THEME DISCUSSION: COLLABORATIVE SERVICE MODELS BETWEEN PUBLIC AND PRIVATE SECTOR WITHIN THE WESTERN CAPE

Present and Apologies

See attendance register attached as annexure to the minutes.

1. Welcome and Introduction

Dr Beth Engelbrecht, Head: Department of Health

Dr Engelbrecht opened the meeting and welcomed everyone present.

She mentioned that as medical aid funds deplete towards the end of the year, patients shift to the public facilities and the demand for public services increase. This adds to the existing challenges of an increase in the population, disease, patient expectation and demand even though the budget is decreasing. The vision for the Province is to provide the best healthcare possible.

Despite the challenges, services are not compromised - life expectancy has improved to 67 years and mortality rate outcomes are the best in the country. Other areas to leverage efficiencies include infrastructure delivery and ICT systems. The National Core Standards (NCS) are adhered to and services are measured by outcomes and outputs. One of the focus areas is to inspire staff to feel proud to be employed by the Department.

To reach the goals set in Healthcare 2030, a strong transformation agenda and a community connected Primary Health Care (PHC) system is required to drive patient-centred care. The Department focusses on implementing good governance, resulting in clean financial audits that speak to financial management.

Dr Engelbrecht reflected on the December Congo Fever success story of the Department; most of the staff was on leave but were committed enough to come to work during this period. By the beginning of January 2017, more than 200 contacts were engaged as per protocol and the patient was discharged from Groote Schuur Hospital.

A measles outbreak was also reported in Stellenbosch. The amazing co-operation from WCGH staff and the three high schools helped contain the outbreak. Within three days, all the children in contact were immunised and there were only nine cases left after three weeks. The system has proved to be positive and WCGHs staff is resilient.

Socio-economic factors influence social illness such as depression, violence, drug and alcohol abuse. Instead of trying to treat patients, the aim is to resolve the causes of these factors. To address this, a new model has been explored that will be rolled out in four geographic areas: Drakenstein-Paarl, Gugulethu-Nyanga, Khayelitsha and Saldanha. The Department is collaborating with eight other departments, municipalities, Non-Governmental Organizations (NGOs) and the communities to achieve preventative treatment rather that curative.

Dr Engelbrecht highlighted that the meeting topic focusses on Collaborative Service Models and the Western Cape's perspective on NHI. She quoted a comment by Professor Household from the previous minutes, which stated that 'Partnerships between public and private are complicated because of the differing dynamics. The private sector is very competitive compared to the public sector where the focus is on patient care and health outcomes.' The options would be to either find compatibility or look at new methods.

Minister Mbombo conveyed her apologies. She was unable to excuse herself from a Cabinet meeting.

The HOD invited members to suggest themes for the PPHF meetings.

2. WCGH's approach to Universal Health Coverage (UHC):

2.1. Inputs on the NHI White Paper

Dr Anthony Hawkridge, Director: Health Impact Assessment

Dr Anthony Hawkridge explained how the NHI will work, what the Province does not agree with and alternative solutions. The table below demonstrates the differences:

Agree	More Information	Concerns
• Intent & principle of UHC • Remove payment from point of care • Strategic purchasing of Goods/Consumables • Strengthening of the Public sector and District Health Services (DHS)	• Costing model of NHI • Role of provinces • Role of National Department of Health (NDOH) • Governance and accountability arrangements	• Unconstitutional erosion of provincial powers and functions • Fragmentation of services • National management of central hospitals • Direct contracting & funding of providers bypassing provinces • Affordability

The WCGH is committed to UHC and proposes that the challenges raised should be addressed with discussions and engagements before fully implementing because there are other alternative and robust models.

2.2. Partnerships within a resource constraint environment

Ms Juanita Arendse, Director: Northern Tygerberg Sub-Structure

Ms Arendse gave a summary of the framework whereby the Department has defined its Service Transformation Strategy so as to provide the context for providing maximum benefit within a resource

constraint environment. This could also provide the parameters of engagement and/or partnering with non-governmental entities moving forward.

The current reality is that patients have an expectation of healthcare with increasing patient numbers and limited resources. The Department would like to deliver a service that projects the iC²AIR² values, bearing the Healthcare 2030 strategic vision in mind, with a clear focus on patient centred quality care which will strengthen the system towards improved resilience. Furthermore, Primary Health Care (PHC), search for innovation, prioritising economical interventions, consistently reflecting and reviewing progress will be heightened as the dynamics of the burden of disease is transforming.

The five service priorities are:

- Patient-centred care;
- Service pressure mitigation;
- HIV & TB outcomes;
- Maternal, neonatal and child outcomes (1st 1000 days strategy); and
- Non-communicable disease outcomes (integrated chronic conditions management).

The plan to address these priority areas is to do a population-based approach, service design and enabling and responsive critical support services. Community Oriented Primary Care (COPC) is a model or vehicle towards achieving Universal Health Coverage.

The Department has successfully implemented the Comprehensive Service Plan: HC 2010 Strategic Plan which channels 90% of the uninsured population to the nurse-driven PHC clinics, Community Based Services Platform ((Home Community Based Care (HCBC) and International Classification of Functionality and Community Oriented Primary Care (ICFs)) and the Level 1 District Hospitals. 8% of the uninsured population requiring health services are channelled to the secondary level hospitals and 2% to the tertiary (Central) level hospitals.

The Department remains committed to disease prevention through strengthening the health system and good governance.

3. Private sector's intervention into the burden of disease in public health

3.1. Metropolitan Health - Dr Boshoff Steenekamp, Strategic Projects

Dr Steenekamp mentioned that the big question regarding NHI is funding. The White Paper on NHI describes a National Health Service similar to the service in the United Kingdom (UK) which has a purchaser provider split. The funder then purchases from different providers whether private or public. There is no empirical evidence that the purchaser-provider split by itself has been an effective intervention in the UK.

UHC is a different concept which specifically deals with health finance and details who and what is covered. All services will never be able to be free. There will always be out of pocket payments, some services will not be rendered and all people will not be covered.

South Africa's score on the Social Development Index is high and in line with South Africa's GDP. However, SA's health related index values are much lower than expected. SA is in the group of second poorest performing countries when it comes to health system outcomes. A formal analysis of SA's health system was done in accordance with World Health Organization methodology which concluded that the challenges in the country are with stewardship, governance and oversight, creation of resources and service delivery. Revenue collection is at an acceptable level, but there are challenges with pooling, purchasing and benefit selection. This can be addressed with a health financing strategy which defines changes to revenue raising, purchasing, benefit design and overall system architecture and governance. It is important to address problems that limit progress toward UHC and develop a system that can be implemented within current and future constraints.

Dr Steenekamp also presented on MMIs HIV programme which also consisted of a HIV GP network. The network was call-centred based driven by trained and experienced nurses. Adherence to Anti-Retroviral Therapy (ART) is normally 65% but the programme had up to 95% adherence. The cost is lower if you join a medical aid scheme later in life for treatment. This motivates the need for proper health financing and thus, the HIV programme could find application in PPP's.

MMI formed a partnership with McCord Hospital in Durban, a provincial eye hospital that lacks surgeons and administrative capacity. By partnering with the international Dr Agarwal's Group of eye hospitals the members will use the facility at a lower rate than the private sector for cataract surgery. The hope is to increase capacity and maintain the training policy. These surgeries can offer quick replacements for backlogs of the public sector.

Dr Steenekamp concluded that NHI needs much more discussion although UHC can be achieved with adjustment to current systems without major increases in health expenditure.

3.2. Cipla Foundation (Sha'p Left Initiative) - Dr Harold Amaler, CSI Advisor

Dr Amaler reported that healthcare globally is in a state of crisis. In developed countries there are issues of over servicing, spiralling costs, litigation and in developing countries there is a dearth of services, infrastructure and the ever-increasing fundamental healthcare needs of a growing population. There is also the shifting burden of disease on our continent – Non-communicable diseases are on the increase while infectious diseases, especially HIV, TB and others remain prevalent.

The Sha'p Left project is exploring the objective to deliver sustainable quality healthcare to low income groups. It is patient centred, population focused and cost aware. The model uses a hub-and-spoke configuration - different sized, high-quality, re-deployable units configured to provide a range of PHC services including the distribution of chronic medication through the CDU process. At the heart

the project, nurse surgeries are run by Clinical Nurse Practitioners. The units are strategically located in peri-urban using validated clinical algorithms and a defined medicines formulary. The nurse surgeries can be scaled into Healthcare Centres where a wider range of Healthcare services (e.g. dental services) can be offered, or downscaled to provide supportive services through Community Care Workers. The Sha'p Left Initiative has 8 units in the field currently and plans to scale the model up over the next three years.

3.3. Unity Health (low cost medical insurance) - Mr Vernon Chorn, Chief Executive Officer

Mr Chorn presented the role of the low cost PHC insurance. Unity Health is a division of Ambledown Financial Services and administers about 300 000 health insurance policies through a network approach. The offering is largely for employees who do not have medical aid cover. PHC is an essential need for the majority of SA based on the General Household Survey of 2015. PHC insurance can significantly reduce the burden on the public sector and allow those remaining in the public sector to receive a better level of care, as there will be fewer patients to treat. It is cheaper than medical aid.

NHI requires about a 50% higher employment rate to operate in other countries vs SA that has a 40% employment rate. This increases the risk of having a large scale government fund for SA. The solution is to encourage PHC insurance. This will increase partnership opportunities, share risk, encourage ongoing investment in the private healthcare sector and reduce queues at public facilities. PHC Insurance will also lessen the funding requirement for a "modified NHI" (i.e. for those without insurance) which will make it a lot easier to implement and sustain.

Demarcation regulations came about from medical aid schemes complaining that insurance members are taken away from their risk pool. This regulation was passed in Parliament on 23 December but PHC is not in the regulations and have been granted an exemption. Provincial Treasury will not pass regulation without the exemption and thus, PHC insurance will continue for at least another 2 years.

4. Q & A - Group Discussion

4.1. Mr Dominic Wilhelm from Qonda enquired from Dr Amaler if he considered having a mobile facility rather than fixed structures?

Dr Amaler responded that they have looked at mobile clinics but it meant that the clinic will always be absent from one location. The learning from the community was that they wanted a facility that they knew was there and present. He concluded that they took a hybrid approach - the clinics are not mobile but it is movable.

Mr Wilhelm further enquired from the panel if there is a forum or if the Province has looked at issues like access, distribution of finance, human resources and upstream determinants through the lens of mobile health as opposed to fixed structures?

Dr Engelbrecht responded that the PPHF forum was created for this kind of connection depending on the need but for specific geographical areas the Department can facilitate such discussions.

4.2. Mr Solly Fourie from the Department of Economic Development and Tourism expressed his interest in Mr Chorn's presentation on the issue of PHC, particularly the danger of younger people leaving medical aid schemes for private health insurance when it is really aimed at lower category members. He mentioned that the depleting medical aid schemes risk pool is going back to the public healthcare system, presenting the cycle of care between insurance, medical aids and the public sector. He proposed that further collaborative approaches can be explored to mitigate risk.

Dr Engelbrecht added that thoughts can be expressed as to what and where government can assist with the private sector.

Mr Chorn explained that he has been engaging with the Council for Medical Schemes (CMS) who developed a low cost benefit option guideline within the medical aid scheme environment and transitioned it again into that environment as the plan. The CMS also has concerns that members are buying down into low cost benefit options therefore they are exploring a suitable benefit design that can diminish this risk pool. Meanwhile, Unity Health will be used for gathering data for the CMS. He also mentioned that the CMS are aware of the design flaws within the medical aid scheme environment. Unity Health did not allow medical aid scheme members to buy their product in respect of the risk pool issue. Dr Boshoff added that the CMS recently requested discussions around development of revised benefit act and MMI support the process. Risk pool problems are worldwide and it is addressed by having either compulsory membership or cross subsidisation for everyone. To address this there should be a low cost NHI package for PHC but it would need to reform in a private medical facility with referral. In doing this, low risk members will still be lost.

Mr Fourie further asked if the results of the MMI HIV and cataract programme can be shared with the public or if there space for collaboration with public health on their data intelligence with regards to the care plans?

Dr Steenekamp responded that they want to participate and contribute within the regulated guidelines of patient confidentiality and member data. It can be a fantastic partnership in assisting the public sector in analysing the data.

4.3. Ms Jacqui Stewart, from the Council for Health Services Accreditation of SA enquired if everyone works together, will NHI work?

Dr Boshoff responded that firstly there should be uniformity in the vision whereby UHC is distributed evenly and should be explicit, realistic feasible, implementable and compliant by all.

Dr Amaler responded that there is a good sense of what should be done but the question is the details of how and who? It is a complex method and simplified solutions should be explored by working on the ground level to find synergies. This has to be a unified commitment enabled by the private and public sector.

Mr Chorn reiterated that Unity Health is a possible solution.

Dr Hawkridge responded that one aspect that can make NHI work is if National allows provinces some flexibility to work out customised solutions since each Province operates differently. For example let the Provinces do the contracting.

Dr Engelbrecht alluded to Dr Boshoff's comments that within the current legal framework and legislation there is scope to do what is needed to implement UHC. Funding will remain a challenge. Having the total pool of funds in a central space is concerning, given the track record of parastatals and their stewardship capacity and performance. In the event that something goes wrong then the entire health sector of the country will be affected. The National Health Act does provide much more involvement of Provinces with the private sector.

Ms Stewart also enquired the panels view if vertical initiatives from the National Department of Health, like Ideal Clinics are making a difference to the quality of care?

Dr Engelbrecht responded that 80% of specifications of an Ideal Clinic are specified in the National Core Standards of Primary Health Care. The Department focussed on what systems should be in place to make things work, how to improve outputs and patient experience. The Ideal Clinic has a role to play in service delivery but it is not the sole solution. Dr Amaler added that their clinics are not totally compliant due to size but it does reach the desired outcomes.

4.4. Mr Harry Hausler from the TB/HIV Care Association highlighted that there is little mention of the role of NGOs and how they fit into the NHI model.

Dr Amaler responded that there is a need for NGO services especially for scheduled medicines. For unscheduled visits, there can be referrals from a care worker to a permanent facility which is being explored. Dr Engelbrecht added that the patients that visit these facilities are young men who feel that clinics are for women and children.

Mr Hausler further enquired from Dr Amaler as to how do they allocate their units geographically so that it is not in competition and as assistance to the Department? Are there interactions with the NGO's community workers out in the field there as well?

Dr Amaler responded that they do a geo mapping analysis to indicate what other services are offered. They also work on the ground to obtain a better idea and not infringe on anyone else. They have an understanding of the need to collaborate with other NGO's to choose sites correctly.

Mr Hausler mentioned that in his experience, specialised services within key populations such as mobile services works well in small areas. He asked whether there is scope for this service in NHI, and if not, how can the need be explored in the Province?

Dr Hawkridge responded that NHI doesn't specifically mention specialised health needs but it is implied in the general design that the services are determined by the communities health needs.

4.5. Mr Sikhumbuzo Hlabangane from E-Health News referred to the stats that was presented by Ms Arendse and observed that the Department is not doing much to reduce the social issues and seems to always work alone. Won't the issues be addressed if there is collaboration with other departments?

Dr Engelbrecht mentioned examples of current collaborations that exist to address the social issues such as walking busses, whereby the parents walk the children home to ensure their safety. This is done in high risk areas based on stats. Ms Arendse added that there are platforms that exist at all levels because the Department acknowledges that this cannot be done alone and thus have an ongoing collaboration with the Provincial Departments of Social Development and Community Safety. Dr Engelbrecht added that even the Minister has committed to collaborations and passed legislature in order for the community to be heard. She has established clinic committees to interact with the Health Facility boards and the District Health council which reports to the Provincial Health Council. Ultimately the aim is to make everyone responsible for their own health.

4.6. Mr Sithembiso Mkhize from the Medical Services Organisation referred to Mr Chorn's presentation of and mentioned that we do not compare to the rest of the world. Can the panel advise if this country can afford UHC?

Dr Boshoff responded that there are benefits but no country has ever managed to achieve UHC, depending on the definition of the benefit package.

4.7. Mr Mkhize further enquired from the Department whether there is a mechanism in place whereby private providers can suggest innovative ideas.

Dr Engelbrecht responded that Mr Michael Manning is the point of contact for the private sector with the Department.

4.8. Mr Lindsay Curran representing the Western Cape Medical Cluster observed that the common theme of today's discussion is the drivers of cost therefore he acquired from Dr Boshoff if there is room for collaboration and opportunity for Metropolitan Health to exert some pressure for the private sector to procure from local manufacturers. Currently 90% devices are imported and there are equivalent products of superior quality manufactured in the country?

Dr Boshoff acknowledged that this is an important issue and they have direct partnerships with some local manufacturers such as prosthetics, etc. to increase the local buying power.

5. Closing Comments

Dr Engelbrecht thanked everyone for attending.
The meeting closed at 12h00.

Speaker Presentations of the meeting will be available on the PPHF website:
https://www.westerncape.gov.za/general-publication/public-private-health-forum-pphf

Annexure A

PRESENT	
Dr Beth Engelbrecht	Head: Health
Anthony Hawkridge	WCGH
Juanita Arendse	WCGH
Boshoff Steenekamp	MMI Health
Harold Amaler	Cipla
Vernon Chorn	Unity Health
Akhona Stemele	Clicks Group
Andre Nel	Dischem
Andre van Aswegen	Medirite
Angela Waring	Cure Day Clinics
Annecke du Toit	Bagkem Apteek
Beauty Wright-Sipondo	Heart & Stroke Foundation
Bev Pedro	Medscheme
Bibi Meyer	Advanced Health
Bonga Magwentshu	WCMDC
Carolyn Clark	PWC
Charlene Jones	Life Esidimeni Intermediate Care
Chibuzo Anaso	Anasodiabitiz Inc.
Daniel van Dalen	Life Path Health
David Grier	Cipla Foundation
Debbie Regensburg	Society of Private Nurse Practitioners
Dominic Wilhelm	Qonda
Donald Jansen	MediRite Pharmacies
Elizabeth Vinagre	Alpha Pham
Eugene Samuels	Vencorp Group
Faldie Kamalie	Medscheme
Francois Fehrsen	Private
Gakeem Basardien	WCGH
Grant Pepler	Med X Solutions
Hanif Hamdulay	GVI Oncology
Hannelie Fourie	Private
Harry Grainger	The Western Cape Health Foundation NPC
Harry Hausler	TB/HIV Care Association
Hélène Rossouw	Spear Health
Ian Duvenage	Fast Net

Ilizma Muller	Batsumi
Inge Cunningham	WCGH
Jaco Vorster	Royal Haskoning DHV (Pty) Ltd
Jacqui Stewart	Council for Health Service Accreditation of Southern Africa
Jean le Roux	Mediclinic
Jeet Dayal	Med-e-Mass Western Cape
Jenny Hendry	Western Cape Rehabilitation Centre (WCRC)
Jessica le Roux	WCGH
Kandel de Bruyn	WCGH
Kobus Venter	Masincedane Community Service
Koos Franken	Philips
Krista Roberto	Mobile Health Clinics
Lee Roering	Philips
Leendert Jansen	Infocare Health
Len Davies	Umsinsi Health Care
Liezl Bouwer	Healthbridge
Lindsay John Curran	VIVA Medical
Lisa Parkes	CCDI
Lizelle Alexander	Mediclinic
Lizelle Viljoen	Essential Health Pharmacy Group
Louvaine van Rensburg	MMI Holdings
Lynne Marais	Batsumi
Mahboob Roomanay	WCGH
Mandi Bell	WCGH
Mari Bruwer	MLA Consulting
Marietjie Gericke	Medscheme
Mariki Smit	Vencorp Group
Mark Blecher	Provincial Treasury
Mark September	IS
Marlene Seaford	Pick n Pay
Michael Manning	WCGH
Muhammad Moosajee	WCGH
Muneer Omar	Mediclinic
Natalia Louw	NRC
Nolan Daniels	Netcare Kuils River Hospital
Patti Olckers	WCGH
Phil Ginsberg	Private

Preneshen Naidu	GE Healthcare
Raeesa October	WCGH
Rajen Naidu	Endomed Medical & Surgical Supplies CC
Rammoelo Ditsoane	MMI Holdings
Randell James Ford	RJF Investments
Rika vd Post	Batsumi
Rone Murray	Alpha Pharm
Roshan Saiet	WCGH
Samantha Bloem	RAF
Samierah Achmat	WCGH
Sara Hilliard Garrett	Vula Mobile
Shane Maclons	Immploy Medical Recruitment
Sibusiso Gxwala	GE Healthcare
Sikhumbuzo Hlabangane	ehealthnews
Simon Elliott	Med-e-Mass Western Cape
Sithembiso Mkhize	MSO - Medical Services Organisation
Siviwe Gwarube	WCGH
Solly Fourie	Department of Economic Development
Taryn Springhall	ehealthnews
Terri Chowles	ehealthnews
Uwe Schön	Mobile Health Clinics
Vernon Foxcroft	Digicape
Yusrie Jacobs	WCGH
Yusriyyah Lutta	WCGH
Zena Erasmus	Premium Consulting

APOLOGIES	
Nomafrench Mbombo	Minister of Health
Antoinette Frontini	MSO - Medical Services Organisation
Amanda Wilde	Umsinsi Health Care
Andries Van Niekerk	WCGH
Bhavna Patel	WCGH
Cathleen Malan	WCGH
Clinton Van Zitters	Aspen Pharmacare
Daniel Stegmann	Infocare Health
Garry Whitson	PN Medical
Handri Liebenberg	WCGH
Japie du Toit	Life Healthcare

Jessica Gallas	WCGH
Josh Fisher	Wits Health
Keith Cloete	WCGH
Krish Vallabhjee	WCGH
Len Deacon	LDA
Lieselle Shield	Netcare
Michelle Geneva	WCGH
Pamela Naidoo	The Heart Foundation
Peter Chetty	Netcare Kuils River Hospital
Pikkie Bekker	Medicross
Thabang Tladi	WCGH
Tracey Naledi	WCGH
Trudy Petersen	Life Path Health
Varn Diab	MMI Holdings
William Mapham	Vula Mobile