

Universal Healthcare: One place, many paths

July 2016

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“UHC is the greatest gift a country can give its people. We all have a responsibility to make it a success.”



Something to teach, something to learn



Dr Anuschka Coovadia
Head of Health Africa

Many of us fear getting sick – the pain, the isolation, the uncertainty, the disability, the untoward effects of the medications, the complexity of seeking care, the impact on our families and our ability to work, and the deep fear of becoming financially devastated. We all know that healthcare is becoming prohibitively expensive so many of us question whether we will be able to afford treatment when we are faced with a diagnosis of a major disease.

In a country which has a fully functional National Health Insurance (NHI) system or Universal Healthcare Coverage (UHC) every citizen has access to care regardless of their ability to pay. The standards of care are defined, consistent and transparent, and populations are cared for in a holistic, integrated, humane manner.

In our country, not only is access to healthcare our Constitutional right, but it is a part of our path to economic transformation and social upliftment. Today, we stand at the intersection between circumstance, history, ideology and reality. Our actions, or failure to act, will determine the health and wellbeing of many future generations of South Africans, the future economic performance of our country and the extent to which we overcome our current challenges, inequalities and divisions.

As the KPMG Head of Health for Africa, I am regularly involved in consultations with different governments, ministries of health and private sector organisations around the world, to discuss their progress along the difficult path towards achieving UHC. Many admire South Africa, having supported us during our liberation struggle, closely following our post-Apartheid development and respecting our tremendous response to the HIV/AIDS epidemic. They are now keen to learn more about how we plan to achieve UHC, given our current social, political and economic constraints.

The world is watching to see how we:

- finance this massive investment
- design an insurance fund that can provide coverage to our diverse population
- reform our provider market
- structure a sustainable benefits package
- align our polarised market
- overcome vested interests

- upgrade the existing public healthcare services
- collaborate with the private health sector
- demonstrate good governance, accountability and brave leadership
- create momentum that sustains through political cycles

And most importantly, how we overcome the magnetic pull of the present to ensure we take the right steps now, that will set our country up for success over the long term, because we all understand that the attainment of UHC is indisputably linked to our future economic and social stability and progress.

Considering the place that we are at as a nation, I thought it would be opportune to share a few of the similarities and differences that I have noticed in my study of UHC systems in other countries and our own. We all have something to teach and something to learn.

From a review of different countries that have achieved UHC around the world it is clear that many lessons can be learned. Firstly, some mandatory element is essential to rapid progress towards UHC – systems that rely on voluntary enrolment into private insurance, like the United States, simply don't see the benefits accrue to those who would benefit most *. Secondly, countries that have pursued a 'breadth then depth' strategy have seen much greater success than the reverse – this means starting with a shallow layer of coverage for everyone and improving it, rather than trying to get full UHC for a particular group or community then spreading it out**. Thirdly, while some systems have achieved UHC purely through mandatory private insurance, KPMG analysis suggests that some form of public option – whether it competes with private insurers or acts as a single or dominant payer – is associated with a number of important benefits.

Just as important as any of these design features, however, is the political will and skill to carry through change. Even perfectly designed UHC programmes hit multiple hurdles and setbacks along the way, and take a decade at an absolute minimum to implement.

Determination to hold the course, overcome opposition and see through delivery from policy to people's pockets is the most important success factor of all.

UHC is the greatest gift a country can give its people. We all have a responsibility to make it a success.

* World Health Organization, Making fair choices on the path to universal health coverage, WHO (2014)

** Nicholson D et al, Delivering universal health coverage: A guide for policymakers, World Innovation Summit for Health (2015)



“From Geneva to Johannesburg, the momentum behind UHC as a global priority is now unstoppable. The goal is clear, but how we get there will be one of this century’s greatest challenges of political will and technical skill.”



Dr Mark Britnell
Chairman & Partner
KPMG Global Healthcare Practice

The Global Perspective



What is the destination?

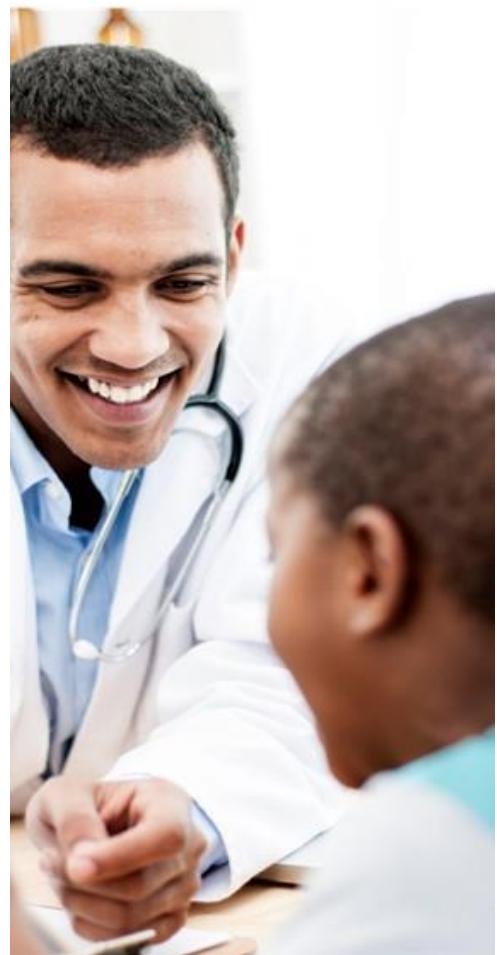
Patients

What is clear is that while there are many 'paths' to UHC, there is only one 'place' that matters – the place where a patient is assured of treatment at a clinic close to home; a clean hospital; an empathetic nurse ; a well-trained and compassionate doctor; safe and affordable medicines; and access to consistent care, free of the fear of financial devastation

Such a place can only exist when:

- Patients are empowered
- Communities are managed as populations
- Wellness is valued as an investment, not a cost
- Care is delivered through integrated medical teams
- The state provides an effective overarching regulatory and governance framework
- Career paths exist for all healthcare professional, including researchers, social entrepreneurs and innovators
- Clinicians are remunerated for producing better healthcare outcomes
- Systems and incentives are put in place to enable a high performing, motivated, engaged clinical workforce
- Data is used to drive transparency, benchmarking and profiling
- Funders create competition amongst providers through strategic purchasing agreements
- An active, responsive health ombudsman exists and serves as a patient protector
- All healthcare facilities are monitored, evaluated and accredited by a national authority
- Investment is driven into the sector from multiple funding sources
- Unique partnerships form to create high quality low cost healthcare services

From the patient's perspective the funding, insurance and reimbursement mechanisms of such a system are not of immediate concern nor does it automatically include all the important aspects mentioned; hence the popular transition in terminology from "National Health Insurance" to the broader goal of "Universal Healthcare Coverage."



Country

As more and more countries make progress towards UHC, we are understanding the many kinds of benefits that its achievement offers: *

- Lower poverty rates
- Improved health and life expectancy
- Increased labour productivity
- Higher GDP
- More efficient health services
- Social stability
- Boost to domestic spending

World

Only some 60 of the world's 192 countries are thought to have achieved universal health coverage, leaving 40% of the world's population with no healthcare coverage and many of the rest with partial coverage that still leaves them exposed to catastrophic healthcare costs.* Some countries, such as South Korea, made rapid progress - achieving UHC in just 12 years - while for others, such as Germany, the journey took many decades.**

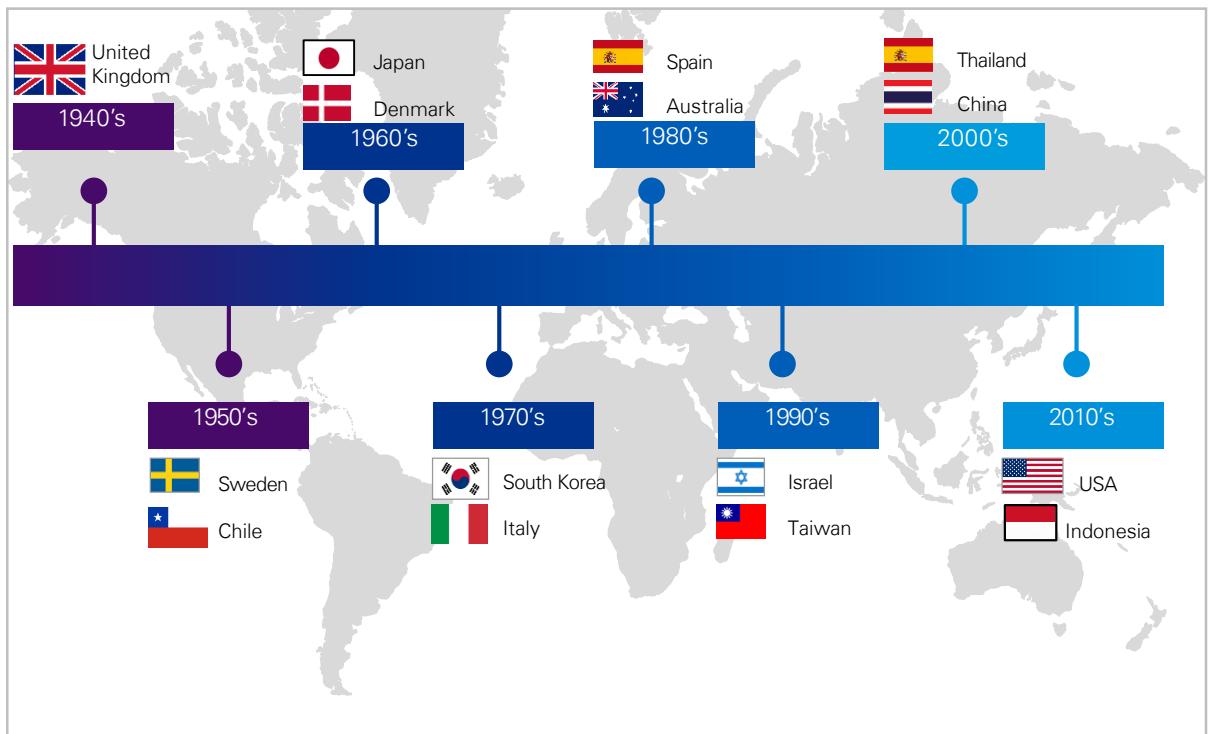
South Africa cannot afford to wait until the 2050s before we have an accessible, affordable, effective and equitable healthcare system.



* International Labor Organization, World Social Protection Report 2014-2015 (2015)

** Britnell M, In search of the perfect health system, Palgrave (2015)

A steady global trend of social progress



UHC Performance in Other Places

"Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"*

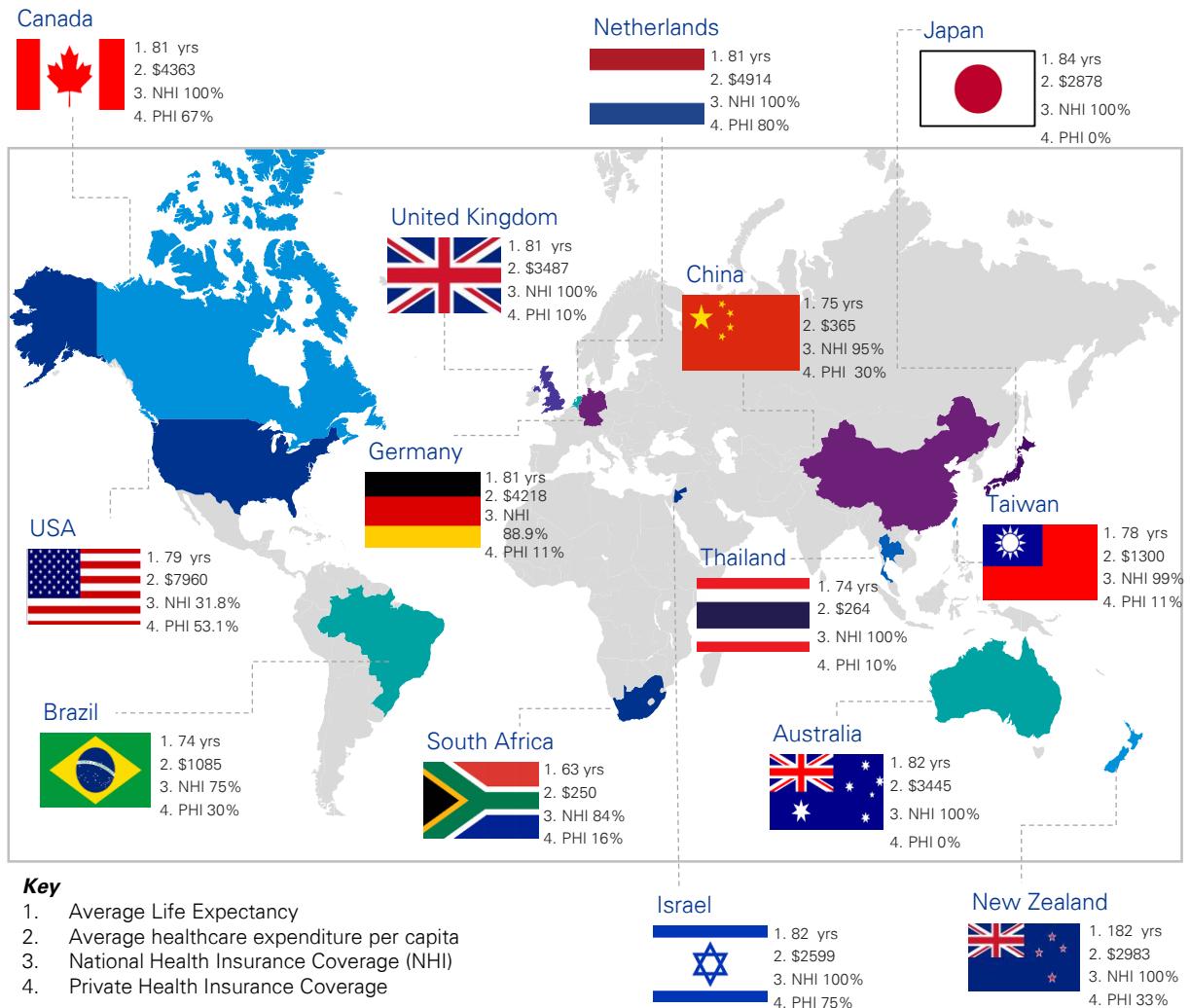
UHC is about far more than spending more on healthcare - the design, performance and equity of the system arguably have a much greater impact on progress than spending. This is evidenced by low-spending nations such as Israel, Singapore and Brazil that have nonetheless achieved UHC, and high spending ones such as the United States and Russia that have not.

In accordance with Goal three of the United Nation's Sustainable Development Goals (SDGs)*, "**Ensure healthy lives and promote well-being for all at all ages**", the attainment of UHC for all countries has been identified as a key global target. Many countries in the world have developed UHC systems over the last few decades and many more are on the path now.



* United Nations Sustainable Development Goals

UHC performance access, quality & cost



There is a wide range in structure, funding and performance of UHC systems around the world.

It can be seen that the Average Life Expectancy generally improves as the Average healthcare expenditure per capita increases; however this is not always the case. Average Life Expectancy also hides the variation in outcomes within a country, which can be significant in countries with a high degree of inequality.

In some countries, like South Africa, Russia and the US, the health system performance is inadequate relative to the healthcare investment that these countries are making. This demonstrates that access alone is not sufficient - good healthcare outcomes in a population are also related to the social construct of the country.*

*KPMG Spoon Full of Sugar



How do we know when we've got there?

One of the difficulties with implementing universal health coverage is the lack of a clear threshold of when it has been achieved, and how to measure progress towards it. Experience from the Millennium Development Goals shows clearly that what gets measured matters, and the targets selected for health programmes have a major impact on how those programmes are designed.

Debate is currently ongoing within the international community about how to measure UHC. Some are supporting a very high level indicator that only takes account of the proportion of people who hold health insurance in a country, regardless of what that insurance entitles them to. Others favour a higher standard – measuring the number of people who fall into poverty each year due to healthcare costs, or who face ‘catastrophic’ healthcare bills (40% or more of their annual income).

Whichever of these headline metrics is approved for the SDGs, all countries pursuing UHC quickly see the need for much more detailed measurement frameworks to accurately understand the impact that their programmes and policies are having. In working with health systems around the world, KPMG have broadly constructed two kinds of framework with our different clients.

- 1) The first set of frameworks focus on the ‘demand side’ journey – whether the entitlements, financing and enrolment are sufficient to offer coverage across the population. Here we look at which health services is it most important to cover, the extent of financial protection given to people, projected impact on out of pocket and catastrophic health spending, important groups that may be missed, and many other indicators covering the flows of healthcare funding.

- 2) The second set of frameworks focus on the ‘supply side’ journey – whether capacity exists in the healthcare system to provide the new care services that people are entitled to. Here we look at access levels to particular services, shortages of human and physical infrastructure, the prices and payment systems for care and ultimately, the impact on families’ health, wealth and wellbeing.

Even with good directions, you can’t get where you want without knowing where you are. Only when both the financing and delivery systems are understood can realistic goals be set and priorities chosen. Smart measurement of UHC really can make the difference between success and failure.

From our research on countries that have achieved UHC around the world emerge three clear design elements that are important to include in any UHC system:

1. Some element of mandatory inclusion or membership in the scheme is required. If insurance or cover is not mandatory then, quite simply, not everyone will opt to get coverage. This can become worse over time in systems where people must pay to be covered, as many healthier people will choose to opt out because they will be contributing more to the scheme than they receive back in benefits. Their withdrawals will cause the required contributions from the remaining members to increase, which in turn will lead to many of the healthier remaining members withdrawing from the scheme, and so on.



2. It is highly beneficial to pursue a 'breadth then depth' strategy, i.e. to first try to provide coverage to the entire population for basic primary healthcare, before trying to expand the depth of this coverage to include more complex primary healthcare as well as secondary and tertiary healthcare. The most basic reason for this is that primary healthcare produces the most benefit per unit of resource spent providing it.

However, there are also political benefits to this approach: it avoids the need for difficult political decisions to be made around which section of the population should be covered first. Even making a decision to begin with covering the poorest section of the population – which for many would sound like a politically acceptable idea – can create political problems. These services would acquire a reputation as "being for the poor" and thereby run into problems being accepted by the wider population when the services are rolled out to them.

3. Include some form of public insurance or financing option, even if a private health insurance market is envisioned. We have seen a number of benefits from including a public financing option, such as: *

- They are around twice as effective at bringing down the share of out of pocket healthcare spending.
- They are better able to control healthcare costs, including costs falling on government.
- Low and middle income countries that 'outperform' wealthier countries on UHC all do so with programmes that have some form of public payer.
- They are more difficult for provider industries to "capture". A payer which is not completely independent from all providers would no longer be able to function as an effective purchaser of healthcare services

Even by simply including one public insurance or financing option to compete with a market of private payers can put pressure on the private payers to keep costs down and remain competitive



* KPMG analysis of 35 countries with UHC programmes

Different countries have taken different approaches to paying for UHC systems and these can broadly be split into three groups: single, public payer; multiple payers including both public and private options; and multiple private payers. Each of these approaches has been used in multiple countries and the table below summarises the key features, advantages and disadvantages that each approach has shown to date.

System	Key Features	Advantages	Disadvantages
Single payer (Public) E.g.. UK, Italy, Cuba, Thailand	<ul style="list-style-type: none"> A single public sector fund with mandatory membership Often tax funded 	<ul style="list-style-type: none"> Equity Large scope for raising resources Potential Administrative efficiency Strategic purchasing opportunities Coordination of care No need for risk equalization Payer power helps control cost 	<ul style="list-style-type: none"> Sensitivity to political pressure Potential inefficiencies from lack of competition Funding can be unstable if government finances deteriorate Lack of responsiveness to member needs Lack of choice and innovation Downward pressure on price can cause provider dissatisfaction
Multi-payer (mixed) Eg. Australia, Israel, Brazil, Chile	<ul style="list-style-type: none"> Single or multiple funds (public and/or private) Mandated insurance, but with a choice of public, quasi-public and/ or private funds Often tax and employer/ employee funded" 	<ul style="list-style-type: none"> An additional revenue stream (from employers) Less dependent on healthy government finances Highly redistributive (from rich to poor) Individual choice Responsive to member needs Efficiency of administration Public option minimizes potential market failures Competition stimulates performance 	<ul style="list-style-type: none"> Possible exclusion of the poor (if 'cream skimming' isn't regulated against) Tends to escalate costs Fragmentation of care Complex (especially if there are too many (+20) insurers) Need for risk equalization Need for a strong governance framework
Multi-payer (private) E.g.. France, Germany, Netherlands, Switzerland	<ul style="list-style-type: none"> Mandated insurance but with no 'public option'. Often funded through individual and employer contributions, as well as some tax funding. 	<ul style="list-style-type: none"> Incentivizes innovation Helps finance health services not covered publicly Commonly more responsive to member needs Provider able to negotiate tariffs 	<ul style="list-style-type: none"> Need for risk equalization Lack of integrated care High administrative costs Young and healthy tend to opt out so cross-subsidization is undermined Some evidence this creates a slower/less equitable path to UHC and Associated with higher health system costs

As this table shows, there is not necessarily a clear "best practice" for funding healthcare and the choice of funding approach made will need to depend on the needs, capabilities and political situation of an individual country.

The Local View



Where does South Africa stand along this path?

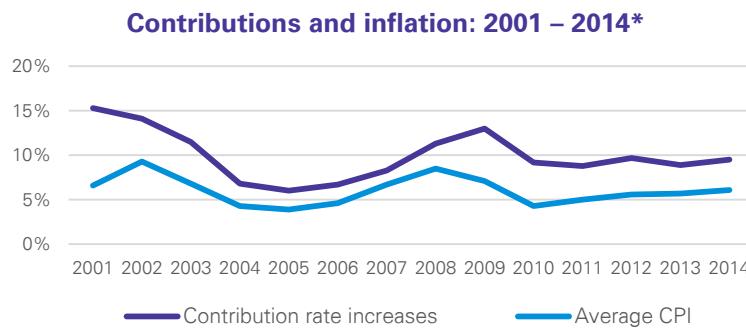
South Africa has been discussing how to implement UHC since the Second World War. Post 1994, the calls for equity, quality, affordability and access have amplified, due to the gross service delivery failures in the public healthcare sector and the relative unaffordability of the private healthcare sector.

Unaffordability

Medical Scheme contribution increases have been on average four percentage points higher than CPI inflation in every year between 2001 and 2014*. Whilst the compound inflation over this period has been 227%, the total increase in medical scheme contributions has been 375%.

Service Delivery Failure

From a shortage of doctors and nurses, to an evolving disease burden, to mismanagement of funds, operational failures and underserviced rural communities, millions of South Africans are suffering from illness and injury, without recourse to proper (or any) treatment. For a regional leader like South Africa, the situation is untenable and unacceptable.

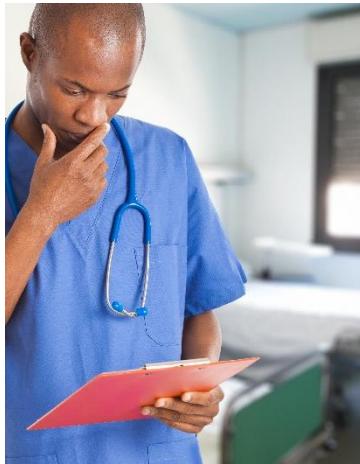


Over the last two decades, the political discourse and debate has been closely intertwined with these discussions – healthcare, is by its very nature, at the root of any country's social, political and economic reforms. In December 2015, the boldest policy proposal yet was put forward - the White Paper - which has provoked strong public reaction and debate.

Headline News

"It will be an ultra-marathon, not a sprint" Dr Aaron Motsoaledi

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Medical Scheme Industry Body Views



Dr Humphrey Zokufa
Managing Director
Board of Healthcare Funders
(BHF)

"The private healthcare funding industry, resources, expertise, skills, and competencies should be regarded as a National Asset when it comes to managing healthcare financing and related matters. This asset must be utilized in the design, managing and implementation of NHI/UHC.

The published NHI White Paper makes some provision for this. The great challenge is for this industry to embrace the NHI/UHC, and break out of the current model based on various medical schemes that are fragmented and do not benefit adequately from cross subsidies. The industry must do a lot to be seen and perceived by government as unequivocally supporting the NHI.

The Thought Leadership of the industry must embrace this challenge, and concretely do something about it soon."

The Options

Beyond the headline-grabbing controversies, a long road lies ahead for South Africa's UHC reforms, with many key decisions that need to be made during the design, establishment and implementation of a UHC system. Each decision involves a trade-off, associated with distinct advantages and disadvantages. As with any country the construct, character and composition of the existing healthcare system and population restricts the choices of the design of the new system.

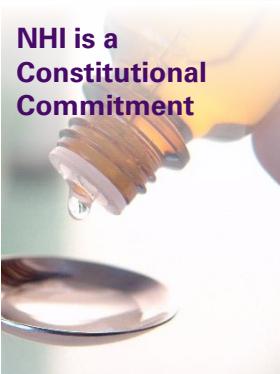
 How will the system be financed?	 What is the role of the State?	 What is the role of the Private Health Insurers?
 How will the system be regulated?	 Will there be a single fund or multiple funds?	 How will the fund/s be administered?
 What will the benefit package comprise of?	 How much will the package cost?	 Who will be covered and for what?
 Will services be free at the point of access?	 Will there be a cap on the Out-of-pocket expenditure?	 Will any risk-sharing arrangements be used?
 How will vulnerable populations be prioritized?	 How will the services be delivered?	 How will the system be governed?
 Will patients have an element of Choice?	 Will the population need to be registered?	 Will the General Practitioner be the Gate-keeper?
 How will the doctors be paid and managed?	 What is the role of private and public hospitals under the new system?	 How will the provision of care be monitored and evaluated?

In order to answer these questions, one needs to understand that in the South African healthcare system, as much as elsewhere, an unprecedented number of transitions are taking place every day, tumbling over each other: these include epidemiological, demographic, political, migratory, and socioeconomic changes. Our current system is failing to cope with these complex, interrelated, sometimes opposing, forces.

The proposed healthcare reforms aim to build a healthcare system that is able to meet the needs of all our people, irrespective of their ability to pay for services. The design of this new system is captured in the decisions, choices and trade-offs in the NHI White Paper.

The Choices

The best place to start is from where you are. Difficult decisions have been proposed in the White Paper based on the need to avoid embedding Healthcare Apartheid into our future healthcare system. Reality needs to meet ideology and our history has influenced where that intersection will take place. According to the White Paper, the following elements are key relevant features of our proposed National Health Insurance (NHI):

NHI is a Constitutional Commitment 	All South Africans will be covered by the NHI	Mandatory prepayment from all those who are eligible	Populations will be registered and receive a NHI card
Comprehensive packages of public health services	Services include community outreach, primary healthcare, promotion and prevention, curative, specialised, rehabilitative and palliative care	Primary healthcare (PHC) will be delivered through the Ideal Clinic model, School Health Teams and District Health Teams	
Central hospitals, which provide tertiary services, will be managed nationally	Certification by the Office of Health Standards Compliance (OHSC) and accredited by the National Health Insurance Fund (NHIF)	Payments will be made by capitation models for PHC and Pay-for-performance models using a DRG system	Standard clinical protocols, Referral guidelines, the Essential Drug List and the Essential Laboratory List
Care will be free at point of access and there will be allocation of a catchment population	Services will be delivered by accredited teams, including private practitioners	Health Technology Assessment, NHI Benefits Advisory Committee, NHI Information System	The Medical Schemes Act will be amended so that Medical Schemes only provide Complimentary Cover

A Phased Roll-out has been proposed to retain a measure of stability in the system. The complexity of the health economy is such that it is not possible to plan and predict in detail every aspect of how a major redesign will turn-out.

Details of the specific implementation of the different components of the system, such as the costing per project, will need to be adjusted and adapted based on the output of each preceding phase, as well as the new healthcare environment that it creates.

PHASE 1 (2012/2013 to 2016/2017)

Focuses on strengthening the public health sector, but also implementing key enablers such as the Office of Health Standards Compliance (OHSC).

PHASE 2 (2017/2018 to 2020/2021)

Focuses on registration of the population and the creation of a transitional NHI Fund to purchase non-specialist Primary Health Care (PHC) services from "certified and accredited public and private providers", but also with amendments to the Medical Schemes Act.

PHASE 3 (2021/2022 to 2024/2025)

Focuses on bringing the NHI Fund into full operation as a strategic purchaser and single payer of comprehensive health services, including specialist services

At this stage, the White Paper has not adequately clarified:

- how the system will be financed
- which benefits will be covered
- and how much they will cost
- the exact role of the existing private health insurance sector
- the extent that members will have the right to choice
- how the proposed reforms to the Medical Schemes Act will proceed
- the governance and regulatory structures of the future National Health Insurance Fund (NHIF)
- the future engagement strategy
- payment terms of doctors
- the role of the provincial health departments
- how the system will be resourced, particularly in terms of medical personnel
- the specific, sequenced steps of implementation





A Legal Perspective on the National Health Insurance White Paper



Professor Yousuf A Vawda
School of Law, University of
Kwazulu Natal

The attainment of universal health coverage (UHC) is a complex process, but a necessary one which the proposed National Health Insurance seeks to address.

The basic premise of the NHI proposals is redress of the current fragmentation between the public and private sectors. The expectation was that the document would provide a clear way forward, fill the gaps identified in relation to the Green Paper, and in particular include clear guidance, backed by the Treasury, of the financing options to be exercised. Implementation of NHI will also require amendments to related existing legislation and enactment of new laws to ensure legislative alignment and policy coherence across government departments and spheres of government, as

well as regulatory reforms relating to the medical schemes industry. The White Paper falls short of a number of these expectations, and leaves many questions unanswered.

From a legislative perspective, one of the key steps in the implementation process will be the amendment of the Medical Schemes Act (Act 131 of 1998). The White Paper is rather vague on the exact reforms to be implemented. The contribution of the existing Prescribed Minimum Benefits (PMBs) to the "rising costs of the private health sector" is acknowledged, but the problem is also firmly located within the context of the dominance of the fee-for-service reimbursement model in that sector. However, another key costs driver is identified as the "uncontrolled introduction of new

healthcare technology", which is alleged to be associated with "cost increases without an improvement in the quality of care".

One of the most debated points in relation to NHI is that of the basket of services to be covered. The White Paper states that "NHI will provide a comprehensive package of personal health services", but also that priority-setting and progressive realization will characterize the process: "NHI will not cover everything for everyone".



The document is thin on details of the expected package or basket, and proposes the creation of an NHI Benefits Advisory Committee to determine "service entitlements for all levels of care". In order to ensure that financial risk protection is extended to those who use the public sector, the White Paper proposes that the Uniform Patient Fee Schedule (UPFS) in the public sector be abolished in the early stages of the transition. In addition, it states that "a massive reorganisation of the health system would be required to create a new platform for service provision and health care financing". In particular, the policy document proposes legislative changes to the "functions, responsibilities and relationships within the three spheres of government". This implies wide-ranging changes to the National Health Act, and perhaps to the Constitution. In addition, an NHI Act is planned, which will establish the NHI Fund and its governance structure, the NHI Commission. It is envisaged

that the NHI Fund will report to the NHI Commission on a quarterly basis and to Parliament annually.

Much of the media coverage of the White Paper and the reactions from various stakeholders have focused on the financing options listed. Only "illustrative projections" are provided, and no clear preference between the listed funding options (direct taxation, indirect taxation, payroll taxation and premiums) or their combinations is evident. In order to formalise the development process, terms of reference for National Health Insurance six "work streams" have been gazetted, namely, prepare for the establishment of the NHI Fund; design and Implementation of NHI Health Care Service Benefits; prepare for the purchaser-provider split and accreditation of providers; the role of medical schemes in an NHI environment; complete NHI Policy paper for public release; and strengthening the District Health System.

Predictably, the responses from the private health sector have hardly been sanguine, given their vested interests in retaining the status quo and their insistence on self-regulation. This is precisely what led to the Competition Commission inquiry into the private health care sector, which is expected to complete its work by December 2016. The aims of the NHI may be ambitious, but

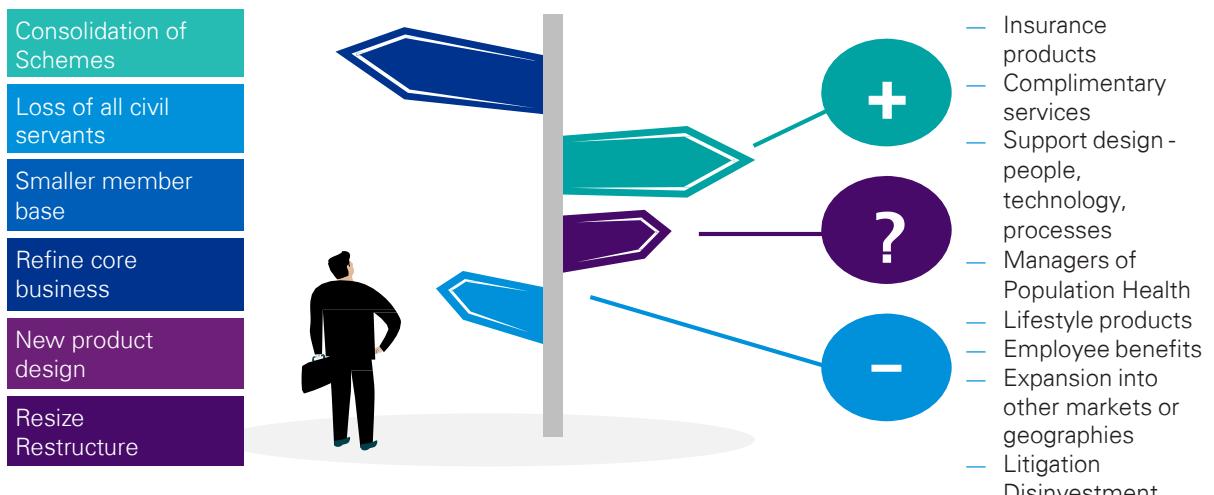
it is the only show in town which attempts to address the goal of universal health coverage. It also provides us with an opportunity to address some critical challenges of our health care system— the vexed issues of human resource capacity and management in the public sector, and the quality of health care across the board.

What is the end-game for Private Health Insurance?

Anxiety abounds in the medical scheme industry, as the NHI white paper has stated that private health insurance may not provide cover for anything that is covered by the NHI, but without stating what that basket of services will be. Consultation and engagement have been thin, and this has left many in the industry nervous about how much of a role private health insurers will have in the South African healthcare system. Yet many are hopeful that private insurers have valuable assets which can be leveraged in a NHI system – in terms of the existing pool of people, platforms, systems, technologies and clinical risk management tools. The industry has much to boast about, including but not limited to:

1. The Government Employees Medical Scheme (GEMS) already provides coverage to approximately 1.7 million lives and has demonstrated strong governance, performance and contracting capabilities. It could be a forerunner for a potential future public insurer.
2. Discovery has pioneered innovative lifestyle risk modification programmes, underpinned by its Vitality offering, which have been recognized globally, for the impact it has on health outcomes of its membership.
3. Momentum (MMI) has supported university-led training programmes for community healthcare workers and is currently exporting its systems, capabilities and people to develop the health insurance market in India.

With consideration to the position taken in the White Paper, it can be expected that there will be a level of consolidation in the industry; product diversification; geographic expansion into other jurisdictions; and some insurers could potentially cease to exist.



A strong, relevant and unified voice will be required from the private funding industry in order to carve out a meaningful role for themselves, in the new health economy.

Leadership, compromise and collaboration is key.

In other countries with UHC, including single payer public systems the role of private sector health insurers remains embedded in the national system. Their function ranges from covering comprehensive health packages, in countries like the Netherlands and Australia; to providing access to higher quality care, in better facilities with shorter waiting times, in countries like Brazil and United Kingdom. The proportion of the population covered by supplemental health insurance products also ranges significantly from 25% in Brazil, 33% in New Zealand, 75% in Israel and almost 100% in the Netherlands.





Partnerships - a Doctor's Perspective



Professor Morgan Chetty
Chair KZNMCC & Independent Practitioner's Association Foundation (IPAF) of SA

One longstanding polarized debate in Global Health concerns the appropriate role and balance of the public and private sector in providing health services in populations in low and middle income countries.

If we review the International Universal Health programmes we conclude that each sector has its own strengths and weaknesses, but importantly, in both sectors there are financial barriers to care and each has challenges with poor accountability and transparency. This is compounded by global economic recession, which places major constraints on government budgets, the major funding source for healthcare expenditures in most countries.

To assess the role of the private sector in national healthcare initiative it is prudent to inspect the International Universal Health programme.

The Netherlands healthcare system, characterized as being "in transition" introduced healthcare reform which enhanced the transition from supply and price regulation in healthcare to

"regulated competition". There was a strong role of primary care considered to prevent unnecessary use of more expensive secondary care and provided consistency and coordination of individual care. The public – private participation led to managing healthcare costs, improved quality, improved hospital efficiency and was person-centred which increased consumer choice. This was also seen in the Portuguese NHS, where services are obtained from the private sector, which included imaging and laboratory services. In Belgium there is public funding with a predominantly private health provider.

In SA, it is our belief that the private sector fares well for quality of care. The private sector also has excellent management, financial resources, skilled personnel that the public sector can "tap" into. However the private healthcare delivery has to be regulated, to manage costs and promote "regulated competition". Governance of the process is key. The debate of private and public sector seems anachronistic. Today

the role of the private sector in delivery of healthcare services is undeniable and in Africa the private sector accounts for approximately 50% of healthcare provision. It is no longer the question of the private vs public sector but rather "what is the best and most efficient mix for local context".

Universal healthcare is an aspirational goal. There is a need for increased resources for struggling healthcare systems and a need to lessen financial pressure on those seeking care.

Reaching a balance on health sector requires a strong government stewardship to maximize the systems contribution to population health. Both the public and private sector have vital "tools" for realization of the right to access healthcare.

It is our vision in the IPA Foundation that both to fast track and successfully implement NHI, a public-private solution is imperative. This has been borne out by successful international programmes.



Big Pharma Support for System Reformation



Dr Rudy Onia
Area Medical Director
Africa and Asia Developing
Countries
GlaxoSmithKline

GSK fundamentally supports enabling greater access to healthcare by patients across the socioeconomic spectrum. As a company we are determined to do all we can to help improve people's health and well-being no matter where in the world they live, while balancing this with the need to generate the returns needed to sustain our business and to invest in the research and development of new medicines.

Over the past few years, we have made fundamental changes to our business model and management structures to ensure our medicines and vaccines are as available and affordable as possible, to encourage more research into neglected diseases, to support communities to strengthen their local health infrastructure and to form partnerships with governments, NGOs and other companies to help amplify our efforts. In our effort to expand access to our medicines, we have led the industry in adopting a flexible approach to pricing of our medicines and vaccines based on a country's wealth and ability to pay and introduced greater flexibility with respect to our IP in Least Developed and Low Income countries.

GSK has been ranked number 1 for the fourth consecutive time in the Access to Medicines Index, which ranks 20 individual pharmaceutical companies on their efforts to enhance access to medicines across a range of strategic and technical areas. While we recognize that there is still much to do, this is a clear validation of the company's ongoing strategy to improve universal access to high quality healthcare.

A Way Forward



Our Path Forward

As South Africa embarks on the journey towards UHC, there are a number of key lessons we can learn from the experience of others who have walked this path before us:

-  Strong committed brave leadership is needed at all levels
-  Trust is built slowly by honest, sincere, consistent consultation
-  UHC needs to be viewed as an investment, not a cost
-  Implementation should be slow, realistic and affordable at every step
-  Patient-centricity should be an over-arching goal that pulls all reforms together
-  There is no substitute for strong governance, transparency and accountability
-  Communication should be clear, consistent and relevant
-  Health systems function best with a healthy, motivated, engaged workforce
-  Primary healthcare reform is a good place to start
-  Provider reform needs to mirror funding reform
-  Focus on progressive implementation of sequenced, prioritized, coordinated projects
-  Process and standardization are necessary to reduce variation
-  Technology is a critical enabler
-  Performance needs to be monitored in terms of clinical outcomes, costs, access, patient satisfaction, effective capital utilization and operational outputs
-  Partnerships unlock opportunity and build unique capabilities



IPASA's views on the NHI



Dr Konji Sebati
CEO
**Innovative Pharmaceutical
Association South Africa
(IPASA)**

IPASA fully supports and agrees with the principles of the right of access, social solidarity, effectiveness, appropriateness, equity and affordability, as expressed in the White Paper. These are noble objectives for which to strive and will ultimately benefit all South Africans. IPASA welcomes the fact that issues relating to medicines and patient access to pharmaceuticals and pharmaceutical services are being featured prominently in the White Paper, a shift from the Green Paper, which in IPASA's opinion signifies the recognition, by the National Department of Health (NDoH), of the importance and benefits of medicines, and the contribution of medicines to improving patient care and health outcomes.

IPASA remains ready and willing to partner with the Minister of Health and the Department, to ensure successful universal health coverage for all South Africans, as enshrined in the South African Constitution; and the SDGs - SDG 3 includes a statement that reads - "achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all".



Provider Reformation



Brian Ruff
CEO
PPO Serve

We note that there is too much focus on financial arrangements and pooling rather than on purchasing and the evolution of a well-functioning highly productive healthcare system. We believe that the key to a unified healthcare system can only come from a far better functioning national healthcare delivery system.

To achieve this needs a clear vision and the engineering required to achieve it. This needs:

- population level structural planning
- a variety of new

commercial organisational models based on teamwork and useful competition between integrated systems

- supportive State funding
- supportive State regulation
- clear process and outcome measures
- outcome linked rewards

Unfortunately, the NHI White Paper is largely silent on supply side reform, appearing to believe that the public sector needs a few tweaks to make it a viable basis and that any gaps can be contracted from private

providers.

This simply isn't realistic.

In our view, the key to reform are new models of care delivery that are based on:

- population medicine and patient centered care
- integrated teams competing for Scheme contracts
- the value contract that rewards outcomes not inputs
- with modern patient care IT and reporting systems PPO Serve is based on this insight.

A Unique Solution for a Unique Country

A UHC system in any country needs to fit in with the country's political imperatives. However, the path that a country's healthcare system takes towards complying with these political imperatives must inevitably take into account the practical limitations imposed by the economy and healthcare system that it begins its journey with.

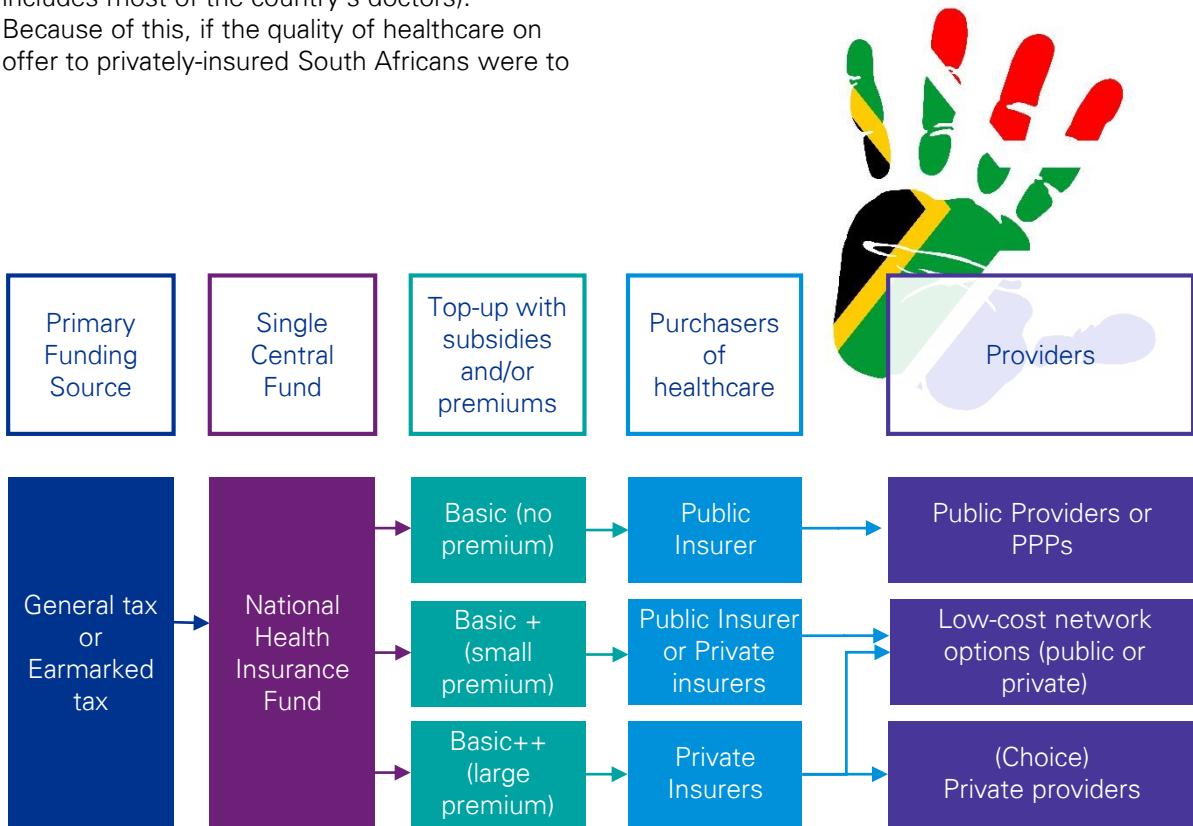
For example, in South Africa there is a very clear political imperative – reinforced by the country's history of apartheid – that the ability to pay must not lead to higher-quality medical treatment. The country will not accept a "poor system for the poor". However, there are practical problems that arise from how South Africa's economy and healthcare system are currently organized that could limit the type and rate of change that is possible. The minority of South Africans who earn enough to pay tax are largely the same minority who are currently enjoying high-class private healthcare (which includes most of the country's doctors).

Because of this, if the quality of healthcare on offer to privately-insured South Africans were to

decrease substantially enough to prompt a significant number of them to emigrate, there would be a significant risk to the ability of the South African government to continue to adequately fund a UHC system.

As such, South Africa has a moral and ideological mandate to provide quality healthcare for all of its citizens, but it must contend with the practical problems brought about by having so much economic power concentrated among so few.

One potential model that could allow for a smooth transition to a UHC system that provides quality care for all is outlined below. In this model, we suggest start with the "two healthcare systems" that we currently have in South Africa (private and public) and introduce a third, 'mid-way' option. This would initially require a small financial contribution and provide access to modern, low-cost, high-quality designated service provider networks.



For this model to work it is critical that the 'mid-way' package (Basic+) grow and become the package to which the majority of the population belongs. The transitions to allow this to happen would occur in stages.

For example, the initial focus for the public providers could be to improve their primary healthcare provision, perhaps supported by rolling out the Ideal Clinic Model.

Next, the Government Employees Medical Scheme (GEMS), which is currently a closed scheme available only to government employees, could be opened up to the whole population and form the precursor to the public insurer. The creation of an effective payer – one that is able to negotiate quality care at reasonable costs from either public or private providers – would be a key step in allowing the lines between public and private provision to blur.

The Office of Health Standards Compliance is tasked to ensure compliance with certain standards of care regardless of in which sector it is provided, and any providers unable to meet the requisite quality standards would eventually be shut down. The income that they were

receiving from their patients' subsidies and premiums would be diverted to higher-performing providers, providing a competition mechanism which would raise the quality of care across sectors.

It would be prudent to model the above steps in as much detail as possible, as well as potential alternative steps, and to continue to plan beyond these steps. However, given the rapidly changing environment in which healthcare inevitably finds itself – whether due to short economic or political cycles, changing technology, changing demographics or other causes – we must accept that it is virtually impossible to anticipate how the entire process of the implementation of a UHC system will play out with certainty. We cannot allow perfection to be the enemy of progress, so despite these limitations we must always strive to make progress towards the creation of a UHC system. This progress must be done in incremental steps which will allow us to reevaluate and readjust our plans at regular intervals to ensure that we remain on course to providing quality and affordable healthcare for all.



What happens next?

In accordance with the World Health Organisation's framework on UHC, the Ministry of Health has set up six task teams to debate and discuss the details of the implementation of the NHI.



These work streams each have a set of critical questions and challenges that need to be addressed.

Governance and Leadership

- What is the strategic vision and the governance structure?
- Is there transparency in the structures, processes and systems?
- What is the single point of accountability?
- Is there participation and fairness?
- Is there a clear mandate with relevant goals?
- Is there a defined, effective decision-making authority?
- Is there effective oversight?

Healthcare Financing

- What are the financing arrangements and flows of funds?
- What are the cost estimates for the different components of UHC?
- What are the different funding sources?
- How will we fund the NHI under the current economic conditions?
- How will the value of the investment be monitored and evaluated?
- Will healthcare outcomes be measured?
- What type of payment mechanism will be used to reimburse providers?
- Is there a process for fee negotiations with providers?
- How will the public insurer be administered?
- What is the role of the private health insurers?

Healthcare Workforce

- Is there an Integrated Human Resources Strategy for health that will support the NHI?
- What are the current programmes and interventions being used to recruit, train and support healthcare workers?
- What existing capacity and capabilities exist?
- What are the gaps in the workforce and what are the expected future gaps under the NHI?
- How do we attract, retain and train clinicians?
- How do we incentivize healthcare workers to serve rural areas?
- How do we support the training of the next generation of doctors, nurses, scientists and healthcare managers?
- How do we reorganise the providers to work in medical teams and ensure continuity of care

Service Delivery and Infrastructure

- What are the infrastructure requirements to deliver the different phases of the NHI?
- What are the capital costs and human resources requirements to build, upgrade and maintain the infrastructure and equipment?
- What are the requirements to implement effective, accessible, integrated primary healthcare services?
- What is the role of public-private partnerships?
- What are the key gaps in the current health systems strengthening programmes?

Information systems

- What are the existing IT systems?
- Is there an IT Strategy to develop an information system which provides meaningful, timely and relevant information to all the stakeholders?
- Can the system manage financial, clinical and operational information?
- How can privacy be maintained and security implemented to protect personal information?
- What are the opportunities to expand the telemedicine services?
- Have key definitions been standardized?
- Is there a training strategy to teach the end-users how to collect good data?
- Does the architecture of the system allow it to integrate to other platforms?

Legal

- Is there appropriate legislation in place to support UHC implementation?
- What are the legal reforms that need to be made to the current regulations?
- What are the gaps and limitations?
- What does the legal structure look like for a public insurer?
- What are the processes and key milestones for legal reform?



These issues are complicated, often sharing dependencies and involving difficult choices and trade-offs. It is critical for the NHI task teams to work together to sequence the next steps of the roll-out of each of the work streams of the NHI in a sensible, controlled, achievable and affordable manner.

Communication is a critical component, throughout the process, as information, participation and transparency fosters trust. The citizens of our country need to understand the meaning and the value of the reforms; and they need to see and experience better patient care as a visible outcome of the reforms.

Above all, the leaders, implementers and guardians of our future UHC system will always need to find the delicate balance between consultation, engagement, analysis, action and slow incremental change.

Ultimately, a UHC system is a reflection of how society chooses to organize itself. Given our pervasive inequalities and disparities in South Africa, it is at the heart of our healing as a nation. It is critical to the next steps of our unification, progress and development. And it is fundamentally a social transformation process with clinical and economic benefits.

UHC is the greatest gift a country can give its people. We all have a responsibility to make it a success.



Writers



Dr Anuschka Coovadia
Head of Healthcare Africa
KPMG



Dominic Carrell
Healthcare Specialist
KPMG

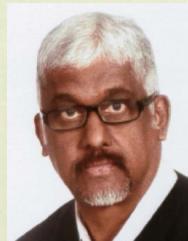


Jonty Roland
Global Health Executive
KPMG



Dalene van Greune
Healthcare
Project Manager
South Africa

Contributors



Prof Morgan Chetty
Chair
KZN MCC



Dr Rudy Onia
Medical Director
GlaxoSmithKline



Dr Brian Ruff
CEO
PPO Serve



Dr Konji Sebati
CEO
IPASA



Prof Yousef Vawda
Faculty of Law
UKZN



Dr Humphrey Zokufa
Managing Director
Board of Healthcare
Funders (BHF)



Contact Us:



Dr Anuschka Coovadia
Head of Health Africa
anuschka.coovadia@kpmg.co.za



Dalene van Greune
Healthcare Project Manager
dalene.vangreune@kpmg.co.za
M: +27 (0)82 719 0587



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