

Beyond Band-Aids: Reflections on public and private health care in South Africa

Michael Edmeston and Kate Francis discuss some of the challenges facing public and private health care in South Africa



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Public Sector Health Care in South Africa

The overwhelming majority of South Africans rely on the public health sector. This means that in many ways the public sector forms the cornerstone of the national health system in South Africa and, no doubt, has a crucial role to play in the socio-economic well-being of the country. Yet any adjective used to convey its current condition would be a cliché – ailing, failing, crumbling, collapsing – they have all been used before. Despite the issues facing the private sector and regardless of the proposal for a unified, single-payer health system (i.e. NHI), currently, it is towards the public sector where the greatest amount of resources and focus needs to be directed.

Medical science is a complex field. Years of training are needed in order to become a qualified practitioner. The actual provision of public health care, on the other hand, is far less complex. It essentially comprises of a number of certain fundamental, non-scientific elements, without which a public health system fails. In broad terms these fundamentals include:

- managerial efficiency and competency
- strong leadership
- a culture of good governance
- accountability

From this perspective, it becomes clear that establishing an efficient public health service is not all that different from creating efficiency in any other service-oriented sector, public or private.

It is this perspective which is most relevant when thinking about ways to reform the public health system in South Africa. It could be argued that, at times, the public health sector is approached, by government in particular, with a sense of contrived exclusivity – an approach that believes public health care requires something unique and specialised. Truth be told, the measures which would have the most

far-reaching effects in improving the country's health system are relatively simple, at least in theory. Yet these fundamental factors are too often completely overlooked and ignored, with complex descriptions of technical health care models replacing simple, direct and honest action.

What follows is a brief discussion of two main pillars of public health care in South Africa: public hospitals and primary health care. The problems relating to both are manifestations of obvious, yet profoundly far-reaching failures. In exploring these issues, it is hoped that some light can be shed on the nature of the crisis facing the public health sector.

The Question of Public Hospital Management

Public hospitals have, by default, become the foundation of the South African public health system. Far from the ideal, this is largely a consequence of the neglected state of the primary health care system and clinic services in South Africa, which in turn drives the public's lack of trust in making use of these lower tiers of system. In a well functioning public health system, hospitals operate as the providers of in-patient (i.e. secondary and specialist) care and emergency treatment¹. Despite instituting a

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three tier national health system – with primary care provided at clinics and secondary and tertiary care provided in feeder hospitals and specialist hospitals respectively – the system remains under-resourced and largely dysfunctional². The result is that, in addition to the difficulties in attending to in-patients, public hospitals are often forced to deal with out-patients referred to them because of the inability of the lower

tiers to do so, as well as those patients who simply have 'learnt' to by-pass lower tiers³.

A case-in-point is the way in which Gauteng public hospitals are forced to function. Not only are people from Gauteng going directly to hospitals, but those from the North West, Limpopo, Mpumalanga, and even as far afield as Swaziland, are making direct trips to the province's hospitals. This is due to the inability of their respective local clinics to provide even the most rudimentary treatments⁴. In essence, public hospitals have, therefore, come to represent the public health system itself. With respect to this current reality, the well-documented 'management' problems facing the country's public hospitals should be of immediate concern if we are serious about 'health for all'.

This fact is not lost on the media or government, as the need for better management is not an under-reported problem. Government is open in admitting to the current state of crisis and the need for better management, whilst the media is never free of reports on the poor state of public hospitals and the management failures. The question that never seems to be asked though is: what is the nature of these management problems? It seems that there are two issues which simultaneously need to be dealt with in this respect.

The first, and most widely reported and discussed, relates to management problems at the level of personnel. Undoubtedly, this side of the story garners the most attention as it is the most well known. In a fair, yet perhaps misguided, response to this problem, Health Minister Aaron Motsoaledi, advertised 92 CEO hospital posts in February this year to ensure qualified medical and managerial staff are

recruited to lead these facilities⁵. While such an intervention is perhaps necessary, as of September 2012, media reports indicated that the Department of Health (DOH) is no closer to finalising the hiring of new heads because the process had to be done centrally at the national office⁶. This all too common situation begins to reveal the second management issue: the bureaucratic and institutional snares that hinder the actual processing and implementation of otherwise good strategies and policies.

Hypothetically, if all 92 posts are filled by qualified persons, there remain a number of out-dated bureaucratic, almost paternalistic, protocols constraining the individual efforts of hospital managers. The limited power of CEOs means that even if the most capable individual is heading up a hospital, due to the centralisation of hospital management, he/she is out of the picture when it comes to issues such as hiring and firing and budget control⁷. The problematic nature of the operational protocols for public hospitals is highlighted by the following observation on the way the system operates:

“Currently all state hospitals fall under the remit of the Department of Public Works (DPW), whilst the running of the facilities is done by the Department of Health (DOH). This creates huge challenges for those who are put in charge of running the hospital. If a boiler blows up, or repairs need to be made to any equipment, then the manager cannot phone the supplier directly, as he has to contact the DPW first.”⁸

The White Paper also makes mention of an intent to establish hospital boards to increase local accountability and power. As long as these protocols remain to be implemented, however, ensuring a responsible, integrity-based institutional culture is all but impossible.

A major problem worth noting that results from such a bureaucratic arrangement is that it makes finger pointing and blaming other departments and individuals for on-site problems the norm. In turn, it is almost impossible to enforce or entrench any sort of accountability. According to the 1997 White Paper on Health Services Transformation, hospital management should be decentralised in order to promote efficiency and cost-effectiveness. The White Paper also makes mention of an intent to establish hospital boards to increase local accountability and power. As long as these protocols remain to be implemented, however, ensuring a responsible, integrity-based institutional culture is all but impossible.

It is thus apparent that much of the country's current (and historic) health policy is in fact well structured and has the potential to improve the health system if implemented properly. Decentralisation of a health system, for example, is a well established norm in health care policy. The fact that its importance was recognised over a decade ago indicates that it really is not in the making of policy that we ought to be focusing on, but its implementation. This point itself has been made many times before and is not new. Whether the DOH is willing to compromise on its clearly evident desire to control from the top, is something only time will tell.

There is, however, another, albeit less direct, angle from which public hospitals could also see improvements. This is via greater attention being placed on the renewal of primary health care services. Attending to the quality of primary health care services would, at worst, provide partial relief to the overwhelming burden that large patient numbers place on public hospitals. The following section discusses this sidelined, almost forgotten, aspect of the public health system.

Public Health Beyond Public Hospitals

So far, what has been discussed relates to the supply-side of public health. In addition to advocating what the public health system ought to be doing, it is just as relevant to discuss the demand-side of public health. It is true that much of the country's disease burden, and subsequently the burden facing the health system, could be significantly reduced with better access to education, sanitation and housing. In other words, there is much that can be done from a preventative, or at least early intervention, perspective.

Long-standing social determinants of ill-health, resulting from the legacy of apartheid and perpetuated by service delivery failures, continue to hamper South Africa's progress towards greater health outcomes⁹. Admittedly, many of these factors fall outside the control of the health sector. Nonetheless, the DOH's role in the provision of primary and preventive care should be at the top of the list in terms of its strategy for dealing with the failures of the current system.

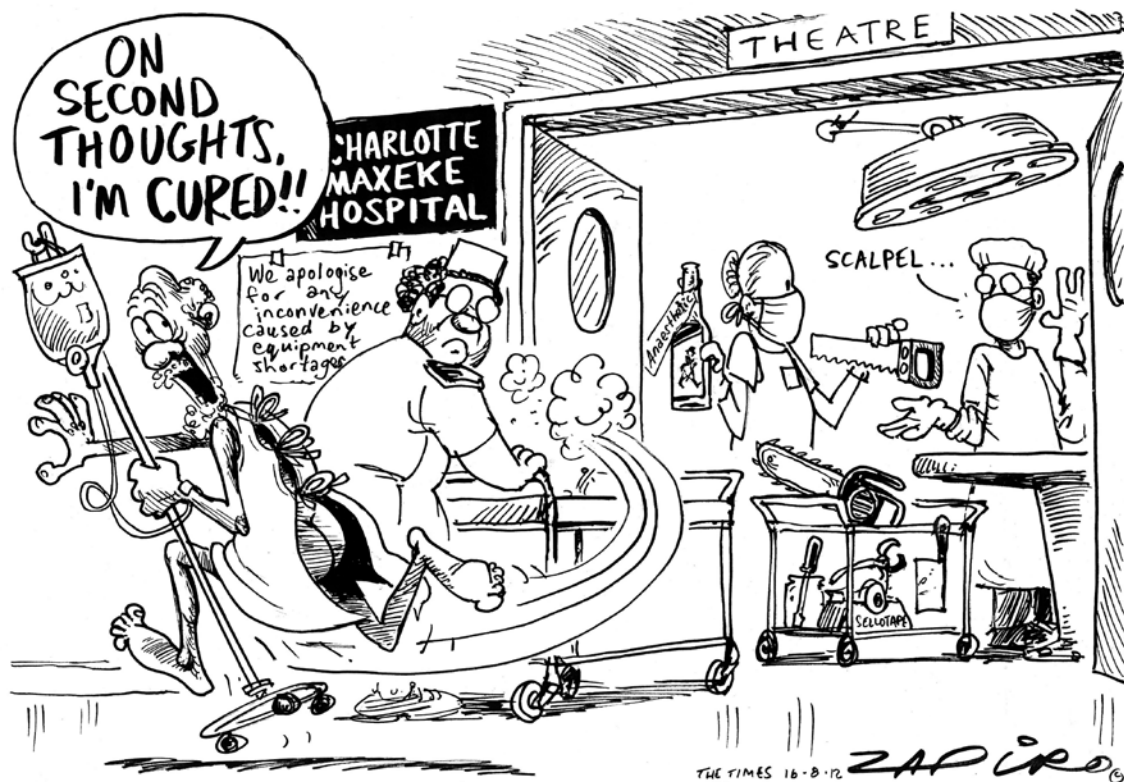
Although the DOH's 10 point plan for 2010 - 2013 makes mention of "Refocusing on Primary Health Care", very little attention has been focused on this element of public health provision and one does not see it mentioned enough in public health discourse. In admitting to this fact, the Health Minister has been recently quoted as saying "in South Africa, we still think little of primary health care".

South Africa's poor health outcomes have been significantly attributed to a weakly developed primary health care system¹⁰. The irony of this fact is that the primary health care concept of public health care partly traces its origins back to a small health unit situated in Kwa-Zulu Natal in the 1940's¹¹. Unfortunately, this and other progressive health care initiatives and models that held great promise, had little chance to make an impact and find traction "as a result of hostile state interventions and an egregious policy environment prior to and throughout the apartheid era"¹².

Given that we are now 18 years into our democracy, it is surely a truism that today's government is failing the country in much the same way. Although the DOH's 10 point plan for 2010 - 2013 makes mention of "Refocusing on Primary Health Care"¹³, very little attention has been focused on this element of public health provision and one does not see it mentioned enough in public health discourse. In admitting to this fact, the Health Minister has been recently quoted as saying "in South Africa, we still think little of primary health care"¹⁴.

Primary health care has a direct impact on the patient burden experienced by public hospitals by virtue of the fact that the service acts as the first port-of-call for patients, as opposed to hospitals, which ought to be for more specialised care and emergency treatment. Secondly, its preventative and patient-empowering focus reduces the burden on the state over the long term. With this in mind, the question of the NHI pilot sites becomes relevant.

The fact that the NHI has thus far only been published as a Green Paper, yet there is already an establishment of pilot sites as the first phase of the NHI roll-out, is a concerning development. This begs the question as to what the establishment of the sites is really about. The obvious answer is that they are simply an attempt to strengthen, or re-establish, the primary health care system. Innovative Medicines South Africa (IMSA), a pharmaceutical industry association, supports this notion in a brief describing the pilot sites. This brief notes that "Despite political rhetoric, the NHI pilots are effectively piloting the role of the District Health Authorities



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as outlined in [the White Paper on Health Services Transformation in 1997]¹⁵. Furthermore, many of the actual stated objectives of the pilot sites suggest an attempt to assess and improve the public health sector at the bottom tiers. At the launch of the site, the Minister of Health noted that the aim of the sites is to¹⁶:

- focus on the most vulnerable sections of society across the country;
- reduce high maternal and child mortality through district-based health interventions;
- strengthen the functioning of the district health system;
- assess utilisation patterns, costs and affordability of implementing a PHC service package;
- assess whether the health service package, the PHC teams and a strengthened referral system will improve access to quality health services particularly in the rural and previously disadvantaged areas of the country.

The best one can hope for is that the pilot sites, irrespective of their rationalisation or ideology, will indeed result in improvements in the health system at the local and district level. If a re-establishment of some sort of primary health care system can emerge from this initiative, the effect it would have on the burden faced by public hospitals and many of the horrific health statistics of South Africa, may be enough to steer decision-makers back to a focus on the basics.

If the government were to provide greater clarity on its intentions and where it is implementing changes and what progress it is making, public discourse would arguably be far more conciliatory than it currently is. The pressure faced by public

institutions from a discontented, media-informed public often does more to provoke rhetorical defensiveness, than it does to inform a change in action. The final section below briefly discusses this idea in light of the pervasive lack of trust which seems to characterise much of society's experience with government's poor record in delivering public services.

Talking 'bout a revolution

Over the last year there has been constant talk of 're-engineering primary health care', especially from the DOH. Whilst very little may be said of the progress that has been made concerning this 're-engineering', perhaps just as great a problem is that of the language used. The expressive jargon that seems to be the trend in government is frustrating for the mere fact that, in itself, such complex talk does more to reveal inadequacies than it does to hide them – the very reason, one suspects, that such rhetoric is drawn upon in the first instance.

It is only logical that a far less technical approach would be the best way not only to realise real changes in the provision of health care, but to win the trust of the public. The use of words such as 're-engineer', 'national health insurance', 'universal cover' and 'pilot sites' can only appeal to popular support for so long. Surely if nothing has changed in the public sector for the better - and in places certainly seems to be steadily getting worse - the promise and continual touting of the NHI over a year and a half later will do little to win the support government continues to seek?

Amongst the empty words and concepts used to describe what is going to be done, there is, however, a seemingly genuine intent to improve the public health system. Unfortunately, what we hear from government is only what they are going to do, the models they are working to implement and policies they hope will augment change. Since the release of the NHI Green Paper, little more than intentions, vision and strategies have been reported. Rarely do we hear about what is actually taking place to improve the system and what the nature and outcome of these changes are. As discouraging as this appears, without a doubt, somewhere pockets of the health system are working well. And, perhaps more than the public, the DOH needs to hear about these anecdotes, for the lessons they hold are surely valuable. Getting such news into mainstream media is important in the trust dynamic. Of course, any positive developments reported on would have a difficult time not getting washed away by the flood of despair brought about by the overall negative picture. Nonetheless, the belief such a redirected public relations approach by the DOH might engender, would be a small, but promising step towards the larger improvements.



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Private health care and the right to health

by Kate Francis

Despite the comparatively large number of people reliant on the public health system, it is important to remember that both public and private health care are vital tools for the realisation of the right of access to health care. Serving around 8.7 million people who are members of medical schemes and unknown millions more who pay for private health care out of pocket, private health care, nonetheless, forms a sizable part of the social protection framework in providing access to health care.

The generally excellent quality in the private health sector suggests that there are few problems. There is, however, increasing concern that inefficiencies, conflicts of interest, information asymmetries, corruption and lack of or inappropriate regulation could threaten the way it operates. Although these problems may not be nearly as worrying or as large as those facing the public sector, it is still worth making sure that the right debates and discussions are taking place. Problems need to be accurately diagnosed in order to make sure our entire health system functions to ensure that health care fulfils its role as a social protection mechanism. This section examines the debates that the country needs to have regarding some of these key challenges facing the private health sector.

Challenges facing private health care

Before progressing to a discussion of some of the challenges facing private health care it is worth noting that any discussion of private health care needs to be located within a worrying global trend of increases in health care prices¹⁷. Our Minister of Health is also clearly concerned with rising private health care prices. He has been quick to emphasise that his jurisdiction as Minister does not only cover public health care but private health care as well. The Minister has thus set the reigning-in of private health care costs as one of the five focus areas falling under the (so-called) piloting of the NHI. This has led to pressure to investigate the causes of rising private health care costs and potential inefficiencies in private health care. There has been much discussion that such an investigation might take the form of a market inquiry organised by the Competition Commission. Such an inquiry would possibly be similar to the Banking Inquiry set up by the Competition Commission in 2006 which investigated certain aspects of competition in South African retail banking. In this regard it is important to question whether a debate simply around increased prices is the right way to go. Although unfettered increases in prices are a major concern, such increases could also be a consequences of other factors which we will consider in due course. Some of the major issues that have been flagged revolve around escalating costs in hospitals and specialists and medical schemes, as well as concerns that appropriate regulations have not been implemented.

Market failure

One of the features that makes the private health care market different from most other markets – like markets in cars or milk – is that private hospitals, doctors and specialists do not generally compete based on price. For example, where most consumers may buy Clover over Douglasdale milk if Clover is cheaper, the same phenomenon does not occur in the health care market. This is because, in

an environment where most medical expenses are covered by a third party payer (medical schemes), patients are not likely to choose a specialist or a hospital based on how much it costs them as they are not the final payers of the bill. There is thus no incentive for your cardiologist to lower her fees to compete with other cardiologists. Basic economics tells us that price competition is a useful tool in bringing down prices. This signals that a lack of price competition in the absence of appropriate regulation or tariff setting is a factor in explaining escalating costs. When this is coupled with a relative shortage of skills when it comes to specialists a pattern emerges.

When making excuses for general lack of action – no one doing anything constructive – it is easy to claim that the private health care market is complex and technical.

When making excuses for general lack of action – no one doing anything constructive – it is easy to claim that the private health care market is complex and technical. Even if we are currently not exactly sure what is causing prices to rise, the fact is we have seen a rapid increase in private health care costs over the past decade¹⁸. In this regard an interesting line of enquiry suggests itself: what would we expect to see in a market where prices are increasing? Surely such an environment would result in new entrants to the market, increased efficiency and increased innovation – a clear example of this is the market in mobile phones. Yet this has not been the case. Why? One possible answer could lie in the market power of hospitals.

Market power of hospitals

A concern that has been raised relates to hospital market concentration¹⁹. There has been a trend of rising hospital costs, but the jury is out regarding what is causing such increases²⁰. A recent paper compiled by Genesis Analytics signaled that hospital profitability has increased with hospital market concentration, and that this profitability could be declared as high relative to international benchmarks²¹. Another study by Econex finds that increases in prices are rather the result of increases in hospital usage with patients being admitted more often and staying longer²². These divergent studies make it clear that the underlying cause of increases in hospital prices needs to be accurately determined before making an appropriate intervention.

Despite a relative lack of clarity regarding the cause of increasing hospital costs, hospital market concentration can raise difficulties in other areas. Hospital market concentration can become problematic for medical schemes if the market is dominated by a small group of players²³ as the bargaining power of Medical Schemes can be reduced. Netcare, Life Health Care and Medi-Clinic hold around eighty per cent of the hospital market²⁴. As Medical Schemes form a large part of the social solidarity principle ensuring that the right of access to health care is achieved, it is important to fully understand the effect of this concentrated market.

Over-servicing

Another issue that needs to be addressed is that of over-servicing, which is a challenge on its own, but can also be a symptom of the two challenges mentioned above. Over-servicing generally means the provision of a treatment that is not necessary or appropriate. The practice can often occur if there is a profit motive to conducting a procedure. As patients are heavily reliant on the advice of their

health care practitioner, they may not have the required information to make an informed decision about a treatment option²⁵. An example which helps to explain this issue is that of a Durban-based specialist to whom Medical Schemes refer their clients for a second opinion. The Medical Schemes feel that this referral is necessary because they trust that this particular specialist will give measured advice on whether the procedure is actually necessary. This prevents the Medical Scheme from having to pay for a procedure that the patient does not actually need. It also ensures that the patient does not have to take an unnecessary risk. Not only does an unnecessary procedure put the patient at risk, but it increases the costs and decreases the efficiency of the entire private health system, potentially jeopardising the right of access to health care.

One needs to determine what regulations will improve efficiency and reduce costs and what regulations are holding back innovation and causing bottlenecks.

The problem of over-servicing is further exacerbated by what has been deemed a type of 'medical equipment arms race', undertaken by private hospitals in an attempt to attract specialists who are in short supply²⁶.

Regulation – is it working?

Another debate that needs to take place involves the role of the DOH in regulating the private sector. One needs to determine what regulations will improve efficiency and reduce costs and what regulations are holding back innovation and causing bottle necks. In this regard much of the current medical scheme regulations such as *community rating*, *open enrollment* and *prescribed minimum benefits* ensure that medical schemes perform as a social protection mechanism. Such regulations ensure that medical schemes cannot charge exorbitant premiums to those who are old or have pre-existing conditions. It also requires that they accept all individuals that apply for membership. The prescribed minimum benefits ensure that a basic level of care is covered by schemes.

In spite of these measures that protect members of medical schemes there still appears to be a lack of focus on other issues that are potentially damaging Medical Schemes. Such damage could reduce the capacity of Schemes to provide appropriate cover. A key issue is anti-selection. Anti-selection is the practice where people only become members of Medical Schemes when they are sick and leave again when they are healthy. Such a practice could put upward pressure on premiums and affect the functioning of the Schemes as not enough healthy members would be subsidising the unhealthy. Perhaps the issue of mandatory membership for all in formal employment needs to become part of the debate. Stricter penalties for anti-selection also need to be discussed²⁷.

A further consideration is that regulation in the form of a Risk Equalisation Framework has apparently been moved off the policy agenda. Such regulation would enable risks to be distributed across schemes and so prevent schemes from being penalised for having older or less healthy members. Reports that the DOH and the Council for Medical Schemes are looking to address this matter, as well as matters of Medical Scheme governance, are welcome²⁸.

In determining what interventions to make, the DOH needs to ensure that the policies put in place protect Medical Scheme functioning and encourage the private sector to provide quality and affordable care.

Market inquiry

As mentioned, a market inquiry to look into pricing and competition in private health care is potentially in the pipeline. It is hoped that if a full scale market inquiry occurs it has appropriate terms of reference and goals that encourage participation by the private sector. A well thought out investigation might point to factors causing price increases. A broader focus on determining what causes inefficiencies in the private sector and how the DOH could play a more enabling role would also be useful.

If private health care fails, if costs escalate, if it becomes overly exclusionary, former private sector patients could overwhelm an already ailing public sector.

A further consideration is that any action taken by the DOH regarding private health care needs to be evidence-based. This is particularly relevant as the NHI Green Paper tends to drift in the direction of either blaming the private sector or inequalities between private health care and public health care for many of the problems with the South African health system. Such a diagnosis is neither accurate nor useful.

Although the private sector clearly has its own problems, we must be careful of blaming the failings of the public sector on the failings of the private sector.

It is also important that private health care players and the DOH do not use the complexity of private health care as an excuse for lack of action or the failure to arrive at workable solutions. Its technical and complex nature must not be used to avoid addressing problems. Whether or not a market inquiry goes ahead, there are still measures that can be taken in the interim to correct some of the problems in private health care.

If efficiency in private health care can be improved, access could be extended to cover lower income earners. If private health care fails, if costs escalate, if it becomes overly exclusionary, former private sector patients could overwhelm an already ailing public sector.

Let us not forget who this is all for

In so many technical health reform discussions, the glaring absence is proper consideration of patients and what they need. We need to remember that public and private health care exist to serve the needs of patients. Any health policy or regulation needs to be in the public interest and evidence needs to be provided to show as much. With vested interests and lobbying becoming features of both public and private health care, those representing the public interest need to be heard. When it comes to the development of policy, wide consultation is vital in ensuring that the public, or those representing the public, are informed on these matters. In private health care it is important that any efficiencies resulting in savings for hospitals or medical schemes need to result in these savings being passed down to consumers as well.

South Africa needs to ensure that health policy discourse becomes depoliticised in order that the right and most useful debates may take place. Globally there appears to be no miracle solution to failing health systems. The correct identification of the real causes of the problems and a focus on innovation, accountability, governance and management might be a first step in addressing the real constitutional requirement for access to appropriate health care.

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