

KEY ISSUES IN HEALTHCARE - AN ISLAND HEALTHCARE PERSPECTIVE

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Register for the

**2015 KPMG Island
Infrastructure Summit**

October 4-6, 2015

JW Marriott Marquis Hotel,
Miami, Florida



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Countries surveyed: key facts

We have researched the healthcare provision in 15 jurisdictions with similar profiles in order to gain a greater understanding of the key healthcare issues faced by island nations (we have included Suriname in the analysis due to its strong links to the Caribbean region).



Country: Bahamas (BHS)
Population: 356,000
Debt to GDP ratio: 56%
Number of public hospitals: 3
Funding: Public, non-mandatory private insurance and self-pay



Country: Gibraltar (GIB)
Population: 27,000
Debt to GDP ratio: 5%
Number of public hospitals: 1
Funding: Public funding, private insurance



Country: Malta (MLT)
Population: 421,000
Debt to GDP ratio: 71%
Number of public hospitals: 6
Funding: Mainly Government funded, private insurance and self-pay



Country: Barbados (BRB)
Population: 300,000
Debt to GDP ratio: 105%
Number of public hospitals: 1
Funding: Mainly Government funded, private insurance and self-pay



Country: Guernsey (GGY)
Population: 63,000
Debt to GDP ratio: 0%
Number of public hospitals: 1
Funding: Public subsidy and private co-pay for primary care, secondary care Government funded, private insurance



Country: Sint Maarten (SXM)
Population: 40,000
Debt to GDP ratio: 26%
Number of public hospitals: 1
Funding: Government funding, private insurance



Country: Bermuda (BMU)
Population: 65,000
Debt to GDP ratio: 22%
Number of public hospitals: 2
Funding: Government subsidy, Government health insurance and mandatory-private insurance



Country: Isle of Man (IMN)
Population: 86,000
Debt to GDP ratio: 15%
Number of public hospitals: 2
Funding: Government funded, private insurance



Country: Suriname (SUR)
Population: 542,000
Debt to GDP ratio: 17%
Number of public hospitals: 6
Funding: Primarily Government funding, private insurance, charitable funding grants and out of pocket



Country: British Virgin Islands (VGB)
Population: 30,000
Debt to GDP ratio: 14%
Number of public hospitals: 1
Funding: Government subsidy, non-mandatory private insurance



Country: Jamaica (JAM)
Population: 2,700,000
Debt to GDP ratio: 133%
Number of public hospitals: 23
Funding: Primarily Government funded, charitable funding and private insurance



Country: The Turks and Caicos Islands (TCA)
Population: 31,000
Debt to GDP ratio: 29%
Number of public hospitals: 2
Funding: Government funded (National Insurance plan), private insurance



Country: The Cayman Islands (CYM)
Population: 57,000
Debt to GDP ratio: 23%
Number of public hospitals: 2
Funding: Indigent provision and Government subsidy, mandatory private insurance



Country: Jersey (JEY)
Population: 99,000
Debt to GDP ratio: 0%
Number of public hospitals: 3
Funding: Public subsidy and private co-pay for primary care, secondary care Government funded, private insurance



Country: Trinidad and Tobago (TTO)
Population: 1,300,000
Debt to GDP ratio: 45%
Number of public hospitals: 9
Funding: Government funded and private insurance



Introduction

Throughout the world, healthcare systems are facing unprecedented pressure to cope with rapidly aging populations, a higher prevalence of chronic diseases and ever rising expectations in the delivery of healthcare.

For members of the public it is easy to mistake higher prices for higher quality of care. However, for many of the islands which have significant out-of-pocket expenditure, co-pay or private health insurance, the rate of growth in healthcare costs and annual premium increases have impacted the disposable income of users and led many to question:

"Are we getting value for money?"

Healthcare provision is becoming increasingly consumer driven. The increased collection and utilisation of whole system data is allowing providers and regulators to better assess the quality of outcomes, the needs of the population and tailor the appropriate healthcare reforms.

There is still much work to be done to ensure the effective use of data across many smaller jurisdictions who typically have less advanced IT infrastructure, collection and reporting of data. The data available publicly for the islands reviewed was limited in terms of the timely collection and reporting of information, especially private healthcare expenditure, making reliable comparisons between the jurisdictions within this report difficult.

We can obtain a crude measure of value for money by examining total healthcare expenditure per capita against life expectancy at birth. The more effective the healthcare expenditure, the greater the life expectancy of the population, at a lower cost per capita of delivery.

The OECD average spend per capita was \$3,500 in 2012 against the latest available average life expectancy at birth of 80 years (2011).

The data does not allow for a more rigorous comparison based on adjusted purchasing power parity, which may distort direct comparisons between jurisdictions.

Containing the spiraling cost of healthcare and ensuring value for money are high on everyone's agenda. We have grouped together and highlighted the key issues facing healthcare providers, payers and users across island health systems.

These problems are not unique to the jurisdictions highlighted in this document and around the world the solutions to these challenges have taken many different forms. There are lessons to be learnt and new and innovative ways of approaching healthcare.

The data we have used is from multiple sources and has not been verified to the original point of collection where obtained through a third party.

* Private sector expenditure estimates were not available for VGB, CYM, GIB, IMN, SXM and TCA.

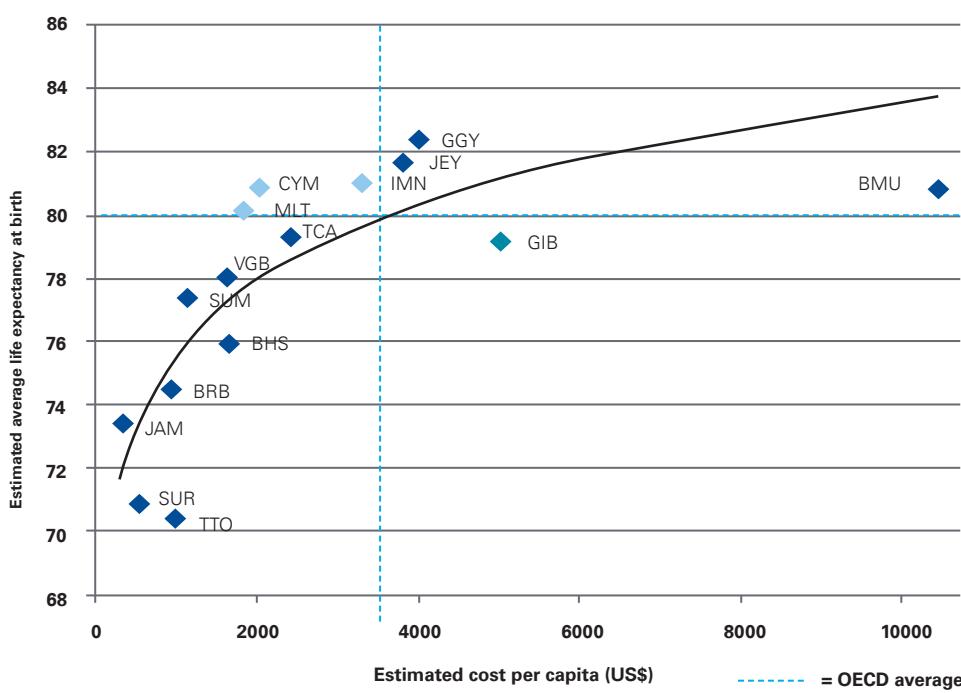


Figure 1: Healthcare spend per capita against average life expectancy at birth

Figure 1 highlights the relationship between spend and quality of outcomes. The trend line shows the expected relationship between cost per capita and average life expectancy at birth. Those jurisdictions falling below the curve could improve the value they derive from their healthcare expenditure.

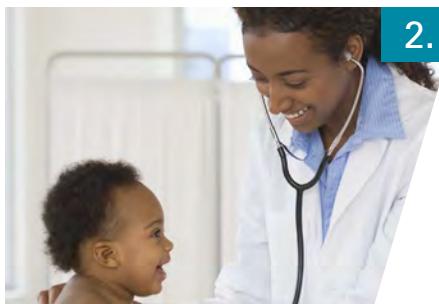
The trends seen on a global scale indicate that those countries who spend very little on healthcare can see significant improvements in outcomes by spending more (i.e. there is a steep rise at the far left of the curve).

Key issues



1. Capacity and utilisation - the demand and supply conundrum

Capacity, utilisation and the use of overseas treatment is a key issue for island regions where provision of specialist diagnostics, surgeries and treatments can be limited. Many jurisdictions are struggling to control the utilisation of high cost diagnostics and overseas treatments.



2. The role of primary care - ensuring population health outcomes

The healthcare system is fragmented in many jurisdictions due in part to incentive payment mechanisms, poor communication between providers and a lack of enabling technology. Primary care provision needs to change to create a sustainable healthcare system.



3. Creating the right incentives - funding methods and payment reform

The challenge for payers, regulators and governments is how to create a set of incentives that support innovation, experimentation and evolution while holding providers firmly to account but without unintended adverse consequences, bureaucracy and box ticking.



4. Infrastructure - enabling effective healthcare delivery

Effective infrastructure is a key component in ensuring the delivery of quality healthcare. The island health systems we have analysed in this report have seen a number of large infrastructure projects over the past five years. It is important that lessons are learnt to ensure the financial sustainability of future infrastructure projects.

1. Capacity and utilisation: the demand and supply conundrum

- Capacity constraints;
- Over utilisation of services; and
- Cost of overseas treatments.

Figure 2 illustrates the capacity in each of the jurisdictions surveyed, showing the number of beds per 1,000 of the population. The OECD average was five beds per 1,000 persons in 2011. We can see that the jurisdictions with the highest capacity in their healthcare system: Bermuda and Gibraltar, also have the two highest per capita expenditure levels.

Supply induced demand

Many jurisdictions are struggling to control the utilisation of high cost diagnostics and overseas treatments.

Existing payment systems tend to pay for care activities rather than rewarding integration of care and the outcomes of care.

Most accept that this approach actually stimulates high volumes of these activities. Even those that have replaced their 'pay per piece' system with a 'pay per admission' or 'pay per elective intervention' system seem to suffer from a clear supply-induced demand effect.

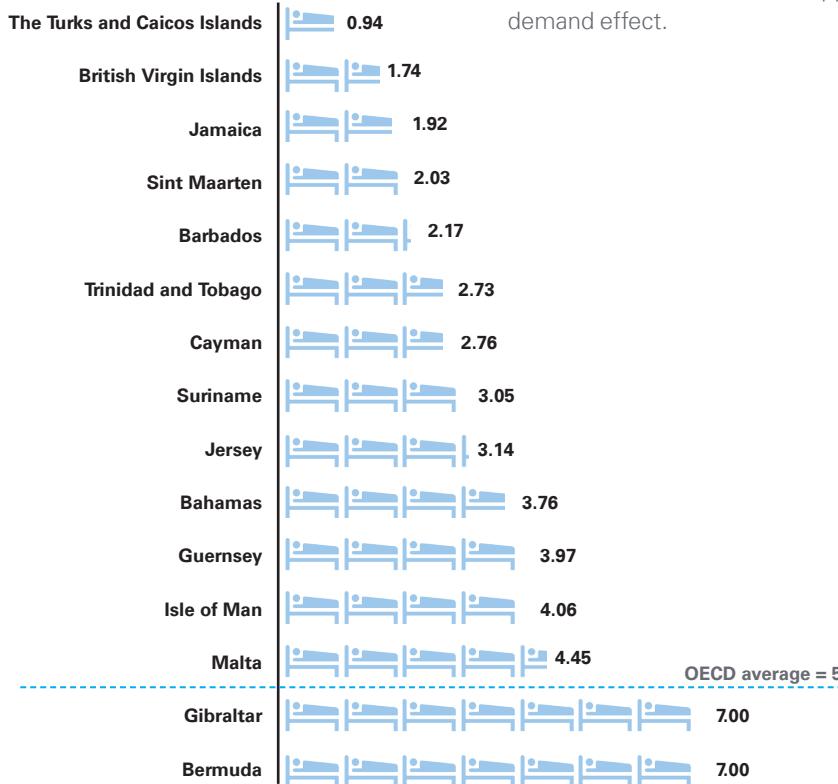


Figure 2: Bed capacity per 1,000 persons

|| The issues around capacity, utilisation and overseas treatment can be condensed into two areas: **supply of services and demand for services**. Therefore, in simple terms to minimise the issues of capacity and utilisation in healthcare systems you must either **restrict supply or reduce demand**. We talk to these further in section 3 on funding and payment reform. ||

Managing supply

Governments and insurers can influence the cost of the system through the level of coverage they make available. Figure 3 (as seen on next page) outlines some key options, or configurations, that may be considered in developing a basic package.

Governments are also able to manage supply for certain elements of healthcare expenditure through regulation. Importation and operation licenses for certain high cost machinery, like MRI machines, can restrict the supply available in the local environment.

Essential Care	Primary care	Inpatient only	Catastrophic only	Comprehensive
Package is limited to only the most essential intervention to avoid death and disease, for example, vaccines.	Services limited to those that can be provided by a general practitioner (GP) in an outpatient setting. Drugs may or may not be included for primary care managed conditions.	Coverage includes only care that is provided in hospitals. Inpatient drugs linked to a specific intervention are typically included. Drugs required after discharge are not included. Potential bundling with pre-and-post hospitalisation follow-up visits.	Typically includes only the highest cost, non-elective procedures that could lead to financial ruin. Examples would include cancer treatment or dialysis. Potentially defined as all care in excess of certain expenditure.	Usually covers all non-experimental care available to patients. In many cases, the lack of a specifically defined package determines the comprehensiveness of the package by availability of domestic supply.

Figure 3: Defining the basic package of services.

Volume and quality

There is a fine balance between creating excess capacity in the healthcare system and providing effective and timely care to patients.

It is often not cost effective to provide all services locally and depending on the volume of cases, it may be more efficient and effective to use overseas specialist facilities rather than provide these services on island.

Therefore, if there is relatively low demand on an island for a specialised medical treatment it may be more appropriate, from a cost and quality of care perspective, to transfer the care to a specialist overseas provider.

There is a widely held understanding that there is a positive correlation between the volume of cases and quality of the outcomes as highlighted in the case study below.



Volume and outcomes: Size does matter - a case study from the UK

The Cooperation and Competition panel National Health Service (NHS) conducted a study on the relationship between volume and outcomes. They found that higher procedural volume leads to superior outcomes.

For example, patients with acute myocardial infarction showed that once the annual volume reached 610 patients, an increase of 100 patients in hospital volume was no longer significantly associated with reduced odds of death. (*"The impact of hospital treatment volumes on outcomes"* Working paper vol. 1, no. 1, 2010).

2. The role of primary care: **ensuring population health outcomes**

- Fragmented care;
- Inappropriate payment incentives; and
- Outdated care models.

Most economies globally are facing a rising prevalence of chronic disease bringing greater focus to unhealthy lifestyles and behaviours.

Using primary care facilities to try to minimise the need for hospitalisation is key in controlling the spiraling costs of healthcare.

Key issues in primary care:

1. Payment mechanisms

There are too many payment mechanisms that incentivise the wrong type of behaviour by clinicians. We discuss this further in section 4.

2. Treating multiple conditions

Care is not designed for those with multiple conditions. Primary care needs to become person-centred. Patients should have the minimum number of separate consultations necessary with primary care providers to treat all symptoms together rather than one at a time.

3. Availability of care

Primary care practices typically offer short appointments during working week hours. Primary care needs to be accessible to all when needed. This avoids the escalation of issues to the point of hospital admission owing to people being unable to visit their GPs.

4. Preventative care

Primary care is reactive not proactive. Healthcare providers have seen a shift from healthcare delivery to an increasing role in the prevention of disease and modifying patient behaviours. Care should be proactive and population-based where possible, for example, through early risk based cancer screening or through incentives to drive healthy lifestyle choices from insurers.

5. Using technology

Providers do not use technological innovation effectively (email, telephone consultancy). These can provide more effective and efficient ways to manage patient care. It is important that front line clinicians are the ones responding via email/ telephone. Social media can be used to engage with the population.

Primary care providers have historically been late adopters of technology. Given the payment models for primary care, physicians for example, are usually only compensated by physically seeing the patient even if text, email or telephone consultations would have been more effective and often preferred by the patient.

Jurisdictions that have embraced technology in primary care settings are able to manage more patients and focus on keeping patients well as opposed to only focusing on episodic treatments.

Integration of Electronic Medical Records (EMRs) with secure health messaging, virtual visits (via telemedicine), e-scheduling, mobile solutions and

e-consultations are just a few examples of how technology could potentially transform primary care.

6. Communication

The poor communications between primary care providers, hospitals and specialists have resulted in a fragmented care system compromising the quality of healthcare outcomes and the costs of healthcare for society. Primary care needs to have better links to other services in the community (e.g. housing, social care and the voluntary sector).

It is important there is open communication between all providers to ensure the successful transition of care from one provider to the next to avoid episodes resulting in acute hospitalisations.

In many countries, insurance companies and providers have taken a strong first step toward improving quality through data sharing. In many cases, professionals and providers are simply unaware of the outcomes of their care, or how these outcomes compare with the prices they charge, and so payers can make a significant difference just by showing them their results.

Primary care plays a vital role in all healthcare systems. It needs to be excellent in treating both the condition and the whole person. A way needs to be found to have the best relationship-based primary care with continuity for those that value it, as well as rapid and convenient access for those to whom it is important.



Collaborating to effect change: The Bermuda Healthcare Symposium

A collaboration between the Bermuda Health Council (BHeC), Bermuda Hospitals Board (BHB) and the Ministry of Health and Environment, the symposium was designed to ensure that Bermuda's physicians had the opportunity to participate in the island's healthcare reform process. A broad scope of topics were covered including Government's vision for overall healthcare reform: challenges currently facing the system, long-term sustainability requirements and proposals for potential reforms that address quality of care, patient safety and cost containment. Speakers from Bermuda, the Cayman Islands and the United States highlighted key issues and potential solutions which were well received. The audience debated the merits of potential options during an informative question and answer session with all of the panelists.

3. Creating the right incentives: funding methods and payment reform

- Creating value for payers, providers and patients;
- Managing coverage; and
- Ensuring accountability for costs and results.

Payers can influence both the system and patient behaviours. They are starting to recognise that providing better value often means ensuring that care is consistently high in quality, lower in cost, appropriate and timely.

Increasingly, insurers and governments are becoming more 'activist' in their payment behaviour, either by altering the level of coverage they are willing to pay for (as discussed in section 1), or imposing outcome-based conditions on healthcare funding.

The challenge for payers, regulators and governments is how to create a set of incentives that support innovation,

experimentation and evolution while holding providers firmly to account but without unintended adverse consequences, bureaucracy and box ticking. These approaches may allow many different solutions and be permissive on many things but will need to be tight on governance, open book accounting and mitigation of conflicts of interest.

There is a need to move away from the vertical silos of the current healthcare model in most jurisdictions to outcome based bundled payments.

There are a number of options for payers to manage healthcare. There is a growing move from transactional and adversarial/

coercive methods towards systems that foster partnership and are value focused.

Although jurisdictions have different histories, regulations and system characteristics, what is clear is success can only be achieved by moving away from paying for inputs, and moving towards paying for outcomes, or value delivered.

// Policy makers need to create mechanisms to ensure that the health sector is efficiently producing good quality. //

(Something to Teach, Something to Learn, KPMG International 2013)

Figure 4 illustrates how the widely used fee for service payment mechanism, with a low level of accountability and financial risk for the provider may lead to sub-optimal outcomes. Instead the system should move towards payment mechanisms that create accountability and incentivise correct behaviours.

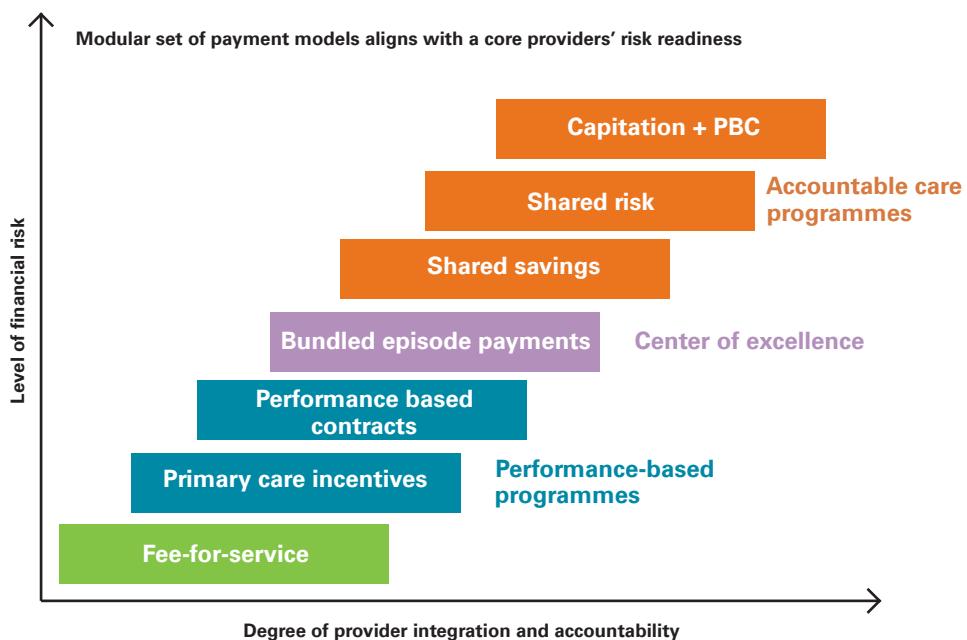


Figure 4: Value based payment continuum. Source: United Health Group, 2012

Figure 5 illustrates the various options that can be used by payers.

Micro-focus

Controlling utilisation has been attempted through techniques such as pre-authorisation, strict treatment criteria and physician profiling (to target variation). These are generally well understood but can be expensive to operate and unpopular with providers and patients as they focus on individual episodes rather than value for the patient. This not only fragments care, but also steers dangerously close to micromanagement where payers take on risks and responsibilities that should sit with providers.

Standardisation and guidelines allow for transparency and accountability. This can be managed through peer review but requires good governance to be in place.

Systems focus

Developing new outcome measures to facilitate payment by performance. Although, the use of evidence-based guidelines linked to payment mechanisms also creates certain challenges by taking the payer into clinical territory.

Population focus

Focusing on overall population health rather than patient outcomes, ultimately looking towards capitation. Although this is arguably the most ethically responsible path, this may result in economic outcomes that are not conducive to provider participation.

Patient/subscriber focus

There are several approaches that attempt to change patient behaviour by directly altering or restricting patient choice. These could be used to encourage the use of

primary care rather than hospital care through co-payments and other incentives.

Influencing patient behaviour – an example from Jersey

"According to many respondents (to the survey) significant numbers of people visit the Emergency Department rather than seeing a GP because there is a charge associated with the GP, whereas a visit to the Emergency Department is free. The majority agreed that if a charge applied to visits to the Emergency Department for minor conditions, they would be more likely to go to see their GP" States of Jersey Public Consultation, Health and Social Services White Paper: Caring for each other, Caring for ourselves.

Focus

Approach

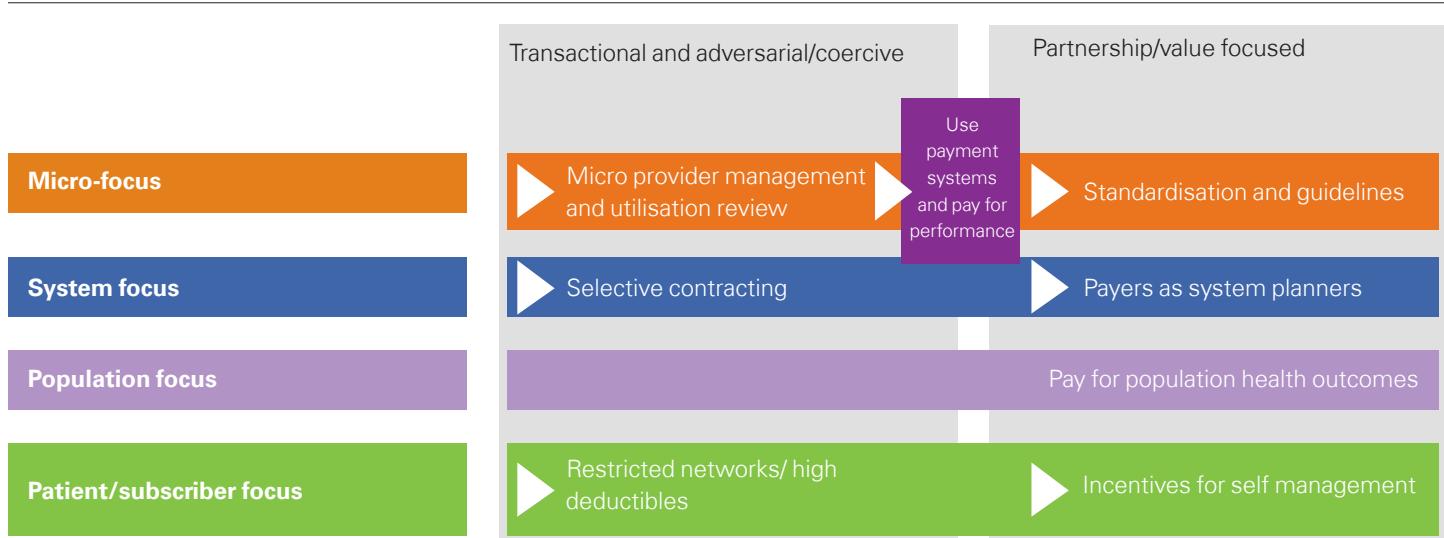


Figure 5: The range of options for payer

4. Infrastructure: enabling effective healthcare delivery

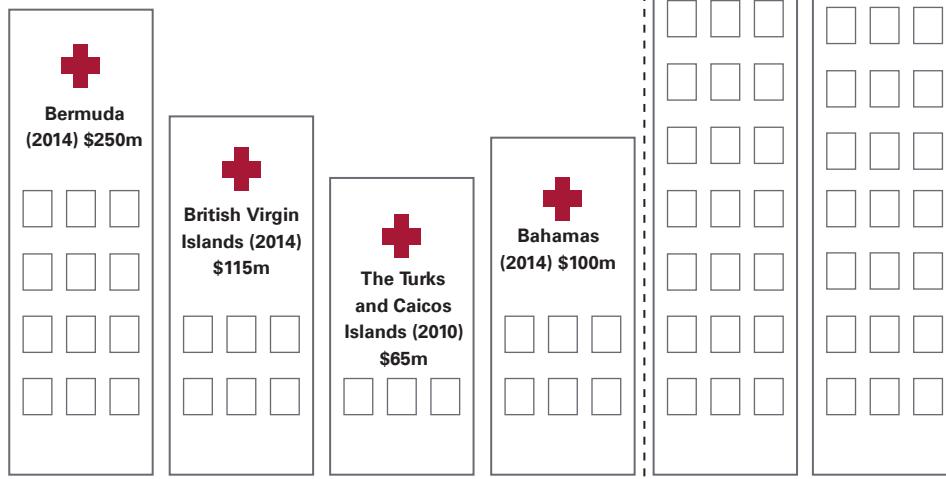
- Aging physical infrastructure;
- Funding constraints;
- Staffing shortages; and
- Outdated or under-utilised I.T. systems.

Effective infrastructure is a key component in ensuring the successful delivery of healthcare.

Infrastructure is not just the bricks and mortar of a hospital building, but all components that are needed to deliver healthcare, including: equipment, technology and people.

Buildings

Many buildings in healthcare systems are over-specified, expensive to operate and are not fit for purpose.



Infrastructure projects in prior 5 years All figures are approximations

Pipeline Infrastructure

Figure 6: Historic and future infrastructure spend estimates

Equipment

Rapid technological advances can mean new equipment can quickly become outdated and it can be prohibitively expensive to remain at the cutting edge of technology, especially for public sector organisations.

Staffing

Staffing costs are usually the single largest expenditure item for healthcare providers.

The staffing shortages experienced in some jurisdictions reviewed can lead to a reduction in staff morale, reduced patient health outcomes and increase the cost of healthcare provision (requiring the use of agency workers or additional overtime payments).

Human Resource (HR) strategy has historically focused on reducing cost, however, there is a move towards managing employee engagement, job design, pay and conditions and developing the basic systems to improve workforce management.

Figure 6 highlights the investment that has taken place and is planned in the region.

Investment in acute care and geriatric care will remain key themes in the future.

Technology

Our use of technology in everyday life has increased exponentially over the past five years, however, many healthcare providers have not yet caught up with this trend.

Technology is not a solution to the problem but can be used to enable more effective work flow management, better coordination between providers, communication with patients and payers and data analytics to make informed decisions.

New tools are being continuously developed that support the advanced analytics of healthcare information.

This is driving better clinical decision making, care systems redesign and creating opportunities to develop healthcare systems that are patient centric and sustainable.

Information sharing has facilitated great collaboration around all the participants in a patient's care.

Innovations like mobile health have opened new channels of communication between healthcare providers and their patients.

Mobile health solutions have allowed patients to take greater control of their own health outcomes, using innovative mobile "apps" and health tracking.

|| Coordinated care requires information to be **shared between providers** and used in predictive models to identify patients at risk. ||

(Necessity: the mother of innovation, KPMG International, 2014)



Using technology to foster communication - an example from Jersey

KPMG has been working in partnership with The States of Jersey who are performing a review of their e-Government offering. They are creating a vision and implementation plan with the aim to have an information portal covering all Government departments - a joined up electronic platform. The portal will include healthcare information available for the individual user to view, putting the data in the patient's hands. Primary, secondary and tertiary care providers will be able to access a complete set of records for their individual patients allowing greater transparency and a higher standard of care across the board. In the future, the project aims include considering tele-health services to drive greater efficiency across the health service.

Conclusions: transitioning to a better model of healthcare

The individual building blocks of creating a low-cost, high-quality health system are well understood. Assembling them is difficult in environments with many stakeholders with different perspectives.

Change will not be immediate and a transition step-plan needs to be agreed by all protagonists for any system reform to be successful.

Making informed decisions

To fully understand the strategic options and models available, many organisations will have to think deeply about what they do, how they work, who they work with and the fundamental nature of their business. This will involve not only consultation but rigorous analysis of data.

Empowering the right people

Excellent management is consistently seen as the key to successfully achieving low-cost delivery. Empowering frontline clinicians and creating the right environment for a co-ordinated healthcare system avoids many of the pitfalls of struggling jurisdictions.

A single electronic healthcare record for patients should be accessible by relevant organisations and the patient to foster greater collaboration.

Payment reform-creating value

There needs to be appropriate incentives for payers, providers and patients to ensure the system functions effectively and efficiently.

Payers need to move away from contracts that count visits or require large amounts of box ticking, to using outcomes as a

payment mechanism, ultimately focusing on population health outcomes.

Facilities need to be flexible, clinical quality must be routinely regulated and processes should be standardised where possible.

Managing stakeholder expectations and ensuring quality

Metrics can be used to measure performance in real-time and to shape the current and future system. These should be made available so that the wider public can hold healthcare providers accountable.

The role of primary care

There is a shifting expectation in the provision of healthcare. More emphasis is being placed on primary care and prevention of chronic conditions, such as diabetes, and the social issues that cause them.

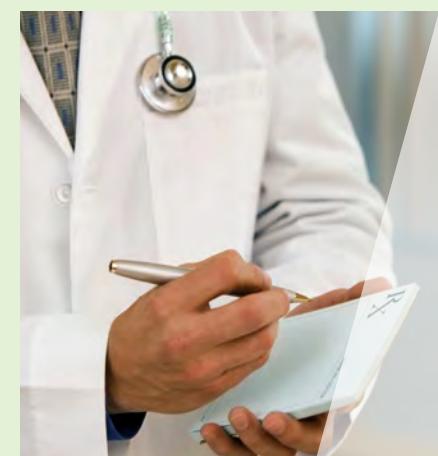
Governance

Investment in a strong governance process and independent, knowledgeable oversight by an appropriately qualified board is essential.

Effective governance needs support through measurement systems and the ability to compare performance against others, thus ensuring learning can be adopted from elsewhere.

Investing in technology

Early investment will lay the foundation for creating a care system that is robust and sustainable in the long term. There is so much information collected throughout a patients experience and being able to review this in one portal is a powerful tool to drive improvements in efficiency and quality of care.



Providers cannot create a successful low cost system on their own – payers and policy makers have a crucial part to play.

Political will is not sufficient on its own. All protagonists in the healthcare system need to be working towards the same goals, from insurance providers to patients and charitable groups to regulators.

Strong governance, informed decision making, benchmarks to measure success and clear accountability are the keys to successful healthcare reform.



Bringing all stakeholders together to drive change: The National Healthcare System - an example from Suriname

The National Healthcare System is a vision on redesigning the healthcare system of Suriname including the healthcare delivery and financing system. KPMG has partnered with the Government of Suriname to (re)design the National Healthcare System. The objective of the National Healthcare System is to ensure that each citizen will have equal access to optimal and sustainable healthcare services, enabling all citizens to have a basic health insurance package. The report advising on the National Healthcare System was developed through consultations with the parties, data analysis and strategic sessions with the Government and other stakeholders. Besides mandatory health insurance for all citizens for a uniform basic healthcare package, the system includes uniformity in professional fees and quality of care, income, age and gender solidarity, a greater focus on preventive care, minimising waste and inefficiencies, automation of health information, and a functional governance structure with separation of supervision, policy and execution. The Government of Suriname enacted the National Health Insurance Law in 2014, thus introducing a national social insurance system with coverage for all citizens.

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www.kpmgislandinfrastructuresummit.com

For further information, please contact:

Simon Townend

KPMG in The Bahamas
T: +1 (242) 394 9980
E: stownend@kpmg.com.bs

Lisa Taylor

KPMG in Barbados
T: +1 (246) 434 3915
E: lisataylor@kpmg.bb

Steven Woodward

KPMG in Bermuda
T: +1 (441) 294 2675
E: stevewoodward@kpmg.bm

Russell Crumpler

KPMG in the British Virgin Islands
T: +1 (284) 852 4814
E: russellcrumpler@kpmg.vg

Kris Beighton

KPMG in the Cayman Islands
T: +1 (345) 914 4392
E: krisbeighton@kpmg.ky

Linda Johnson

KPMG in Guernsey
T: +44 (0) 1481 741 835
E: lindajohnson@kpmg.com

Robert Kirkby

KPMG in Jersey
T: +44 (0) 1534 632 549
E: rkirkby@kpmg.com

Henk de Zeeuw

KPMG in the Dutch Caribbean and Suriname
T: +599 (9) 7325 156
E: dezeeuw.henk@kpmg.com

Micky Swindale

KPMG in the Isle of Man and Gibraltar
T: +44 (0) 1624 681020
E: mswindale@kpmg.co.im

Raymond Campbell

KPMG in Jamaica
T: +1 (876) 922 6640
E: raymondcampbell@kpmg.com.jm

Jan Grech

KPMG in Malta
T: +1 (356) 2563 1037
E: jangrech@kpmg.com.mt

Dushyant Sookram

KPMG in Trinidad and Tobago
T: +1 868 623 1081
E: dsookram@kpmg.co.tt

Gary Brough

KPMG in the Turks and Caicos Islands
T: +1 (649) 941 3882
E: gbrough@kpmg.tc

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