithms (to the extent that the workings of the algorithms were disclosed) and methods that the administrators and schemes use to identify FWA.

709 However, using the data that Discovery, GEMS and Medscheme provided the Panel and its expert, there is a substantial difference in FWA outcomes between Black and non-Black practitioners over the period January 2012 to June 2019.[716]

709.1 Over this period, across all disciplines and the aforementioned three schemes and administrators, Black practitioners were 1.4 times more likely to be classified as having committed FWA than those identified as not Black.

709.2 The probability that this distribution occurred by chance (i.e. that there is no correlation between racial status and FWA outcomes) is for all practical purposes 0 (zero);[717]

709.3 The starkest differentials are evident amongst the following:[718]

[716] Dr Kimmie's report, 18 November 2019, p 22.
[717] *Ibid*.
[718] Dr Kimmie's report, 18 November 2019, p 25, where Dr Kimmie also analysed the differentiation in FWA outcomes by various disciplines within healthcare practitioners.

709.3.1 Black general practitioners are 1.5 times more likely to be identified as FWA cases than their non-Black counterparts;

709.3.2 The rate at which Black physiotherapists are identified as FWA cases is almost double (1.87) that of their non-Black counterparts;

709.3.3 Black psychologists are three times more likely to be identified as FWA cases;

709.3.4 Black registered counsellors and social workers are also three times more likely to be identified as FWA cases. More than 50 percent of Black registered counsellors *have* been identified as FWA cases – this is the highest rate among the disciplines analysed; and

709.3.5 Black dieticians are 2.5 times more likely to be identified as FWA cases compared to their not Black counterparts.

710 There are clear differences in the scale of racial discrimination between the three administrators and the schemes.

710.1 Discovery was 35% more likely to identify Black providers as having committed FWA.

710.2 GEMS was 80% more likely to identify Black providers.

710.3 Medscheme was 330% more likely to identify Black providers as guilty of FWA.

711 Although each of the three schemes and administrators presented expert evidence to contest the findings of Dr Kimmie, we find that the disproportionate impact on Black providers, which amounts to unfair racial discrimination, remains.

711.1 With regard to Medscheme, assuming the correctness of their expert's methodology, it is 35% more likely to find Black providers guilty of FWA.

711.2 On GEMS own version it is 47% more likely to find Black providers guilty of FWA.

711.3 On Discovery's version it is 36% more likely to find Black providers guilty of FWA. However, Discovery reduces the risk ratio further to 1.09 on the basis of what it describes as confounding factors. The Panel requested that this be directly addressed by Dr Kimmie.[719] We find that the theory that there are confounding factors that affect the risk ratio is not credible.

712 Based on an assessment of the evidence, together with the application of anti-discrimination law, the Panel is of the view that the outcome of the FWA investigations, conducted by Discovery, GEMS and Medscheme between

[719] Dr Kimmie, the final report, 29 October 2020, p 14 - 15, para 5.3.

2012 and 2019, amount to unfair racial discrimination against Black practitioners.

28.4. Unfair processes

713 The schemes and administrators were also accused of not following fair procedures when implementing their powers under section 59(2) and (3) of the Act. Again, GEMS, Medscheme and Discovery denied that there was anything unfair about the procedures they follow.

714 A substantial part of the difficulties that emerge from the implementation of section 59(2) and (3) of the Act relate to the fact that there is contestation about the interpretation and reach of these subsections.

715 The Panel is of the view that these subsections are capable of a clear and coherent interpretation with a particular reach. Such an interpretation flows from the ordinary meaning of the subsections as well as the assistance that the rule of law, administrative justice right in the Constitution (and its implementation through PAJA) brings to the subsections. In sum the Panel is of the view that:

715.1 Section 59(2) of the Act requires schemes to pay providers or members the current benefits which are owed to them. Regulation 6 of the Regulations implements section 59(2) of the Act and requires schemes to raise any issues with current invoices within a period of 30 days so that the provider or member has an opportunity to correct invoices and re-submit such invoices for payment;

715.2 Section 59(3) of the Act works in lock step with section 59(2) in that it allows a scheme to claw back amounts from future benefits which are to be paid. One of two conditions must be met for such a claw back to take place: either a provider or member must have been paid, on a *bona fide* basis by the scheme, a benefit to which they are not entitled; or the provider or member must have engaged in fraud, theft, professional misconduct or negligence and caused a loss to the scheme;

715.3 The scheme is given a significant power in section 59(3) in that it can unilaterally decide to claw back an amount, assuming one of the two conditions are met;

715.4 The nature of the power that the scheme exercises in clawing back such amounts is a public power which is subject to section 1(c) and section 33 of the Constitution as implemented by PAJA. We have given an extensive analysis as to how we have reached this conclusion. Such a power must be exercised lawfully, reasonably and in a manner that is procedurally fair. Without such constraints the schemes would be engaging in a form of self-help which is prohibited by the Constitution;

715.5 The three requirements of lawfulness, procedural fairness and reasonableness require the schemes to *inter alia* always ensure one of the two pre-conditions are met when considering a claw back, be able to justify any decision to claw back and ensure that it does not cause undue or disproportionate harm, give the provider an

opportunity to meaningfully comment on a proposed claw back before a decision to claw back is taken;

715.6 Furthermore, the exercise of powers in terms of this subsection would also be subject to common law administrative law controls and would at the very least require the scheme to justify its decision to ensure it is not arbitrary or irrational and to give the provider an opportunity to meaningfully comment on a proposed claw back before a decision to claw back is taken; and

715.7 We emphasise that these constraints on the scheme's powers to claw back monies from providers are significant and should do much to address the providers' allegations and concerns regarding unfair treatment.

716 It is not only claw backs that were cause for concern, but also the schemes decisions to place providers on indirect payment when the schemes were of the view that a provider has engaged in FWA or where providers do not cooperate with the schemes during an FWA investigation.

717 The Panel is of the view that although there is no express provision in the Act which allows schemes to place providers on indirect payment, the schemes may do so where either a provider has contracted with the scheme on terms which allow for this; or where the scheme has included such a possibility in its internal system of proper financial controls (section 57(4)(c) of the Act mandates that the schemes must have such systems of control).

718 However, the requirement that a scheme must have a proper system of financial control also places constraints on the scheme when it places a provider on indirect payment. Like with the decision to claw back monies in terms of section 59(3), when a scheme contemplates a decision to place a provider on indirect payment in terms of its internal policies its decision must be reasonable and not cause undue harm; and it should before any decision is taken give the provider an opportunity to meaningfully comment on the proposed decision to place such provider on indirect payment.

719 This interpretation of sections 59(2) and (3) of the Act also has consequences for the manner in which the schemes determine the amounts to be clawed back from providers and the amounts that providers and schemes might agree in any settlement agreement – more often than not, concluded to avoid a claw back in terms of section 59(2).

720 Any amount which is clawed back by a scheme must be reasonable and must be based on a methodology which is reasonable. We accept that for practical reasons the schemes (and for that matter, providers) probably need to estimate the amounts which may be clawed back, as there is not time or resources to locate and trawl through numerous records. Absolute precision in the calculation of the amount clawed back is not a requirement of section 59(3).

721 In relation to the current methodologies implemented by the schemes and administrators, we note that none of the methodologies are made available to providers or members. In order to ensure good decision making and

transparency they should be easily available in advance of any engagement with the provider. Further, GEMS uses approximately one year's historic claims data to estimate claw back amounts, Discovery can, and often does, use up to three years of historic claims data to estimate claw back amounts. Medscheme appears not to have an explicit methodology and rather adopts a case by case approach to how it calculates claw backs. There is little doubt that Medscheme's approach operates most arbitrarily for providers.

722 We are also concerned about an aspect of Discovery's approach to calculating amounts to be clawed back as the approach may be disproportionately harsh on providers who are required to pay back amounts over a period of up to three years. We do not believe that this approach to calculating amounts owed is justifiable – this is particularly so where the schemes' systems are capable of picking up unethical conduct or misdemeanours in a much shorter time and could notify providers that they are being flagged much earlier than is currently the case. We say more about this in our recommendations below.

723 Finally, there is little doubt that there is a power imbalance in the settlement negotiations between schemes and providers. There are a number of reasons for this. The first is that if a provider does not agree to the terms of an AOD she is likely to be subject to a claw back in terms of section 59(3) of the Act. This makes it difficult for a provider to refuse to agree to an AOD. The second reason is that providers are usually individual practitioners, whereas the two administrators are large, well-resourced and powerful corporations; GEMS is the second largest scheme in the country and is also more resourced and powerful than an individual provider. The third reason is that the schemes and

administrators are in effect performing a function akin to policing in the implementation of their FWA systems and they are given a unilateral statutory power to claw back monies from providers. This is a significant power with real and immediate consequences for the financial well-being on providers.

724 In circumstances where there is a power imbalance in an AOD negotiation the schemes and administrators should proceed with caution and ensure that mechanisms are put in place which ameliorate the risk of providers agreeing to AODs under any form of duress, whether it be due to actual or perceived threats and whether it is economic duress or otherwise. On this score we further note that Medscheme is financially incentivised by one scheme, through a bonus, to collect monies from providers – this incentive operates over and above Medscheme's flat fee. GEMS historically also incentivised investigators to collect monies from providers. This introduces real and practical scope for abuse as Medscheme is not only acting in the interest of the scheme (who should be acting in the public interest) but in its own interest – where it has the opportunity to make extraordinary financial gains.

29. RECOMMENDATIONS

725 The Panel is not a court or tribunal with the functions of determining a dispute between litigating parties. However, given the importance of the subject matter of the Inquiry and the finding of unfair discrimination on the grounds of race, recommendations aimed at remedy are necessary. In any event, the

Terms of Reference mandate the Panel to make recommendations to the CMS.[720]

726 The Panel is guided by the legal principles applicable to remedies that have been articulated by our courts. In *Fose*, the Constitutional Court held that appropriate relief means effective relief:

> *"I have no doubt that this Court has a particular duty to ensure that, within the bounds of the Constitution, effective relief be granted for the infringement of any of the rights entrenched in it. In our context an appropriate remedy must mean an effective remedy, for without effective remedies for breach, the values underlying and the rights entrenched in the Constitution cannot properly be upheld or enhanced. Particularly in a country where so few have the means to enforce their rights through the courts, it is essential that on those occasions when the legal process does establish that an infringement of an entrenched right has occurred, it be effectively vindicated. The courts have a particular responsibility in this regard and are obliged to 'forge new tools' and shape innovative remedies, if needs be, to achieve this goal."* [721]

727 Since *Fose*, the Constitutional Court has "consistently emphasised that, where a litigant does establish that an infringement of an entrenched right has occurred, he or she should as far as possible be given effective relief so that the right in question is properly vindicated."[722]

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[720] Terms of Reference, para 6 (ii) – (v).

[721] *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC) ("***Fose***"), para 69. See also: *National Coalition for Gay and Lesbian Equality and Others v Minister of Home Affairs and Others* 2000 (2) SA 1 (CC), para 65:

> *"Although the remedial provision considered by the Court in Fose was that of the interim Constitution, the two provisions are in all material respects identical and the . . . observations in that case are equally applicable to section 38 of the Constitution…."*

[722] *Gory v Kolver NO and Others* 2007 (4) SA 97 (CC), para 40.

728 An appropriate remedy is also one that is "specially fitted or suitable".[723] Kriegler J in *Fose* found that—

> *"suitability is measured by the extent to which a particular form of relief vindicates the Constitution and acts as a deterrent against further violations of rights enshrined in [the Bill of Rights]. In pursuing this enquiry one should consider the nature of the infringement and the probable impact of a particular remedy. One cannot be more specific. The facts surrounding a violation of rights will determine what form of relief is appropriate."* [724]

729 Similarly, in *Motau*[725] the Constitutional Court held that to grant appropriate relief, the court must determine what is fair and just in the circumstances of a particular case:

> *"The various interests that might be affected by the remedy should be weighed up. This should at least be guided by the objective to address the wrong occasioned by the infringement; deter future violation; make an order which can be complied with; and which is fair to all who might be affected by the relief. It also goes without saying that the nature of the infringement will provide guidance as to the appropriate relief."*[726]

30. UNFAIR DISCRIMINATION

730 As the Panel has found, the unfair racial discrimination arises from indirect discrimination in the FWA processes. Where policies are designed by people

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[723] *Fose*, para 97.
[724] *Ibid*. While this was a concurring judgment in *Fose*, the Constitutional Court has since approved this passage in *Electoral Commission v Mhlope and Others* 2016 (5) SA 1 (CC), para 83.
[725] *Minister of Defence and Military Veterans v Motau and Others* 2014 (5) SA 69 (CC) ("***Motau***").
[726] *Motau,* para 85.

with power, they may not realise, or choose not to realise, that their positions of power are the result of, and may continue to perpetuate, race inequality.[727]

731 There needs to be a diversification of the people who design policies and procedures. There is a much greater chance of implicit bias entering a system if the creators of the system are homogenous. Diversity, on the other hand, ensures that there is a diversity of life experiences created by historical structures of racism. This in turn will help identify the potential pitfalls of a system.

732 According to Professor Steyn two questions must be asked when seeking a process which does not unfairly discriminate on racial grounds:[728]

732.1 What are the potential unintended consequences of the process on any particular racial population?

732.2 What are the appropriate alternative courses of action?

733 The complaints of racial discrimination must be taken seriously by the schemes and administrators. In order to understand how a normative system creates unfair consequences it is necessary to consider the position of the people who are telling you it is not working for them. This is because "the power relations operate from the position that is established as the norm and so it operates for the comfort and benefit of the powerful norm. And it works

[727] Prof Steyn (Transcript, 18 October 2019, p 15, lines 18 - 25).
[728] Prof Steyn (Transcript, 18 October 2019, p 18, lines 22 - 25).

not only to establish privilege but maintain privilege and prevent privilege from being eroded".[729] She continued:

> *"in formulating policies it is important for people in these dominant positions to seek out the perspectives of others and critically assume there is racial bias in their system. Not to start with the assumption that somehow you have been able to … 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 wrongdoing … but actively to take steps to ensure that one is thinking through how these things may be operating within ecosystems. … even though it is important to anonymise data bases, at the same time we also have to reintroduce race and keep race very clear in our thinking as we formulate policies, as we formulate implementations, as we look at how things play out".*[730]

734 In order to avoid discrimination as a result of implicit bias, it is necessary to:

734.1 Assume that there is racial bias in the system (as opposed to assuming that systems are neutral);

734.2 Seek out the perspectives of others regarding the way in which a system may have unintended negative consequences for one group of people;

734.3 Build into the system a racial impact assessment; and

734.4 Take steps to mitigate those unintended consequences which operate in the ecosystem in which the policy or practice is developed.

[729] Prof Steyn (Transcript, 18 October 2019, p 15, lines 18 - 25).
[730] Prof Steyn (Transcript, 18 October 2019, p 16, line 19 - p 17, line 8).

735 In order to achieve any of these steps, institutions should understand that their operations have large-scale impact on South African populations. This power necessitates a constant research and monitoring programme to pre-empt, identify and address racially skewed outcomes.

736 The Panel recommends that the administrators and schemes:

736.1 report to the CMS, within 3 months of the issuing of this Report, on the measures that they will introduce to mitigate and remove the unfair discrimination, against Black providers, that has been shown to be evident in the implementation of their FWA systems.

736.2 each conduct a racial impact assessment[731] of the impact of their respective FWA policies and approaches on an annual basis.

737 Further, bearing in mind the finding that that the outcome of the FWA investigations, conducted by Discovery, GEMS and Medscheme, for the period in question amount to unfair racial discrimination against Black practitioners, the Panel is of the view that these administrators and schemes should apologise to Black healthcare providers in relation to this finding. The apology should be unconditional and public and should take due account of the emotional and psychological impact of the discriminatory outcomes.

31. REGULATORY AUTHORITIES

[731] Prof Steyn (Transcript, 18 October 2019, p 17, line 15 - p 19, line 1).

738 The two key regulators who can assist both the schemes and providers in addressing FWA fairly and reasonably are the HPCSA and the CMS. Both regulators have been heavily criticised for not playing an adequate role in creating certainty regarding rules. The CMS has not given us evidence to show that it has been robust in its regulatory function. Certainty is required in relation to:

738.1 The disclosure of confidential patient information;

738.2 Scheme rules regarding suspension of direct payment. This is particularly contentious because Black practitioners are, given the socio-economic circumstances of their patients, probably more likely to be paid directly by a scheme;

738.3 The procedures to be followed by schemes in implementing their powers in terms of the Act;

738.4 The remedies available to parties who feel aggrieved by conduct of schemes; and

738.5 The penalties against schemes in the event of a breach of the Act.

739 The Panel recommends that:

739.1 Both the CMS and HPCSA establish a division, or dedicate personnel, which focus on FWA prevention;

739.2 The CMS should issue more regular guidance on the issues which arise out of the FWA detection, investigation and sanction processes

by the schemes and administrators. The complaint procedure in the Act, which means the CMS is the closest to these emerging issues, make the CMS well placed to do this;

739.3 Where the HPCSA or CMS is approached by providers, members, schemes or administrators for guidance in relation to particular FWA issues they should be responsive, transparent and publish such guidance with a reasoned justification for the guidance given; and

739.4 The HPCSA speed up disciplinary proceedings against providers accused of professional misconduct and work more closely with the schemes and administrators who report providers.

740 Although this Report considers the issues that were raised in relation to coding, and the considerable uncertainty that results, the Panel notes that this issue is the subject of recommendations by the Health Market Inquiry. The Panel underscores the need for a standardised coding system.

32. PROCEDURAL FAIRNESS

741 At the heart of the concern regarding procedural fairness is the unequal bargaining power between the scheme and the provider. The first letter received by a provider often places the provider on strict terms. In a few cases a sanction of indirect payment occurred before the investigation was concluded. With regard to face-to-face meetings, the consistent complaints by providers is that they were, or felt, intimidated.

742 The period of time over which the provider is alleged to have engaged in FWA is often lengthy, which makes the production of records much more difficult. The timeframe is entirely within the control of the schemes and administrators.

743 The FWA systems of GEMS, Medscheme and Discovery, all use claims data and are all capable of identifying behaviours that fall outside the norm within particular disciplines. In our view the analytical systems are being under-utilised as an early warning system, for both the schemes and the practitioners, and could be better used to pick up anomalous behaviours and encourage behavioural changes by providers.

744 This is best illustrated by way of an example: the analytical systems can immediately identify claims that explicitly violate certain rules, for example, a claim for a paediatric examination on an adult would be automatically rejected. Other potentially problematic claims are not capable of immediate identification and will only emerge over time due to the patterns in the data. For example, that a particular GP has longer consultations than her peers. Currently, the point at which this sort of 'outlier' behaviour is investigated a significant amount of time has passed (probably more than one year). After this amount of time, the financial consequences for the scheme and providers are serious and the ability of the provider to defend her behaviour is likely to be compromised (finding records going back a year or more is difficult). It therefore seems that if the schemes and administrators used their analytical systems more pro-actively to identify problematic behaviour by providers earlier it would benefit both the schemes and the providers.

745 We therefore make the following recommendations:

745.1 Providers should be notified within three months of any billing irregularity. This will:

745.1.1 allow the provider to be placed on warning;[732]

745.1.2 allow the provider to desist from the conduct at issue and thus reduce FWA;

745.1.3 enable the provider to submit the necessary paperwork in order to justify the services provided;

745.1.4 lead to less hardship for providers who face clawbacks or AODs going back over a period of years; and

745.1.5 benefit the schemes in that providers who are actually engaged in FWA are likely to change their behaviour on receiving the warning. This should result in less financial loss to the scheme.

746 There are concerns regarding the identification of FWA *and* the quantification of any amounts owing. The Panel recommends that an independent mediator is appointed to be present at meetings between the scheme and providers during which the description of the FWA is confirmed, the amount implicated is determined and payment mechanisms are negotiated. We consider this to

[732] Such a warning could read as follows:

> *"Our regular run of our analytics system has identified behaviour on your part that could* ***potentially*** *constitute fraud, waste or abuse. This identification is not proof on any unethical behaviour on your part, nor is it an accusation that you have acted unethically. The aim of this notification is simply to alert you that we may at some future date need to review your documentation in order to satisfy ourselves that the scheme has not suffered any damage. Please retain all documentation related to the behaviour identified."* (our emphasis)

Such a warning should also be followed by a detailed description of the behaviour identified by the system.

be a statutory function of the CMS and therefore recommend that the CMS appoints and remunerates the independent mediator.

747 Finally, although the FWA systems employed by GEMS, Medscheme and Discovery are not fully automated, the systems all rely on algorithms to identify providers for further investigation. Noticeably, only Discovery was able to give explicit details as to how their algorithm was constructed and which factors were taken into account. Both GEMS and Medscheme purchase or licence systems from international software providers – and these providers were not willing to share explicit details about the construction of their algorithms since they considered it commercial sensitive and valuable information.[733] The result is that Discovery can interrogate their algorithmic system in a comprehensive way to ensure that there are not unintended consequences associated with the use of its algorithm. GEMS and Medscheme are not similarly placed and are reliant on arms-length assurances from the international service providers.

748 Algorithmic transparency is important. This is the principle that the full workings of the algorithm should be visible, transparent and accessible to both the people who use algorithms but also to the people who are *affected* by the algorithmic systems. Specifically, it is necessary that the inputs into, and construction of, the algorithm must be known. While algorithms have the appearance of neutrality, they are constructed by humans – and therefore

[733] Both GEMS and Medscheme's international service providers confirmed that race was not an explicit factor used in the algorithm.

potentially discriminatory. Racially biased outcomes have increasingly been recognised as a problem that can infect software algorithms and datasets.[734]

749 It is also important to note that, increasingly, there is a demand for algorithmic accountability, which means that the entity or organisation that uses algorithms must be accountable for the decisions made by the algorithms, even if the decisions appear to be formulated mechanically.

750 There are degrees of transparency – and different conceptions of transparency, including transparency of outcomes – that may be provided, and it is beyond the scope of this report to explore those. However, it is clear that the following principles must be considered by the schemes, their administrators and the CMS:

750.1 Schemes and their administrators should have a functioning knowledge of the factors and codes on which the algorithms are based, so that discrimination may be detected;

750.2 If schemes and administrators fail to do this, they may be responsible for any discriminatory outcomes; and

750.3 This form of knowledge and transparency would alleviate concerns of those affected by the algorithms, such as the complainants in this Inquiry.

[734] Selena Silva and Martin Kenney, "Algorithms, Platforms, and Ethnic Bias" *Phylon* Vol. 55, No. 1 & 2 (2018) p 9 - 37.

751 Without transparency, at least in relation to the factors driving algorithmic decisions,[735] one can never properly assess if the algorithms on which the schemes and administrators rely are not racially discriminatory and/or lead to racially discriminatory outcomes.

752 In our view it is undesirable for South African companies or schemes to be making use of systems and their algorithms without knowing what informs such systems. There may well be factors within the algorithms which are directly or indirectly discriminatory and therefore create unconstitutional effects. Bearing in mind that we have suggested that Discovery, GEMS and Medscheme conduct a racial impact assessment, it seems GEMS and Medscheme will only be able to conduct a proper assessment if they have better information about the algorithms they use.

33. CONCLUDING REMARKS

753 We have concluded that some of the current procedures followed by schemes to enforce their rights in terms of section 59 of the Act are unfair. We have also found that Black providers are unfairly discriminated against on the grounds of race. These findings are both serious and far-reaching. But we believe that it is important to stress that we have not found evidence of deliberate unfair treatment – the evidence shows the unfair discrimination is in the outcomes. Our Constitution regards the form of unfairness that we have found to exist as constituting unfair racial discrimination.

[735] See Kartik Hosanagar and Vivian Jair, "We Need Transparency in Algorithms, But Too Much Can Backfire" in *Harvard Business Review* (July 2018).

754 Although the appointment of the Panel was in terms of legislation – the Medical Schemes Act – the participation by everyone was voluntary. This has been the strength of the Inquiry. Information was also voluntarily provided. Where appropriate requests for confidentiality were made, we have attempted to respect these. But we have also attempted to balance requests for confidentiality against the need for transparency since this was a public inquiry.

755 We had no power to find anyone guilty. Nor were we appointed to investigate the veracity of each individual claim of unfair treatment and unfair discrimination. But we would be failing in our duty if we ignored the degrading, humiliating and distressing impact of racism against the individuals who testified before us. A part of our function was to provide a platform for the expression of individual experiences of racial discrimination and other forms of unfair treatment.

756 We do not believe that we have covered each and every possible complaint of providers against schemes. That was not our mandate. We also do not claim to have explored all possible manifestations of racial discrimination and unfair procedures. But we have received sufficient data and information to make informed and reliable conclusions of the patterns of conduct by the schemes. In certain respects, our conclusions – which are evidence based – accord with individual experiences. Affirming these individual experiences as fact has been an essential element of the work of the Panel, confirming that the majority of the complaints were not frivolously made.

757 Our expectation is a constructive engagement with the findings and recommendations in this report. Rather than conclusive, our findings will hopefully provide a basis for the necessary reconstructive work which must be undertaken by the role-players in the medical schemes industry. We do not see the issue as a binary conflict between schemes and providers, but as reflective of fissures of the past that remain unresolved.

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4 December 2020