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I also confirm that all audios presented to me are treated in a confidential manner.

JUSTICE NGCOBO Good morning everyone can we all get seated so that we can get started? May I take this opportunity to welcome all of you to these public hearings into the Competition in the Private Health Care Sector? Perhaps before we commence with our formal hearings, I just want to make 1 or 2 remarks just to put these proceedings in context and perhaps for the benefit of those who have not attended our previous stakeholder meetings where we have dealt with some of the issues that I am going to outline very briefly.

The Health Market Inquiry is now entering its final phase of the investigative process which, are the public hearings. You will recall that the Health Market Inquiry was initiated in 2014 under the provisions of Chapter 4A of the Competition Act of 1998 and very briefly, a market inquiry for the benefit of those who have not been part of this process, is no more than a formal enquiry in respect of the general state of competition into a particular sector and experts in these areas, have described market inquiry as being essentially research projects which are intended to gain in-depth understanding of how sectors, market or market practices are working.

The purpose of the exercise is essentially to determine whether the process of

competition in these sectors is working well, or whether it can be improved and these enquiries of course provide a framework for identifying, analyzing and where appropriate, remedying sector-wide and market-wide competition problems. What I need to emphasize and this is a point that I have emphasized throughout this process, is that the nature of this enquiry, is fundamentally investigative in its nature, no one is accused of having committed any conduct that is anti-competitive. The focus is how the markets in the private health care sector as a whole, functions however the process as is required by the law, must be conducted in accordance with the principles of fairness.

Essentially what the Act does, it empowers the Competition Commission to conduct a market inquiry perhaps in 2 situations. The first is if it has reasons to believe that any feature or combination of features of a market for goods or services prevents, distorts or restricts competition. Secondly, you can also conduct a market inquiry in order to achieve any of the listed purposes of the Act. The market inquiry is generally triggered by concerns about the functioning of the market or the markets and of course, these concerns may arise from the behavior of firms, market structure, lack of information, consumer conduct, or public sector intervention by way of policies.

Let me just say very briefly where we are with the process of investigation so that you can get a sense of where we are going and how far are, we from the end. The Health Market Inquiry has been in operation as you might be aware since early 2014 and has accomplished many of its key milestones in a long and a very complex process. We have recently published a revised statement of issues which discusses the major elements of the work to-date and provides some indications of the issues that the stakeholders have raised through their various interactions with us.

The market inquiry is presently in the investigative phase which is concerned with gathering evidence on possible impact of market structure and the conduct of market players on competition in the private health care sector. This investigating phase further involves a refinement of focus areas, the identification collection and analysis of data and information, the formulation of provisional conclusions on data and information collected and the preparation of position papers on specific key issues.

This phase will also guide the request for any additional information and clarity that the market inquiry requires as it enters the public hearing phase. In the administrative phase which preceded the investigating phase, the

market inquiry received some sixty eight initial written submissions from stakeholders totaling to some fifteen thousand pages. Where there were no issues of confidentiality, these were published on our website for each and every one of you to have a look at hose and to assess the accuracy or otherwise of the information that is contained there.

Certain submissions as you would have noticed attributed the cost increases to market power in 3 groups of stakeholders, hospital groups, medical schemes and their respective administrators and specialist medical practitioners. In so far as market power is concerned, the views tend to vary largely in relation to the stakeholders location within the market.

A number of submissions have also raised concerns about the regulatory environment some have submitted that there is a lack of regulation or adequate enforcement of applicable regulations due to ineffective oversight by the regulatory bodies. Others have submitted that there is over-regulation in certain areas, resulting in barriers to entry expansion and innovation in the private healthcare sector.

Certain submissions argue that the regulatory gaps remaining after the introduction of social solidarity principles to the funding side of the system,

have had an adverse consequence on cost as well as negative effects on the vulnerable people who depend on the private healthcare sector. They argue that elimination of the regulatory step will improve market outcomes with positive effect, yet a number of submissions raise concerns about the lack of information which is available to patients highlighting the general lack of transparency in accessing private healthcare information, in particular on pricing cost and the quality of services.

We have submitted this lack of information, places patients at a disadvantage when making decisions on services and that this disadvantage has huge implications for competition. What the Health Market Inquiry seeks to understand, is the inter-relationship between the various markets in the private healthcare sector, including the contractual relationships and the interactions between and within the health services providers, the influence they have on the dynamics and the functioning of the markets, the nature of competition and within and between these markets and the ways in which competition can be improved.

The Health Market Inquiry also wishes to assess the impact of the Competition Commission's interventions in the private healthcare through

enforced mal-action and measure regulation, including any possible impact this has had on prices, bargaining mechanisms, consolidation and competition in the healthcare sector.

All this explains why the Health Market Inquiry has embarked on extensive stakeholder engagement in order to determine more specifically the framework for the information gathering and analysis phases. This process guided the development of detailed information and data request, which set the categories and the nature of the information that the Health Market Inquiry required to undertake the intended analysis.

These engagements will continue throughout the remainder of the process. In the course of requesting information and data from the stakeholders, other stakeholders understandable, sought some clarity on the request and the way the data that we requested from them, had to be presented and we had others also requested an extension of time within which to submit to us, that data.

It is the submission of the data and the request for extensions of time that has somewhat delayed the finalization of our analytical phases which is still ongoing at the moment. Also to understand the private healthcare sector in

South Africa, as well as the relevant role players, we also conducted [indistinct 12:59] engagements with a wide range of stakeholders.

We are currently finalizing a methodology paper which deals with market definition as with the profitability analysis, some stakeholders have provided us with their views, in particular how they define the various markets and the assessment of whether or not they have market power. The HMS is also in the process of finalizing our market definition methodology that will contribute to the determination of whether and where market power exists.

The paper will be published shortly once it has been completed and it is against this background that we are now entering the final phase of the Health Market Inquiry which is the public hearings. Of course although I mentioned that this is the final phase, this must be understood of course as being subject to the need that may arise for a particular information to be obtained subsequently to fill in possible gaps that may be identified and for further engagement with particular stakeholders if the need should arise.

The determination of the panel to conduct the enquiry fairly and in a transparent manner will not be compromised in this regard. Very broadly speaking though, the primary purpose of the public hearings, is to afford the

public, the stakeholders, policy makers, the regulators, expert witnesses as well as international experts, the opportunity to debate and provide insight into the healthcare market, how these markets operate and to provide evidence if any, of market failures but at the same time, they provide the opportunity to test some of their assertions that have been made in the written submissions.

In addition, where intervention is required, they provide the opportunity for understanding the impact of any proposed recommendations, in particular the practical implications of the proposed interventions, including understanding the extent if any, to which similar interventions in other parts of the world have been successful in addressing competition challenges and the lesson for South Africa from this experience.

But what this process of public hearing will also do we hope it will educate the public about, how the private healthcare sector functions. This purpose is especially important if regard is had to the fact that access to healthcare services in our country, is a fundamental right which is guaranteed by Section 27 of the Constitution and more recently, this country has ratified the international convention on economic social and cultural rights, which

therefore means the right of access to healthcare is not just a constitutional obligation, but it is also an international obligation on our country.

Now you would have seen from the program which we have published on our website, that there will be 6 sets of sessions of public hearing. The hearings will commence with a general session which is intended to set the scene for hearing and during this session and the following sessions making up the first set of hearing, we would like to hear from all stakeholders in the private healthcare sector which includes the users of the system, consumers and consumer groups, service providers comprising of hospital groups and practitioners, funders and financiers which include brokers, schemes, administrators and managed care organizations and regulators as well as policy makers.

The purpose of this session which commences today and will run for the next 4 weeks is to gain an understanding of how these groups interact with one another and their experience in interacting with one another. We hope that this session will enable the Health Market Inquiry as well as the general public to gain a better understanding of the nature of the private healthcare sector, how private healthcare services are provided and funded and the

regulatory framework for the private healthcare sector.

The first set of these hearings commences today and it will run up until the 10th of March. Due to limited resources, these hearings will only be held in Gauteng, Kwa Zulu Natal, as well as in Cape Town.

This session will then be followed by 5 more sets of public hearings. These will involve focused sessions which will focus on specific aspects of competition issues such as the availability of information about private healthcare services, competitive dynamics among funders, service providers and the impact of regulatory framework on competition among sector stakeholders.

These specific sessions will be conducted during the period which will commence on the 29th of March and will be completed on the 9th of June. The intention is that these hearings will be held on Tuesdays, Wednesdays and Thursdays. There will of course be a break of about a week in between, so as to give panel members the opportunity to synthesize the information presented in the preceding hearings and to prepare for the next hearings.

The way these proceedings will be conducted is this. We have identified a

team of evidence leaders, which will assist with the examination of information that will be presented here. The team will also assist individuals who require assistance in the presentation of their submissions and these proceedings will be conducted strictly in accordance with the guidelines that we have published on our website.

These guidelines address a number of issues, including how one deals with confidentiality of information that might arise from time to time. Indeed one of the issues that appears to concern most of the stakeholders time and again, is the protection of confidential information. The Health Market Inquiry will adhere to the guidelines dealing with the presentation of confidential information at the hearing.

In September last year, we issued supplementary guideline number 2 which aims to address these concerns. The guidelines set out the framework for managing access to confidential information. In addition, the guidelines empower the Chairperson to exclude from the hearings, members of the public, specific persons, categories of persons from the hearings if the information to be presented is of a confidential nature and the whole purpose is to protect the confidentiality of the information which that particular

stakeholder might present or might wish to present before us.

Perhaps by way of concluding, I do want to stress the point that I have made before, namely that this is essentially an investigative inquiry which is intended to gain an understanding of how the private healthcare sector functions. It is very informal, but yet it will be conducted strictly in accordance with the rules of fairness. The whole purpose of the exercise is to assess whether competition is functioning efficiently within the private healthcare sector and how we can improve efficiency within the private healthcare sector.

The promotion of competition is not an end in itself, one of the objectives of promoting competition, is to provide consumers with competitive prices, product choices and enhance access to healthcare services. This objective of competition policy must be understood in the light of the place of healthcare services in our country and as I have pointed out before, Section 27 of the Constitution guarantees to everyone the right to have access to healthcare services. This constitutional right requires among other things, that the State should facilitate access to healthcare services regardless of who provides

these services.

Access is not just limited to physical accessibility of premises that provides healthcare services, but it also includes affordability of healthcare services. To this extent, the Constitution requires the State to take reasonable legislative and other measures within its available resources in order to achieve the progressive realization of this constitutional right. It is therefore in the interest, not just of competition law and policy that the private healthcare sector functions effectively and efficiently, but is also in the public interest that the private healthcare markets function in a way that promotes rather than undermines the purposes of the Act.

With those few remarks, we are now going to commence with our proceedings. The first group that will present will be the technical team of the Health Market Inquiry which will give us a sense of what they have been doing and where the process is at the moment.

Now before each one of you makes his or her presentation, if just for the record, you could just place your name on the record and who you are and what you are doing and you can then tell us perhaps how you intend to make your presentation, thank you.

It can happen to anyone, it also happened to me as well, please make sure that you switch off your cell phone, so that it doesn't disturb us, thank you.

MR MTHOMBENI My name is Sipho Mthombeni, I am part of the Technical Team. My colleagues to my left are Ms Mapato Ramokgopa and Ms Pamela Halse and I will be giving our presentation today.

What we are presenting is really a summary of work that has been done by the Technical Team looking into understanding what the healthcare sector in the country looks like. we intend on publishing a report in this regard, so what you will see here, is not the entire content of the work and the research that was done by the Technical Team, but it is merely a summary just to provide an overview of what the industry looks like and also to provide context to a number of the issues raised in the statement of issues and the revised statement of issues.

How we will conduct our proceedings today, is that I will start by just taking you through an overview of what the South African sector looks like, both public and private. We will then also talk about some of the regulators and the healthcare practitioners. Mapato will then take you through the healthcare facilities and Pamela will then take you through the healthcare financing. I

will then just round off everything else just talking through the suppliers and supporting players in the industry.

Now just as a starting point, JUSTICE NGCOBO also mentioned that Section 27 of the Constitution guarantees the right to healthcare services to everyone in the country and this is basically the starting point of trying to understand what the South African sector or the healthcare sector looks like. What we do see in our country, is that a lot of the population accesses healthcare services through the State, so through the public sector, but obviously noting that there is a place that has been played by the private sector in the country.

What we have seen in the public sector is that it is obviously mainly funded through tax. There has been, a number of submissions and stakeholders who have stated that while the sector is under pressure because of a number of issues, I think we have quoted there, issues around the quadruple burden of disease, issues around the infrastructure and also shortages in key personnel and these are some of the issues that have been raised that have been put to the public sector under pressure.

In relation to the private sector, we have noted and our research has shown that it is about approximately 8.8 million South Africans who access the

private sector through medical schemes. There are those then that also access the private healthcare services through the use of healthcare insurance, so the likes of your hospital covers and gap covers of that nature.

There are South Africans who also pay out of pocket in order to access private healthcare services and also we note that there is the Road Accident Fund and Compensation Fund which would also access services in the private sector. What we found then in the sector itself when we were talking about private healthcare sector, it consists really of the healthcare service providers, which includes your practitioners and your facilities those are your hospitals and your doctors. It has the finances which here we are referring to your medical schemes and administrator's health insurers.

There are product suppliers, those who supply pharmaceuticals and technology. We also have other supporting players in terms of people who provide other services for instance the practice management services providers who are in the sector.

What we found and this is according to the NDP, is that the expenditure, between, the private and the public sector is not very far off, even though there are disparities in terms of the number of people that are covered. The

expenditure in the private sector amounts to approximately about R146 million which was in 2013/2014, whereas in the public sector, it was R140 million and this was according to NDP.

Now what has always been of importance to us, is to point out how the private sector and how the consumer or the patient interacts with the private sector. What we are talking about, is that the South African consumer really mostly has the choice to either access the sector through either the public or the private sector. What affects these choices is obviously their needs, their resources, the quality of information that they have about the services that they need and also incentives and actions of those that they interact with, so for instance, who they referred to who the referring practitioner is. They may refer them to different parts in the healthcare sector.

Now in relation to decisions that are faced by consumers, we found that consumers are faced with decisions around which medical schemes to join, which doctors to go to or to consult with, which hospitals to go to. These are some of the key decisions that are faced by a consumer. However, the problem that lies there is that often at times, consumers do not have enough information in order to understand the healthcare services and products that

they are buying, so this leads to the issue around information asymmetry in that consumers don't always necessarily have the right information to make the appropriate choices.

What we have also looked at, is how consumers then pay for these services, the private health care services. Firstly, consumers make a choice to either join a medical scheme, or to sign up for a product from a medical insurer. The scheme insurers will then be responsible for paying for the services that a consumer or a patient then receives.

What the research has shown and what we found in a number of submissions as well, is that there is an issue where it is taken that consumers are not necessarily alive to the costs around the services that they consume especially regarding where a third party is making payment on their behalf. Now when consumers are not covered, this is really when we are talking about consumers who have insufficient or they have exhausted their benefits from their medical aids, or they don't have a medical aid or insurance cover at all. So for these people who are not covered, their option is really to pay out of pocket for the private healthcare services, to make use of the public sector or

then the worst case scenario, is that they do not get any care at all.

Now as we've mentioned, these are the key 5 stakeholders that we have looked at in relation to the patient and how they relate to the patients and these are the people that we are going to talking you through today. This may look complicated which kind of explains what the sector looks like. What this tries to do, is to show the interrelations between the different players in the industry, where they belong to and how they relate.

Just to highlight there, in the green, we are looking at the public sector players whereas in the blue, those are the private sector players. What the rest of our presentation is going to try, to do for you today is just to, kind of, break down and try to simplify this diagram for you in terms of who the players are and how they relate to each other.

We will start off with our regulators. It is notable that obviously the National Department of Health is the head of the healthcare system and is constitutionally mandated in terms of the provision of healthcare services in the country. There are a number of Acts that are relevant, including the National Health Act and other key Acts like the Medicines and Related

Substances Act which are relevant and provide the mandate for the provision of healthcare in the country.

However, it is also notable that there are other provincial and district departments. We also noted that there are sector and professional related regulators which we will discuss further as we speak to specific stakeholders. Our next, stakeholders which we will talk to, is really the practitioners in the country. In relation to and why we have looked at healthcare practitioners, it relates to theory that was identified in the statement of issues which relates to possible market power and distortions of healthcare practitioners in the country.

As a starting point, we defined healthcare practitioners as those professionals in the healthcare system, that is including your GP's, your specialists, nurses, your pharmacists, physicians, dentists and also physiotherapists, just to name a few. We have noted that in South Africa like in many other countries, practitioners are regulated and there are a number of regulating Acts as they are listed there you will see in front of you that relate to the regulation of practitioners in the country.

In relation to regulators, we have noted that there are regulators the first one listed there is the Health Professionals Council which regulates people like your general medical and dental practitioners, specialists, optometrists and radiographers, those are just a few examples given.

Another regulator that we have taken note of is the Allied Health Professions Council of South Africa which regulates professions such as your homeopathy, chiropractic and osteopathy professions to name a few. Further regulators in the sector as well that have been recognized is the South African Nursing Council which regulates the professional nurses, midwives, staff nurses and auxiliary nurses. The South African Pharmacy Council which regulates your pharmacist's and also the South African Dental Technicians Council which has the name suggests, regulates dental technicians.

In relation to issues around practitioners, I think the first one, it might sound obvious to a lot of people, but it was necessary to point out that there is the requirement that practitioners get the relevant training in education before they start practicing. We have found that in some instances, consumers are not even aware of these requirements for their practitioners to display or

determine that they have the necessary training in education.

We have noted that healthcare practitioners operate in very different forms, including your solar practices, your group practices and also those in partnerships and associations. We have noted as well which is a big factor as well, is that a number of the practitioners who are employed in the public sector, also participate in the private sector and as we go further into further hearings, these are some of the elements that will come through.

A number of the practitioners, there are a number of practitioner associations, forums and groups. I think there are way too many for us to list in this thing however we have noted that that is the manner in which the sector operates in the country.

I will then hand over to my partner to then take you through the facilities.

JUSTICE NGCOBO Thank you Mr Mthombeni.

MS RAMOKGOPA Thank you Chair and the panel, good morning everyone, my brief here is to take you through the healthcare facilities market. [indistinct 38:27] from the statement of issues deals with market power and distortions in relation to healthcare facilities. What do we mean

by healthcare facilities? Healthcare facilities refer to, areas where, various healthcare services are provided, that includes, hospitals, day clinics, specialized care centres and other similar facilities.

In terms of regulators, we don't have a specific sector regulators for healthcare facilities, but there are 2 that need to be pointed out which is the provincial Departments of Health, they deal predominantly with healthcare facility licensing, so it is in relation to issues such as development of new hospitals, renovations, maintenance etcetera.

We have noted that there are various provincial regulations, so each province has got its own set of regulations, but the 2 that are dominant, is the R187 which is used by the Western Cape and the R158 which is used by the other provinces, but what we have picked up, is that the application of the regulations differ across the provinces.

Then we have got the office of the Health Standards Compliance. It monitors compliance with norms and standards of healthcare delivery. It is basically things such as inspection of facilities, the cleanliness, infection control, the attitude of staff, safety and security of staff and patients, waiting times and drug stock outs.

In terms of distribution of facilities across the country, generally there is a fairly wide distribution of facilities across the country, so the little blue dots represent the public sector facilities and the little stars represent the private sector facilities. What we are observing is that with regard to the public sector, there is sort of a wider distribution across the country. We have realized the private sector players are more concentrated in your large metropolitan or urban areas, so for instance if you look at Gauteng, KZN and the Western Cape, that is where you see a lot of private sector players and I mean this also applies to the public sector where we are observing that there is a general bias towards the urban areas and it seems like that there is not so much distribution of facilities in the rural areas or the rural provinces.

This is just the number of facilities and beds between the public and the private sector. The numbers are fairly equal so we've got around four hundred and ten public facilities and three hundred and fifty three private sector facilities. The beds as well, the difference is around five hundred beds, but we must also bear in mind like Sipho stated earlier that the population that accesses the private sector is smaller compared to the public sector, so you just need to bear that in mind.

We have also tried to estimate the bed per thousand population ratio. This ratio basically measures the number of facility beds available relative to the population of a specific area. How we estimated this, is that we know that in South Africa, predominantly access to healthcare occurs in 2 ways. There is the insured population that accesses services in the private sector, there is the uninsured population that defaults to the public sector, but there are other dynamics here that we took into account, for instance the fact that in some instances you would have the medical aid schemes that would have designated provider arrangements with the public sector, so you are an insured consumer, but you then consume your services in the public sector.

Then we also have out of pocket uninsured consumers that would then use the private sector facilities, but despite these dynamics, we think that the estimation that we have, it will give us sort of a rough indicator of the bed per thousand people. So the solid line that runs across is the average for the entire country, so that includes the public sector and the private sector. It sits around 2.6, meaning that we've got 2.6 beds per thousand people in South Africa.

The blue buzz represents the private sector beds and then the red buzz

represents the public sector beds. So for instance, when we look at provinces such as Limpopo, the numbers are very low, so for instance, it is between 1.5 and 2 for both the private and the public sector, so what it is saying, is that for a thousand people in Limpopo, we've got about 1.5 beds.

There are provinces such as Gauteng where the number especially in the private sector, is a big high, but when you look at the public sector beds, it is still below the average. Then we try to compare our figures with the OECD benchmarks. The orange line there just shows you the OECD benchmark which is around 5. South Africa, we are below that. The first red line is the private sector beds and then the second line is our average and the third red line is the public sector beds. I think this is just an indicator that we are way below the average when you compare ourselves with the OCD countries.

So in terms of the private sector, we've got 6 main groups, we've got Netcare, Life and Medi Clinic, these are the big groups that are listed on the JSE and then we've got clinics and JMH, Joint Medical Holdings. These are largely the Black owned groups and they are found mainly in the underprivileged or emerging markets and then we've got another group which really is just a consortium of one hundred and eighty one independent facilities. They are

still competing facilities they operate under an exemption from the Competition Commission in terms of Section 10, so the exemption is really to allow them to bargain and negotiate collectively with the funding market.

The other private sector facilities that we've got, we've got mining facilities, the 3 that we identified as Anglo Ashanti, Harmony Gold and Goldfields. These really provide services to the mining workers and then we've got religious or NGO based facilities. We don't see these 2 groups as competing in the private sector, there are different dynamics there, these profiles might differ. Mining hospitals would deal largely with eye injuries and the burden of disease such as HIV and TB and also the fact that they are not bound by some of the regulations such as they can directly employ practitioners.

In terms of the industry associations, we've got 2 key industry associations, that is the Hospital Association of South Africa, it has got around 212 member facilities representing plus minus 80% of the private facility beds and then we've got the Day Hospital Association of South Africa representing largely the day facilities and these are members of the NHA.

In terms of distribution of private facilities per province, again you've got a

lot of facilities around Gauteng, KZN, Western Cape and the other provinces this is where we are seeing a shortage of facilities.

This is just a distribution of the various hospital groups across the country, again highlighting my point that it seems as if the rural provinces are neglected. This is just an estimation of the market shares. It is not market share calculation as we would normally do in a competition analysis, but it is based on the number of beds in the country, so we see that the 3 big groups account for close to 70% of the market and then followed by the NHN, but again when you look at the NHN, you must remember that it is a group of competing hospitals and if you break them up, then that market share will be diluted

Then we've got others such as clinics JMH and the mining hospitals. I will now hand over to Pamela.

MS HALSE That you Mapato, thank you Chair and panel members and good morning to everyone this morning, this morning I am going to be speaking to you about [indistinct 48:57] which relates to market power and distortions in healthcare financing. Very briefly, I am going to speak about medical schemes, medical scheme administrators managed care organizations,

health insurers, brokers and then the Road Accident Fund and Compensation Fund.

I have put the last 2 in brackets because it is not really a focus of the enquiry, but it is important to mention them as they are a means for individuals to access private healthcare. So first off, medical schemes are an essential pillar of financing private healthcare. They are not for profit entities. How they work, is that individuals contribute a monthly fee to the medical scheme. You will then pool all of their members' contributions and then pay from those for the healthcare expenditures for their sick members.

So ultimately what this means, is that healthy members subsidize the sick, so in some years, a healthy person will contribute more towards the fund than what they will take out, but then when they become sick later on in life, they will end up using more than what they contribute. This practice is commonly known as risk pooling.

There are various types of medical schemes. Any member of the public can join an open medical scheme provided they pay the monthly contribution. There are about twenty three medical schemes that are open medical schemes, otherwise you get the restricted medical schemes and these are where the

membership is limited to a select group of people, so this can either be through an employer group, an organization or a union as such.

Within each medical scheme, they differ per medical scheme, but each medical scheme typically offers a range of benefits, ranging from your very basic cover to a comprehensive cover. Some medical schemes will offer a huge number of different options for members to choose between, whereas others offer only one.

In this graph here, we've plotted the number of medical scheme members based on the number of beneficiaries. What you will see in this graph, is the red line represents the restricted medical scheme members. The blue line represents open medical scheme members and then the dotted line is the total between open and restricted. As you can see in this graph, the number of open scheme members has remained fairly consistent during the 10 year period from 2004 to 2014. They did dip slightly in 2007 and then it has increased again somewhat, whereas what you will see in the red line which represents the restricted schemes, there has been an increase in the number of membership particularly around the 2007 period. This could largely be attributed to the entrance of the government employees medical schemes

GEMS.

What this table shows is the top 10 medical schemes based on the number of beneficiaries, so just for clarity, beneficiaries includes your main member as well as your dependents. In this table, you can see the 2 largest medical schemes Discovery Health Medical Scheme which is an open scheme and the government employees medical scheme which is a restricted scheme, have a very large number of beneficiaries compared to the third largest which is Bonnitas and as you look down the table, you will see the number of members decline quite rapidly through the top 10.

What you can also see from this table, is that there are 7 open schemes in the top 10 and only 3 restricted and that in a way makes sense because a lot of the restricted schemes are quite small employer based schemes. Medical schemes are regulated through the Medical Schemes Act Number 131 of 1998. Very broadly the purposes of the Act include the establishment of a council for medical schemes and then also to appoint the Registrar for Medical Schemes.

It makes provision for registration and control of certain activities of the medical schemes and it is to protect the interests of members of the medical schemes. It also provides measures for the coordination of medical schemes.

Well I won't go into detail on a lot of what is covered in the Act, but it will be important to touch on a couple of points that will come out quite a bit through the public hearings and were also key features in the submissions that we have received.

The first one that I would like to talk about very briefly, are prescribed minimum benefits. These are where medical schemes are required to provide minimum benefits regardless of the benefit option that the member is on. The aim of this is to protect the members against catastrophic health expenditure. The Minister of Health prescribes the list of these minimum benefits to be covered and what they are, is that the medical schemes have to cover in full the costs related to the diagnosis, treatment and care of any emergency condition and then a set of two hundred and seventy medical conditions and then twenty five chronic conditions.

Two others that are worth touching on, are community rating and open enrolment and community rating really refers to where medical schemes cannot differentiate members contributions based on the age or health status, so where a member is older or sicker, they cannot be charged a higher premium to someone that is young and healthy for example. This ultimately

removes the ability of the medical scheme to risk rate.

Open enrolment is where medical schemes cannot deny membership to applicants of a medical scheme. This means that they cannot risk select, meaning that they cannot only decide to take on the young and healthy members when an older or sicker member may wish to join. However, there are 2 things that are important to bear in mind here, that medical schemes can charge a late joiner penalty if a member is over the age of thirty five and they can implement waiting periods in certain instances.

Next moving onto medical scheme administrators, so the running of a medical scheme requires quite a lot of administration functions as well as a sophisticated IT platform to make payments to the required providers of healthcare services. There are some medical schemes that will provide these services in-house throughout their own systems and they called the self-administered medical schemes, whereas a large number of medical schemes were opted to contract their administration functions to third party administrators.

These third party administrators are for profit entities and they require accreditation with the CMS. Very broadly, the types of services that

administrators provide include membership record management, contribution management, claims management financial management reporting, information management and data control and then also customer services.

In South Africa we have seventeen active administrators with the 5 largest that I have listed here as Medscheme, Discovery Health, Metropolitan, Momentum and Strata Health. What is important to note in this, is that this is based on the number of beneficiaries from the CMS calculations. What this does do, is it includes GEMS members and beneficiaries in both Medscheme and Metropolitan as they are both administrators for GEMS, so there is somewhat, a duplication in this, but regardless of that, there are your 5 largest administrators.

Then we've got thirteen self-administered medical schemes in the country and the 5 largest of these ones are Best Med, Medshield, SAMO Med, Platinum Health and Umvuzo. In the next category that we will talk about now, are the managed care organizations. These are organizations that contract either with the scheme or the administrator and they seek to aim control of healthcare costs and the quality of care.

It is also important to note that they are for profit entities and there are forty two registered managed care organizations. A lot of time, the managed care organization functions are also provided by an administrator and they are then accredited for both managed care and administration services.

The CMS classifies managed care services into 7 categories. These categories include hospital benefit management services which, is, your, pre-authorization, your case management and your clinical audits. You also have pharmacy benefit management services, active disease, risk management services, disease risk management support services dental benefit management services and managed care network services and risk management and then healthcare services.

The next category that we will touch on, are health insurers. These are quite different to medical schemes and there is quite a variety of products that health insurers offer. I have only mentioned here the top 4 or the 4 that seem to be more common that a lot of the others and even within each of these, there are variations of the types of products. The first one is your dread disease or critical illness cover. This is where the health insurer will pay the insured person a cash payout typically in the form of a lump sum if the

insured person is diagnosed with this specific critical illness that is covered by the policy.

The next type of health insurance product is your gap cover. This is where the insurer will pay the difference between what the provider charges and what the medical scheme pays. Again it is typically paid to the individual and then that individual will then pay the provider directly.

The next category, are your hospital cash plans. What these are is where they will pay the member a specified amount if the member is hospitalized. It often comes in the form of an amount per day that the member is in hospital and again, this amount will be paid directly to the member and not to the hospital where the member is receiving the treatment.

Finally, the primary health plans, is where the insured person will be able to visit a GP, dentistry, may receive some basic radiology and pathology and these amounts are generally covered by the health insurer.

Health insurance is regulated by the Financial Services Board and the 2 Acts that are important for them are the Long Term Insurance Act and the Short Term Insurance Act. It is important to note that the health insurers have a

very different environment that they operating in. They do not for example, need to cover prescribed minimum benefits and they can risk rate, so they can vary premiums for their members based on their health and age at the time.

As Sipho mentioned earlier, there is a lot of information asymmetry in the market and individuals are often faced with very difficult decisions on what insurance product or medical scheme to join and then within a medical scheme, which benefit option to select. This is where brokers play a critical role in providing this type of information to the member or a potential member and then as well as employer groups. There are various types of brokers. You have independent brokers which represent a variety of different medical schemes and provide information on the different medical schemes as well as health insurance products.

You also have your tied brokers which will then provide a particular product of a particular company or scheme or insurance company. Brokers that wish to sell medical scheme products require accreditation from the CMS and a license from the FSB and if either one of these are removed, the broker can no longer sell medical scheme products.

The Medical Schemes Act stipulates amounts that medical schemes can pay brokers from their monthly contributions. This amount is adjusted over time and the amount is gazetted. As I mentioned earlier, there are 2 other ways that individuals can assess private healthcare, is through the Road Accident Fund and the Compensation Fund, so the Road Accident Fund is generally where a member of the public is in a car accident and requires medical treatment. The Road Accident Fund will pay either the member or the member's family for the medical and related expenses. The contributions from this come from the fuel levy.

The Compensation Fund on the other hand, provides compensation for occupational injuries, diseases that have been sustained or contracted in the place of work. The Compensation Fund generates revenue from the levies that the employers pay. Back to Sipho thank you.

MR MTHOMBENI Thank you Pamela. I am going to talk through the suppliers and supporting players. You would have noted that from the statement of issues, there was no specific [indistinct 1:04] that related to suppliers and other supporting players that I am going to talk to now. However we found that it would be important that in order to get a full

understanding of how the sector operates, would be to engage with everybody in the sector and through a number of series of desktop research and interviews and other forms of investigation, we then pulled through this information we deemed as relevant.

In relation to suppliers when we refer to suppliers here, we refer to those companies and those firms that are providers of medical devices, technology, pharmaceuticals and consumables. What we have noted, is that in the sector, there are a number of regulators from the MCC which for instance regulates the clinical trials and regulation registration of medicines which is soon to be replaced by SAPHRA. We have noted that through the SABS, is also relevant in this sector and the next one which is the National Regulator of Compulsory Standards which acts behalf of the State to regulate and comply with obligations of the WTO.

We have also noted that SANAS is also a relevant regulator in this sector which accredits certification bodies in the medical device industry.

In relation to supporting players and what we refer to as supporting players, we have noted that there a number of other players in the sector who don't necessarily fit into the other categories that we have described thus far. The

first one I will talk to is the Medical Switches. The role of the medical switches companies is to process claims between healthcare providers, so your, practitioners and your facilities and the finances, so that is your medical schemes in real time.

The second group that we have there are those companies who provide practice management services and what they do, is that they provide services to healthcare providers in order to ensure that they are able to provide their services in a cost effective manner.

The third group that we have there is the software vendors and these are vendors and people sell software that is made use of in practices who are in the day to day operations of a medical practice. There are specific vendors who provide these services.

Other supporting players we found are clinical coding companies these talk to the clinical codes that are used in the sector providing the numeric codes describing the diseases, injury or procedures that are being conducted in the sector. We have also noted of relevance would be malpractice insurers and these are people that provide insurance cover for healthcare providers both in

the public and private sector for instances where there is a malpractice claim that may come about.

This brings us to the end of our presentation. As I mentioned that this work forms part of a research report that was done by the Technical Team, we do intend to publish it in due course. We welcome and do invite stakeholders who do have input. As I mentioned, this is really just a summary of what is contained in that report. If stakeholders do have input to provide to the Technical Team in this regard, we do welcome it and obviously our contact details are, I just noted actually that the contact number that is there, is not correct, but most stakeholders would have our contact details, thank you.

JUSTICE NGCOBO Does that conclude your presentation? All right, but you are supposed to finish at 11:00. Okay so we must have over-budgeted, thank you for the presentation. The next person to make the presentation would be Ms Angela Drescher?

ADV PILLAY SC That is correct Chair, it is Ms Angela Drescher.

JUSTICE NGCOBO Okay is she in a position to commence with her presentation? We are due to break for tea in about twenty minutes. We can

take the tea now.

ADV PILLAY SC May I, suggest, that we take the tea now, just to give Ms Drescher time to settle in.

JUSTICE NGCOBO Yes very well, can we then take the tea break now and then return at 11h00.

ADV PILLAY SC That would be perfect thank you Chair.

JUSTICE NGCOBO Ladies and gentlemen can we break at this stage and then we will come back at about 11:00 to proceed thank you so much.

[END OF FIRST SESSION]

[START OF SECOND SESSION]

JUSTICE NGCOBO Good morning Mam. Could you press the red button on your microphone so that you are on record? I understand that you want to talk to us about the, is it the prescribed minimum benefits?

MS DRESCHER In particular yes.

JUSTICE NGCOBO Yes very well, do you want, to, proceed thank you?

MS DRESCHER Thank you, my name is Angela Drescher. I had seventeen years' experience working for the Stannic Asset Finance Division of the Standard Bank Group in a senior position when I left there eighteen years ago, which sort of gives me quite a good grounding for analyzing products and looking into legislation and financials and so forth.

Twelve months ago, I didn't know what prescribed minimum benefits were at all and I consider myself to be a very well informed consumer. My particular medical aid scheme is Discovery Health and although I will be referencing Discovery Health during my presentation, from what I have gathered with the people that I am working with and have spoken to, the practices are occurring across the whole spectrum of medical aid schemes.

I do also want to say upfront that Dr Johnny Brumberg from Discovery Health and I have been communicating a lot and at the moment, I am working with their marketing team to try and improve brochures and various other methods of improving the disclosure and transparency of prescribed minimum benefits to their members. I just want to say that upfront.

I am going to start with just explaining from a consumer's point of view, or to assist consumers, what are prescribed minimum benefits. Anyone who is on a

medical aid scheme, has to be given cover and it is a minimum cover that you would receive in a Government hospital according to the State hospital protocols for two hundred and seventy illnesses

In addition to that, there are the chronic illnesses like diabetes and epilepsy, bipolar disorder, hypertension etcetera which are also covered under prescribed minimum benefits, but they have further cover specifically medication according to a certain formulary that each medical scheme has. These two hundred and seventy prescribed minimum benefits are listed in Annexure A to the Medical Schemes Act. They comprise of three hundred and forty three pages of what are called ICD10 codes. An ICD10 code is a code specific to a particular diagnosis. The prescribed minimum benefits are listed in order of body organs, like the endocrine system, mental health, brain, cardiovascular etcetera, so from that point of view, they are quite easy to navigate.

The thing about prescribed minimum benefits is that the wording that I find very pertinent is they call them diagnostic and treatment pairs, so in other words, your medical practitioner will diagnose you with one of these illnesses, your medical scheme doesn't diagnose you, neither does your

pathologist and your medical practitioner will or should discuss the treatment options that are available under these prescribed minimum benefits.

This does not happen in many cases. Once you have seen your medical practitioner and they invoice you or your medical scheme and you submit a claim, there is a specific code called an ICD10 code which is a specific diagnosis, so I am just going to give you an example of major depression. There is an ICD10 code for major depression, current episodes severe with psychotic symptoms, then there is another code for major depressive disorder currently in remission or major depressive disorder recurrent and so under each heading, there is a different code for a different aspect of the diagnosis that that person would suffer from.

The other thing is the designated service providers. These are just terms that are used a lot in the brochures they used online, just to tell you what those are, designated service providers are medical professionals that have a payment arrangement with a medical scheme. Now I found out last week with Discovery, that there are actually 4 different levels of designated service providers where payment is from 100% of benefit up to a 167% of benefit, it depends if you in hospital or out of hospital and it also depends on the plan

that you are on, but if you diagnosed with a prescribed minimum benefit, it is advisable to phone your medical aid and find out which designated service provider you should go to.

But I do want to mention I did this and I discovered that there are only 2 endocrinologists listed in Cape Town, so obviously that is not working too well either. My big question across the whole year that I have been studying this is whose responsibility is it to inform the member or patient that the illness that they have been diagnosed with, is a prescribed minimum benefit. I have posed this question to the medical scheme, the Health Professions Council, the South African Medical Association, the Health Professional Council of South Africa and even the Department of Health. I have yet to receive a satisfactory answer.

So when I started with this, on the 17th of December 2014, I had not heard of PMB's. We have been members of Discovery Health since August 2004. In the 2015 brochure, prescribed minimum benefits are mentioned on Page 25 and 26 of thirty two pages. Since I have been working with Discovery, they now have an eighty page booklet, so there is a lot more information in there which is wonderful. The prescribed minimum benefits now take up a full

page, not a small paragraph and they round about Page 6 of an eighty page brochure. So that in itself is a really big improvement for the patient or member. I still don't think it goes far enough.

However, the chronic illnesses, those twenty seven chronic illnesses are referred to very frequently, they are listed and there is a lot of information about them, whereas in the past, prescribed minimum benefits were just mentioned in passing like they were unimportant, which is one of the reasons that I never took any notice of them.

My son was diagnosed with clinical depression in September 2014 and I tried to get therapy cover for him and I was told only bipolar disorder is covered. I was told that by both the medical scheme and the psychiatrist. I reported the psychiatrist to the HBCSA, I was told that the only cover that we have, is to put him into hospital, so we put him into hospital, but it was like he says being in "juvi" because it is more like a rehab facility with people with substance abuse problems and he only spent 1 day there. Incidentally the psychiatrist billed 4 therapy sessions in 1 day, that didn't happen, so there is a lot of room for abuse there.

We then ourselves paid for his therapy. Then on the 17th December, my husband diagnosed with a life threatening illness called Hyponatremia which is low blood sodium and he has a hormone that causes salt wasting and causes the body to retain water in all the cells and what happens, is that all the cells in your body swell including his brain and brain edema can be fatal. I applied for his PBM and it took 7 months to get it approved. It was only approved when he threatened to stop his salt tablets. Then it was approved the following day.

I re-applied this year and even attached his approval from last year including the pathology reports, recommendations from the doctor everything and it was declined again and I actually, in me it caused a complete traumatic panic attack when that happened and my husband on the other hand, is a diabetic and he had a hyperglycemic episode, because we were so shocked that this was now declined. I went to Hello Peter, I in-boxed the CEO and within a day, we not only got an approval for it, but we got a lifetime approval for it, but not everybody has the knowledge that I have and the will to fight for these benefits.

So I want to read an extract from a brochure that was issued by the non-profit

organization Section 27 which really resonated with me and it says the National Health Act refers to users instead of patients, clearly signaling that people who utilize health benefits, are no longer to be regarded as passive recipients of a service for which they should be grateful. Instead, they are seen as people who choose to make use of a particular service and should be titled to a certain standard of care and respect.

I think that particular statement is so true and it isn't being applied and I work with a lot of consumers and we do not feel empowered in any way. Having myself been treated in a condescending, intimidating, disrespectful and uncaring manner by representatives of a number of medical sectors including medical practitioners, medical aid schemes, the HBCSA, Department of Health and Council for Medical Schemes when trying to secure legitimate PMB cover for my husband and my son, I never once felt like an empowered user, not even last week, but instead at worst, like a victimized and violated subordinate and at best, like a bothersome annoyance.

Through a private healthcare social media group, I have interacted with other health service users and I do want to just mention here that there are many people who work for healthcare providers who are members of our group,

including the CEO of Discovery Health, so it is an open group that anybody can join and yes people do rant and vent on there, but there is also a lot of help that takes place and a lot of practical information that we post and so forth, so we are trying to use it constructively.

The general feeling amongst these people is sheer desperation, frustration, trauma, bullying and victimization and while this statement may appear emotionally and perhaps over-dramatic and I am referring to real people, I brought some case studies with me, I have Baby A, they wish to remain anonymous, she was diagnosed with bronchiolitis, asthma caused by the RSV virus, she had an emergency hospital admission until she fought for it, her benefits were not covered.

Amore Jooste, her son had an emergency hospital admission for testicular torsion, there was a co-payment on the bills she also has bipolar disorder she has always paid for her psychotherapy from her medical savings account.

A lady by the name of LeeAnne who has since left the country, she applied for cover and failed to mention a common urinary tract infection on her application form. She subsequently developed a tumor on one of her…

JUSTICE NGCOBO Mam excuse me, now you are giving us names of individuals, now do you have their authority?

MS DRESCHER I do. If I don't, then I will use Baby A and if I do, I can use their names.

JUSTICE NGCOBO What assurance do we have that you have that authority?

MS DRESCHER I have given in my file which I gave to Pamela Halse, there are copies of some of the people that have approved and then the more recent ones, I do have on social media and I can screen grab those copies and give them to you.

JUSTICE NGCOBO Because I would like to make sure that the names that you are mentioning, have authorized you to mention their names.

MS DRESCHER So LeeAnne was discovered to have a tumor on her ovary which is a gynecological issue, because she failed to disclose a visit to a doctor for a urinary tract infection, she was actually rejected off her medical scheme. Another sweet old lady who has 4 chronic illnesses, it is diabetes,

hyperthyroidism, hypertension and hyperlipidemia she is only given 1 consultation per year to see either a GP or a specialist.

Cheryl Naranskie who will be speaking at the hearing as well, her daughter had a motor vehicle accident, the Council for Medical Schemes ruled her in favor 2 years ago, she is still waiting for the medical scheme to pay her bills.

In my own case obviously, my husband and my son and then Dev Baxter whose story I will read later who fought for her comprehensive R400 000 oncology benefit which she was denied for so long, that when the treatment was approved, it was too late and she passed away on 10th December 2015.

Then only last night, I got another query from a lady who I am going to help whose 3 year old son was bitten by a cobra, has been in ICU I think for 3 or 5 weeks, all kinds of co-payments and non-payments are coming up. The thing that strikes me, is that these people are at their most vulnerable and they are being treated inhumanely and in my own personal case and I am a very strong person, when I was fighting for our family's benefits on 2 occasions, I was almost hospitalized for post-traumatic stress disorder, so just to put it into perspective, it may sound like an over dramatization of the issues, but it really isn't and so many people just give up, they just give up.

JUSTICE NGCOBO Mam can I ask you this question? The individuals that you have just mentioned, including your husband and your son, they have all been trying to get prescribed minimum benefit is that right?

MS DRESCHER That is correct.

JUSTICE NGCOBO And initially they were all denied?

MS DRESCHER Yes.

JUSTICE NGCOBO And eventually they were approved?

MS DRESCHER Approved, because I fought very hard. In other cases, I have helped people get them approved and in other cases, they are still pending.

JUSTICE NGCOBO From your experience and in interacting with these medical aid schemes, what, is the reason that is given, for this delay, in according these benefits?

MS DRESCHER They just mention it is not in the basket of care, or it does not follow the clinical guidelines.

JUSTICE NGCOBO What makes them eventually to change their mind and say they are covered?

MS DRESCHER My husband threatening to stop his medication, which would have meant he would have landed up in hospital in a week. They refused to pay his medication, so he said well fine, then he is not going to take it anymore, because you say he doesn't need it and the next day I got a full approval not just for this year, but for lifetime.

JUSTICE NGCOBO When it is subsequently approved, do you get an explanation as to why there was this initial resistance?

MS DRESCHER It was a mistake, but it is 2 mistakes in 2 years with the same illness for the same person, I don't buy that.

JUSTICE NGCOBO Who is making the mistake?

MS DRESCHER The medical scheme said that the person who rejected it, made a mistake.

JUSTICE NGCOBO Is that in the case of your husband?

MS DRESCHER Yes. With the application, I actually filled out the

forms myself using the codes on their approval from 6 months prior, so they had all the information they needed. They had the discharge letter from the hospital, the recommendation from his endocrinologist they had a wealth of information. I was so certain that I had done a good job that it would be automatically approved and I thought I would be able to come here with good news and say if you do this right, it is going to be approved and then when we got the rejection letter, I was physically ill. I thought well what more can we do. It almost felt like randomly things are rejected and hoping that we will roll over and just give up and I have access to the internet, I have got access to a lot of knowledge, I think about like Mo Haarhof, she is an elderly lady, she is a pensioner, she doesn't have the knowledge that I have, she is at such a disadvantage.

JUSTICE NGCOBO Having regard to your experience in dealing with medical schemes in respect of the individuals that you have mentioned, can you tell us what is the reason for this? Is it because it is not clear what is or isn't covered, or are there some other reasons?

MS DRESCHER No I am going to get into that now, because it is to do

with coding. If I follow through here, it should become clearer if that is okay.

JUSTICE NGCOBO As long as you get to that at some point.

MS DRESCHER I am going to get to it very shortly. What I have used as the basis of my presentation, is a document called the Code of Conduct in respect of PMB benefits and I am going to read from it. The Department of Health with the assistance of the Council for Medical Schemes and Health Profession Council of South Africa, held a workshop with affected parties on 11th May 2010.

Parties to this process have agreed that it is in the best interest of the medical scheme members to proceed with a collaborative process whereby solutions to PMB problems could be found, which has led to the establishment of a representative task team. This was during June and July 2010. The task team consisted of 4 members each from 4 different groups made up of representatives from organs of State, medical schemes, administrators, healthcare providers and members of medical schemes and consumers.

The immediate objective was to develop a code of conduct whereby PMB's could be offered to members of medical schemes in compliance with current

legislation. The forth draft was issued by the full task team on 30th July 2010 at which point sufficient consensus was reached to ask the Secretariat to make minor changes to the version of the code for sign off by electronic mail on Monday 2nd July 2010.

It was signed off by most of the task team members, if you Google the code of conduct, it is all there. There were a few of the stakeholders or task team members that wanted clarification on certain issues.

Part 1 was the accessibility of information on access to PMB benefits, including the use of designated service providers, educational efforts by stakeholders in respect of the PMB's. While recognizing that it is not possible, practical or helpful to provide members with all information relating to the coverage of every possible diagnosis at point of entry, pertinent information must be made available when joining a scheme. This information must be updated and communicated at the beginning of each year, or whenever changes are made that directly affect member benefits.

Communication in respect of benefits must be clear, in plain language and must be readily available. The guidelines must consider at least the following matters and access to benefits I took out and the language of communication,

accessibility to older members, the distribution of documents and the role of brokers in such communication.

The process by which members can apply for register for PMB coverage must be made available to providers and members, including the location and contact details of designated service providers and as I have mentioned there when I went online, I could find only 2 endocrinologists in Cape Town.

Registration must prevent re-registration for benefits in cases where conditions are of a chronic nature or where treatment interventions are spread over a longer period. Now I think this is why in the case of my husband now they have given him a lifetime approval, so what I have seen, is most lifetime approvals apply only to chronic benefits. They are not being applied to the PMB's and if you go through the three hundred and forty three pages of thousands of ICD10 codes, I would say that there are many there that should not require re-registration every year and new clinical information, because if you have this illness, you have it for life and the management is the same for life. So that saves everybody a lot of work and a lot of time and a lot of stress.

On request, call centre performance information such as average waiting times, dropped call rates etcetera must be made available to members. I am going to ask for that. Then Part 3, establishing clarity and certainty of the benefits prescribed in Annexure A that is the list of the PMB benefits. Just incidentally there is a copy of this code of conduct on my documentation that I gave to Pamela Halse a full copy.

Where appropriate, PMB's are not restricted to hospital based management, but include appropriate delivery of relevant care on an outpatient basis, or in a setting other than a hospital. That particular point I am going to come to later, but I do think it is something that is being ignored by the doctors. I think it is something that should be looked at a lot more. I believe in the public health system, they are looking at providing more health services on an out of hospital basis as opposed to an in-hospital basis and the difference in cost is phenomenal.

The Council for Medical Schemes will coordinate a process whereby benefit definitions are developed to improve the clarity of the entitlement that members have and the liabilities that medical schemes face in respect of PMB provisions in the Act and regulations. I have written next to there, medical

management under my husband's PMB Hyponatremia, the treatment recommendation is medical management. That is not at all clear and concise, it is open to interpretation. That is certainly not a clear guideline, to the point where I have now written to Groote Schuur Hospital, I have asked Discovery for the protocol and I was referred to the Council for Medical Schemes. They referred me to the Department of Health and nobody could help me, so now I phoned the academic endocrinology department at Groote Schuur Hospital and they are going to give me the protocol for Hyponatremia.

General supportive measures in relation to PMB's including, but not limited to pain management or rehabilitative services, must be included in the benefit definitions. Benefit definitions constitute clear, comprehensive descriptions of the benefits which in terms of the PMB regulations, must be made available for specific prescribed minimum benefit conditions.

Then under Part 5 is the accessibility of alternative interventions where prescribed interventions, scheme protocols or formularies are not adequate or may cause harm to individuals. The manner whereby members get access to clinical appeals process must be communicated and easily accessible. The process of reviewing standard benefits under these exceptional circumstances

must ensure that members and providers are treated fairly and consistently and I would add compassionately.

The onus is on the healthcare providers to supply schemes with relevant clinical information to aid decision making in these exceptional cases. Where alternative treatment is deemed appropriate and meets the criteria for PMB entitlement, payment must be from the risk benefit and may not be paid from medical savings accounts or any other benefits.

Now I believe that that has now been changed and that PMB's can now be paid from day to day benefits as long as they are not paid from medical savings accounts. Since 2010, that legislation has been changed. So if you have day to day benefits for say psychotherapy and you apply for a PMB for depression for fifteen sessions of psychotherapy, that will not come from risk, it will actually wipe out your allied and therapeutic benefit, which means why are you paying for the allied and therapeutic benefit when the person on the hospital plan is getting it out of risk, but I will come more to that later.

Conduct required to accurately identify, PMB conditions and this is where I am going to answer your question. Schemes must capture all submitted ICD10 codes as many of these may trigger a potential PMB benefit. Now I

cannot understand why in the last 6 years with the incredibly sophisticated IT and computer system the medical schemes have, this has not been implemented, because PMB ICD10 codes are put into computer systems, it is not triggered unless you have applied for that PMB, it comes straight out of your savings account, even though the ICD10 code is PMB specific.

Where appropriate, additional clinical information must be used to verify if the claim qualifies as a, PMB benefit. The additional information would include, but is not limited to pathology or radiology results, the drugs used etcetera.

In principle, the onus is on the treating physician to provide a discharge summary that could be used as additional information to assist in identifying PMB claims. Now again in my husband's case, when he was discharged from hospital, the discharge summary was very clear, that he had low sodium levels even when he had the hospital, but he was diagnosed with Hyponatremia, the ICD10 code was correct, but this was not used by the scheme at all, because they declined it.

The onus is on providers to ensure that personnel dealing with clinical codes are adequately trained to improve the quality of ICD10 coding. I know with

the exception possibly of GP's and general physicians, most of the specialists would have only a handful of ICD10 codes that they would need to know, for example if you are an endocrinologist or if you are a cardiac surgeon, you wouldn't need to know them all, so it is not a matter of expecting medical practitioners to know all the codes. As consumers, we seem to be expected to know all the codes.

The onus is on both diagnosing and non-diagnosing providers to submit accurate and specific ICD10 codes on claims to facilitate the identification of PMB benefits and to provide the information considered in Paragraph 3 above. Such pre-registration application or authorization processes must not place an unnecessary burden on and must be readily accessible to patients and providers. That doesn't happen. Registration must prevent re-registration for benefits in cases where conditions are chronic. In a case of emergencies, schemes may not deny benefits, because authorization was not obtained prior to the diagnoses, treatment or care invention.

When my husband was admitted to hospital, we were denied an emergency admission and he had to stay home that night and we only went the following morning and his sodium was so low that his life was endangered for that

period of time. We did phone our healthcare provider for authorization and it was refused.

Schemes must capture authorization information in an electronic extractable format and must keep the original information for at least 3 years. Schemes must again, this is repeated, capture all ICD10 codes and where a valid PMB code is captured, this must act as a trigger for potential payment from the PMB benefit as required in Paragraph 14 below.

Medical schemes claims processing systems must where applicable, automatically pay valid PMB claims from risk pools, not savings accounts. This says all other benefits, but I believe now the legislation has changed and it can be paid from any benefit except the medical savings account.

Then at the bottom, there is a Note 7, the practice whereby non-diagnosing providers including radiologists, pathologists, pharmacists and allied health professionals, submit non-specific Z codes, is not condoned. The diagnosis provided from the requesting provider must be submitted to the scheme. This is a huge problem and one of the things I am going to call for at the end of this on behalf of the public, is an audit of all medical savings accounts. I have my husband's Pathcare accounts, 2014, Z codes, 2015, Z codes, 2016 Z

codes. So what is a Z code is, is your doctor sends you to the pathologist with instructions to take blood or to the radiologist with instructions to take x-rays. The person, who is writing up the report, does not know what the diagnosis is. It could be for any number of illnesses and the x-ray could be for any number of conditions, so Pathcare are not able to put or Tuft and Sons, the radiologists, they are not able to put an ICD10 code onto this account, so they put what is called a generic code, it is a non-specific code.

This account is then submitted directly to the medical aid by Pathcare and because it is a Z code, the funds are paid from your medical savings account. Now what I believe should happen, is that medical aids should refuse to pay these claims altogether and this account must be bounced back to the medical practitioner who must then code it according to his diagnosis and once the PMB application has been submitted, then these pathology and radiology bills which are for diagnosing PMB's, can be paid from the risk benefit, because to do it afterwards, to do all these reconciliations, is a nightmare. I went through 5 months of reconciling accounts and this same thing applies to pharmacy accounts.

I spoke to a pharmacist yesterday and she said they get prescriptions from

doctors for chronic illnesses and they have to look at the medication and guess what the ICD10 code is. The thing that annoys me the most, is that since this code of conduct, there have been 6 years to implement these guidelines and everybody agreed to them and the guidelines have not been implemented, contrary to the letters I am going to read you now.

JUSTICE NGCOBO In so far as these guidelines are concerned, is your concern that they have not been implemented?

MS DRESCHER Yes I would ask obviously in 2010, there was a lot of concern, I think it could have resulted from the Council for Medical Schemes audit of 4 top medical schemes which I have here, which I was going to come to later, but I will read it now.

The Council for Medical Schemes did an audit of the 4 biggest medical schemes, Discovery Health, Medi Help, Fedhealth and Chartered Accountants Medical Aid Fund specifically relating to PMB's, they found that 20% of PMB claims were not paid at all and another 9% were paid from medical savings accounts and that was when [indistinct 43:06] they wrongly deducted co-payments from members savings accounts for 2 years and had to pay members back R9 million, that was in 2009. So I would assume that the code

of conduct flowed from the information that was derived from the audit, but despite all of that, nothing has happened in 6 years.

JUSTICE NGCOBO What do you mean by nothing has happened in 6 years? Is the code not being implemented?

MS DRESCHER If I submit a bill say for my son's psychotherapy, with the correct ICD10, the doctors practice number, the correct treatment code, but say I didn't know it was a PMB, because the consumer cannot be expected to know three hundred and forty three pages of ICD10 codes which are in medical jargon anyway, when that code is put into the medical schemes computer, it should red flag immediately. That consultant or whoever is capturing it should then look to see if this PMB has been applied for. If it has not been applied for, the medical scheme should phone the member and say we have received this account, I am going to send you the brochure about PMB's and this is the procedure you need to follow and that is not happening. It doesn't just apply to therapy, it applies to everything, absolutely everything, epilepsy you see you have to apply for these benefits by filling in forms. The benefits are not automatically given to you when the medical scheme gets that code, but if your doctor is not disclosing to you that it is a

PMB and your medical scheme is not flagging the code as a PMB, how as a consumer, do you know that it is a PMB and so it is paid from your medical savings account.

I want another audit done of all the medical savings accounts of all the medical aids and I want every single ICD10 code that is PMB specific, to be pulled out and I want them looked at, because I think the findings are going to be mind boggling, just from the very small portion of people that I have spoken to.

I have a friend with bipolar disorder she has paid for her own therapy for twenty years. She submits the accounts to her medical scheme, but nobody has ever told her that in terms of the PMB, she gets fifteen sessions of therapy per year, so she has paid for her therapy for the best part of twenty years. She is never going to get that money back. To me, what is the point then of having PMB's, although I think that PMB's are fantastic, they have a very valid place in the healthcare market.

I think the last point on this, schemes should ensure that staff managing registration applications or authorization requests and claim queries, are

adequately trained subject matter experts who can promptly and effectively respond to and assist members and providers with these enquiries.

Unfortunately and I don't know how the other medical schemes work, Discovery have a call centre and you can only phone it if you have a phone that allows you to use voice activated prompting. I can't phone Discovery on my cell phone unfortunately and I am sure there are a lot of people in perhaps in the townships, who have old phones like me and do not have landlines, there is no way for them to contact the call centre, so that is another issue.

So as far as resolving PMB problems, what I have found, is the most efficient way to get a PMB approved and sorted out, is to complain to Hello Peter and the Discovery Health staff in particular, who work on the Hello Peter complaints, are compassionate, very well educated, wonderful people to deal with, very efficient and I cannot praise them enough. They really set a standard for what the other consultants should be aiming at. I mean the one phoned me the other day because he helped us last year, he had heard that I was having another battle and he just phoned me of his own accord to find out how I was doing, how everything was going. You really feel like you are dealing with somebody there who has your interests at heart and not just

reading from a script. So that is the code of conduct.

Another issue that I am going to come to, well in fact before I read that, I am going to read you this letter, I am not going to mention her name, but a senior person at the Council for Medical Schemes. The PMB code of conduct is widely used by most medical schemes, that is, a lie. The reasonable co-payments and co-payments from medical savings accounts are still governed by the Medical Schemes Act and medical schemes have to comply with the Act.

The PMB code of conduct is a live document and is being addressed continuously. I don't believe that. Then she writes we have actually noted from complaints that some major depressions are up-coded to bipolar disorder. Now why would you up-code major depression to bipolar disorder when they are exactly the same PMB? The only other benefit you get on bipolar disorder is you get a generic medicine costing a R100 paid for. Other than that, I can't see any medical professional putting his job on the line to up-code a diagnosis to get a R100 medication paid for. So major depression and bipolar disorder are the same PMB and they have the same benefit.

Then another one which is from a gentlemen from Discovery Health, I won't mention his name, Discovery has actively participated in the Council of Medical Schemes Task Team for PMB's which produced an important document as the guideline to the schemes, I would assume the code of conduct. The schemes members and healthcare professionals setting out how PMB's should be handled, Discovery implemented these guidelines. That is not true, they have not been implemented.

I then also complained to the Department of Health about whose responsibility is it to inform the patient or their guardian or relatives that the condition diagnosed is the prescribed minimum benefit legislated in the Government Gazette, that was around 15th March. I got a reply on 27th July to say sorry for the delay, please be advised that as discussed the National Department of Health in conjunction with the Council for Medical Schemes, the Board of Healthcare Funders and representatives are meeting on 7th August to commence work on all the challenges experienced in relation to PMB's, I will relay your challenges experience to the chairperson for discussion. I have received no further answer to that either.

Then another issue was when my son was diagnosed with depression, he was

eighteen years old. He was prescribed a high dose of an antidepressant by our ex-GP with the diagnostic code of depression contrary to the recommended national health protocol which states adolescents with depression should be treated by specialists only due to the increased risk of suicide ideation when treated with SSRI's. Unfortunately in many cases, when these people are diagnosed with depression, there is still a perception that they are treated by their GP as opposed to a psychiatrist. In our case, there was no referral to a therapist. Over 4 months his conditions had not improved.

We took him to a psychiatrist and she diagnosed him with major depressive disorder and severe anxiety disorder, but again when I asked about therapy, both the psychiatrist and the medical scheme told me that cover for outpatients, psychotherapy was only available for people with bipolar disorder. This I later found was incorrect. Major effective disorder is a PMB and you have the option of 3 weeks in hospital or fifteen sessions of therapy, outpatient therapy.

The next thing I did, was I initiated and collaborated on an investigation and subsequent articles published in the media. The first one was by Laura du Preez of Personal Finance which was again about my issue trying to get cover

for my son. It says how I tried to lay complaints with people and did not get anywhere.

Council says that if the responsibility for informing you about PMB lays solely with the doctors and other healthcare providers, providers could find themselves in an ethical quagmire because they would have to decide whether that particular treatment was in your interest medically or financially. She says the fact that you belong to a scheme, creates a third party payer arrangement which should not add to the legal responsibility of providers, however these arrangements put an additional burden on members who have to interrogate not only the clinical jargon, but also sometimes the complex funding permutations in scheme rules and she is a very seasoned journalist when it comes to prescribed minimum benefits.

She has been writing articles for years and she says I couldn't agree more with Ms Drescher even as a relatively informed writer of medical issues, I found it difficult to navigate the PMB's. I am sure many consumers are either unaware of the benefits to which they are entitled, or give up after a medical scheme refuses to acknowledge that the claim is covered by PMB's. Can you really describe as clear information the publication of a list of clinical

conditions and their related ICD10 codes as they appear in regulations that are largely incomprehensible to ordinary mortals, although there may be merit in the argument that there should not be conflict between doctors treatment, recommendations and the benefit to which you are entitled, the reality is that the doctors often have conversations with patients about the treatment they can afford. It is not helpful if in the course of that conversation, you ask a doctor if a condition is a PMB and the doctor's response is, what is a PMB?

There was another article written by Leane Janse van Rensburg in Rapport which related specifically to pathology accounts and radiology accounts that need to be recoded to change the generic Z code to the actual diagnostic code.

Then my husband gave me a media article by Money Web where again it was mentioned that bipolar mood disorder is eligible for PMB coverage, but other forms of depression are excluded, so I phoned the journalist who wrote this and sent her the list of PMB's and where it states that major depressive disorder is a PMB. She subsequently wrote a really brilliant article about the list medical schemes won't give their members.

They phoned medical schemes, the replies from the medical schemes ranged from that they don't have the list, that the list is for internal use only, refer to

the Council for Medical Schemes which at that stage, didn't have it on, but has since put it on and the gentlemen Craig Burton Durnham said schemes have a legal obligation to inform members proactively of the benefits they are entitled to if the member for example, submits a claim for a condition that may qualify as a PMB without realizing that it does. If a scheme rejects a PMB claim, it has to give reasons.

Unfortunately and this is what the Council for Medical Schemes is saying, the CMS said schemes often only cover it when you moan and then at the end, I put a guideline to people, discuss with your doctor if your condition is a PMB and check the list, get the form from the scheme to register your PMB. In consultation with your doctor, get the correct ICD10 code and make sure that all invoices, prescriptions, pathology reports and pharmacy prescriptions are correctly coded. If you are not satisfied, appeal and if you are still not satisfied, go to the Council for Medical Schemes. If you are still not satisfied, go to Hello Peter.

As a result of this article, that got three and a half thousand shares on social media, Best Med wrote to all their members and they wrote a full 2 page article alerting their members to very concise information about prescribed

minimum benefits. In addition to that, most of the medical schemes do now have a list or a link to the list on their websites. So that is a start.

Another issue and this is where the change happened from 2010 to now, in 2010, PMB's could not be paid from day to day benefits, they now can be, so if you take the basic plan, we have a pretty basic plan Coastal Saver with a medical savings account, our PMB's are paid from the risk pool, but if you elect to pay an extra R4000 a month for a comprehensive plan, your PMB's are actually paid from those extra day to day benefits that you are paying for and that doesn't make sense to me. Once those benefits are exhausted, it then has to be paid from your medical savings account and once that is exhausted, you have this threshold, this self-payment gap that you have to cross until you get to this threshold when they will pay again.

Even after a year of studying all these schemes, I still can't get my head around these eighteen different plans and the different baskets of care that they have. It is so intricate and it is so involved and it is certainly not accessible to the average consumer.

I have written here draconian and tedious regulations and procedures are implemented by medical aid schemes in what is perceived by members to be a

deliberate strategy of evading or deferring both authorization and payment of PMB's.

Asking repeatedly for PMB forms to be resubmitted as codes are unclear, practice numbers are unclear, when clearly they are not unclear. Requesting repeatedly for medical professionals to submit and resubmit motivations, clinical reports, diagnostic tests, sometimes years after the original diagnosis, a member of our social media group was asked for thirty four years of medical history. Another had to ask twelve specialists to compile a monthly progress report backdated 3 years after her daughter had been severely injured in a motor vehicle accident and this was after a CMS ruling in her favour. She is going to be speaking at the Commission.

The member has to speak to a different consultant every time they call for progress on a pending authorization, claim or payment. Even though notes are made with respect to the call, surely a lot of information and important details could be lost in interpretation. I logged a total of fifty five calls in 3 months while trying to secure PMB benefits for my son and my husband. Many calls are not logged at all and then as I said earlier, you can only phone the call centre if you have a fairly updated cell phone, because you get to an

answering machine and there is a voice prompt press 1 for health or press 2 for Vitality. I can't do that on my phone. If I am a person who is more impoverished and I have a cheaper phone which I paid cash for at Pep Stores and I don't have a landline, I am not able to contact the call centre at all and that is a problem.

Many of the senior consultants robotically repeat words when it comes to emergencies for example, like loss of life or limb when referring to PMB's, loss of life or limb. Menopause does not result in potential loss of life or limb, but it is a PMB. Sometimes with emergencies, a specialist can undergo various diagnostic tests to find out what is causing that particular PMB illness or illness in general. At any stage during that diagnostic process, the severity of that illness can escalate to a point where it becomes a medical emergency and there needs to be an emergency hospital admission.

In my husband's case, because the doctor suspected that his Hyponatremia could have been caused by his blood pressure tablets, they changed the blood pressure tablets, re-did pathology tests and it was still dropping, but not yet bad enough to send him into hospital. Then they did other tests, but then a test was taken where it was now life threatening and he had to go straight to

hospital and the endocrinologist was actually on annual leave and he phoned a partner to assist my husband and again in this particular illness, there are 2 types of Hyponatremia, acute and chronic, my husband has chronic. If you treat chronic Hyponatremia the same way as acute Hyponatremia by bringing the salt levels up quickly, you will kill the person, so it is not like I could just phone Discovery, get a DSP and they could help my husband. There needed to be communication with my husband's endocrinologist, so in my husband's case, his was declined, emergency was declined, because the diagnostic process had taken place over 2 weeks, but it wasn't an emergency at the beginning because it could have been a simple reason for, they could have changed his medication and it could have been fine, but after running a number of tests, it became an emergency and it became life threatening, but I was told that because he had already been treated for 2 weeks, it wasn't sudden onset. I am not happy with that explanation, because I am sure there are other illnesses where diagnostic work is done, but at a point, they escalate to a point of severity where there has to be an emergency hospital admission.

JUSTICE NGCOBO Excuse me Mam, can you indicate at this stage, how far are you with your presentation?

MS DRESCHER We are getting very close to the end.

JUSTICE NGCOBO We would like to hear and to listen to every word you want to tell us, but at the same time, we do have some other individuals who would like also to have their day here.

MS DRESCHER Okay I am watching my time.

JUSTICE NGCOBO I note that in your written statement to us, you did refer us to certain recommendations that you would like to see.

MS DRESCHER I will read those.

JUSTICE NGCOBO I would be grateful indeed if at some point, if you could come to those recommendations.

MS DRESCHER Okay.

JUSTICE NGCOBO Thank you.

MS DRESCHER The other points I will go through a bit more briefly. I do think in the case of medical practitioners, not all instances, but in some instances, patients are just automatically hospitalized because it takes away the burden of paperwork, where possibly it could have been treated on an out

of hospital basis. In the case of my son, a 3 week stay in a psychiatric institution would have cost R106 000. Fifteen sessions of outpatient therapy cost R9000. That is difference of R97 000. Even if the therapy which I think it should be, was updated to weekly therapy or fortnightly therapy, the cost would still be between R25 000 and R35 000, still a fraction of the crisis management of 3 weeks in hospital which in the long term, is not going to help that person.

JUSTICE NGCOBO I wonder if I can just take you back to a matter that you raised in your oral submission. I think it is at Paragraph 11, where you talk about the difference between what you were quoted and what you paid. Could you please that to me, how that happened?

MS DRESCHER Okay my son's psychiatrist decided that he needed to be put into hospital. Now, my son, has no behavioral or substance abuse issues, so it was absolutely not the right environment for him, at all. He was only there for 1 night, but the quote that we got from the clinic for 3 week hospitalization including psychotherapy or electroconvulsive therapy and medication, totaled in the region of R106 000. That is the one option of

treatment of that PMB.

The other option of treatment on that PMB of major depression or bipolar disorder or unipolar disorder, is fifteen sessions of outpatient therapy. My son's psychologist charges R600 a session that totals R9000 for the whole year. Now in my son's case, that last about 3½ months. We then paid for his therapy for the rest of the year. This year we have decided to use that fifteen sessions wisely and because he has learnt so much last year, we are now doing his therapy fortnightly, so now the fifteen sessions should last 8 months which means we only have to pay 4 months out of our pocket.

But what I am saying is that my son went from not leaving his bedroom and being suicidal to passing Matric with a Bachelor's pass 2 distinctions and he is starting university tomorrow. He plays golf, he fishes, he goes to gym, the change in my son was phenomenal, whereas I know other teenagers who went to hospital for 3 weeks who were exposed to drug addicts and people with substance abuse and behavioral issues, who 2 months later, needed to go back to hospital because there was no further therapy provided.

That to me is a serious concern. My son is actually telling his story at the Commission in Cape Town so I don't want to speak too much about him he is

actually going to do it himself. What I am saying is that the difference between out of hospital and in hospital is huge. I think doctors are putting people into hospital not all the time, but in many instances, it takes away the burden of administration and I think that that is something that needs to be looked at and another thing that has to be looked at is, if a person has been in overnight and they are ready to go home at 2:00 in the afternoon, they should be allowed to go home at 2:00 in the afternoon, but that day should still be paid for. It should not be said that because he didn't stay another night, you have to pay for the second day. That also happens, so doctors keep patients in for 1 extra night even though they are finished with the patient at 2:00 in the afternoon and I am not mentioning names, but that does happen.

What I do want to read is my reply from the Health Professional Council of South Africa when I laid a complaint because my son's psychiatrist did not inform us that he had a PMB and that he had out of hospital cover. This is from a doctor, he is the Ombudsman of the HPCSA, "you are responsible for the knowledge of what your medical covers and what your medical aid does not cover. Doctor X had no obligation to inform you that major depressive disorder is a PMB. That is the information that should be known by yourself

and your medical scheme. Based on the above, there is no basis to pursue this complaint against the doctor and I will close the file". That disturbs me.

I am just going to give another example of a prescribed minimum benefit which is postnatal depression which is called severe behavioral and mental disorders of the puerperium that is not accessible to consumers. Acute obstructive laryngitis is croup that is not accessible to consumers. I am working closely with Discovery marketing team and they have now agreed to include the PMB for postnatal depression, the PMB benefit under the maternity benefits in their brochures, so when people are looking through the maternity benefits and I have asked for this specifically, they can see oh postnatal depression and if they get that, it will ring a bell, because it should rather be there than sitting in another document, I think it is a very important one.

Another concern is that people are resigning from their medical schemes to join medical insurance schemes, unaware that they do not have chronic and PMB cover and that if they want to rejoin their medical aid scheme, they could face a 3 month waiting period, or a twelve month condition specific

waiting period. I am very concerned about that.

The Council for Medical Schemes deals with the following unfair practices, complex, legalistic and user unfriendly information on application forms, rules and monthly statements, misleading or inaccurate or false advertising, provision of inaccurate incomplete or misleading information by call centre or other agents, insufficient information to beneficiaries on how to utilize the system, non-communication of vital information regarding contributions, rights, benefits, pre-authorization formularies etcetera. A very important one is the focus of information provision primarily to urban and electronically literate beneficiaries. What about the pensioners? What about the people I the townships? Insufficient information on how to make complaints, late or non-payment of valid accounts, especially PMB accounts.

I have experienced all these unfair practices.

Okay my recommendations, medical scheme brochures and websites need to have far more information on PMB's, including a visual flowchart of both the application and claim process, because many people understand things better visually as opposed to when it is written. This flowchart must include the recoding, resubmitting and reconciliation of PMB once there has been

diagnosis for pathology and radiology accounts. Medical practitioners who do the diagnosis and treatment plans, should be held legally and ethically responsible for informing their patients that their condition is a PMB and what the treatment options are. They are not called diagnostic treatment pairs for nothing. To me, that implies a duty on the medical practitioner.

With reference to my correspondence with the South African Medical Association which I won't have time to read out, but they have agreed to get together with the Council of Medical Schemes and the Department of Health to include a module on the subject of medical financing for medical degrees and diplomas. I have that in writing from a very kind gentleman at SAMA.

Medical aids must be held legally responsible for identifying all PMB ICD10 codes on claims, accounts and prescriptions presented to them. All medical scheme computers need to flag PMB specific ICD 10 codes. If no PMB has been applied for or approved, the medical aid scheme must be held responsible for contacting the member. The consultants who do these follow-up calls must be trained specifically to deal with PMB queries and the member must deal with the same person on that query and not have to phone

in and speak to a different person all the time.

An Ombudsman should be appointed to protect and represent the interests of the medical scheme member, patient user. I don't believe that the Council for Medical Schemes is fulfilling this role adequately.

PMB902T which deals with mental illnesses should be expanded to include post-traumatic stress disorder, generalized anxiety disorder, obsessive compulsive disorder and borderline personality disorder. Given the high rates of violent crimes, sexual abuse, physical and emotional abuse in our country, I find it so bizarre that so many ICD10 codes, eighty pages of them, are related to methods of attempted suicide, whereas there are only twenty six ICD10 codes for mental illnesses like depression that precede these suicide attempts.

Dentistry and spectacles should become a standard benefit for all children under the age of eighteen as it is in most countries. The PMB 2010 code of conduct recommendations and procedures must be implemented as agreed by the Department of Health, CMS, HPCSA and the Medical Aid Schemes.

On behalf of medical scheme members who I am representing today, I request

that a new audit be carried out specifically pertaining to the non-payment of PMB's, or the incorrect payment of PMB's in contravention of regulation 106 of the Medical Schemes Act. I ask for special attention to be given to the payment of PMB diagnostic pathology and radiology accounts, paid from members' medical savings accounts, those with the generic Z ICD10 codes that were submitted directly to the scheme by the laboratories.

I have not worked in the financial environment for many years and I understand that the law requires the medical schemes to have a reserve equivalent of 25% of risk of the scheme. I understand this with regard to the smaller schemes, but a scheme with 2.2 million members and 11.7 billion in reserves, perhaps it is time that percentage was reduced and members derived more benefits or lower premium increases, especially considering that only 16% of the population are on medical schemes.

Then in closing, I want to dedicate my presentation to a lady by the name of Dev Baxter, who was a founder member of our group, our social media group where I got involved in all of this and this is on behalf of her and her family. She passed away before she could get the opportunity to speak at these hearings, but I am sure she would have been there. I met her through a social

media group. She was the one who encouraged me to do this and who inspired me to do this.

She was a warrior as in a warrior, a fighter she literally fought for her life. She helped others access their medical benefits for cancer. She was brave, humble and inspirational. What I am reading, are excerpts of her posts on social media. Let me by way of this letter, introduce myself to you, Ms Beverley Mae Baxter aged 47, married to Greg, 2 children Jenna aged 19 and Brenda aged 17, diagnosed with cancer in February 2010 Stage 4. Comprehensive medical aid plan with a R400 000 oncology benefit, medically boarded at age 42, as treatment would be ongoing and I would not be able to travel extensively which was required as a business development manager for a major South African company.

I successfully fought and maintained with the help of my oncologist to keep my disease bone based. We applied to our medical scheme for authorization for the chemo regime ICE. It was declined by my medical scheme because the protocol is not recognized by the specialist group they consult with. I am very aware that medical aids are not an unending source of funding. I fully acknowledge that what I have is termed incurable, but not uncontrollable

disease, if I am allowed treatment while my disease is actively growing. The reality has been that I have been able to maintain my performance status and ability to be an active mom and part of society despite being on treatment.

I have said Bev's Facebook profile is a testament to this. Gentlemen I am fighting for my life, but I am still very much alive and functioning. Yes I have symptoms of my disease that are restrictive, but I have lived for 5 years. I have attended, planned and celebrated momentous milestones which I had doubts I ever would. I planned and attended my daughter's 18th birthday, I attender her Matric dance, settled her in and saw her complete her first year of a BCOM degree. My son is no different, he made the first rugby team, selected for the Kwa Zulu Natal bass fishing team, made the South African Junior Proteas bass team and was awarded full South African colours and I now eagerly await his Matric dance in April which he did attend, celebrated my 25th wedding anniversary with my amazing husband.

I have been privileged to be able to pay it forward by being start of the start of the cancer support group of Westville, joined and volunteered my medical knowledge to folks not so fortunate who approached campaign for cancer for assistance and assisted my fellow patients in Durban Oncology. Why do I

share what may seem trivial to the likes of yourself? Well it is this, I eagerly await the response of my application for ICE treatment by yourselves and trust that in the face of the clinical documentation supplied by my oncologist today, you would approve my much needed chemotherapy. You choose to continually deny me rightful access to my oncology benefit. I ask that you understand that I do not have a common cold, I am fighting for my life.

I would like to be given a fighting chance of extending this. I am not looking for a cure, but my pain levels and psychological fear as I watch the rate at which my markers are rising a pace with my systems, while a dice is being rolled to decide my statistical odds of my benefit, my good quality of life over the past 5 years, it is and should be sufficient proof for you.

I refuse to accept the adage of lie down and die, not when I am still fit and willing to fight. Then on 14th April, my tumor traces on the treatment they won't pay for, have dropped from 11 000 to a whopping low of 2 500. She actually paid for her own therapy.

Then a Facebook post on 28th April, we have victory, they have relented after being told don't change treatment that is working, we have approved funding. On 26th November, her son wrote as of now, our mom has decided to stop all

chemo and other treatments. After years of fighting, sadly her time has come. No person will ever be missed more. She sends her love to everyone. On 25th November, her best friend wrote a letter to the medical scheme and I echo this because I echo what she is saying to my medical aid for what we went through as well.

I am here to remind you of the absolute hell you put my friend through and even on bad days today when she is fighting for her life and feeling dreadful, we consider them to be better days than when we were having to waste weeks and months begging and pleading and groveling for treatment she desperately needed approval for. There is nothing more soul destroying than the feeling of utter abandonment by your medical scheme. The feeling of time up, we have paid enough and actually quoting amounts already spent. The feeling of we question and disagree with your doctor, the feeling of we actually know nothing about you, because if we did, we wouldn't suggest treatment that requires a pair of ovaries which I don't have to be beneficial.

The list goes on and on, the sleepless nights and off the chart stress you brought upon this family, the Stage 4 cancer treatment has been minor in comparison to the trauma you have put this family through, may God forgive

you, signed by Dev Baxter.

When I was typing Bev's words and reading her social media posts over the past year, I could only imagine the anguish she was going through, literally fighting for her life, begging her medical scheme for use of the R400 000 fully intact oncology benefit she was paying for. I fought for benefits to save the lives of my husband and my son. We all need to demand and become the users referred to in the National Act, no longer to be regarded as passive recipients of a service for which we should be grateful.

We are not asking for any more than what the legislation or schedule of our medical plan benefits entitles us to. We have to fight when we are at our most vulnerable it is not in any way a fair fight, the system is not working for us. We need to fix it, thank you very much.

PROF FONN Thank you for your presentation, I just want to understand one thing and that is when you are discussing Discovery, you are discussing the administrator. In your or any of the people that you are speaking about, various interactions, did you ever contact the scheme and the scheme's trustees and if so, can you tell us anything about that experience?

MS DRESCHER Absolutely the social media group that I belong to, Dr Johnny Brumberg is a member of the social media group. In fact, we communicate on inbox on Facebook. He is an active member on the group. I do understand that a lot of the people on the group are there to vent because they are in a state of anxiety and anger. Wherever possible, he does do his best to intervene and have one of his people take over the query and escalate it.

I have dealt with consultants, I have dealt with Dr Brumberg, I have dealt with the executive consultants, some of whom I find to be very helpful like [Jospher Singh] for example…

PROF FONN I want to interrupt you, because all these examples are people who work for the administrator and the only thing I am trying to understand is if you also, so these are the administration of Discovery?

MS DRESCHER Yes.

PROF FONN Then you're a member of Discovery medical scheme and the scheme has trustees who are there to represent your interests, so I just want to find out if you at all, or any of the people you represent, engage with

the trustees of the schemes?

MS DRESCHER No because nobody ever mentioned to me that it was an option. It was not mentioned by anyone at Discovery Health, no one at the Council for Medical Schemes, no one at the HPCSA, no one at SAMA and no one at the Department of Health, so yes, I possibly could have if somebody had advised me to. I knocked on so many doors, this was the only door that opened, but I am now working very closely as I said with the marketing department of Discovery Health. I picked up a few errors in their brochure and they have thanked me and they are fixing the errors and I have found somebody who I can speak to on the same level who understands my knowledge and does not patronize me or speak down to me.

I am really looking forward to working with them from the consumer's point of view, to make the system work, but the code of conduct needs to be implemented. Why was that ever drawn up? Why are the CMS and medical schemes saying that it is being implemented when clearly and audit will prove that it hasn't which is why I am calling for the audit and I think if the audit is done, there will be such a shock as to the state of the medical savings accounts and how many PMB's are being paid from the medical savings

accounts in contravention of Regulation 106. If anything is going to change the system that is going to change the system, because the law is being broken. The Medical Schemes Act law is being broken.

JUSTICE NGCOBO In Paragraph 2 of your recommendation, you recommend that medical practitioners who do the diagnosis and treatment plan should be held legally responsible for informing their patients that their condition is a PMB and what the treatment options are, but how do you reconcile that with the letter that you received from SAMA, where the doctor who responded to you said the following to you: most of my doctor friends do not even understand their own PMB entitlement. We paid for our hypertensive medicine out of our pocket for a very long time as we did not know that it was a PMB.

MS DRESCHER And those are doctors themselves.

JUSTICE NGCOBO Now if they tell you that they don't understand, this letter is dated 28th January this year and this is what a member of SAMA is telling you.

MS DRESCHER Where that letter originated from, is I have for the past

8 months, since March last year even longer, been writing to various different people at SAMA saying and I have written a very short letter from myself as a consumer knowing that their journals have a circulation of roughly thirty thousand medical practitioners and it is a letter from the consumer and you should have it there. It is not even a very long letter. Let me just find it quickly.

JUSTICE NGCOBO Which letter do you have in mind?

MS DRESCHER What I asked them to do, was to include a letter in their journal that has a coverage of thirty thousand doctors to say I represent a group of private healthcare patients who are members of schemes. Over the past 7 months I have been involved in a protracted battle to get cover for PMB's. It is basically saying that, it is an appeal to the medical practitioners to look at the PMB's that are specific to their speciality and if not know them off by heart, but know enough of them to please inform your patient that that illness is a prescribed minimum benefit.

The doctor themselves has to complete the PMB application form and supply all the clinical data and supply all the motivations, so he is involved in the application process anyway and I thought that if this letter was in the SAMA

journal, the doctors would read it and see it from the consumer's point of view. It is a like a psychologist told me if something was sent to all the psychologists and their patients did apply for PMB's for major depression, they would have a much higher patient retention because the patient would not be running out of money, because the PMB would be paid from risk and not the medical savings account or the members pocket so it is actually in the medical practitioner's benefit to disclose the PMB, because they will keep the patient for longer because it will first be risk then medical savings account and then only out of the patient's pocket, so I asked for a letter to be published in the journal, an appeal to the doctors to please just mention the word PMB, but they have refused to print my letter.

What they have said they will do, is introduce a block or discuss with the Council for Medical Schemes to introduce a medical financing module at university and technikons for all medical health workers and professionals, but that only covers the new doctors. What about the other doctors? My husband when he got Hyponatremia he was not told that was a PMB.

DR BHENGU Thank you for your presentation, there are just 2 issues I want to raise. Paragraph 3 your submission you make reference to the fact

that many medical practitioners do not disclose to their patients that their condition is a PMB and today you have also made reference to the fact that practitioners tend to use just a few codes and Z codes which overall basically suggests that they are not necessarily interested in helping you. Now this to me, is counter intuitive, because my understanding is that the law as it stands, is that PMB is unlimited and that would seem to suggest that as a practitioner, I want you to be diagnosed, at least your diagnosis to be a PMB diagnosis.

Now as an informed user, have you formulated an explanation as to why this is the case?

MS DRESCHER From a GP point of view, you have a 10 minute consultation with a waiting room full of people. There just isn't time for them to put the effort into the coding and I just think the medical profession, don't see it as part of their responsibility at all. I think they see it as a medical scheme's responsibility, because it is relating to payment of claims, but if I read the legislation of PMB's, the first word that comes up, is diagnostic treatment pairs that is what PMB's are.

The medical scheme is not making the diagnosis and the medical scheme is not deciding on the treatment, so again, if say major depression, there are 2

possible treatments if your doctor is not disclosing the PMB they are certainly not disclosing your treatment options either. They just stick you in a hospital and I think one of the reasons that, I mean I think that if out of hospital benefits where it is clinically indicated only, are used more frequently than just putting somebody in a hospital, is going to save the medical schemes an enormous amount of money. I really do believe that and that is not being done, especially in the mental health environment. Everybody is just being put into a clinic and psychologists don't even know that major depression is a PMB.

DR BHENGU No that is fine.

MS DRESCHER When the doctor fills out the form to apply for the PMB, he can charge a R400 fee for filling out that form. Now the weird thing is the minute you go there with a form and they sign and fill out the form, you are debited almost automatically, so they know about the form and they know that there is a fee attached to it and they are not afraid to charge the fee, but somebody has to tell the patient that their condition is a PMB. There is no way a patient can look through three hundred and forty three pages of

thousands of diagnostic ICD10 codes which are not even in English.

DR BHENGU No thank you very much for that. The other question is unrelated but it is a recommendation that medical aid schemes must fall under the FAIS Act, the Financial Advisory Intermediary Act. Why are you suggesting this?

MS DRESCHER Having worked in the financial industry myself and sold insurance products and finance products, I know medical aid schemes are a non-profit entity, but I don't believe they are being run as non-profit entities. I believe they are being run as businesses without any shadow of a doubt. I am only going to use my own medical scheme, but the administrators of my medical scheme which is a (Pty) Limited declared a R2 billion profit last year.

Now I find it strange that you've got this non-profit organization in a holding company of all these profit making businesses and I think the focus has been completely lost.

DR BHENGU But how would, reporting under FAIS get around that?

MS DRESCHER Because I know having worked in the financial sector, things like full disclosure in particular, explaining exactly what you are signing, explaining exactly what you are buying is very tightly controlled and there are very stringent laws controlling that. I know from my days when I had people sign legal documents and documents for products or life insurance or short term insurance. You really had to go through all the wording with them and make 100% sure that they fully understood what they were signing. Why should a medical scheme be any different?

DR BHENGU Are you suggesting that the current regulator of medical schemes is not fulfilling that role that you think FAIS can take care of?

MS DRESCHER Definitely yes.

DRS VAN GENT Ms Drescher can I come back to the last point that we were discussing? If I look at your recommendation number 4, so let's suppose that your recommendation number 4 was fully implemented, so that you are fully informed by the scheme once you send in a bill whether that is a PMB or not and your IT solution for that, suppose that is actually taking place, would it then still be necessary that your advice under number 2, the doctor inform

you in full of the PMB? Would it still be necessary for you to get your rights?

MS DRESCHER My answer would be yes, because the diagnostic and treatment pairs that the doctor has an obligation to give you the treatment options under the PMB.

DRS VAN GENT If he gave you the full scale of options plus the correct ICD10 codes plus the rest of the administrative stuff that he needs to fill in, that is his medical obligation to give you that isn't it? I mean I am looking at the legal liability or responsibility of this doctor wouldn't that be unnecessary if your number 4 is completely implemented?

MS DRESCHER I still think my personal view it is the doctor who is making the diagnosis and they are not called diagnostic treatment pairs for nothing and the diagnostic treatment pairs designated service providers that implies some duty on the medical practitioner. For example with pathology accounts, to warn the patient that I am going to send off for blood tests that pathology account if it comes out of your medical savings account which it could very well do, you must get it and bring it back to me, so I can put the correct coding on. I am talking about that kind of thing.

If I give you a script and you've got 4 chronic conditions, the ICD10 code for each condition must be next to each medication, because I spoke to a lady at a pharmacy. They literally sit there and they guess and they try all different codes to try and get it through. It is almost laughable what is going on. I think the PMB legislation is wonderful. I do think that the biggest improvement would be for all medical schemes across the board, to update these very fancy computers that they have where the minute a PMB ICD10 code is put in and they are specific to PMB's, that it is red flagged straight away and somebody has to call the patient.

That is the thing in the code of conduct that was not carried out 6 years ago that I think if it had been, we would be sitting with a very different situation today. That still doesn't change the fact of the pathology accounts, because those are not PMB ICD10 codes, so I think if a medical aid gets a pathology bill with a Z code, it should be rejected completely, just rejected so then the pathologist is not getting his money or the radiologist, they are going to phone either the patient or the doctor and then at least it is going to prompt a call by the patient or the doctor to find out how do I get this bill paid?

JUSTICE NGCOBO As I understand your basic concern Mam, is that at

some point, somebody in this chain, must inform the patient that the condition is a PMB condition at some point?

MS DRESCHER That is the question that I have been writing in a letter since December 2014 in every letter to everyone that I have written to whose responsibility…

JUSTICE NGCOBO Yes and to the extent that the doctor would complete a form, you take the view that it is the medical practitioner who must provide that information?

MS DRESCHER Well you can't get a PMB approved unless the doctor fills out a PMB application form. The thing is, the doctors are very well informed about the twenty seven chronic illnesses, but then a chronic illness like bipolar disorder also has a PMB component of therapy, fifteen sessions of therapy, so when you get your approval for bipolar, it gives you your medication and how many psychiatry visits you are allowed for your medication, but there is no mention there of the PMB benefit which is the therapy which you have to apply for separately because many illnesses are chronic and PMB's at the same time.

DR NKONKI Ms Drescher thank you very much for sharing your experiences with us. My question is with reference to what you shared on page 10 of your oral submission with regards to brokers, Paragraph 26. While it is helpful for medical scheme members to have accredited financial brokers manage their claims and queries at a maximum commission fee of R75 per month, for the broker there is very little incentive for brokers to manage medical aid plans.

Discovery, on the other hand allocate, in excess 14% of the monthly premium towards administration and managed care. I just wanted to know if could share any experiences of yourself or any of the people you represent of having approached brokers with regards to queries?

MS DRESCHER When we had our issue, at some stage fairly early in the game, I had personally reconciled a pile of bills like that and then a broker was recommended to me by Discovery which is actually not allowed but anyway, but he was basically disinterested, because at R75 a month and you've got to phone there and phone there and send emails and spend a whole lot of time, where is the incentive for the broker to go the extra mile when it

comes to medical aid schemes?

On short term insurance products, I think it is 12.5% commission, life insurance products etcetera, the commission that the broker gets is far higher than on medical schemes, so there is very little incentive. I mean I have a very close friend who owns an insurance brokerage, they just don't do medical schemes at all, because it is not financially viable for them, so yes I think a broker would be a very good intermediary rather than the patient or the member having to do all the liaison, but at R75 a month, I mean my phone bill sorting things out and helping people, is easily R1500 a month and I pay that myself, I don't work for anybody, so if you are going to incur a telephone cost of R200 and you only getting R75 commission there is no incentive for brokers unless they use the patient base to cross sell other products.

That is the only area where the benefit would be, is if they use that patient to cross sell life insurance, short term insurance and what you lose on the swings, you win on the roundabouts. Other than that, if it was just purely for medical aid, so we had our broker and he did basically nothing and within a month, we basically fired him. I was doing a better job than the broker.

PROF FONN When you say you fired your broker, do you know if you were assigned a broker and if you pay brokerage fees every month on your medical aid membership?

MS DRESCHER We went directly to Discovery almost twelve years ago so we have never worked through a broker with any of our insurances, just because of my background in finance, I kind of act as the broker, but things were just getting so bad and I was nearly hospitalized from the trauma of having to deal with all these bills, so then I phoned Discovery and they appointed a broker to us, a very nice guy, but he did a little bit and then we kind of never heard from him again.

PROF FONN So at this point, do you know if some of your contribution that you paid Discovery goes to brokerage fees?

MS DRESCHER I don't think it does anymore because we told them to cancel the brokerage.

PROF FONN Did you see a change in the amount you paid every month consequent on that?

MS DRESCHER The payment stays the same, it comes out of the premium. It doesn't change the premium at all, but what I am saying is that if you compare the R75 a month that goes to the broker to administer your scheme and you compare that to the administration fee charged by the health scheme themselves, there is a huge disparity. There is a very big difference, so it is just not in the interests of brokers to help people on medical schemes, unless they are using that member to cross sell other products.

JUSTICE NGCOBO We have come to the end of your presentation, but before we release you, is there anything that you would like to draw to our attention finally?

MS DRESCHER Well I would just firstly like to thank the Commission really from the bottom of my heart and all the other people that I represent for giving us the opportunity to have our voices heard. We are feeling disempowered and when you are sick and you are vulnerable or if you have sick family members, you want to use all your strength and resources to get well, not to be fighting medical bills and getting final notices in the mail. I mean that it is not good for your immune system.

If like my husband, you've got diabetes, it can set up hypoglycemia. If like my mother in law you have high blood pressure, it can affect her blood pressure and I live with post- traumatic stress disorder, it triggers panic attacks in me. I feel far calmer here speaking to a room of people and I can do this easily, but the minute I get an email from Discovery or I hear the tone of their phone when you are holding on, I actually have to take medication to prevent a panic attack and I am actually not joking. It is traumatic, it is really traumatic.

I come from an abusive childhood and so I know about feeling violated and feeling disempowered and that is why I have post-traumatic stress disorder and dealing with my healthcare provider and the practitioners, has retriggered my post-traumatic stress disorder and it really is traumatic. I don't know how to explain clearly enough how traumatic it is. I have just had an email last night from a woman whose little 3 year old was bitten by a cobra and she is being hounded for bills, I mean it is just inhumane. It is inhumane and it is cruel and it is exploiting people when they are at their most vulnerable and all we are asking for, all we are asking for, is what we are legally entitled to and what we are paying for.

We are not asking for anything more than that, but I would really like to thank the Commission and the enquiry for allowing me to speak. I feel very privileged and honored and humble to be able to do this on behalf of the people I represent, thank you.

JUSTICE NGCOBO Thank you indeed for sharing with us your experience with prescribed minimum benefits, thank you very much indeed for making time to come and talk to us thank you.

MS DRESCHER Thank you. Can I just say that if anyone wants a summary of my submission, I do have?

JUSTICE NGCOBO In the course of your presentation, you referred to a number of documents, I don't have some of those documents and I wonder whether you would be kind enough to make those documents available to the Technical Team so that we can have them, those that you have referred to in the course of your presentation. I think one of those was the code.

MS DRESCHER Okay.

JUSTICE NGCOBO Thank you.

MS DRESCHER I will do that, thank you very much.

JUSTICE NGCOBO The next person to make the presentation is Professor Michael Herbst. Is Professor Herbst here?

ADV PILLAY SC Chairperson we have arranged for Mr Lester to swop the slots with Professor Herbst if he is not here in time for his presentation.

JUSTICE NGCOBO Okay but is Professor Herbst coming though? Do we know what time he is coming?

MS MURANGUA Chair Professor Herbst is scheduled for 2:30, so he would be coming this afternoon, We have been in touch with him through the Technical Team, so that is why we are going to have Mr Lester go next so long.

JUSTICE NGCOBO Okay very well. Is there someone that is available that we can deal with shortly after the lunchbreak?

MS MURANGUA Yes Chair Mr Lester is available.

JUSTICE NGCOBO He will be ready at 2:00?

MS MURANGUA Yes Chair.

JUSTICE NGCOBO Okay very well thank you. We will take the lunchbreak and then at 2:00, we will commence with the presentation of Mr Craig Lester, thank you. We will then take the lunchbreak.

[END OF SECOND SESSION]

[START OF THIRD SESSION]

JUSTICE NGCOBO Okay, we're about to start. I wonder if we could all try and settle down so that we can be ready to start, that we don't have to keep Mr Lester waiting for a long time. Are we ready to start?

ADV PILLAY SC We are, Chairperson. The next consumer presenter, Chairperson, is Mr Craig Lester.

JUSTICE NGCOBO Could you repeat?

ADV PILLAY SC The next consumer presenter is Mr Craig Lester.

JUSTICE NGCOBO Yes, good afternoon, Mr Lester. How are you this afternoon?

MR LESTER I'm very well, thank you.

JUSTICE NGCOBO Yes. Now, you have given us a written presentation, haven't you?

MR LESTER Yes.

JUSTICE NGCOBO Which has subsequently been supplemented.

MR LESTER Yes.

JUSTICE NGCOBO Yes. Are you going to be speaking to your presentation?

MR LESTER Yes, I'm going to stick to it.

JUSTICE NGCOBO Yes. Very well. Do you want to go ahead? Very well. Thank you.

MR LESTER Thank you for the opportunity. I'm going to start with the reason why I'm doing this, is about my son. He was born in 2009, seven years old. He was born with a very short umbilical cord, struggled to breastfeed, he was a poor sleeper. Once he started becoming mobile he was a danger to himself, very hyperactive when he started walking. He has been diagnosed with neurofibromatosis type 1 before the age of two. He was diagnosed with ADHD age four, he has

Aspergers autistic traits, it's not a complete diagnosis as yet. He has sensory processing issues. He's a highly intelligent little boy, been to multiple schools before he attended Grade RR, he attended a private school last year and this year he's attending a special needs school in Brackenfell, called Paarl School. He has had many hours of therapy and he's on drugs, for his ADHD, called Ritalin, Concerta, Risperdal and he takes melatonin to help him to sleep. He's a poor eater, he struggles with sensory issues, the world around him. He has signs of poor self esteem already emerging. He's very difficult to look after, he's demanding and he's busy and he requires constant attention. He still needs lots of occupational therapy and specialised education. He's socially awkward and unable to relate to other peers and he has tremendous potential, as we've been told.

Now I would like to just lay a foundation as to what is attention deficit disorder, neurofibromatosis and autism. These are three things that are not well understood.

I'm going to start with ADHD.

According to Russell Barclay, who's one of the pre-eminent experts on ADHD in the United States, written many books on the subject, it is a current term for a specific developmental disorder seen in both children and adults that's comprised of deficits in behavioural inhibitions, sustained attention and resistance to

distraction and regulation of one's activities to the demands of a situation.

The major characteristics are: an impaired response inhibition impulse control or the capacity to delay verification; not being able to stop and think what you're going to do, what are the consequences of your actions; excessive task irrelevant activity or activity that is poorly regulated to the demands of a situation; not being able to focus, just not concentrating, fidgeting; poor sustained attention or persistence of effort to tasks – when a child or an adult with ADHD does something that I want to do, they battle with concentration. There are impairments to their everyday lives.

Now, these are the three most common areas of difficulty associated with ADHD but research is suggesting that those with ADHD, particularly sub types associated with impulsive behaviour may also have difficulties in the following areas of psychological functioning as well: remembering to do things or working memory – this is very important, just remembering how to do things for a later stage, those with ADHD often have difficulties with working memory, are described as forgetful around doing things, keeping important information in mind that they will need to guide their actions later, and disorganised in their thinking and other activities, as they often lose track of the goal of the activities. In their daily ... recently research suggested that those with ADHD cannot sense time or use time adequately as others in their daily activities.

They're often late for appointments, deadlines, ill prepared to upcoming events and less able to pursue long term goals and plans as well as others.

The very second area is delayed development of internal language, the mind's voice and rule following. This is a very important one. Children are significantly delayed in the development of internal language, so private voice inside one's mind that we employ to converse with ourselves, contemplate events and direct or command our own behaviour, this private speech is absolutely

essential, that the normal development of contemplation, reflection and self regulation, it's delayed in those with ADHD contributes to significant problems with the ability to follow through on carefully ... follow directions carefully, to follow through on their own plans, rules, and to do lists, and even to act with legal or moral principles in mind.

The third area, difficulties of regulation of emotions, motivations, and arousals. Children, adults with ADHD often have problems inhibiting their emotional reaction to events as well as others do of their age. It's not that their emotions are experience or inappropriate, but those with ADHD are more likely to publicly manifest their emotions that they experience than someone else would. For example, my son will throw ... will have a tantrum over something he cannot understand in a shop. People around me will look and say why is he doing that or say he's

just been spoilt. It's not the case. Coupled with this problem with emotion regulation as the difficulty they have in generating intrinsic motivation for tasks that have in no immediate payoff lots of issues with concentrating and just being able to stick to a task.

The fourth area is diminished problem solving ability ingenuity and flexibility in pursuing long term goals. This is also very important. Persons with ADHD find such hurdles to their goals to be more difficult to surmount, often giving up their goals in the face of obstacles and not taking the time to

think through other options that could help them succeed towards their goal. So they seem to be less able or obstructionist when you pose a problem to them, whether in class or in the work situation.

Then the last area is greater than normal variability in their task or work performance. It's typical of those with ADHD, especially those sub types associated with impulsive behaviour to show substantial variability across time in the performance of their work. So one day you're getting an excellent result, the next day you're not. So a lot of people misunderstand. They'll say the person's inconsistent when they're not really. It's a struggle for them.

The other characteristics of ADHD is early onset. My son was diagnosed at age four

but we knew from about age three. The situation variation of symptoms each told is unique, so it makes it very difficult to just diagnose, to lay a blanket diagnosis on these children, and it's a relatively chronic course because it stabilises, but it continues right through life.

What is important here is the adult outcome of these children with this neurological disorder. It's been estimated that anywhere from 15% to 50% of those with ADHD ultimately outgrow the disorder but this must be borne in mind that the figures come from follow up studies in which the current and more rigorous diagnostic criteria for the disorder were not used. So most recent data says that probably only 25% to 35% of children with the disorder no longer have any symptoms resulting in impairments in their adult life. What I want to draw the emphasis is impairment. Over the course of their lives, a significant minority of those with ADHD experience a greater risk for developing oppositional defined behaviour, conduct problems, antisocial difficulties, learning disabilities, low self esteem, depression. Approximately 5% to 10% of those with ADHD may develop more serious

mental disorders such as manic depression or bipolar disorder. Between 10% and 20% may develop antisocial personality disorder by adulthood, most of whom will also have problems with substance abuse. Overall, approximately 10% to 25% develop

difficulties with overuse, dependence upon or

even abuse of legal, that is alcohol, tobacco, or illegal substances with this risk being greatest amongst those who had conduct disorder delinquency as adolescence.

The majority of those with ADHD certainly experience problems with school, performance with as many as 30% to 50% have been retained in their school grade at least once, and 25% to 36% never completing high school. That last sentence has immense relevance to our country. Children who enter Grade 1 and finish matric, there's a huge number missing. How do we account for them? Is it just socio-economic conditions? There's more to it than that, I think. As adults, those with ADHD are likely to be under educated relative to their intellectual ability and family educational background, they're also likely to experience difficulties with work adjustment and may be under employed in their occupations relative to their intelligence and educational family backgrounds. They tend to change more jobs more often than others do, sometimes out of boredom, sometimes out of interpersonal problems in the workplace. They also have a greater turnover of friendships, dating relationships, more prone to marital discord and even divorce. Due to the difficult ... and then the last one is, difficulty with speeding while driving are relatively

commonplace. That's quite common.

Now, I'm going to skip the sub types because that's really just more background to it. I want to go to the prevalence. I'm giving you figures here, but I've got reports which quotes ... it's very variable. I think part of it is because it's so difficult to diagnose but they say it's about approximately 3% to 7%

of childhood population and approximately 2% to 5% of the adult population with the gender ratio in children three to one for boys to girls, by adulthood it changes because they start diagnosing it, girls are under diagnosed.

What he also says here is the disorder's been found to exist in virtually every country and which has been investigated, including North America, South America, Great Britain, Scandinavia, Europe, Japan, China, Turkey and the Middle East. In some places it's not regarded as ADHD, it's called something else. He says that the disorder's more likely to be found in families which others had the disorder or where depression is more common. It is also likely to occur in those with conduct problems and delinquency, tick orders, Tourettes, learning disabilities, or a history of prenatal alcohol and tobacco smoking exposure, premature delivery, significant low birth rate or significant trauma to the frontal regions of the brain.

I'm just going to move to aetiology because this is very important, the cause of it. It has a strong biological contribution to it. There's little question that the hereditary genetics makes up the [lod 00.19.38] contribution of the expression of the disorder, and it actually can compare to height, prediction of height in adults, from children to adulthood. They say, in instances where hereditary does not seem to be affected, difficulties during pregnancy, prenatal exposure to alcohol and tobacco smoke, premature delivery of and significant below birth rate, excessively high body lead levels as well as postnatal injury to the prefrontal of the brain have all been found to contribute to the risk of the ... for the disorder in varying degrees.

What I would like to raise, I know the Western Cape has got one of the highest incidents of foetal

alcohol syndrome and it is seen in these children. My mother in law's a social worker, she worked in a school for children who were sent there and incarcerated, our old reformatories, they call it a new name now, and those children are very much in that category.

What I would also like to say to debunk popular held views is that ADHD does not arise from excessive sugar intake, food additives, excessive viewing of television or poor child management by parents.

I'm going to skip grounds, that was just to give you a background, how they ... this is how they will evaluate. It's a tool that this particular specialist has brought up in the States, but I've just brought it through. They do use, a lot of the psychiatrists use something called the DSM, which is an American manual, and they give criteria to diagnose ADHD, and they say it has to be a persistent pattern of inattention and/or hyperactivity impulsivity. Six or more of the symptoms have to be persistent for at least six months, and they say that several inattentive and/or hyperactive impulsive symptoms were present prior to the age of twelve. What I'm trying to bring here is ADHD is a process, you don't diagnose it, there's no single test for it. It's a constant, constant evaluation that costs a lot of money to do.

They myths about ADHD, one of them is interesting, it's a contradiction but I'll explain why. ADHD is a socio-economic problem. ADHD is found more in affluent families. It's a contradiction but the reason for why I've said that is, a lot of the time the children who come from poorer backgrounds are not diagnosed, and in affluent families they are diagnosed. So that's the contradiction. It's not a result of bad parenting. I have been told that so much, I'm so tired of hearing it.

I would like to move to ADHD in the South African context. There's a study done in 2006, ten years ago, by Norwegians. They went to Limpopo and they were trying to

replicate the results from Norway. The result was replicated almost precisely the same. I've go the study and it does show that. It was done across the population groups, it wasn't one specific population group they looked at. So it is a very significant disorder.

I'd like to now move onto to autism. Autism is a very poorly understood neurological condition. There is no particular defined cause of it, they don't know, but it impairs social interaction, development of language and communication skills with rigid repetitive behaviours. It covers a large spectrum of symptoms, skills and levels of impairments. It can range in the severity, from handicapped, that somewhat limits in otherwise normal life, to devastating disability that may require institutional care. It is a serious neuro-developmental disorder that affects child's ability to communicate and interact with others. At the end of the day, what we do is we talk. Children who cannot talk cannot function in this world. Even between autism, autistic children, they do not communicate. It's a very sad ... my son, fortunately, is not that bad.

When they talk about the spectrum, autism spectrum disorder, it refers to the wide range of symptoms and severity and the symptoms, it's interesting what they say here, some children show signs of ASD, early in infancy, others develop normally for the first few months or years of their life but then suddenly become withdrawn or

aggressive or lose language skills they've already acquired, and they say they have a unique pattern of behaviour and level of severity, from low functioning to high functioning.

I'm going to just miss all of that now because I would like to get to ...

ADV PILLAY SC Mr Lester, given that your submission will be available on the website, I think if you could then deal with your interaction with the medical aids and ...

MR LESTER Yes, that's what I'm trying to get to here.

ADV PILLAY SC Thank you.

MR LESTER I just want to get to the third condition that I was talking about, it's called neurofibromatosis. Neurofibromatosis is something ... will not be diagnosed by a lot of doctors. They will miss it. Symptoms, you see birthmarks all over the body, little bumps under the skin, and it does develop tumours. Now, these are things that doctors don't pick up very often.

I'd just like to move on to the next part of my presentation, which is their fix of these conditions. I've said there it's delayed mental maturation, physical impairments, neurological impairments, impaired social interaction and

social isolation. Social isolation appearance, special education needs, continuation of ADHD into adulthood, physical endangerment of children, depression, home morbidity, which is you often find it with another order of other neurological conditions, possible development of criminal behaviour, as I mentioned earlier.

Now the specific needs for children like this, top of the list is occupational therapy. They're one of the most important disciplines in the medical world. Physiotherapy, speech therapy, those three allied health, as they like to call it, are so important in helping to develop our children.

Then there's the drugs that children with ADHD need. Assessments, pathology, specialist consultations, special nutritional requirements, it's really, really difficult to feed them. Special education, classroom facilitators, sensory integration needs, and then electronic equipment, extra mural activities for stimulation, home care for children whose parents work, for example, au pairs and nurses.

Now, the costs, this is what I've been trying to get to. The costs of these specific medical needs, occupational therapy three times a week, it amounts to R1,600, so you're looking at R6,400 a month. Speech therapy up to R600 a week, based on a thirty minute session twice a week. Drugs, my son takes Concerta, it's R700 for a months' supply. R225 for his Ritalin. His Risperdal, which

is anti psychotic drug is R300. His melatonin which helps him sleep is R70. An assessment by paediatric neurologist, which he has to have every six months to conform with the Act 101 of the ... which allows drugs to be dispensed because they are schedule 6, he has to be seen every six months. An educational psychologist will charge R3,500 for school readiness, which is what we paid. Behaviour modification therapy, several hundred rand a session for a three hour session. Then I've added here, PediaSure. PediaSure is essential. If I don't give to my son, he would weigh less that 20kg. It is a replacement meal. He gets three meals a day of that. It's R200 a tin, it lasts us three days a week. Then the dietary needs, anything up to R1,000 upwards, which is what we have to buy to be able to feed him. The educational facilitator is R2,500 to R3,500, that just assists the teacher in the classroom.

Now, coming to medical aids, with ADHD and autism and this coming from ... we're dealing with this for seven years, the allied healthcare benefit is not seen as a priority by the medical aids. We were on Fedhealth, they give us a limit of R15,700 a year for the whole family for occupational therapy. As I mentioned, what we would be charged for a forty five minute session, it would wipe us

out in three months. It does that to most of the parents. We have large drug costs and a small drug limit for the whole family and sub limits also for each member.

Assessments they don't pay in full because it's an hour session and she's assessing. To me, R1,600 is fair because it's R400 every fifteen minutes, but they don't pay, they'll R400 for that, so it leaves us out of pocket.

Then there are the high costs of the comprehensive plans that do pay for the allied health benefit. If we'd stayed on Fedhealth this year it would have been almost R9,000 for the year, and not paying most of what we need, these are the large out of pocket expense. So we've got to pay the R9,000 plus everything else.

Medical aid plans that stipulate the DSPs, the designated service providers that Angela was referring to, none of the people that we see are DSPs because there's a small pool of them, there just is, there's not enough people doing this work.

Fedhealth had last year brought in a thing that you had to see your GP who would be the gatekeeper to all the specialists. So they demanded that you go see a GP every time you wanted a specialist referral. They would then have to send a letter of referral to the specialist, even if you had a pre-existing relationship with your specialist. So you had to pay for the doctor and then the medical aid pay the doctor and then pay for the referral. It just didn't work because the GPs lacked the expertise to refer or even fully comprehend the necessary needs of children with neurological conditions. It's just a fact. That's why I was trying to lay a foundation to explain

to you how complicated this is. It's not an easy ... it's not easy to do, to diagnose, it's not easy to understand and the treatments are very misunderstood.

Now neurofibromatosis and medical aids is another story. First of all it's not a PMB, which is a disgrace. It should be. It can be a life threatening condition, it should be treated that way. Red Cross Children's Hospital treat thousands of cases every year of neurofibromatosis.

Now, the standard procedure of a diagnosis for neurofibromatosis is best done with an MRI scan to check for optic gliomas, which is a tumour that you get in the optic nerves. My son has those. We've had to do regular annual MRI scans and we fought tooth and nail to get those. Fortunately we were able to get a PMB code which allowed us to be ... for the optic gliomas to be treated as a PMB but the medical aid insisted that we empty our day to day benefit and they would pay the rest. So it's incredibly ... it's not fair to the rest of the family, all the members that you are forced to do that. Now, neurofibromatosis also requires a regular ophthalmologist examination, endocrinologist, my son has, because of the optic gliomas, where it crosses, the optic nerve crosses, and it's pushing onto the pituitary gland, so what we had to watch for is excessive growth, we've had to watch for all sorts of complications that have come from that, and that would require incredibly nasty medication with terrible side effects.

The pathology that has to be done to check things also is never paid for in full and as I said, the specialist fees are not paid in full.

Now, the biggest issue is the financial burden on parents - the high cost of comprehensive medical plans, comprehensive plans that cover allied health in substantial amounts that provide for therapy. That's why you have to be on a comprehensive plan.

Now, I've said here, tax deductible but impinges on cash flow. What's interesting is South African Revenue Services recognises that ADHD is a disability. We can claim all the expenses directly paid for. Now, that's wonderful but it only results in a smaller tax bill but you still have to have the cash to pay for those things. Huge amount of times I've said here, huge amount of times corresponding

with medical aids, you spend weeks to try and break down doors to get authorisation, and I said that the education needs are expensive, with very few options to open to education, and lots of extras that could not be considered medical expenditure, but in truth are medical expenditure, like the PediaSure. It's something that was prescribe to us. We have to give it to him to ensure his weight and his growth.

I've also said here, occupational therapy is a necessity not a nice to have. It is the truth.

These children need to learn to write with a pen. My son still cannot write with a pen. He's seven years old. He's been doing occupational therapy for two years to learn to write. He still cannot master it. What they call dyspraxia, which is the inability to plan, the occupational therapists teach them techniques to plan. The occupational therapists are also involved with sensory input. Now, these children, my son, for example, loves to swing, he doesn't like people touching him, he cannot cope with noise. So they come up with solutions to help us, like hanging a bar that you do pull-up exercises, and put in a licra swing, hammock in so that we can give him that stimulation. These people are vital, they're the key to what we need to do. I've also said there, the therapy as a once off is affordable, but cumulative costs become prohibitive and bankruptcy beckons. It is a fact. You need to do the right thing because you look at your child and you know if you don't do these things he's going to not be able to cope with life, and I said that many specialists are not willing to assist and costs do not vary between

specialists. That's, in some cases, we have found. Very few drug options because overseas there are a lot more, we just, due to regulations here, with the MCC, it's very difficult to get the other drugs registered, it's a costly process.

Now I was asked, in the public sector, how do these children get addressed, do they get

addressed. I don't think they do. I don't think there's any means for them to be looked at. A child living in a rural village with ADHD is never going to get his needs met because there is no means or access, even at a large government hospital, because of the requirements that are needed to diagnose this. If I can't afford it, then I can assure you, that most South Africans cannot either. There are rich people I know that are battling with this situation. We believe that, my wife and I believe that, and I've spoken to our neuro- paediatrician, paediatric neurologist, and she made the point that, and I'm going to get to this now, is that PMBs are so skewed towards adults, they are neglecting the needs of children in this country. There are 270 PMBs. Most PMB conditions will not affect adults, will affect adults but not children, if they do, it's quite rare, like, for example, schizophrenia or bipolar.

ADHD on its own is manageable, it's when you've got the combined spectrum of things, which is mostly the case. It's a very complex ... these are very complex disorders and they need to be addressed through, in my opinion, the PMB route is the best way to go. If we could have that regulated it would make life a lot easier. The neurologist said to me she will not write another letter of motivation to any medical aid. She says, because she gets the impression that there is an intention to not comply or respond to any request. They usually just ignore or just say, no, it's declined when

it's requested. I believe that occupational therapy, speech therapy, physiotherapy should be part of that treatment, it should be a PMB and it should be covered in full.

We are dealing with children who need to have an education. I personally have ADHD and so does my brother. What we went through as children was not pleasant at school. Lots of physical beatings

from teachers and we were told we were idiots, no self esteem. At sixteen I tried to commit suicide because of the poor self esteem. It's quite common, actually. We need to do something for children, because I believe there is a constitutional obligation in this country to care for our children. I don't see that here in the medical profession as it stands right now, with these conditions. Yes, other things they can cover. They've done wonderful work with polio and the vaccination regime, but we have a situation where there are countless thousands of children. If we were to just go on 2% to 5% of the population with children, how many children does that amount to with ADHD in the general population. It's millions. These things, the neurofibromatosis can be a life threatening disease. It's not even a PMB. It's a disgrace it's not. These children who have these things, what future do they have, you know? I mean, I've written here, the future outlook. I've said it's a poor future outlook. I also know, I read an article that mental healthcare in this country is not a priority, it's not seen as a priority by the

Health Department, private or public. The National Health insurance will not be able to meet the needs of these children, it's just too prohibitive for everybody, but the children who should get it, they should get it out of the NHI, and those that can afford it should be paid by the medical aid. The medical aids just seem to reduce the allied healthcare benefit by not increasing it every year substantially, because it's not a priority, it's not surgery, it's not medicine, it's just therapeutical. It's a wrong approach to take, and the costs are rocketing. You can't blame a occupational therapy for charging another 5% or 6%, but they've got to cover their own cost of living, increases. I don't blame any doctor who treats us. I find that the pediatric side of it is very compassionate, much more than what I found for myself, but my viewpoint is that we need some drastic change. We need to see something happen in this regard, because it's also an educational

situation. I also believe we need new schools to be built for kids. My son is going to a school now where he's getting occupational therapy three times a week, he's getting physio for five weeks now, he's getting speech therapy for twice a week, he's going to be educational psychologist working with his emotional side. It's costing me R850 after seven years of that, R850 is a relief. Now, I'm just trying to save my home and my business, and trying to prevent ourselves from going bankrupt, because of what we

just carry. And I'm not the only one. There are many, many, many like us. We all struggle through this. The emotional cost to myself and my wife is incredible. We're pretty isolated with no support. There just isn't anything that can assist us. This is what I'm asking, that this could be taken into account. It's a very, very serious situation. It demands an immediate response. I believe that the law has to bring it in. Children have to be protected. We want to protect them. We want to say that they have the right to be safe and to an education. I mean, we subscribe to United Nations Bill of Rights for children. This is ... but the medical profession is not doing that at all when it comes to these children, and if you've got just a million, that's a significant amount of children. That's my viewpoint.

ADV PILLAY SC Thank you, Mr Lester.

JUSTICE NGCOBO Yes. Mr Lester, thank you for your presentation. Have you said everything that you wanted to say?

MR LESTER I would just like to thank you guys for the opportunity. I believe I'm not just fighting for my son, I'm fighting for all the kids that have this situation.

PROF FONN Thank you for your presentation. I'm going to ask sort

of a technical question. In relation to engaging with the medical scheme, are you directing yourself to Fedhealth, are those people that you correspond with, or is it the administrator?

MR LESTER Well, at the end of the day, dealing with the medical aid is ... I find it's a very impersonal situation. You have to phone the call centre, you give them the information and then you move, and then you wait for a response. The doctors that you deal with are faceless. You question whether they actually understand what you're talking about. You know, you're dealing with the administration. I don't think they are very open, I don't think they communicate very well to anybody. I think communication is one of the biggest flaws when it comes to medical aids, and the financial issues are the only thing that I think, that is my personal opinion, that they are driven by, I don't believe that they do any good other than to the company that administrates it, because they reduce benefits, they increase premium contributions annually, you see less bang for your buck continually. There's also a question of them being reinsured for most things anyway. They don't lose on anything. The risk that they ... the risk portion is there for a reason. The PMBs are there. I believe that it should work. It should work better. I believe that there should be a framework. You see, I'm of a different opinion to Angela, because my wife is a vet so I do understand what they do. Doctors are not sitting on their backsides all

day long. They most of the time are just trying to do their job. The administration side comes at a very heavy personal price. The PMBs and everything else, they just don't have the time to do it. To me, it should come from a medical aid, there should be a framework and it should be much more fair. This is what you're entitled to. If you have this condition, and it should be that simple.

MS MURANGUA So when you originally chose which medical aid to join, was it a choice or was it a limited choice, did you know if it would cover it or not, what was your experience?

MR LESTER Let me start there with saying we were with Profmed. They are an absolute disgrace because they are owned by the PPS, so it's a Mutual company, they give you terrible benefits and they charge the earth, and they are unwilling to actually bend to anything they don't do, and I will relate this – originally when we wanted to do an MRI, we paid for it ourselves because they refused to pay. Then we had the situation where the second time around [indiscernible 00.50.01] a PMB. There was a court case that they were party to, inviting the PMB regime. They informed me at that point that, no, we've got this court case pending, so, no, we're suspending all PMBs. They did. They suspended every single PMB, based on the potential court case. I wrote to them, I said, excuse me, until there's a ruling you

should not do anything like that, but they did. I've got the correspondence for that. Where it is, I don't know, but it's somewhere. Then when they lost the case they had to pay for it, but I went to the council for medical schemes and they ruled against them and then they settled it. Medical aids are user unfriendly. Their interfacing is bad. I think to a large degree I personally don't think they actually understand the PMB system themselves.

MS MURANGUA Can I just clarify one other point? You said that many specialists are not willing to assist. I wasn't sure what you were getting at.

MR LESTER What I find is if you don't have the money, they won't help you, but what I've also found is there's very little in terms of a consultation between two doctors in the same area. To me that does point to, and I can only imagine that it points to collusion. I'm not sure but

especially where we live, in Somerset West, most of the specialists do not charge below a certain amount of money. So it's pushed the access to it and it's compliant, pushed out of there, so they're unwilling, paediatricians are not willing to do it. It's only when you deal with someone who's actually worked at Red Cross that there is the willingness to give, yet the pure private practice, they're not willing to help. There's a lot of compassion from those who've worked in the public

sector, those who are purely private, they couldn't care less, as far as I'm concerned. I'm quite honest, and that's not just what I've ... my personal experience. It is a bad state. I mean, my wife is a vet and we treat ... it's a very different model. You can't just charge what you like. There's no agreement. It's what people are wiling to pay, you have to charge. See, that's ... I think to a large degree, the medical aid has also maybe ... the medical aid system has maybe pushed up the price of healthcare, because there's a certain amount of money everyone knows they're going to get. I don't know, I'm just imagining it.

MS MURANGUA We've got no further questions.

JUSTICE NGCOBO Yes. Thank you, Mr Lester, for coming and sharing with us your experience, thank you.

MR LESTER I appreciate your time.

MS MURANGUA Mr Chair, the next presentation is going to come from Prof Herbst, he's here.

JUSTICE NGCOBO Yes.

MS MURANGUA Prof Herbst.

JUSTICE NGCOBO Is Prof Herbst here?

MS MURANGUA Yes, he's here, Mr Chair.

JUSTICE NGCOBO Yes, sir. Good afternoon, Prof Herbst.

PROF HERBST Good afternoon.

JUSTICE NGCOBO Yes, how are you this afternoon?

PROF HERBST Very well, thank you. Yes.

JUSTICE NGCOBO You want to come and talk to us on your experience with ...

PROF HERBST Yes, I really feel very ... I think it's very important that I share my story with you, that I felt that I was put in the situation where I had no choice, where I wasn't involved in what was happening around me. I couldn't take any independent decisions, and were very embarrassed in the process.

I suffered for quite a few years already with high blood pressure, but other than that, I'm very active and very healthy. Around about eighteen months ago, and Judge, I want to say to you, I tried to get a more accurate date and I went back to my emails to find that the emails had been deposited in the cloud and at my

age I'm quite challenged as far as the IT is concerned, and I couldn't get it out of the cloud, but it's about eighteen months ago I started developing palpitations, irregular heartbeat,

shortness of breath, tiredness, and being in the health professions, I was getting concerned over my health. I was already seventy years old at that stage, and I decided that after a few weeks I had better do something about this. At the outset I want to say to you, I'm going to mention the name of a cardiologist, but my case is not against the cardiologist, it is against the hospital.

So I went to the Nedcare Hospital at Linksfield Park, and I went to the casualty department, explained to them what my problem was. They took me inside and did the electrocardiogram and the doctor came in, took the electrocardiogram, and went out of the room. I lay there for about ten minutes or more and she then came back and just said to me, the cardiologist is waiting for you. Now, that caused a lot of anxiety because I was thinking to myself am I close to getting a heart attack, what could the problem be, am I maybe a candidate for a pacemaker, you know, all these things start going through your mind with a whole lot of anxiety.

Long story short, the cardiologist's consulting room is in the hospital complex itself, so it's in the same building. So I went up and when I got to the consulting rooms he was

waiting for me and I went straight into his consulting rooms. He started taking a medical history from me, and this is now the cardiologist, Dr Disler, and very professional and he treated me wonderfully well. He took a medical history, then repeated the ECG. Now, that to me was already ... I thought, why didn't they bring the ECG from the emergency department up to his office? So problem number one, my medical aid was billed twice for an ECG, once by the hospital and then once again by the cardiologist, which I didn't know at that stage. He then did a stress ECG and he did an echogram of my heart and about after an hour and a half, two hours, he said to me, well, he thinks it's necessary that I change my medication. He gave me a script for new medication and then on greeting me, said to me, please remember to settle your account before you leave.

Now, I was never informed by the hospital that they are sending me in the same building to a cardiologist who will not accept my medical aid, I have to pay it, and then claim back from the medical aid. It was about five or more days before pay day so I was very embarrassed because I didn't have the excess of R4,000 left in my banking account to pay the cardiologist. So I had to say to the receptionist, she'll have to excuse me, but I'll have to go to the bank and ask my bank manager for an overdraft to come and pay, which she then said it was okay. With that embarrassment I went to the bank, got the money, came back and paid for it. I think it's

very unfair for a system that is so closed that they refer you to somebody within the organisation and you pay separately for the hospital and separately for the medical practitioner, because that wasn't my experience of this very same hospital about two years earlier, when my partner, I found him unconscious in flat, rushed him off to the hospital, he was admitted, he was seen by a neurosurgeon. I never saw any account or anything from the neurosurgeon, it all went straight to their medical aid. But in my case, I had to pay upfront before I was supposed to leave the cardiologist's office, and I think the system is very wrong. It doesn't allow me to make a choice. Had I known that I would most probably have said to them, give me the result of the cardiogram, give me the electrocardiogram copy and I would have gone to a specialist of my own choice.

JUSTICE NGCOBO Thank you.

MS MURANGUA Prof Herbst, I just have a few questions of clarity from you. Were you able at all, I know you spoke to the cardiologist, because he wanted to know your medical history from you, did you at any point try to ask him why he ... what was going on or try to get any information from him?

PROF HERST No, the cardiologist was very nice. As I said, I was very professionally treated by him, but it was in the emergency

room section where I was seen by one of the casualty doctors who didn't inform me anything, just said to me the cardiologist is waiting for you in his consulting rooms. So from the hospital side I didn't get very good treatment. I was not informed of what was happening or anything, and that's why I said at the outset, you know, my problem is not with the cardiologist but with the Linksfield Park Hospital.

MS MURANGUA Did any of the two parties tell you, for example, where you went to the specialist, did he tell you why you were referred to him at all?

PROF HERBST Pardon?

MS MURANGUA Did the cardiologist tell you why you were referred to him before he started conducting tests on you?

PROF HERBST No, he ... I'm sure that he just accepted it that I was being referred to him, and he did his job in getting a whole medical history and a battery of tests to see what my health issue was.

MS MURANGUA I have no further questions, Mr Chair.

JUSTICE NGCOBO Yes, thank you. When you were told that the cardiologist is waiting for you, did you ask the attending doctor why you had to go there? You didn't ask him.

PROF HERBST At that time I wasn't feeling well, I was tired, I was exhausted, I was shortness of breath, I was having these palpitations, irregular heartbeat, and then the anxiety, you just hear the words, the cardiologist is waiting for you, and a thousand things went through my mind, and I didn't know what was going to happen, what was it all about, and I didn't think even at that stage of asking the question. I thought, well let me get to the cardiologist to hear what my real problem is. I cannot afford, at this stage, to have a serious health problem. That is all that went through my mind.

PROF FONN Prof Herbst, just to close the loop, did your medical aid then reimburse you fully?

PROF HERBST Yes, immediately, because I sent them the receipt of payment and they immediately put it back into my account.

PROF FONN I'm not ignoring your point, I did hear it, I just wanted to ...

MR LESTER Thank you, ma'am.

MS MURANGUA Mr Chair, about an issue that was raised earlier with respect to the mentioning of the doctor of the cardiologist by name,

we have made arrangements, I just wanted to put it on record, to send Prof Herbst's presentation to him via email.

JUDGE NGCOBA Prof Herbst, is there anything else that you would like to raise with us?

PROF HERBST I'm comfortable, thank you, Judge.

JUSTICE NGCOBO Okay. Was this the very first experience you had where you were simply told go to the cardiologist, no questions asked, no explanation given?

PROF HERBST Thank you.

JUSTICE NGCOBO Yes.

PROF HERBST I'm very comfortable, thank you, Judge.

JUSTICE NGCOBO Yes, thank you very much indeed.

PROF HERBST Thank you, sir.

JUSTICE NGCOBO Thank you for coming to share with us your experience.

MS MURANGUA Thanks, professor.

JUSTICE NGCOBO Does that conclude this session?

ADV PILLAY SC Chair, that's all the programme for the day, yes.

JUSTICE NGCOBO Yes. There is no one who's supposed to come tomorrow who is willing to come in today?

ADV PILLAY SC We potentially have a presenter who is meant to present tomorrow, Chair. If we can ask for just a five minute adjournment we can ascertain if he's prepared to do his presentation today.

JUSTICE NGCOBO But only if he is willing and prepared.

ADV PILLAY SC Absolutely, we'll try and ascertain that, Mr Chair.

JUSTICE NGCOBO Please make sure. Do you want us to ...

ADV PILLAY SC If we can have a five minute adjournment.

JUSTICE NGCOBO To take a break.

ADV PILLAY SC To ascertain, yes.

JUSTICE NGCOBO Shall we say ten minutes?

ADV PILLAY SC Ten minutes.

JUSTICE NGCOBO Very well. Okay, can we come back at quarter past three?

[END OF THIRD SESSION]

[START OF LAST SESSION]

JUSTICE NGCOBO We have come to the end of our proceedings for hearing one. We will reconvene tomorrow at 9.30 where we will be hearing from Section 27, the World Health Organisation, and the Organisation for Economic Cooperation and Development, and COSAD. Now, do you get ... do they make available to you the programme for the day? You do get that. Okay. Very well. So there is no reason why you shouldn't be here. Because you know what time we'll start. Okay, very well. Can we then adjourn until tomorrow morning at 9.30? Thank you.