FRAUD, WASTE & ABUSE

SUMMIT

CMS Council for Medical Schemes

28 FEBRUARY - 1 MARCH 2019 SANDTON CONVENTION CENTRE

Rapporteur Report

Partnership towards curbing fraud, waste and abuse.

HFA HEALTH FUNDERS ASSOCIATION

B·H·F SOUTHERN AFRICA

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List of abbreviations

ADV	Advocate
AGM	Annual General Meeting
AOD	Acknowledgement of Debt
ATC Classification	Anatomical Therapeutic Chemical
BHF	Board of Healthcare Funders of Southern Africa
BMI	Body Mass Index
CEO	Chief Executive Officer
CMS	Council for Medical Schemes
DDD	Daily Defined Doses
DR	Doctor
FIA	Financial Intermediaries Association of Southern Africa
FSCA	Financial Sector Conduct Authority
FSB	Financial Services Board
FWA	Fraud, Waste and Abuse
GDP	Gross Domestic Product
GEMS	Government Employees Medical Scheme
GP	General Practitioner
HASA	Hospital Association of South Africa
HFA	Health Funders Association
HMI	Health Market Inquiry
HPCSA	Health Professions Council of South Africa
ICD	International Statistical Classification of Diseases and Related Health Problems
ICT	Information Communication Technology
IPAF	Independent Practitioners Association Foundation
IT	Information Technology
KZN	Kwa-Zulu Natal
MCO	Managed Care Organisation
MRC	Medical Research Council
MSA	Medical Schemes Act
NDoH	National Department of Health
NHI	National Health Insurance
NHRPL	National Health Reference Price List
NPA	National Prosecuting Authority
PMB	Prescribed Minimum Benefits
PSCBC	Public Service Co-ordinating Bargaining Council
PSSA	Pharmaceutical Society of South Africa
Q&A	Questions and Answers
SA	South Africa
SADC	Southern African Development Community
SAFPS	Southern African Fraud Prevention Service
SAMA	South African Medical Association
SIU	Special Investigations Unit
SNR	Senior
UPFS	Uniform Patient Fee Schedule
WHO	World Health Organization

Executive Summary

From 28 February to 01 March 2019, the Council of Medical Schemes (CMS) held its inaugural Fraud, Waste and Abuse Summit at the Convention Centre in Johannesburg, South Africa. Appropriately themed, '*Partnership towards curbing fraud, waste and abuse*', the Summit brought together the private healthcare sector including medical schemes, administrators, managed care organisations, policy makers and other role players to discuss strategies for dealing with fraud, waste and abuse towards a sustainable industry.

As an entity mandated with the protection of the interests of members of medical schemes in terms of the Medical Schemes Act, No. 131 of 1998; the CMS is committed to work together with all industry role players to resolve the issue of fraud, waste, and abuse in the sector.

Objectives

The objective of the Summit was:

To provide a platform to bring together industry players to engage on how to deal with fraud, waste and abuse for industry sustainability by:

1. Establishing standards for the industry to effectively deal with fraudulent activities. This includes fair sanctions for convicted fraudsters.
2. The signing of an industry agreement or charter where all stakeholders pledge to contribute to combating fraud, waste and abuse, in line with set standards.
3. The establishment of a structure to continuously deal with fraud, waste and abuse after the summit.

Topics covered included the following:

- Unpacking fraud in private healthcare
- Overall effect of fraud in the industry and beyond
- Setting the scene on fraud, waste and abuse
- Stakeholder interaction
- Ethics of billing – Coding
- Role of coding in fighting fraud, waste and abuse
- The role of ICT systems in fraud, waste and abuse.

Outcomes

- Stakeholders committed to acting in addressing fraud, waste and abuse and took part in the symbolic signing of the industry Charter to affirm their commitment.
- Recommendations were made by different stakeholders throughout the discussions and these will be considered for the development of an action plan.
- Key actions have been identified to begin to implement some of the strategies presented at the Summit.
- Opportunities for industry partnerships and alignment were identified for further engagement.

Participation

The Summit drew participation from stakeholders in both the private and public healthcare industries, including healthcare service providers, regulators, medical aid schemes, professional associations, policy

makers, labour, non-profit and advocacy organisations. A total of 324 delegates attended the Summit. The Minister of Health, Dr Aaron Motsoaledi, delivered the keynote address at a gala dinner event held on Thursday 28 February 2019.

DAY ONE DELIBERATIONS (28 FEBRUARY 2019)

Opening address

Dr Clarence Mini, Chairperson, Council for Medical Schemes

The road to the Fraud, Waste and Abuse Summit
Dr Mini shared the following:

- The new Council was inducted 15 months ago. The Council is appointed by the Minister of Health for a period of three years. At the Minister's discretion this term can sometimes be extended.
- The newly appointed Council then embarked on a nationwide road to engage with the various entities it regulates and their management. These include medical schemes, care organisations and administrators. The Council has thus far seen 37 schemes and will resume roadshows after the summit. Recently the industry has seen the emergence of new entities that do not fall strictly within traditional categories of funds and administrators. Some of them are involved in models of global fees and in alternative reinvestment businesses. These entities were not left out of the Council's extensive engagements.
- The Council also approached industry bodies such as the Board of Healthcare Funders (BHF) of Southern Africa and Healthcare Funders Association (HFA). The purpose of the roadshows was to garner stakeholders' views on how to make the CMS more efficient. In the past CMS has somewhat slacked and the aim of the roadshow was also to correct this and to restore the Council to its rightful place as the centre of knowledge in the private healthcare industry.
- After a few months of roadshows, the CMS made the decision to join the multi-stakeholder forum headed by the Special Investigating Unit, in partnership with the BHF.
- It was decided that the CMS should lead an initiative, in the form of this Summit, where industry players are given the platform to share their different experiences and ideas on how to tackle the FWA challenge as a collective.

The journey thus far – unpacking fraud in private healthcare:

Presentation by Dr Sipho Kabane, Chief Executive & Registrar: Council for Medical Schemes (CMS)

Dr Sipho Kabane, having been recently appointed as the new official Chief Executive Officer and Registrar of the CMS, articulated the vision of the Council and gave an overview of the key discussions for the Summit.

He emphasised that the purpose of the Summit was to expose all the weaknesses within the industry and provide an opportunity to ventilate solutions, towards a sustainable private healthcare industry.

Context for fraud, waste and abuse

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

b. Medical schemes' membership growth has been stagnant, at 8.8% for the past five years. Fraud, waste and abuse is one of the deterrent factors into growing these risk pools, as it contributes to the unaffordability of medical scheme membership.
c. There is a growing trend of scheme members sharing dependants, while others are resigning from medical schemes, essentially creating a sustainability crisis for schemes. Schemes are in danger of collapsing due to low membership and unsustainable pools.
d. Examples of fraud, waste and abuse include:
    - fake ailments
    - instances where membership is substituted
    - dual membership, service hopping
    - people altering invoices
    - identity theft
    - collusion with service providers
    - members using their medical aid cards for non-medical expenses, buying groceries and other non-medical items
    - false claims of goods and services by providers, membership cards used by non-members with the collusion of the provider
    - false claims over billing, falsification of patient information, miscoding
    - supplying non-medical goods and services, and members being admitted unnecessarily or being investigated extensively or dispensing expensive medication that patients do not need.

Stakeholder concerns

Dr Kabane highlighted the following as concerns raised by constituents, who were of the view that the CMS should intervene and provide more leadership in combating fraud, waste and abuse. These included:

a. Schemes and administrators are employing a range of methodologies and systems to detect fraud. There is uncertainty about whether these are rigorous and are achieving their aims.
b. Approaches in managing fraud, waste and abuse cases are in some instances bordering on the illegal, with the use of sting operations and entrapment. These include that:
    - in some cases, service providers are allegedly coerced into signing acknowledgments of debt.
    - claw backs in addressing alleged cases of fraud, waste and abuse.
    - the abuse of Section 59 of the Act by simply not paying legitimate claims, or instead of paying the service provider, for no reason, or paying directly to members.
c. Other potentially harmful practices have been reported where hidden cameras are used, and clinical practices are disrupted, records seized, and intimidation of service providers and patients has occurred.
d. Complaints that the CMS is not executing its mandate as the regulator.

Dr Kabane highlighted that while fraud, waste and abuse are abhorrent, the rule of law should be upheld as the industry attempts to address this scourge.

Arguing on the extent to which the CMS could enhance its capability to address fraud, waste and abuse, he cited that the legislative framework does not give the CMS the powers it needs to regulate fraudulent activities, with specific reference to the Medical Schemes Act (MSA).

Key focus areas

Speaking about key areas of focus for the industry, Dr Kabane highlighted the following:

a. *Coding*: There needs to be focus on coding systems, as these have a direct impact on the billing practices and there is therefore a need to regularise and adopt unilaterally agreed upon coding systems. Fostering a uniform understanding of coding systems will go a long way in enabling those that step outside the norms in terms of the interpretation of these codes to be reined in.
b. *Coordinated and collaborative approach is necessary*: Various stakeholders have been trying their level best to develop systems to detect fraud, but these have been largely the main players in the industry. Units like the HFMU have also done extensive work in this area, but there is a need for collaboration between the CMS and the industry to accelerate information-sharing and various interventions.
c. *Training and development*: There is a need for training and development of law enforcement officers to handle fraud, waste and abuse in the medical aid sector, including assisting law enforcement to develop a comprehensive understanding of the Medical Aid Sector (MAS) to improve investigation and conviction rates.
d. *Standard principles:* Standard principles should be considered to bind all stakeholders with respect to fraud, waste and abuse.
e. *Enhance the role of representative associations*: The role of representative associations in addressing fraud, waste and abuse is critical and must be enhanced.
f. Short, medium and long-terms goals.

Dr Kabane shared that the steering committee has had several meetings and has come up with clear deliverables as follows:

a. *Short-term:* Robust and constructive discussions on how to combat fraud, waste and abuse, and a significant number of stakeholders signing the industry charter. Speaking about the industry charter for fraud, waste and abuse that would be signed on Day 2 of the event, Dr Kabane described it as a living document, open to ongoing adjustment as engagements are held and consensus is reached.
b. *Medium to long term:* After the summit, the industry should develop standards and best code of practice on fraud, waste and abuse; annual summits; monitoring and evaluation to measure progress made by the industry; a multi-stakeholder approach including the inclusion of SADC partners.

Q & A: Ms Grace Khoza, Chairperson of Council for Medical Schemes

Question: I am a healthcare provider. Do we have representatives from what used to be called the FSB in this meeting? Thank you.

Answer: Dr Kabane: For the purpose of summit, we are focused mainly on entities that we regulate and we have started with industry stakeholders that include schemes, administrators, brokers and managed care organisations. As I said in my presentation, this is just the beginning. There are a lot of stakeholders that are not part of this gathering that we still need to bring in, but if you look at the programme for today and tomorrow, you'll see the diversity in terms of the voices that have been brought here. I'm sure if we had more time we would bring in more regulators. I'm sure as a summit we'll be open to getting additional stakeholders coming in and sharing ideas with us. The format of today's summit – we said we wanted to sit in one room and talk about the rules of the game, and this has precluded the inclusion of other people.

Question: I see we focused on fraudulent behaviour and some of the bigger schemes do have things in place to deal with that. What we are not focusing on is the wastage and the abusive behaviour of the members and how we can combat that. There are sections that speak about terminating a fraudulent

member, but when it comes to wasteful and abusive behaviour, I think schemes or insurances are unable to deal with that, neither do we have any kind of recourse. What steps can the CMS perhaps give to us or how can we get to a point where we can find solutions for that kind of behaviour as well?

Answer: Dr Kabane: This is the piece of legislation that I talked about and I said I think it needs to be beefed up. I mention the fact that from a public health perspective, we cannot deny people access to health services simply because they are engaged in fraudulent activities. Let's say you've got this person who's got a communicable disease and is able through medical funding to access treatment for that, and this person is not keen to go to the public sector. Now if we close that person out, we are saying go out there and spread whatever illness that you have as punishment, and I believe that that punishment is actually not focused. Perhaps we can look at other penalties where we can ensure that these are focused on the individual and they are aimed at correcting the behaviour, but I'm sure we will hear from you during the different panels how you think this can be done. If you give us sound suggestions, when the Bill is being finalised, we'll incorporate those.

Question: Your industry reminds me of a plate of spaghetti – all intertwined and very slippery. You must be careful not to get caught up in the disorganisation because as medical scheme administrators, you need to stand up and protect me as a beneficiary. My point is this, if one reads an exceptionally well written report, the Health Market Inquiry (HMI), we need to be careful when we move ahead with your programme and I support it 150% that we don't scope the project too narrowly. Crime in common law is a very difficult thing to prosecute. So my question is did we give sufficient consideration to the findings in the HMI when we put together the Charter? It's exceptionally important that we get the fundamental brief correct which links in with the HMI which links in with the NHI and national government policy. My request to you is how much did we look at those external factors because your problem on the NHI report lies on the supply side. It's unregulated whereas on the demand side we are over regulating and over regulating me and you as a member. I think maybe we may have gotten it the wrong way around.

Answer: Dr Kabane: In the development of the Charter, we have looked at some of the recommendations that are coming from the HMI, one of which is what are the contributory factors to the runaway costs in the private health space. We believe that an initiative such as this one that is aimed at reducing fraud, waste and abuse, if it is successfully implemented, it will make an impact on the costing of the private healthcare services. Yes, the HMI gave us the provisional recommendations. Our understanding is that that is still a work in progress. We are still awaiting the final report that I'm told is going to be released later this year. Can I also just indicate that we couldn't say we will not complete the Charter until we've seen the final report. There's also been a delay in the finalisation of the Medical Schemes Bureau; the thinking is we need to incorporate as many of the recommendations that come from the HMI so that they find a way into the Bill, but we've decided to kickstart the process. This Charter is a living document. For now it will be relevant. Once we've heard the outcomes of the Medical Schemes Bill, the NHI Bill and the HMI final report; we will look at those, interrogate them and see how much of those recommendations will find a way into the Charter. As soon as we leave here tomorrow, and people want to make changes and comments, we will welcome them. Like I said, we'll come back here again and say these are the changes which we've incorporated. Thank you.

Comment: Dr Mini and Dr Kabane talked about member fraud. I think the issue that I picked up was that medical schemes are wholly owned by members and members don't know that because no application form talks about ownership. When you are employed, you are given an application form by Human Resources; if it's a closed scheme nowhere does it explain to the member that you are joining this thing as an owner. Therefore, you end up having members not appreciating the fact that this is theirs. You find that you struggle when you have Annual General Meetings or when you must vote for board members where people will ask you why they should vote for people in Gauteng when they are in Western Cape. To them, they have no relationship with these people. Unless members understand the ownership, they will not be able to appreciate the fact that if they steal, they steal from themselves; if they steal they are making it more expensive for themselves. I think that is the part in the whole value chain where you miss ownership.

Answer: Dr Kabane: We need to inform members about their rights and ensure that they find a way of taking ownership of the scheme, because what I'm hearing is that members seem to be dislocated from the membership of their own schemes. So, this is a challenge that is directed at all of us to see how we can do that.

Comment: Dr Kabane, my question is in two parts. The first is an observation of what you've said, and the second part is a question. The first part is that I agree with what you said about the legislation, but I want to caution you that when reading your legislation, you must be careful not to put it into a silo. It is only a piece of all legislation and common law in this country, and when you read the Medical Schemes Act, and the way it is being interpreted presently, I think you are unnecessarily restricting yourself. I'm a member of a medical scheme. I'm here because the objective and purpose of the Medical Schemes Act is to protect me against all the other stakeholders. In other words, to protect me against the medical scheme itself, which is represented by the trustees as agents on behalf of the medical scheme, and the medical scheme administrator. I work with other regulators as well and I noticed that the most important people, members of the medical schemes, that should be involved in the process are actually left out, that is nine million people – it's about time that we get the balance right.

<*Tea break*>

Panel discussion: Overall effect of fraud in the industry and beyond

Facilitator: Dr Nozipho Sangweni, Principal Officer, Discovery Health Medical Scheme

The following panellists participated in the discussion on the overall effect of fraud in the industry and beyond:

1. Ms Lerato Mosiah, Chief Executive Officer of the Healthcare Funders Association
2. Advocate Andy Mothibi, Head of Special Investigating Unit
3. Dr Katlego Mothudi, Managing Director of the Board of Healthcare Funders
4. Dr Sipho Kabane, Chief Executive and Registrar, Council for Medical Schemes.

The panel discussion on the effect of fraud in the industry and beyond centred on the ripple effect that fraud, waste and abuse in the private healthcare sector has on medical schemes, administrators, the government, and most importantly, the members. Throughout the discussion the issue on the possibilities of what could be done with the amount of money lost due to fraud was a common thread throughout. Speakers highlighted how:

a. R24 billion is lost to fraud, waste and abuse annually.
b. Taxpayers bear the brunt of fraud, waste and abuse.
c. Private healthcare is at risk of collapsing due to fraud.
d. Difficulty in preventing and stopping this scourge remains one of the biggest challenges in the industry.
e. The industry continues to work in silos while criminals continue to organise themselves collectively.

Concerns raised:
The panel cited the following concerns:

Billions are lost to fraud, waste and abuse
The panel highlighted that fraud, waste and abuse is a major challenge in the private healthcare sector in South Africa, with the CMS estimating that the scourge accounts for about 15% (R24 billion) of the R160 billion in claims that medical schemes pay out annually. Interestingly, R24 billion equates to the entire health budget of the Northern Cape Province.

Members and taxpayers bear the brunt of fraud, waste and abuse
A common thread throughout the discussions was that the impact of fraud, waste and abuse has far-reaching effects for all. The R24 billion that medical schemes pay out annually comes from member contributions and tax payers' money. This money could be used for other programmes that need funding, and much needed services could be provided for beneficiaries.
It is not just the denied access to services that taxpayers will suffer as a result of fraud, waste and abuse, but also a constant increase in premiums. When these billions are wasted, it impacts the cost of private healthcare, thus forcing medical schemes to increase premiums at a higher rate than they would normally have done. When premiums increase at a higher rate, membership either decreases or stagnates. When membership decreases or stagnates, schemes struggle to stay afloat and will have to shut down. When schemes shut down, jobs will be lost.

Private healthcare is at risk of collapsing
The panel agreed that fraud, waste and abuse has a potential to sink the industry. The issue of a stagnating risk pool (stagnated at 8.8%) and runaway costs, which has been a serious concern for the industry over the past few years, has reached a crisis level. This growing trend may result in the collapse of an industry that benefits at least 8.8 million people; and without the 8.8 million people there is no industry.
If the private healthcare sector collapses it will have a ripple effect on the entire health system, as it will force those who rely on it to move to the already overburdened public healthcare sector. Currently the public sector provides care to 84% of the population. In the event that the private sector collapses, it will contribute to the poor quality of services in the public healthcare space.
The major problems with the South African health system are the poor quality of healthcare services in the public sector and the cost in the private sector. With increased costs in the private healthcare sectors, medical scheme members will fall on the public sector, and increase the burden on a currently overstretched public healthcare system.

Difficulty in preventing and dealing with fraud, waste and abuse
While all sectors are exposed to corruption, health is one of the major ones. The panel argued that one of the biggest issues identified in dealing with fraud is the question of convictions where fraud is identified, as currently there is no system in place to ensure that convictions materialise.
Currently medical schemes and regulations are not sufficient to give enough power to the CMS to effectively and efficiently deal with fraud, waste and abuse.
The Medical Schemes Act sketches how claims should look, but it also empowers schemes not to pay if a claim is fraudulent. It also empowers them not to pay the member directly and not pay the provider directly if they think there is something wrong with a claim. If a member is errant, schemes can terminate their membership, however they are not going far enough in addressing the problem and there needs to be some input in those areas so that there are a set of regulations that address the matter effectively.
Overall there is difficulty in getting successful, as there is uninformed interpretation of the definitions of the various regulations and laws and different approaches and methodologies that are used by the industry.
This raise concerns around the issue of termination of membership, as members who are found to have committed fraud can still join a different medical scheme without facing any consequences. This is one of the major loopholes in the system and presents a lot of difficulty in dealing with fraud, waste and abuse.

The panel agreed that termination of membership is a short-sighted solution, and a long-term solution that looks at behaviour change mechanisms should be explored, including re-educating and rehabilitating members.

Challenges

The panel discussion identified the following challenges making it difficult to prevent and deal with fraud, waste and abuse:

a. CMS does not have systems in place to effectively and efficiently deal with fraud, waste and abuse.
b. There is an uninformed interpretation of the definitions of the various regulations and laws.
c. There are currently different approaches and methodologies being used to combat fraud, waste and abuse, but all interventions are being done in silos.
d. The risk pool remains stagnant at 8.8%.
e. There is poor gatekeeping – where a member is identified as having committed fraud and their membership is revoked, they are still able to register with another scheme.
f. Blacklisting a member found to have committed fraud is viewed as unfair as it will infringe on their right to be a member of another scheme.
g. Healthcare providers can easily register a new practice number if they are blacklisted and can continue engaging in fraudulent activities using a different practice number.
h. The CMS currently does not have enough power to effectively and efficiently follow through in dealing with convictions of those found involved in fraud, waste and abuse.
i. Terminating a member's membership requires the involvement of the employer in instances where they are subsidised, and that may give rise to disciplinary action.
j. Collusion between schemes and administrators, and practitioners and patients, is very high.
k. There is poor governance due to schemes having Boards of Trustees that are not fit and proper for the job.
l. Fraudsters have become brazen in their approach and the industry needs to step up its approach in dealing with fraud, waste and abuse.

Recommendations

a. There is a need to change the approach and the methodologies used to deal with fraud.
b. Fraud needs to be managed as a business risk. This means having adequate and relevant policies in place supported by relevant structure. These units must be properly resourced and include recognised risk management procedures.
c. Stereotypes must be stopped. Fraud, waste and abuse is not a healthcare provider issue but can be a board issue, employee issue, or that of the schemes and the administrators. Policies need to be all encompassing.
d. Beneficiaries must be empowered to know that they own the scheme and therefore have no reason to steal from it.
e. Combating fraud, waste and abuse must not be a policing act but an intervention that will ensure the sustainability of the private health funded systems.
f. The Medical Schemes Act must be reviewed to give the CMS powers to take decisive action in specific areas in dealing with fraud, waste and abuse.
g. Measures must be put in place to ensure the sustainability of the industry by growing the scheme membership.
h. Stakeholders must report fraud, as committing fraud is a crime.
i. Stakeholders must work together in unity and use the available resources to fight fraud, waste and abuse in the private healthcare sector.

j. There is a need to explore a more long-term solution focused on behaviour change, re-education and rehabilitation of members to addressing fraud, as termination of membership is not a short-sighted solution.
k. There need to be mechanisms in place to ensure that the monitoring and investigative capacity of both the regulator and the scheme are strengthened to detect fraud, waste and abuse early.

Industry gaps

a. There is no uniformity of interpretation of the definitions of the various regulations and laws, and of the different approaches and methodologies.
b. The SAPS still do not fully understand the legislation enough to appropriately apply it when fraud, waste and abuse cases are brought.
c. There is still no collaboration within the industry in dealing with fraud, waste and abuse.
d. The industry does not have a central information sharing platform.

It was clear from the panel discussion that fraud, waste and abuse in the private healthcare sector ultimately results in misappropriation of very limited resources and if the trend continues it will lead to the collapse of the industry.

All key stakeholders agree that there is no better time to curtail this than now. They committed to giving the scourge the attention that it deserves – which means more accountability and successful prosecutions. Stakeholders also committed to helping and working with the CMS in its effort to find preventative measures as opposed to the current paying and chasing method, which is a more reactive approach. A proactive approach is necessary to effectively combat fraud, waste and abuse.

Questions, answers and comments

Question: Why do most anti -corruption initiatives fail?
Answer: Advocate Andy Mothibi: What we have found is that when investigations are done, and a report submitted, there is no effective follow up to make sure that actions are taken to ensure that all those who are responsible are held accountable.

Question: Is there collusion within the schemes and members or even administrators?
Answer: Ms Lerato Mosiah: What I would say to that is that there should not be, and any event should be reported; CMS is one of the structures in place to report such an event. The reason we are here is to make sure that we work together with our regulator to make sure that we have a fool proof system.

Comment on collusion: Dr Katlego Mothudi: When you examine the HMI report it does raise some concerning facts about the relationship between the schemes and the administrators and raises several issues around governance. When you look at the issue of collusion it does happen and as I said in my opening brief no entity is immune. In some instances, individuals within an administrator are colluding with schemes' officials, practitioners and even with patients. There are reports that extend from the HFU that indicate that these types of collusions happen in that environment.

Question: What is the role of industry bodies in mitigating this effect?
Answer: Dr Katlego Mothudi: If you look at what we seek to promote, we always talk about promoting ethical leadership, but that would only be to the extent that it is acceptable through some codes of conduct within the environment. There are certain interventions to which industry bodies can commit and this includes training and making sure that the people that are entrusted with the beneficiary funds actually know and understand good governance practices and that they are empowered to make those specific decisions. Also having forums like these is critical to allow people the opportunity to report and give inputs.

Question: Have there been any interventions by the industry bodies to share information on fraud, waste and abuse?
Answer: Ms Lerato Mosiah: Yes, there have been quite a lot of interventions so far and we have heard of other players that have put up robust systems around big data that are actually assisting the industry

in monitoring and assessing the scale of fraud, waste and abuse and sharing such information across the industry.

Presentations: Environmental scan: setting the scene

Facilitator: Dr Sello Motaung, Acting Group Functional Specialist: GEMS MC, Medscheme

Presentation 1: Healthcare Forensic Management Unit (HFMU), Board of Healthcare Funders (BHF) of Southern Africa: Dr Hleli Nhlapo, Chairperson: HFMU

Context on what the health forensic management unit does:

a. The HFMU consists of medical schemes, forensic companies, banking institutions, managed care organizations, and medical schemes, and administrators – these are the main stakeholders that have come together to form the HFMU.
b. It's not only BHF members who are part of the HFMU, schemes also outside of the BHF network form part of the initiative.
c. The organization has partnerships with Global Healthcare and Anti-Fraud Network and also works closely with the Health Sector Anti-Corruption Forum; and the Health Professions Council of South Africa (HPCSA); and everyone involved in healthcare funding.

Considerations and recommendations

Dr Nhlapo made the following recommendations:

a. A partnership driven approach in tackling industry challenges is necessary, as the industry cannot fight fraud, waste, and abuse in silos.
b. Collaboration will play a critical role towards enabling the success of efforts towards tackling fraud, waste and abuse, and such collaboration should not just be with South African stakeholders, but with stakeholders across the SADC region, as the issue of fraud, waste and abuse affects the entire region.
c. There is a need to work together as an industry and share information for the benefit of all schemes and in particular smaller schemes; as they cannot afford some of the big systems being used

Challenges

a. There is very little success in winning court cases as there is no understanding of the Medical Schemes Act and cases get thrown out as a result
b. The disciplinary processes of the HPCSA are also ineffective as a practitioner will be guilty of 30 cases where there are hundreds of thousands of Rands involved but the sentence will be a fine of R10 000 that is payable within 90 days
c. Practitioners end up doing harm to the patients once they start practicing despite signing a Hippocratic Oath that vows to do no harm to the patients
d. There's collusion between members and practitioners that occurs towards the end of the year when members find that they have not used all their benefits
e. Prosecuting and getting a conviction is difficult
f. Some of the names that we see today that that we saw in the 90s are still the same names; and the same people creating problems within the funding industry.

Available tools

a. The BHF has set up a portal, which is a tool that is used by members that are registered and participating within the HFMU should be used to effectively address some of these issues.
b. The newly established anti-fraud initiative is a very good tool, you just put in a practice number of any practice that is suspicious or that you just want to see what is happening in the practice,

and the tools provides everything about the practice, who the practice belongs to and all information pertaining to the practice.

d. Every month the HFMU brings together member schemes to share information, do analysis as a collective.

Presentation 2: Medscheme: Mr Paul Midlane, General Manager: Healthcare Forensics, Medscheme

Examples on fraud, waste and abuse in the different provinces:

a. In Gauteng, one practitioners claimed R1million for surgery that he had not performed.
b. Another was a case of a dialysis claim for R4.7 million in a year; yet the dialysis was being done in the premises not fit for medical purposes at all; a place where no medical aid would want their members to go.
c. One instance was a pharmacy where the scheme had to pay about R80,000 per month for over the counter medicines, and yet there were no products dispensed, or scripts available or invoices, and members would cooperate with these pharmacists because they get cash kickbacks for this.
d. Another claim was of a cardiologist claim for R10 million in a year, and the doctor was charging over and above the actual value of an angiogram.
e. One orthopedic surgeon claimed R17 million in two years. The orthopedic surgeon was charging some members that code more than anyone else – it is called code unbundling, for example a biopsy claim can vary depending on the size of the member, for a really large person the doctor was charging code extra, he was getting extra for operating on a really large person as an orthopedic surgeon.

In specific patterns and trends, you can begin to pick up those outliers; and when you look at the patterns then begin to form a disturbing picture of markups of up to 1 500%.

Challenges

a. The current burden on the criminal justice system to deal with other types of crimes, its ability and capability to arrest a cardiologist or medical practitioner for over coding, etc. is a challenge.
b. Perverse incentives that are possibly giving rise to overcharging and over servicing.

Funds that are currently being lost to fraudulent and wasteful claims could be redirected to fund biological cancer treatment drugs or can go towards funding more elective surgery; and funding a whole lot of other medical needs.

Presentation 3: Discovery Health, Mr Marius Smit, Head of Forensics, Discovery Health

Some insights on the work that Discovery has been doing in tackling fraud, waste and abuse; and their experiences:

a. Over the last 18 or 20 years, Discovery Health has been deploying different types of technology to tackle fraud, waste and abuse.
b. In 2004, Discovery introduce a quality integrated case management system; and today the scheme has more than 150,000 investigations or information related to move on 50,000 investigations on that case management system.

c. Such systems can enable schemes to gain deep insights into trends within the industry, and how these trends change over time.
d. Discovery has also started relying more on artificial intelligence and machine learning, as a key component to addressing fraud, waste and abuse challenges.
e. If Discovery had not deployed such technologies to address fraud, waste and abuse, from 2012, it would have meant that the solvency of the scheme would have dropped to about 16% currently, and if nothing had been done, the scheme would be sitting at 27% to 28% solvency.
f. Discovery has seen the value that can be achieved in rehabilitation. Since 2012, Whenever an investigation is concluded, the scheme continues to monitor the change in behavior; and has seen that there is real value in managing this.

Challenges

a. It is difficult to adequately address the problem with coding if you don't rely heavily on technology.
b. The industry relies on a one size fits all model and that cannot work.
c. Members are being put at risk in instances of some of these fraudulent activities, as a result of abuse being perpetrated by hospitals – because admitting healthy people into hospital comes with risks.

Recommendations

a. The industry needs to rely on a mix of preventative and proactive strategies as the industry has relied heavily on a reactive approach.
b. There is a need to focus on focus on changing member behavior and rehabilitation; and the same should apply to healthcare professionals.
c. If the patterns for recoveries are tracked over time, one can begin to realise the value
d. the industry should not make the issue of fraud, waste and abuse become a doctor issue as there are a number of players involved.
e. The industry has a wealth of information that already exists, and there is a need to optimize the value that currently exists across the industry to ensure that it benefits everyone.

Presentation 4: Government Employees Medical Scheme (GEMS): Mr Ishmael Mogapi, Senior Manager: Operations Risks, GEMS

Highlights on some claims experiences from the Government Employees Medical Schemes (GEMS):

a. One claim was from a psychologist who claimed for 491 hours in one month.
b. Another was of a dietitian who claimed 73 hours in a day for a solo practice.
c. Other claims were fabricated, for instance for Voltaren scripts, yet the patient's illness or diagnosis did not align with the medication dispensed, someone would have influenza or depression but would get Voltaren – which is a muscle rub.
d. Some members are going to hospitals to claim for personal use; and yet with the admissions no evidence relating to pathology tests of that patient are available.
e. One medical practitioner who owns a construction company, would claim against a member to do the member's home renovations.
f. Members make claims for ambulance use, and yet they are not taken to hospital, but they use ambulances as a mode of transport, as a taxi service to go and do their shopping.
g. KZN presents the biggest challenges in terms of fraud, waste and abuse.

h. One practitioner brought in 36 practitioners to his practice and was using the practice numbers of these newly qualified practitioners to submit claims of up to R93 million – he is currently out on bail; he even tried to bribe one of the investigators.
i. Between 90% to 60% of fraudulent claims were against one practice.

These instances of irregular claims prompted the scheme to implement and develop systems to prevent this type of excessive claiming.

Challenges

A trend has been observed where healthcare practitioners employ graduates to register practice numbers against their names to use for fraudulent claims.

Recommendations

a. Industry stakeholders need to collaborate, share knowledge, learn from each other and implement.
b. There is a need to build relationships with provider associations, realizing that medical scheme fraud, waste, and abuse is not competitive – but it is an illness that the country faces and must be rid of.
c. There has to be consequences and an agreement on how the industry should deal with offenders.

The 2020 Summit must be a platform to report back on efforts by the industry as a whole.

Presentation 5: Southern African Fraud Prevention Service (SAFPS): Ms Lynette Swanepoel, Manager, New Business, Healthcare & Insurance (SAFPS)

Ms Lynette Swanepoel acknowledged that the effects of fraud, waste and abuse had discussed at length throughout the Summit. In her presentation she focused on the lack of reliable data, which has reduced current statistics to conservative 'guesstimates'. She raised the following issues around cooperation in the bid to end fraud, waste and abuse:

Challenges

a. The lack of reliable data, which has reduced current statistics to conservative guesstimates.
b. It is currently not possible to gage the effects of fraud, waste and abuse on the entire industry from a monetary value. Until the entire industry works together, it will not appreciate the true extent of the problem nor will it be managed adequately.
c. Medical schemes are doing well in terms of keeping a good tab on what this triple threat is costing them, however the industry falls short in ongoing monitoring and observing behavior changes
d. While there is a lot of informal fragmentation, the is still fragmented, there is a need for industry-wide cooperation that goes beyond individual affiliations.
e. There is a general concern and fear among industry players that information-sharing will result in them losing their competitive edge.
f. Criminals do not work in silos, and the same perpetrators of fraud in the medical schemes environment are the same perpetrators in the insurance environment, and the banks and retailers; and so there has to be collaboration with all stakeholders.

Recommendations

a. Promote information-sharing to have helicopter view of what is happening in the industry and for quicker identification of repeat offenders.

b. In the past, a strategy that worked was the use of high-level data that can be entered into a central repository and aggregated for a national and global perspective. While there are confidentiality issues, it is possible to ringfence data and make access available only to those interested parties.
c. Create a non-competitive environment where stakeholders can share knowledge or expertise without giving away valuable information property or trade secrets
d. In instances where fraudsters hop from one scheme to another, collaboration will close those loopholes.
e. Present equal opportunities for small and large schemes to contribute and benefit from anti-fraud forums.
f. Enable sharing fraud information, savings and losses for a more accurate picture of the real extent of the problem.

Opportunities for training

a. The focus of the South African chapter of the Certified Fraud Examiner (CFE) is to develop a training course.
b. In 2012, the body recognised a real need for formal training within the healthcare forensic environment and since 2012 there have been efforts to develop a training course under the auspices of the American College of Physicians (ACP) – which has already had its professional standards approved.
c. The academic standards are currently up for comment on the website. The institution is also in the process of establishing accreditation criteria stakeholders are invited to get involved in the process.

Presentation 6: Insurance Crime Bureau: Mr Garth de Klerk, Chief Executive Officer, Insurance Crime Bureau

a. In his presentation Dr de Klerk highlighted that there are different things and different skills that one needs to bring to the table in dealing with fraud, waste and abuse.
b. The Insurance Crime Bureau (ICB) and its work:
c. The ICB is a non-profit-organisation that was established in 2008 and has been in existence for 11 years.
d. The organization's vision is to play a part towards addressing organized crime in this sector and the organization aims to start acting as an intelligence hub to ensure that there is a central approach to fighting crime and fraud in South Africa.
e. Currently the Insurance Crime Bureau can centralize multiple data sources, with specialized skills and unique technology collaborations the organization is able to detect and prevent insurance related fraud and crimes in order to convict and recover for members.
f. The Insurance Crime Bureau has recovered over R1 billion in actual Rands for its members. This has been possible as a result of the insurance industry working together in collaboration to fight fraud and crime.
g. In 2015, the ICB had 16 insurance members, and that has increased to 32.
h. The role of the organisation is to combat organised crime syndicates, within motor, non-motor, commercial, life insurance and funeral policies. The ICB also does general investigations such as on staff, service providers, brokers, government, etc.
i. Currently, the insurance industry has about 3 040 cases of fraud reported per month.

Lessons learnt

a. Whistle blowers play a crucial role in helping to combat fraud.
b. The insurance industry has positive law, similar to army law or corporate law etc, and one of the problems with this is that it also imposes restrictions.
c. Organised crime keeps getting more innovative.
d. The industry has a long list of stakeholders that we all brag about and yet that list is not being utilized. Dr de Klerk highlighted that the ICB utilizes the full list of its stakeholders to work together to fight against crime and fraud.
e. The ability to continuously engage relevant stakeholders such as the NPA, the Road Accident Fund (RAF) and other stakeholders has played an important role in driving the organisation's success in tackling fraud and crime in the insurance space.
f. The insurance fraud line that the ICB introduced for the industry to report fraud has played an important role in tackling crime and fraud.
g. Syndicates are still able to operate, even while in jail, they can still perpetrate fraud from jail, currently the ICB has four syndicates who are in jail and they are still able to operate.

Recommendations

a. The industry needs to legislate but must be careful of being restricted by legislation.
b. Fraudsters should be involved in product development, as they been able to come up with some of the most innovative scams over the past 20 years; and they should not be employed because of their qualification but based on their capabilities.
c. Identify joint ventures to share information and bring related parties together to provide intelligence systems and product technology to the fight against crime and fraud.
d. Stop working in silos, because criminals are organised, they don't work in silos, they work together; and so, the industry needs to work together to tackle fraud, waste and abuse.

ICB claims experience

a. Some of the top investigations that the organisation has conducted include, serial habitual claimants, incident staging, hijacking, theft, fast track claims, walking dead – which is an instance of fraud where people claim they died; and the pattern then uncovers that the same person has died several times, yet they are alive etc.
b. There are some instances where people pay for children who don't even exist in the system, these are the expensive paper children claims.

Presentation 7: Dr Simon Mangcwatya, Principal Officer, Sizwe Medical Fund

a. Sizwe Medical Fund is currently dealing with medico-legal cases, some amounting to R2 million.
b. Internal governance structures played a very important role in improving results on efforts to tackle fraud, waste and abuse for the scheme.

Recommendations

Dr Mangcwatywa made the following recommendations

a. There must be regular engagement and reporting on fraud, waste and abuse in the industry going forward.
b. Internal processes must be strengthened to deal with crime and corruption.

c. Elevate the issue within the medical scheme space and put processes in place to adequately respond in the form of committees and through the participation of committee members and the board.
d. There needs to be collaboration with internal and external stakeholders.
e. Use proactive strategies such as member education around what fraud is and what members can do to help manage the issue.
f. Utilise detection analyses assessments.
g. Implement resolutions and recommendations post-Summit.

Panel discussion: Stakeholder interaction (Part 1)

Dr Sello Motaung, Acting Group Functional Speciality: GEMS MC, Medscheme

The following panellists participated in the first part of the discussion on stakeholder interaction:

1. Ms Aneesa Mahomed, Director of Corporate and commercial law: Gildenhuys Malatji
2. Mr Barry Childs, Chair of the Healthcare Committee: Actuarial Society of South Africa
3. Advocate Maile Ngake, Chief Director: National Department of Health
4. Mr Gary Feldman: Financial Intermediaries Association
5. Mr Nkululeko Conco, Attorney: Section27
6. Dr Mvuyisi Mzukwa, Board Chairperson: South African Medical Association (SAMA)
7. Mr Frikkie De Bruin, General Secretary: Public Service Coordinating Bargaining Council

The panel highlighted some of the observable fraudulent activities including:

- codes-manship.
- care-seeking entitlement behaviour which emanates from the patients belief that contributions are so expensive that they should be able to get whatever they want.
- phantom members.
- phantom patients and governance failures at a macro level.

Industry gaps

a. The panel highlighted that the medical scheme environment is a very complex one and lends itself to fraud, waste and abuse risk because of its third-party payer system, significant information asymmetry, incomplete regulatory structure, lack of guidance on non-negotiated prices and limited cooperation amongst stakeholders.
b. Fraud in the private healthcare sector is unlike embezzling money out of a public health department where the result would be patients denied care, and an inability to hire enough doctors or to stock enough medicine. Because of the way the private sector works, it always translates into higher contributions and people having less coverage because of buying less benefits. This in turn leads to increased out of pocket expenditure.
c. Fraud often starts before a member even becomes a new member, for example in instances where a member does not truthfully disclose the full state of their health.
d. Members tend to go to specialists before seeing their GP or even trying self-medication, because people still see medical aid as a grudge purchase; and therefore, want to make use most expensive treatment they can access.

e. The competitive advantage factor is missed out in the provider space because patients do not usually source more than one quote for medical procedures before the insurer can approve; they instead settle for the first provider they see – therefore leading to waste. In addition, there is not enough emphasis on the use of generic medicines to ensure savings for medical schemes and members.
f. Hospital-centric benefit plans are a major contributor to waste. This approach favours the hospitalisation of scheme members for certain procedures. Globally family practitioners are regarded coordinators of care yet in the South African context there are several benefit plans that allow members to bypass their family doctor. The result is a duplication of services, poor coordination and a significant increase of hospital admissions because of sub-optimal care in the hospital environment, largely due to the fee for service model which promotes an individualistic approach to the management of care.

The inflationary effect

a. Fraud, waste and abuse is not merely a fixed cost in the industry, it contributes to inflation.
b. The second order effect means that there is probably a 1% - 2% addition to contributions because of the results of the costs being high in the first place. The frequently quoted R20 billion is only the first effect.
c. From an actuarial point of view the higher the costs, the higher the medical scheme contributions will be. When contributions are higher than they need to be, members do not see value for money and because there is no complete regulatory framework with mandatory membership, anti-selective behaviour emerges where people buy down as they cannot afford higher plans.
d. Members simply claim within the confines of their plan. Alternatively, people selectively lapse out of the environment or reduce the number of beneficiaries on their plans, which becomes a card farming exercise; and when these factors compound, medical schemes have no choice but to increase contributions.

The role of fraud in medical negligence

a. Offenses related to medical negligence in the public sector tend to be associated with medical practitioners who are not necessarily medical practitioners. In the prosecution of cases in relation to people masquerading as doctors and ultimately creating problems in the healthcare sector; identifying a fraudulent doctor is dependent entirely on the health professionals council.
b. There is a rising trend of cases linked to organised crime. The Department of Health has pledged to continue to work with the SIU in the early detection, prevention and in raising awareness of corruption in the health sector.

The perspectives of medical healthcare professional associations

a. The public image of doctors adversely affects the quality of care and seriously compromises the sustainability of the private medical practice.
b. SAMA believes that there is a need for a comprehensive and integrated engagement with as many as of its members as possible.
c. SAMA would like an opportunity to engage its members further to ensure that their views are fully reflected in the industry charter on fraud, waste and abuse.
d. SAMA will not support with full conscience or defend activities that undermine the professional integrity of the organisation.. The members of SAMA fully support and endorse the Summit.

e. SAMA cautioned against a simplistic narrative that is one sided and fails to address the complexity of the beast that is fraud, waste and abuse. As such, SAMA was committed to working with different stakeholders to change this narrative, to change the scenario and call for transparency, fairness, equity in the process.

Challenges

The panel discussion identified the following challenges making it difficult to prevent and deal with fraud, waste and abuse:

Implications for access to healthcare

a. The private healthcare sector serves a fraction of the population, but far more is spent on the private healthcare sector. It is unaffordable for most South Africans.
b. Public healthcare is affordable but falls short of the requirement of access.
c. The upward spiral of healthcare inflation makes private healthcare unaffordable for most of the population. There implications are that:
    - The consumer is then forced to access public healthcare institutions. The simplistic reason for that is the need for healthcare does not end with their ability to belong to a medical scheme.
    - A public healthcare system that is barely coping with the needs of providing adequate medical care with the poor of the poorest is now faced with coping with an influx of a new group of middle-class dependents that now makes use of these facilities.
    - Fraud, waste and abuse hampers the ability of the industry to achieve universal healthcare to all citizens.

A hostile environment

a. Funder-provider relationships are presently very strained; this needs to be reined in as the industry is never going to cooperate if this level of animosity continues.
b. It appears that professional associations take a wait and see approach and defend their own constituents' roles.
c. Cooperation should not be reduced to lip service.

Industry gaps

a. The panel expressed their disappointment in the further delays of the final outcomes of the HMI (Health Market Inquiry) but anticipates that the inquiry will make a difference in the industry.
b. The panel noted the tendency to define the role of the CMS far too narrowly.
c. Regulatory bodies such as the CMS must be reminded of their role, duties and the broad scope of their powers.

Recommendations

a. There is a need for collective action is necessary to address the systemic issues that promote wastage. Some progress can be made with smarter contracting and benefit designs.
b. The industry has got to invest in data and analytics. The BHF and HFA currently in the throes of a data aggregation exercise to gain a helicopter view of what is happening not in financial terms but at an activity level. So far, about 80% of the medical aid scheme lines have expressed a willingness to participate.
c. The pace of change in the regulatory framework is much too slow, which means that fraudsters are always one curve ahead. A more agile legal framework is needed to make a huge dent in curbing fraud, waste and abuse.

d. Support from all stakeholders is very critical in dealing with fraud, waste and abuse offences.
e. From a financial perspective, the medical schemes sector in South Africa is pressurised; curtailing widespread fraud, waste and abuse will make medical aid more affordable and accessible to more South Africans.
f. Regulation needs to change to allow for members to be disqualified for a non-disclosure.
g. Brokers must play an active role in educating members on how to understand their benefits and claims statement to enable them to readily detect collusion.
h. Intermediaries are instrumental in educating against doctor hopping as this leads to an abuse of the system.
i. Revisit product structures to make more them affordable or effective for the long-term sustainability of the medical scheme environment.
j. The panel supports universal healthcare to improve quality, coverage and equity, however the country must first fix its existing public healthcare systems.
k. Poor quality in the public sector must be addressed through various mechanisms and affordability in the private healthcare sector should be revisited.
l. The HMI recommendation must affect the MSA amendments, ensure supply side regulation, and strengthen regulatory bodies such as CMS.
m. The panel called for the CMS to take proactive approach to curbing fraud, waste and abuse through training to help aid ordinary members of schemes to correctly interpret PMBs.
n. Membership contributions should not increase at the rate that they do.
o. Members themselves should not be contributing to further fraud, waste and encouraging over-servicing from healthcare providers.
p. With the high degree of mobility of fraudsters who have been identified as bogus healthcare service providers, they become difficult to detect when they disappear into the private sector. There is need for some kind of register where such offenders are made be known to the industry as a means to deter these behaviours. This Summit gives the industry an opportunity to make sure synergy exists with consequence management with all those who are involved in fraud, waste and abuse.
q. Efforts to halt fraud, waste and abuse can be significantly improved.
r. There is need to revisit the legislative framework including the Medical Schemes Act and proposed amendments.
s. Power relations between the service providers must also be revisited
t. The NHI is likely to be implemented in the foreseeable future. This will improve access to healthcare if implemented as per principle of universal healthcare.
u. The CMS should investigate areas of board representation and broaden representation to allow for people to be representation by their trade unions.
v. The panel argued against the perspective that the most efficient way to deal with fraud was to deal with the member as about two thirds of fraud happen between health professionals and corporate individuals, and only a third of that can be attributed to the member. In addition, professional associations representing doctors and lawyers should unpack factors leading to high levels of fraud and corruption in the professions.

A common theme that emerged from this discussion was that provider organisations should play a more active role in curbing fraud, waste and abuse. Secondly, an incomplete regulatory framework is one of the major contributors to this ongoing challenge, and therefore the regulatory environment needs to be fulfilled with reasonable coherency.

Q & A: Dr Sello Motaung, Acting Group Functional Specialist, GEMS MC Medscheme

Question: This goes to Section 27. As you said, the medical aid always increases your rates by 10% according to the economy. Please be aware that for the healthcare practitioners they increase it by 5%. I also want the Actuarial to take a good look at this that how much healthcare practitioners' worth. Medical aids pay dieticians 250. They're worth 250. GPs are paid 350, 450. Are we worth 350, 450? I was in the tariff committee at the HPCSA which we couldn't discuss this because of the Competitions Commissioner

and these topics must be handled by the Minister of Health. Can you please, actuaries, look at this? We've been robbed as healthcare practitioners by the medical aids. Another thing is Section27 it's about individuals must have the right to have access to any health services. With this pre-authorization and we are told we don't authorize this, what are you saying, exactly, medical aids? Prescribed minimum benefits. I have the medication I must be told which one I must prescribe and so on and so on. This also limits us. The autonomy of the healthcare professional has been taken away from us because I must do what is the best interest of the patient, but I am no longer doing that.

Question: I don't think I'm suitably qualified to speak about how to work within the parameters of PMBs and the prescription of medications so that question should be better directed to my colleague from SAMA., but with respect to the increase in the rates paid to doctors and the medical aid contributions, I think that's a discussion that's between medical aids or the administrators as well as the doctors. We as consumers expect that we will be able to receive medical treatment and that we won't pay exorbitant amounts. How that arrangement is reached, we can't govern that. But we can say whatever factors are unnecessary drivers of the cost should be eliminated. If those are in the form of fraud, waste, abuse, incorrect interpretation of legislation, then that's what should be dealt with.

Answer: Barry Childs: So, it's almost what I tried to illustrate in the first point I made in the second order effect of fraud, waste and abuse or having a high cost base in general whether it's because of incomplete regulation or fraud, waste and abuse. I'll add a couple of extra things in. So, the question of medical aid contributions going up by a difference of 10% or others getting 5% increases in the tariffs. The difference between those two is utilization. So, 5% more people are going to healthcare providers and healthcare facilities and getting medicine. Medical schemes are a zero-sum gain. The money can't go anywhere else. There's no dividends paid out, there's no taking the money out in any kind of way. They pay for services to third party administrators, if they're open schemes, they pay for brokerage, CMS fees and other things like that but by far the bulk of the money goes to paying medical schemes and providers and that's a zero-sum gain. And they must balance the books every year. There are regulatory requirements for solvency and for self-sustainability so if prices go up because the claims go up and the utilization goes up, contributions have to go up in that magnitude. It's a zero-sum gain. If prices for providers went up 10% the contributions would be going up 15%, not 10%. So every year that little bit of increase utilization is what's the difference between the provider prices, the price increases that they get, and what the contributions go up. Here we get into some interesting conundrums because you're quite right because the focus of the practitioner is to give the best care of the patient in front of him. But unfortunately, that's not the best place to do rationing is. We have very much the tragedy of the commons phenomena where if we add up what's in the best interest of the individual, that's not what is the best interest of the community as a whole. So, from a medical scheme looking after a population point of view, their perspective is to balance their books on the whole population rather than the doctor which is in the best interest of the patient in front of them. When I spoke about altruism, that's what happens. Doctor is trying to get the best care that he can for the patient within the confines of complicated benefit designs that he might be faced with. So, in those cases, he or she is going to work around the rules or admit the patient to unnecessary excess care because that's what they're trying to do. They're trying to get care for their patients. And there are, I've spoken to many doctors, where this is the cause of their driver behaviour.

Question: Barry you say you've done a lot of work within the medical industry and medical aid industry. What is your opinion in terms of reducing fraud, waste and abuse within the medical industry if medical aids provided and were able to fund preventative medicine instead of only funding curative medicine?

Answer: Barry Childs: So, the industry, over the last 10 or 15 years is starting to come around to understand this. About 20 years ago it became the way to compete to offer rich benefits and to offer freedom of choice and a sort laissez faire way of care. We are reaping the negative benefits of that now in the way that people have become entitled in the way that they access care. What we are seeing now emerge which is encouraging and slow is the adoption of more conservative benefit designs where members, in return for a lower contribution, nominate a primary care provider that acts as their care coordinator and in some of those more progressive benefit designs can only access specialists when they've gone through the provider so when we speak about progressive benefit design, that's what I mean. It's insignificant savings there, it's the kind of active based contracting that I was talking about earlier. Even on plans like that there is much less fraud and a much more active contracting basis with the provider and not a random new practice number that's been registered and you don't know who this person is. There is a contract somebody would have had to sign, and it comes with obligations that can be audited and, in those cases, not only will there be less fraud, waste and abuse but the care continuum that those patients will follow will be much better at a lower cost.

Question: Mine is more a comment than a question but you might be able to distil a question out of it. I thank the CMS for putting this kind of thing together and perhaps to bring it around to what envisioned or what I saw this as being. This is an opportunity for the industry to sit around the table and say, "we've got a big problem". We have fraud, waste and abuse which is leeching money out of this entire system and it's causing this ship to sink. Barry crystallized it well where we are starting a downward spiral and what I'd love to hear from the speakers coming on is what are the core challenges? How can we address them? And what needs to be done to address them? I think the reason why CMS invited the various parties is so they can say when we come to this solution, we'd like to see this happen rather than say we are not going to be part and parcel of a solution. So, I'd very much love to hear how we solve these problems. Not pointing fingers at who's causing it but identifying it so thanks to the first round of speakers who have sort of gave a very granular picture of what fraud, waste and abuse looks like in our industry and the next set who are hopefully going to give us a broad strategic view of how we are going to address this problem so that we can take this forward. If you can find a question in there, I'm happy but it's probably more of a comment than an actual question.

Question: We all know that medical schemes are not for profit, but the problem is the administrators are for profit. So, the people that are being used to administer are for profit, so they will do whatever they want to save, at times at the expense of the patient. For example, there is a case where a patient was admitted and two days later was discharged from hospital. Two days later the patient needed to be re-admitted to hospital, but the scheme (I won't mention the scheme name) declined the admission and said the patient had recently been admitted – clinically, this is not how we speak, in clinical terms the scheme should have asked what is happening with the patient and what is the reason for the readmission. The patient went back home and did their home remedies, but there were complications, and the patient was taken to another and admitted there. Two hours later, the patient died. There must be a multi stakeholder forum to talk about these issues, as well as issues around PMBs.

Answer: Barry Childs: Do you think the administrator makes more money by denying care to the patients? That's the question because this comes up a lot. I can tell you that they don't. Administrators don't get more money if they deny care to patients. It's not in their contracts, the CMS has forbidden performance-based fees of that nature for this kind of reason, so they don't. The administrators make what they make in their contract with the medical schemes. I'm not here to defend the business models

or the levels of profit but the argument that says that administrators who are for profit make more money because the care is denied to patients is completely incorrect.

Panel discussion: Stakeholder interaction (Part 2):

Ms Nokuzola Mtshiya, Head of Marketing, Board of Healthcare Funders of Southern Africa

The following panellists participated in part two of the discussion on stakeholder interaction:

1. Ms Elsabe Klinck, Managing Director, Elsabe Klinck and Associate
2. Dr Elijah Nkosi, Chief Executive Officer, Independent Practitioners Association (IPA)
3. Dr Prudence Buthelezi, Secretary General, National Healthcare Professionals Association (NHPA)
4. Ms Anri Hornsveld, Pharmaceutical Society of South Africa (PSSA)
5. Ms Milly Ruiters, Acting Commissioner, Compensation Fund

Note: Dr Dumisani Bomela from the Hospital Association of South Africa (HASA) was supposed to be part of the panel but was not present.

The second part of the discussion on stakeholder interaction highlighted the plight of healthcare professionals who are at the receiving end of forensic investigations. The discussion focused on:

a. How to represent and assist healthcare professionals who are at the receiving end of forensic investigations.
b. The need for the application of a lawful framework in engaging with stakeholders suspected of fraud.
c. How to recover losses due to misconduct.
d. The need for medical schemes to adhere to all law.

Presentation 1: Ms Elsabe Klinck, Managing Director: Elsabe Klinck and Associates

Elsabe Klinck and Associates assists healthcare professionals who are at the receiving end of forensic investigations.

Ms Klinck shared the following experiences:

A lot of the cases they deal with involved ICD 10 codes, there are a lot of instances where claims are made against the same ICD 10 code in every instance.

The role of the law and some concerns

a. The law is a great equalizer. The law should set the framework for dealing with this and that's how it's approached.
b. Fraud is defined by law and theft is defined in law.
c. Section 59 gives you two basic big grounds on which to recover monies. It's to recover payments that were not due and in instances where has been misconduct and that's a massive grey area; as this does not clearly articulate who makes the call as to when there misconduct – and this is a big area for consultation to seek clarity.

Industry gaps

a. Definitions of different terms such as negligence and misconduct remain vague within the context of the law.
b. There is a provision in the Medical Schemes Act that says medical schemes must adhere to all law, this means that while medical schemes exercise their function, they must also adhere to administrative justice principles, and consider professional legislation; however, this is not the case across the board.
c. Healthcare professionals are easily intimidated by the whole process and the first reaction is always that when they are approached, they have done something wrong.
d. There is usually overall misunderstandings between investigators and healthcare professionals, the two don't understand each other.
e. One practitioner lost her practice because of the issue on coding; and that's the kind of thing that does not sit well in the sense of justice.
f. Issues of healthcare professionals not being understood, there needs to be procedural fairness and not necessarily forensics.

Ms Klinck suggested that if the industry wants to resolve the coding issue, then there must be price regulation.

Presentation 2: Dr Elijah Nkosi, Chief Executive Officer: Independent Practitioners Association Foundation (IPAF)

a. The organisation is a doctors' association with more 5 000 doctors.
b. The organisation was formed 10 years ago when four networks came together; and has offices in Durban, Cape Town, Pretoria and Johannesburg.
c. The organisation has contacts with schemes and administrators and the directors are involved in various committees; and one is in the office of Healthcare Standards and the other director is in the Peer Review Committee.

He provided the following perspectives:

- Fraud is unlawful and is not a victimless crime. It drives up the cost of care, resulting in members paying a higher premium.
- IPAF is against any form of fraud is continuously working with its members to urge members to exercise care and caution when providing medical services and claiming from schemes for services rendered.

Concerns

Dr Nkosi raised the following concerns:

a. Doctors are experiencing several challenges and entrapment is one of them, the IPAF, is against that kind of entrapment; as doctor intimidation threatens the process of reporting to the HPCSA, when they have signed an AOD.
b. Any person is presumed innocent until proven guilty and any unethical matter has to be reported to the HPCSA and if there is a criminal matter, it has to be reported to the SAPS.
c. In terms of section 34 of the Prevention and Combating of Corrupt Activities, a fraudulent activity that involves the amount of R100 000 has to be reported to the HPCSA; he noted that the IPAF's is against the position of intimidation and entrapment by forensic units.

Recommendations

a. Fraud should be separated from waste in that there is an intention to deceive but when it comes to waste and abuse, it's a different situation.
b. Categories of waste would in fact be failure of care coordination.
c. Peer reviews can be contributing towards improving overall care coordination, the objective of peer review is to promote quality and cost-effective healthcare, it's a collegial process.
d. Peer reviews also help in the mentoring process of that particular doctor; and through the process it becomes easier to isolate practices that might be fraudulent or wasteful or where there might be abuse. Where fraud is suspected the IPAF hands over such cases to the scheme; but in instances of waste and abuse, the mentoring process takes place.
e. More schemes need to be part of this process as this would probably do a lot in terms of reducing waste and abuse through the peer review process and mentoring.

Presentation 3: Ms Anri Hornsveld, Pharmaceutical Society of South Africa (PSSA)

The PSSA has just have over 6 800 pharmacists who are members of the society.

Concerns raised:

a. The Charter mentions that there will be a system to address fraud, waste and abuse, but there are not details on how this is going to be carried out.
b. Section 14.2.3 of the draft Charter that has been circulated; states that medical schemes, administrators, MCOs agree that they will always act in a fair, transparent and objective manner when dealing with matters of fraud, waste and abuse and that they will act within the law at all times; but the industry's experience has not been this up to date.
c. Currently when PSSA members are exposed to these forensic investigations there is no fairness or transparency or objectivity.
d. Pharmacists face several problems from buying groups because smaller pharmacies cannot benefit from buying in larger quantities on their own.
e. The Pharmacy Council allows these buying groups but seemingly, the forensic investigation units do not.
f. When pharmacists are being investigated, or if there is some form of investigation, payments are held back; and in rural areas this has very severe effects, as it means that members from medical schemes would have to pay cash for medication which they do not always have; and they do not usually have the cash to pay for their chronic medication to then later claim it back.
g. The Charter must set out clear processes on how it is going to be implemented, and how the industry will ensure that such a process is fair, transparent and within the law.

Presentation 4: Prudence Buthelezi, Secretary General, National Healthcare Professionals Association

Dr Prudence Buthelezi provided the following perspectives:

The NHCPA does not promote fraud, it stands against fraud, waste and abuse and hence has engaged with medical schemes to ensure that healthcare practitioners who commit fraud, or are found selling products in exchange for medical aid with members should be brought to account.

Concerns raised

Dr Prudence raised the following concerns:

a. In terms of reimbursement of healthcare practitioners, healthcare practitioners are paid little by medical aids, they are paid what they are not worth. Dieticians are paid R250, general

practitioners are paid R350 and specialists paid R700; and this is something that must be reviewed.

b. The DIP service provider selected by the medical aid, by law this is unethical as this will lead to healthcare practitioners being controlled by medical aids schemes and in turn affecting their ability to provide the best service to patients.
c. There is abuse of healthcare practitioners by medical schemes, schemes are installing cameras at premises of doctors, which is in violation of our rights to privacy, they are demanding patient files which violates the patient's right to privacy and confidentiality. Medical schemes must do things right.
d. Healthcare providers are being exposed to fraud entrapment and there is abuse of Section 59 by medical schemes, entrapment is unethical and illegal; this must stop.
e. There is also abuse of section 27 as some healthcare practitioners are being forced to sign *this AOD* because they are under duress. Section 35 of the Constitution is being violated, because they are unable to get legal representative or appeal what they have been accused of – we must investigate this.
f. The National Healthcare Professionals Association has brought many cases to the CMS relating to the abuse of healthcare practitioners by medical schemes, but the Council has turned a blind eye to the cases presented to them, as nothing has been done.
g. Patients have brought complaints to the CMS and it seems the Council continues to turn a blind eye, relating to the abuse of medical schemes.

All stakeholders, including the HPCSA, healthcare providers, medical schemes must do things the right way and in line with the law in a fair manner. The Council for Medical Schemes must regulate the medical schemes.

Presentation 5: Ms Milly Ruiters, Acting Commissioner, Compensation Fund

a. The Compensation Fund provides medical assistance to about 13 million employees who in the line of duty get hurt or contract occupational disease.
b. In the previous financial year, the Compensation Fund paid out about R3 billion to medical service providers, registered just over 184 000 claims and processed just over 750 000 invoices across nine provinces.

Claims experience

a. Fraud due to invalid medical service providers.
b. Over servicing of clients.
c. Problems with lawyers, litigations and third parties.
d. There is a whole industry that was created based on the inefficiencies of the Compensation Fund, and so there are several third parties and litigations.
e. There are syndicates working to defraud the Compensation Fund.
f. There is a lot of fraud in occupational therapy, and a lot of fraudulent claims when it comes to prostheses.

Efforts towards reducing fraud and corruption

a. The Compensation Fund for a very long time has been known for its inefficiencies. Over the last two to three years, there have been some structural reviews and changes within the organisation to address challenges.

b. A decision was taken to divide the organisation's core business into three core functions, namely, the pension fund, insurance, and the medical aid division.
c. To tackle fraud, waste and abuse, the Compensation Fund has created an anti-corruption and integrity management unit, and there has been successful prosecutions, however the efforts being made are just a drop in the ocean given the millions of Rands being lost due to fraud.

Q & A: Ms Nokuzola Mtshiya, Head of Marketing, Board of Healthcare Funders of Southern Africa

***Question: Ms Nokuzola Mtshiya*:** Besides the poaching of the specialized skills in the industry, how can schemes assist the Compensation Fund? Give me two areas where you feel the schemes can come and assist.

***Answer*: *Ms Millie Ruiters*:** Schemes can assist the Compensation Fund with sharing of knowledge. We have approached some of the schemes proposing to collaborate and they have not gotten back to us, sharing knowledge will be very critical for us. We have set up a medical aid unit and we need the knowledge. Stakeholder engagement and collaboration would benefit us.

Question: Ms Nokuzola Mtshiya: In terms of your line of work, what's your view in terms of how we handle the conflicts that you guys come across? There's most probably conflict between the funders and the providers and at times with the members. How do you feel we can handle some of this conflict?

Answer: Ms Elsabe Klinck: That' s what interested me in this summit initially is the opportunity to create joint rules that all of us can abide by. If we sort this by either make patients sign in and sign out of practices so that we can prove the exact time of it, let's just agree on it. Rarely do I see the conflict with someone totally guilty of bizarre stuff. It comes because somebody feels I've been treated unfairly, and the funder then feels that Elsabe has written us a letter with referencing section 59(3)(b) and everybody is kind of getting worked up on this. We know where the issues are, and we need to address those. We can't delay. If there's an issue on pricing and mark-ups on consumables, don't try to say a consumable is now a medicine and you can charge 26%. Don't do that. Let's then agree that there is a problem with mark-ups on consumables. Let's address that. Currently we're using all kinds of funny ways to try to solve the different problem and I think that's what causes the problem.

For me the law can be a great equalizer as it sets the rules for everybody and I think that's where we need to go. If the law is not clear, we need to make it clear. We're voting again in May for a Parliament, if the law is not clear, let's fix the law. So, I think the conflict comes because there is no agreement as to what the rules should be.

Question: Nokuzola Mtshiya: I heard you complain about the unfair treatment coming from scheme. In your view, how best can schemes handle providers that are fraudulent in your view?

Answer: Dr Prudence Buthelezi: Health practitioners who are fraudulent must be reported to HPCSA. We are regulated by HPCSA as healthcare practitioners. They must be reported to police stations and open a case.

Comment*: *Dr Prudence Buthelezi: Again, they must also respect section 59. If they see that I'm fraudulent within 30 days they must tell me within that 30 days, so they must also abide by their law, section 59. I spoke about the premiums, the problem with the 5% increase of the premium it leads to co-payment of which it affects their members. If they pay monthly their premiums and at the end of the day they must pay me another co-payment, it increases in their pocket, so they should look at that. To create a better relationship between the medical aid and the healthcare practitioners, they should just respect the rights of the healthcare practitioners, the right of the patients when it regards to privacy. The PMBs which judge Everson in July 2010 declare that it was null and void they should follow that. Council of Med Scheme should make sure that medical schemes follow that, and they look at this prescribed minimum benefit. I think if we can all of us follow the laws of South Africa we can do better.

Discussion delegates:

Comment: The biggest chunk of spend goes towards private hospitals, more than two thirds. If you add specialists, more than 80% of the spend of medical schemes is in hospitals and around specialists in private hospitals.
Now that is where a big chunk of the wastage would be, and we spend all this time focusing on individual practitioners. GPs get 6% of the total spend. When last did we hear of a hospital group where there was fraud and wastage? Because those cases exist but why are they not projected there repeatedly?
Comment: Another thing is that the council of medical schemes needs to come to the party especially around how schemes conduct investigations when it comes to fraud and how they go about dealing with it. There have been enough reports in the media and in Carte Blanche or where for instance a medical scheme was discovered to have allegedly extorted R23 million a month.

***Recommendation*:** I change the word extortion to questionable methods because the issue is it cannot be right for someone to say you owe me so much and if you don't pay and sign this acknowledgment of debt I will report you to the Hawks, I will report you to the HPCSA and sign those under duress. I think we cannot protect fraudsters but there must be a process that is legal like these are the allegations of fraud, these are the channels that you follow and not use underhand methods to collect. Ultimately, we want those fraudsters to be punished and we want to recover the money.
If you use those methods, you might get your money back, but the fraudster then targets other schemes and we do not solve the problem. You are supposed to get those people punished and the law takes its course and that's where we can make inroads in the fraud issue.
And the other thing that the medical schemes can help us with is to help members partner with the associations and help members with billing and coding so that a lot of these mistakes that happen at that level can be corrected and people can now know that look we've tried to help with people claiming coding. If someone does anything outside of this they commit fraud, not to say let's look at where the problems are and solve them. Thank you

Comment: Dr Elijah Nkosi*:* In terms of the processes that we have the peer review process, we can see where there might be fraud and waste and abuse. In a way once we then have this collegial process of that peer review, we can change the behaviour. In some instances, the doctor would see that if he looks at his profile and is shown other providers' profiles or if he's fraudulent in a way, he can see that he's just an outlier.
Through the mentoring and monitoring process he can change behaviour. But in instances where he refuses to be peer reviewed, in that case we then let the scheme decide how they take the matter forward. We are against any form of entrapment, we are against the signing of the acknowledgement of debt. Doctors in a way are being pushed into a corner to admit liability. At times for things that they might not have done. He can open the tap and be paid for the services he has provided. In a way if these forensic units could then be regulated somehow and have a standard that we all know how they go in terms of assessing fraud. In terms of how they manage the processes, in terms of ensuring that they stay within the law and not do things which are outside the law as well as try to recoup money that has been lost. In a way you can't use crime to prevent crime. It just becomes a self-perpetuating wrong.

Question: Elsabe is there a way except yourself as a lawyer or maybe do we need a tribunal that will then say because we have a dispute between a health professional and a funder who will listen to both sides of the story with representation from yourself and with representation from the funder and then make a decision and start to allow this health law to evolve beyond where we are currently. I think that would be able to help us.

Answer: Ms Elsabe Klinck: There have been a couple of cases in the Council for Medical Schemes that I tried to follow the principles of administrative justice and tried to set that, and I think that has helped. But I do think there is no agreement which that is why we have this ruling that says we can't make this pronouncement on this physiotherapist before the HPCSA has made a pronouncement and that just delays the thing.

We all know there are patterns. I can tell you what the issues are with physiotherapists, I can tell you what the issues are with dieticians and that's why I think that this is a solvable thing so if we can get rules around that it would be great because then we know.
I like this peer review thing where you say hang on there's somebody who can actually make a call which is why we love to work with the professional societies because the societies can tell you know what you cannot charge these two codes together or it's not possible to see that patient three times a day or you cannot have a constructive group session if there's 50 people in the group.
Those types of things I think are helpful, it's not formalized so in three cases it's done, in 20 it's not done, and I think that's the type of agreement we could reach to kind of help the process along because I hate the forensic stuff. I'd rather work on how we increase access to healthcare or how do we create better systems.

***Comment*:** Providers are faced with problems relating to how medical schemes are dealing with the. One thing that I want to raise is that there is relationship that exists between the medical scheme and the providers. When the member goes to see the provider, there is a contractual relationship that exists with the provider consent because the member is expected to fill in the form that says if the medical scheme doesn't pay I'll pay for the additional costs. In addition, the member has the contractual relationship with the scheme.
My concern is that because of different expectations that the providers have with scheme, vice versa, there is this perception that the medical schemes are not treating us fairly. What I'm trying to say is that the member has this relationship. It's tri-part relationship, there is a member, there is a scheme, there is a provider. And we need to take that into consideration that when the member goes to see the provider, there are scheme rules that are binding. However, those scheme rules may not supersede the medical schemes Act, especially in relation to the prescribed minimum benefits. Even if the member has prescribed minimum benefits, there are those that we call discretionary benefits, but the concern is that if the member is not involved in the cost of healthcare, it creates a challenge in terms of the funding of the healthcare services.

***Recommendation*:** Although there is autonomy in terms of the practice of the health professionals, there should be an understanding of the relationship that exists between the provider and the scheme and the member. And, section 6 of the National Health Act says that the provider has an obligation to inform the member of the cost of healthcare and the alternatives. Unfortunately, we don't see that taking place very often. You find that it is the providers opinion that this is the best treatment for the member.
Another challenge is that the standards in the private health sector are not the same as how we see things done in the state sector. What I'm trying to say in conclusion is that even if the doctor has the autonomy, there must always be this understanding that there is a contractual relationship between the member and the scheme, but the scheme rules do not supersede the Act.
The providers also have a duty to inform the member of the cost involved in healthcare because unfortunately when the member presents and whoever providers, you find that if they are sending the member for a scan they don't even know how much a scan is going to cost and who is going to pay for the scan.
If I request so many blood tests, when last did this member have similar blood tests? So those are the issues that we should also be mindful of with the expectation of having costs covered by the medical schemes. We sit with complaints where the member was not involved with the cost of care and the member had an expectation that the scheme is going to pay. Therefore, both the member and the provider are not really understanding because of this information asymmetry that exists within the health insurance industry. What are the actual entitlements in terms of what the member has purchased for provision.

***Question*:** If we are concerned about the challenges associated with fraud, waste and abuse, why is it that when we look at the private hospitals we find that in most cases we do not have what we call high care? You are either normal or you are in the ICU. Those people that are supposed to be in high care are charged rates at the rate of the ICU. Now the biggest problem that the health service providers, especially the practitioners, is that how do we deal with the issue of fraud, waste and abuse? Are we

being humane? Are we being fair? Are we being transparent? Are we being legal? Are we dealing with these things in a very professional way?

***Comment*:** From the discussions that we have heard today, it makes me even more convinced that the health professionals, especially the medical profession, has abdicated its responsibility to the legal profession, medical aid administrators, government officials, politicians and NGOs such as Section 27 with very little participation of the people who matter most who are the patients.
It is for the medical profession and health professionals to reclaim their roles in the very same way as the lawyers do. I have listened very carefully to the discussions as they were as we went on throughout the day. I find that it is mainly focusing on the members and the service providers and it is very little focus on the improved quality of service to members but mostly focusing on savings and recoveries and profits.
The issue of fraud, waste and abuse for those that might just reflect it only affects 20% of the people that are the practitioners. Whether they are general practitioners or health practitioners. If we go back and we reflect on what they call the 60-20-20 rule, you'll find that in most instances it's only this 20% that is problematic. There is a reason why we need the laws.
I would like to plead that the concerns that have been raised by Dr Buthelezi and the solutions that she has proposed should not be ignored. bulldog approach where the administrators are riding rough shots over health providers and if you look at it we must also be able to list very clearly as to what are the investigations that we are embarking on especially as from the side of the medical aid industry. In closing, whatever agreement ends up being signed, it must include all the stakeholders. That is, it must be binding to the members, to the health services providers, to the medical aid schemes and to the administrators so that it can then have weight. Thank you very much.

***Comment*:** To CMS especially, the problem that we are sitting with here is other people are referees and players at the same time and we won't go very far. And the last speaker I'll agree partly with what he put forward.
The providers, the funders, those are the people who are busy taking money from the members and those members should be protected but the people who are talking here are the people who are busy fighting to take money from those members.
CMS must come very hard on this to protect those members. And Dr Buthelezi was correct in saying this is what they are doing. They don't like medical aid because medical aids put control. They want to charge what they charge ultimately who suffers is the member. CMS must protect the member with decisions to control and regulate everybody across the board for the sake of the member.
And if you can look at what members are committing, you can count all those things. The biggest money goes to these professionals. They are the ones who are taking the money and we can't wait and say because it's after 30 days we can't do this. It is important that it can come up clearly and CMS playing that role and assisting them that the law must take its course. Lastly, I thought we would be sitting in commissions of some sort to say let's debate further and come up with recommendations which can be turned into a commitment that we'll be making.

Closing and announcements: Ms Grace Khoza, General Manager, Stakeholder Relations, Council for Medical Schemes

Ms Grace Khoza closed the day's discussions by thanking delegates for an engaging discussion and insights to addressing the challenges of fraud, waste and abuse. Announcement were made relating to the gala dinner in the evening and engagements for day two of the summit.

Gala dinner: keynote address by Minister of Health, Dr Aaron Motsoaledi

The Minister of Health, Dr Aaron Motsoaledi, delivered the keynote address at the FWA Summit gala dinner held on the evening of the first day of the summit (Thursday 28 February 2019).

The Minister pointed out the significance of the event given the groundswell of support for anti-corruption and anti-fraud, and the good governance movement being spearheaded by President Cyril Ramaphosa.

He said the relevance of the summit is underscored by the fact that one of the key objectives of the Presidential Health Summit that was held in 2018, whose report was recently launched in Cape Town, was to rally all stakeholders in the health sector around eliminating fraud, waste and abuse. He commended the private healthcare industry for its very public stance on fraud, waste and abuse through hosting the summit.

He further spoke about the following:

Medico-legal cases
There is a concern about the rising levels of medico-legal and malpractice claims as a result of doctors' carelessness and negligence. While the SIU under the leadership of Advocate Mothibi have expended great efforts to clamp down on corruption in the sector, there is still work to be done.

The Minister informed delegates about a recent case involving a doctor in the Eastern Cape who put in six claims worth R90 million. All claims made were without exception fraudulent. He explained that the modus operandi in such cases:

a. The plaintiff doesn't know the claim was submitted in their name. Unsuspecting people are made to sign a blank form granting lawyers power of attorney.
b. The claim is fraudulent in that the plaintiff has never had the specified medical condition.
c. The plaintiff was not born in the said hospital in the first place – a method was found to include the child in the hospital records, and the hospital is sued.
d. The plaintiff does not exist.

The relationship between the private and public sectors
According to Minister Motsoaledi, corruption and fraud are non-discriminatory social ills, pervasive in both the public and private sectors. The Minister said he had spent the last two years fighting corruption in the public sector in partnership with the SIU; and is aware that such efforts were incorrectly labelled 'anti-private-sector'.

He pointed out that his mandate as the Minister of Health is often misinterpreted to mean he can only deal with the public sector but should allow the private sector to proceed in its current trajectory. As such, there is a fundamental flaw in this interpretation as the Constitution and the supreme law of the land do not make mention of a minister of public sector. Only the Minister of Health is mentioned, and as the Minister of Health he oversees healthcare matters of the entire healthcare sector.

Challenges
The Minister pointed out the following industry challenges

i. The quality of care in the public sector remains a challenge.
ii. It will be difficult to improve the quality of care in the public healthcare system if the private sector continues to dump patients who are no longer able to afford private healthcare into the overburdened public healthcare system. When people cannot pay for private healthcare, the alternative is public healthcare. Unaffordable and unsustainable costs in the private sector need to be addressed.

iii. The private and public healthcare systems are interconnected. The minister compared the two sectors to 'conjoined twins' who can suck the lifeblood out of each other, and this makes it important to ensure that both stay in a healthy condition.
iv. Exorbitant and rising costs of medical aids, far exceeding the consumer price index, as well as high out of pocket expenditure resulted in potential new members not joining medical schemes, members leaving schemes or members cancelling dependent membership.

Reflecting on the NHI, Minister Motsoaledi said the NHI does not exclude improving quality of care and has been identified as an instrument of improving quality of care.

Caution against vigilante tactics

While acknowledging the need for urgency and decisive action to rid the industry of fraud, waste and abuse, the Minister also cautioned against the use of vigilante tactics. He condemned abuse, coercion, bullying and the criminalisation of healthcare professionals on the basis of unproven allegations. He said these practices were tantamount to vigilantism and were in no way an antidote to criminality; as vigilantism prevents law enforcement from investigating criminal and corrupt behaviours and instead redirects their efforts and resources towards dealing with unlawful acts of cases of harassment.

He expressed shock at the tendency to justify unconscionable activities such as entrapment, illegal camera placement in doctors' rooms, as well as backdating and clawbacks of claims already paid, without evidence or justification. He reminded delegates that by law, schemes cannot arbitrarily decide whose claims to pay; there must be a clear justification for withholding payment of claims.

Minister Motsoaledi challenged delegates to find solutions to fraud, waste and abuse; and implored them to do so within the legally acceptable way. Failure to do so will see the industry move out of a crisis of fraud, waste and abuse to a new crisis of vigilantism.

In closing, the Minister congratulated the industry for establishing the Charter, and said he hoped it would establish acceptable conduct and specific principles that would guide the industry moving forward. He noted that as he would not be able to attend the second day of the summit due to another engagement in Cape Town, he committed that he would sign the Charter to show the Department of Health's commitment to the work being done on fraud, waste and abuse.

End of day one discussions

DAY TWO DELIBERATIONS (01 March 2019)

Presentation 1: Ethics of billing (Coding)
Dr Olurotimi Modupe, Snr Manager: Clinical Unit Council for Medical Schemes

a. Unethical billing is a worldwide problem and poses a significant challenge to the future of healthcare funding and sustainability of the private healthcare sector in South Africa.
b. Some healthcare professionals are abusing coding to expand benefits in a fraudulent way;
c. Sometimes incorrect coding occurs as a result of a lack of the practitioner's knowledge around coding.

The purpose of coding

a. Coding is useful in measuring the health systems' performance, especially healthcare finance.
b. It allows for research and for international comparison between disease management programmes. Many parameters within the healthcare system are based on coding.

Current observations

i. In the private sector there is a National Reference Price List (NRPL) for services by medical practitioners, the latest of which is the 2000 edition of the Current Procedural Terminology for medicines and the Anatomical Therapeutic Chemical (ATC) or defined daily dose (DDD).
ii. In the public sector there is the Uniform Patient Fee Schedule (UPFS) for procedures, for an example.
iii. The difference in coding systems makes it very difficult for the two sectors to integrate. There is a need to look at addressing the lack of integration by the government, in order to facilitate collaboration at system level.

iv. The gap around coding provides opportunities for abuse by certain schemes. Members have in the past come to the CMS in cases where schemes used coding as a justification to escape funding the obligation they need to meet. For example, they will dispute a certain code and use it as a basis to not fund healthcare procedures of their members.
v. The current coding system is inadequate and there are several procedures that do not have codes attached to them.
vi. Sometimes claims submitted on an updated code are rejected by the system and that creates a problem.
vii. At times PMB benefits are not paid correctly by schemes.

Recommendations

Dr Modupe shared some measures that the industry can adopt to deal with the issues around coding:

i. There is a need for more collaboration among stakeholders, and this should involve big data collection and analysis.
ii. Set up smart IT systems and employ skilled individuals who will continuously monitor fraudulent, wasteful and abusive activities.
iii. Coding should be embedded in the curriculum of practitioners in all academic institutions. In addition, there should be ongoing professional training on clinic coding.
iv. Adopt a unified coding system that will work with both systems. Different discipline groups or professional societies will then regularly update and amend coding systems.
v. Establish a coding regulatory forum task team that will involve all industry players. The forum will be instrumental in the adoption of a unified coding system, providing thought leadership ruling on coding disputes.

vi. Financial consent should be sought as part of informed consent, where scheme members are made fully aware of the financial implications of the procedure and whether there will likely be out of pocket expenditure, as opposed to merely seeking consent for non-clinical issues around adverse outcomes of the procedure.
vii. Lobby providers to assist their patients with detailed accounts for services rendered. Adopt International Classification of Disease (IDC)-11 and domesticate them for the South African context.

Presentation 2: Role of coding in fighting FWA

Mr Michael Willie, General Manager: Research & Monitoring Council for Medical Schemes

Noting the complexities involved, Mr Willie cautioned against an overly simplistic approach to coding.

Prescribed Minimum Benefits

i. Section 59 of the Medical Schemes Act, which refers to the relevant diagnostic and the relevant health service, makes provision for the Minister of Health to describe the level of benefits that must be offered to all members of medical schemes.
ii. The issue of PMBs is complex. Of concern is that there seems to be a shift to PMB diagnosis. In 2012 the expenditure on PMBs was 66% and it increased in 2013 to around 72%.
iii. The CMS Annual Report 2017/18 indicates that almost 50% of the benefits paid out were related to PMBs.
iv. Within the PMB benefit package, almost 80%, a staggering R62 billion, is attributed to the hospital sector; the private hospital is a cost driver of overall expenditure.
v. On average the expenditure on PMBs in 2017 was an estimated R746 million.
vi. There is a lot of variation in the way different schemes are dealing with PMBs. Some schemes on average pay up to R2,000 on a beneficiary but some schemes pay as low as R500. There are many reasons that explain this variance in the market – some schemes are not able to track PMBs correctly, some schemes are not coding correctly, some might not have adequate systems in place, so they simply pay whatever comes through their system.

Challenges

i. There is a lack of standardisation across the industry
ii. There is no national standard ICD code in South Africa and this is a real issue of concern in the market.
iii. Diagnosis of disease is open to manipulation and this is related to the lack of a unified coding system in South Africa.

Recommendations

i. Invest in analytics as well computer assistance; it will go a long way in eradicating fraud.
ii. Standardise coding systems.
iii. Transparency and information-sharing is key.
iv. Collaboration across the industry is important, whether one is on the supply or the demand side.
v. Develop a standardised costing system, it will have a significant impact.

Questions and Answers: Ms Grace Khoza, General Manager, Stakeholder Relations Council for Medical Schemes

Question: Dr Modupi I'm just wondering to what extent does the scope of a practice also come into coding? For example, we do know that there is a scope of practice and obviously administration systems set up to cope with codes that apply to a certain practice; but we do see charging for codes outside the scope of practice. Sometimes you can say it's definitely outside the scope of practice which could be

fraud, waste and abuse and other times you will sit there puzzled to say is it something we should be rejecting? I'd just like to hear your comment on scope of practice, coding, and fraud, waste and abuse.

Answer: Dr Olurotimi: Thank you very much for raising these issues. Scope of practice is very central to the discussion around coding. It needs to be updated and clearly defined from coding system to actual function; that's the conversation we should be having with most stakeholders, especially the regulators of professionals within the healthcare system so that members are not always [disadvantaged] when there are disputes around coding.

Question: An important point that schemes need to engage with providers where they think there is an error in coding, but what we've encountered as a provider is where you are now having a person on the other side attending to your query who is seemingly dismissive and not engaging. The second thing is we are not apologetic about it, we are still going to raise the issue of hospitals, the hospital groups, the ones that are on top of the industry – they receive the bigger pie. I would like a coding discussion between providers and the CMS to materialise, because we have already seen with specialists that they don't want to engage with medical aids because you will send a patient to a specialist and they say it's fine we will bill the patient cash, he/he will submit to the medical aid so that I don't get involved. This engagement is very important because if we keep fighting with the funders, the patient is affected, badly.

Question: From a consumer perspective, how many members of medical aids actually understand the coding system? I'm addressing all the medical aids who might or might not be in the room here, particular around pathology and radiology – is it one coding system? For example in pathology, it is not provided for by medical schemes and been rejected or been paid from areas that do not apply in the PMB element. One other thing that is unique is pharmacy. Many years ago, they developed a map because they had actually been paid in real time by medical aids because mapping codes identify the ICD 10 and the medical aids have gone to the extent of actually pre-programming their system to understand what is and what isn't a PMB. What is done in the rest of the industry, for example in radiology?

Answer: Mr Willie: On the consumer perspective, there is room for improvement about the education and communication as well to members. At some point we conducted a study that shows that there is some element of a correlation between training, for instance, as well as customer satisfaction. I know that some of the medical schemes are already putting in efforts as well as investment around that specific area to ensure that they educate and communicate effectively to members; but I think an area that really needs an improvement in my opinion is some of these codes. Many times, medical scheme members find that some of the codes are very difficult to explain and understand. There is an opportunity here to engage members more effectively, educate and try as much as possible to simplify some of the processes. Healthcare is a very complex subject but there are ways and means we could try and simplify where we can. The issue around codes and pathology has been raised. That now is an issue that needs to go the regulators' forum to address the issues around coding again. Regulators need to begin to talk to each other and find common ground and solutions that will not put healthcare in jeopardy as a result of disagreement.

Question: I'm a medical scheme beneficiary. My question to you is do you believe that the solution lies with further regulation, or is it a matter of education?

Question: Are we going to move towards regulating the claims submission process, because a lot of providers are concerned about being exposed unnecessarily by submissions on claims by bureaus or claim staff?

Answer: Mr Michael Willie: In the last two years CMS has taken a decision that because of the impact on scheme members, the CMS needs to come into that space and play a role which could be around the protection of scheme members. We have increasingly begun to increase capacity and knowledge around issues of clinical coding and disputes that arise around coding. You will also notice perhaps that in the last two years CMS has increasingly pronounced on disputes around coding as it affects members. Just

a short one, with the improvement around the claim process and picking up valid claims, I think that's where scheme and management have to play a better role so that when there are obviously claims that are doubtful or there are issues around the validity of a particular claim, a discussion is held as quickly as possible in order to resolve this claim that is not clear.

Question: Please clarity from the CMS side where the 0018 is chargeable?
Answer: Mr Michael Willie: Let me start with the one whether there is a case for improved regulation or improved education; I would say it's both. There is definitely clear justification for improved regulation around coding. A lot of education needs to happen; educating consumers, providers and all the other stakeholders. It has to go a step further because some of the issues that come into place, for instance, whereby members get mistaken and there is no proper definition or explanation to say why a specific benefit has been denied. Over and above that, feedback from the medical scheme is key, and if that can be optimised, I think it will reduce a lot of flaws and it's also an opportunity for improvement.

Panel discussion: Role of ICT systems in Fraud, Waste and Abuse

Facilitator: Ms Neo Khauoe, Principal Officer: POLMED

The following panellists participated in the discussion on the role of ICT systems in fraud, waste and abuse:

1. Dr Gregory Pratt, Senior Clinical Advisor, Medscheme,
2. Mr Heyn van Rooyen, Principal Officer, Medihelp,
3. Mr Charlton Murove, Head of Research, Board of Healthcare Funders of Southern Africa, and

Dr Eugene Burger, Head: Claims Risk, MMI
Analytics to determine patterns to identify issues:

a. The panel argued that data plays a critical role in determining fraud, waste and abuse; and data can either be used as a drunken lamp post to stumble from one point to another or it can be used to illuminate the way.
b. The panel agreed that information is at the core of forensic work and provides a foundation for the implementation of interventions to address fraud, waste and abuse; and data is critical in this exercise mainly to enable the detection of fraud, waste and abuse through profiling, as an analytical tool to link analysis between the practices and referral practices and for improving the admin systems, plan rules and funding policies.
c. The data captured is validated, sanitized and organized to enable intelligent analysis of the data. Such data is also used for contextual comparisons, for benchmarking and peer review mechanisms. In many instances predictive analytics is used to obtain greater accuracy in identifying where the issues are.

BHF portal

- The BHF have developed a portal where information on investigations can be shared. The platform works similar to Facebook or a Twitter account where the objective is to share information, ask questions on fraud, waste and abuse and coding.

Challenges

The panel identified the following challenges:

a. Procedures and the structures that are built into the systems may be archaic.
b. There are problems with protocols that are operating on bespoke systems.

c. Once systems are known by practitioners, they are easily evaded.
d. The systematic manner in which funds are taken through fraud keeps getting advanced and the industry in some instances in lagging behind.
e. Fraud cannot be determined within 30 days, there is a system and a manner in which analytics are done and patterns determined to establish whether a claim is fraudulent

Recommendations

The panel made the following recommendations:

a. There needs to be intelligent analytical systems that use multiple sources of data and information, as this can be a very powerful in detecting fraud, waste and abuse, and enabling analysis to determine the correct action by any forensic unit to inform preventative enhancements.
b. Good communication systems need to be put in place to provide a platform for shared information between service providers and members
c. Investment must be made in analytical tools and technology
d. Strong forensic audit teams but be set up
e. There needs to be an intelligent analytical system that uses multiple sources of data and information
f. Put in place peer review mechanisms and platforms for engagements and input
g. The industry should make use of the portal created by the BHF to share information
h. Retrospective audit is fundamental to determine patterns of abusive.
i. Focus on a three-pronged approach that looks at preventing, managing and detecting possible fraud.
j. Good communication systems with detailed information shared between services providers and members; and encouragement of members scrutinizing their bill in a more critical way can go a long way in advancing efforts aimed at addressing fraud, waste and abuse.
k. Detection needs to be done in an analytical and integrated manner, and all units should work together.
l. Legal action must be taken to ensure optimization of the systems being used to combat fraud.
m. Block chain, technological innovations and other systems should be employed to ensure that there is proper compliance.
n. Efforts to tackle fraud, waste and abuse should not be done in isolation, but should be systematic and coordinated.
o. Investment in ICT as well as data analytics is needed to gain more ground on fraud, waste and abuse.
p. Industry stakeholders should work together, because fraudsters are working together and are aware of the efforts being made by industry.

Questions and Answers: Ms Neo Khauoe, Principal Officer - POLMED

Question: Medscheme is saying they cannot detect a claim in 30 days was coming from the providers, so we cannot shift the goal posts and we need to have a cut off, what is the cut off?
Answer, Mr Paul Midlane: The cut off period is between two and three years. Going back 10 years is pointless and illegal.

Question: Is there no better way do this by centralizing data
Answer: Centralizing data is a good idea. It's using data in a specific way to get a specific outcome that will allow you to use that correctly. If you have a blanket data approach and everyone dumps stuff, the analytics they have is not very focused.

Question: What about the security element of systems centralization? Systems created by humans can be broken. What is also the role of the regulator in ensuring that you have a balanced objective room on this system that you're coming up with?
Answer: In terms of forensic investigations, why is there a lot of energy and effort in forensic investigations of independent pharmacies compared to public pharmacies?

Comment: The issue of racial profiling as there is a tendency of showing other races as more corrupt and crime has no colour.
Response: That's exactly how we feel. We work with every practice the same and there is no racial profiling. It's a misconception that circulates in the media and we are committing to dealing with every practitioner on the merits of the specific case only

Concern: Diagnosticians are making medical decisions on behalf of the consumers, and this should not be so.

Draft definitions and industry charter

Dr Guni Goolab, Principal Officer, Government Employees Medical Scheme

Reflecting on the discussions from the summit, Dr Goolab highlighted the following:

i. The summit discussions centred around claims and processing quantities, including the need to ensure that better standards and guidelines are established to deal with issues of waste and abuse by all parties.
ii. Collaboration came out as a key theme throughout the discussions.
iii. While ensuring that the needs of the providers, members and schemes are all taken care of is a difficult balancing act; all these needs must be equally addressed.

Dr Goolab provided some context on the process leading to the preparation of the draft Charter:

a. The Council of Medical Schemes led the process which commenced with the establishment of a Steering committee; with the Board of Healthcare Funders Association of Southern Africa (BHF) and the Health Funders Association (HFA) as part of the core members of the committee. The two associations represent a large number of medical schemes.
b. Through the participation of some of the role players from the medical schemes affiliated to the BHF and the HFA, a draft Charter was prepared and distributed widely to stakeholders for comment and input.
c. The feedback from the consultation process was considered, and these have been incorporated into the revised draft Charter.
d. From the submissions made and discussions, a key emerging issue is that over the previous year, there has been a lot of areas of concern regarding the forensic processes that are deployed by medical schemes and their administrators. It is clear that these processes need to be well defined.

Presentation by Dr Tebogo Phaleng, Chief Strategy Officer Discovery Health

Dr Phaleng pointed out the following:

a. While collaboration among the stakeholders has not been defined; it is encouraging to see that there is a commitment to the principle, that all will eventually collaborate and that there will be no tolerance for fraud.

b. Measures to prevent fraud, waste and abuse need to be strengthened for any collaborative effort to be fruitful.
c. There also needs to be a consideration for a preventative approach, for instance providing technical assistance to partners.
d. While the Charter provides a technical and advisory role, the Regulators will need to play their part.
e. The Charter will enhance the integrity and accountability of the environment, geared towards affordability of the sector on a sustainable basis.

He explained that the committee has worked on a number of definitions to articulate processes; for instance, the Charter defines what constitute healthcare fraud, as well as what is waste and abuse.

Definitions:

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

Waste and abuse are defined as claiming for healthcare treatment and services that are not absolutely medically necessary.

The Charter principles:

a. The Charter is not a regulatory instrument, it is a document that commits all role players to conduct themselves in a certain way, and it gives direction at this stage on innovative mechanisms to deal with fraud, waste and abuse.
b. It will assist in moving towards a best practice benchmark, based on evidence as well as on clinical guidelines.
c. The CMS must consider the direct representation of patients in the Charter.

    - Develop industry guidelines, support and development in enhancement.
    - Provide legislation, guidance within the scope of the Act.
    - Become part of monitoring the dynamics and offer assistance in improving the systems in place

d. All Regulators involved must give clarity around policy imperatives as well encourage honesty and integrity over the members under their scope of regulation.
e. Medical schemes and administrators to act in the best interests of the patients and members.
f. They also need to execute their mandate as well as to act fairly and objectively at all times.
g. They need to commit to participating in the industry initiative as an imperative for information exchange.
h. There is a need to ensure that the procedures around sanctions are objective and fair.
i. Clinical access and best practice bench marks would need expert service providers.
j. Critically, doctors, pharmacists and all health care practitioners will have to form part of the journey towards the value based as well as sustainable healthcare system.
k. Make sure the healthcare professionals are sustainable as well.
l. Industry representative bodies to create a platform for collaboration as well as to constantly inform all medical scheme administrators as well as organisations about the fraud, waste and abuse initiatives.
m. Engage with the regulatory authorities on a continuous basis.
n. The provisions for signatories are binding.

o. The role of CMS as the custodian of the Charter is subject to consultative process which hopefully will happen within the industry and in the committee.

In closing Dr Phaleng said, as per a directive from one of the submissions to CMS on the Charter, there is a need to move towards a value-based system. The value-based system has the following three elements:

i. Expanded access
ii. Improved quality, and
iii. Cost effectiveness.

Symbolic signing of the industry Charter

Various stakeholders attending the summit took part in the symbolic signing of the Charter and pledged their commitment to actively participate in industry initiatives and interventions aimed at tackling fraud, waste and abuse in the sector.

The following organisations, and individuals representing the independent schemes that are not affiliated to the BHF and the HFA, were signatories to the Charter:

1. National Department of Health (in absentia)
2. Special Investigating Unit
3. Council for Medical Schemes
4. Board of Healthcare Funders Association of Southern Africa
5. Health Funders Association
6. Delegated representative: Dr Jonathan Broomberg (in absentia)
7. Delegated representative: Paul Midlane

Note: The South African Medical Association (SAMA) announced that it was not in a position to sign the industry Charter; and requested an extension in order to properly consult with its 17 000 members, especially given the seriousness of the issues dealt with at the Summit. The organisation highlighted the importance of member buy-in, in order to ensure that its members fully support the process for the Charter to achieve the desired results.

Roadmap

Dr Sipho Kabane, Chief Executive & Registrar Council for Medical Schemes

In his presentation of the roadmap, Dr Kabane highlighted the sentiment shared by most delegates, that the summit was as success and had achieved its intended goals. He emphasised the fact that the summit was only the starting point of the work that laid ahead, pointing out that the CMS will be working in consultation with all stakeholders towards curbing fraud, waste and abuse in the sector.

Dr Sipho Kabane outlined the following important issues for action going forward:

a. As industry agreements are key definitions, the industry Charter has to be signed by a significant number of stakeholders.

b. There is a need for an industry agreement to establish a structure that will deal with anti-fraud, waste and abuse issues beyond the summit.
c. In the medium to long term, a structure needs to be established to coordinate and drive anti-fraud, waste and abuse activities in the industry between these summits. The structure must ensure that inputs given are developed and implemented.
d. Outstanding issues such as standards, code of good practice and other key issues are part of what needs to happen beyond this Summit. These must be either incorporated or documented in the strategic plans that will be developed moving forward.
e. Where there are policy recommendations, these should be directed to the appropriate places like the Ministry.
f. Where there are suggestions of additional legislation and regulations, the CMS is going to take incorporate those in the Bill.
g. There is a need for extensive discussion around issues of coding.
h. There is a need to have a permanent structure and therefore terms of reference need to be developed; a draft form will be circulated. Many elements will be incorporated but the structure needs to be representative and reasonable in size, so as to make the required progress and impact.

He explained that the terms of reference among other things will outline the purpose, composition, the logistics, the hours and how the structures will be governed.

Way forward

1. The CMS will facilitate a platform to review the charter, update and maintain it every two years.
2. The Steering Committee will be enhanced and expanded to be more inclusive, and there will be further extensive consultation.
3. The next project after the Charter will be the draft Code of Good Practice for the industry.
4. The Charter and the Code of Good Practice must be implemented with clear timelines.
5. Monitoring and evaluation mechanisms will be put in place.

Closing remarks, Dr Clarence Mini, Chairperson for the Medical Schemes Council

In his closing remarks, Dr Clarence Mini informed delegates that the CMS' intention with the summit is that it should be an annual event. He emphasised that it was everyone stakeholder's responsibility to make sure that the summit becomes an annual event, and not a once-off a talk shop occasion. All must ensure that the summit becomes a platform where stakeholders hold each other accountable. He told delegates that the CMS will not allow the event to be a talk shop.

Dr Mini expressed his gratitude to everyone who participated in the summit, including the teams that had made the summit possible; especially the members of the Steering Committee for their work. He thanked the Registrar and his team for the work done in putting the event together.

All stakeholders attending the Summit were invited to sign on the Charter commitment wall.