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Statement of Issues

1 August 2014

I. INTRODUCTION

1. On 29 November 2013 the Competition Commission ("the Commission"), in the exercise of its powers under section 43B of the Competition Act, No 89 of 1998 as amended ("the Act"), published a notice that it would conduct a market inquiry into the private healthcare sector ("the Inquiry"), as well as the Terms of Reference for the Inquiry.[1]

2. The Commission has appointed an independent Panel of experts to conduct the Inquiry on its behalf ("the Panel"). The names and particulars of the Panel are set out on the website of the Commission.

3. The Panel takes as its point of departure the Terms of Reference. This Statement of Issues must be read in conjunction with the Terms of Reference and is not intended to restrict the scope of the Inquiry contemplated therein.

4. The Terms of Reference define the private healthcare sector as that portion of healthcare services that is funded by private patients themselves, either through medical schemes, insurance, or out-of-pocket payments.

5. The private healthcare sector comprises a number of interrelated markets. The Terms of Reference divide these markets into three broad categories, namely the financing[2] of healthcare, the providers

[1] The Notice as well as the Terms of Reference was published in the Government Gazette, Volume 581, No. 37062, on 29 November 2013. Any reference to the Terms of Reference is a reference to the Terms of Reference as it appears in the Government Gazette.
[2] Healthcare financing refers collectively to Medical Schemes, Medical Scheme Administrators, Managed Care Organisations and Healthcare Insurers.

of healthcare services (including facilities[3] and practitioners[4]), and consumables.[5] The Panel is required to inquire into various facets of these interrelated markets. In particular, the Panel is required to "conduct an analysis of the interrelationships of various markets in the private healthcare sector, including examining the contractual relationships and interactions between and within the healthcare service providers, the contribution of these dynamics to total private expenditure on healthcare, the nature of competition within and between these markets, and ways in which competition can be promoted".[6] This includes investigating the position of consumers as patients, members of medical schemes, health insurance policyholders, and/or beneficiaries, in each of these markets.

6. In this Statement of Issues, the Panel sets out a framework for approaching the Inquiry in order to assist participants in the Inquiry to focus on issues the Panel envisages being most relevant to answering the questions arising from the Terms of Reference. What is set out in this statement reflects the Panel's initial view of the appropriate framework for the conduct of the Inquiry. What must be emphasised is that the points raised in this Statement of Issues are intended to be topics for investigation and do not represent any settled views or findings of the Panel.

[3] Healthcare facilities include hospitals, day clinics, sub-acute, specialised care centres and other similar facilities where healthcare services are provided.
[4] Practitioner refers to any person, including a student, who is registered with the Health Professions Council of South Africa (HPCSA) in a profession registrable in terms of the Health Professions Act 56 of 1974, including specialists, general practitioners etc.; as well as certain allied professions registered with the Allied Health Professions Council of South Africa (AHPCSA).
[5] The Terms of Reference for this Inquiry refers to "consumables" as including pharmaceuticals, medical devices and other consumables. For the purposes of this Inquiry, the Panel interprets "consumables" to include "medicine(s)" and "medical device(s)" as defined in the Medicines and Related Substances Control Act, no 101 of 1965 (as amended). In this document, the term "medicines and medical devices" will be used. See further paragraph 47.
[6] Terms of Reference at p 85 (section 4).

7. Apart from setting out the framework for approaching the Inquiry, this Statement of Issues also invites participants to make full submissions on matters raised therein.

8. As the Inquiry progresses further, the Panel may amend the Statement of Issues.

The general task of the Panel

9. In initiating the Inquiry, the Commission stated that it has reason to believe that there are features of the private healthcare sector that prevent, distort or restrict competition and that the conduct of this Inquiry will assist the Commission in achieving the purposes of the Act.[7] The task of the Panel, in general terms, is to determine whether or not there are such features and, if so, to identify them and their effects.

10. The Panel construes "features" to mean any notable characteristics of a market, particularly its structure, its interconnections with other markets, and the conduct of the participants within it. The Panel further construes the phrase "prevent, distort or restrict competition" broadly to cover any effect adverse to potentially better competitive outcomes, whether present now or likely to occur in future as a result of the features concerned. This is what the Panel generally has in mind when referring to "harm to competition".

11. The Terms of Reference also require the Panel to establish a factual basis for recommendations that support the achievement of accessible, affordable, high quality and innovative private healthcare in South Africa in the context of competition law and policy.

[7] See section 43B(1) of the Act and page 75 of the Terms of Reference (paragraph 2).

Assessing Competition

12. The Panel has identified potential sources of harm to competition. These include market power, barriers to entry into a market, imperfect information and the regulatory framework. Based on these potential sources of harm to competition, the Panel has identified several "theories of harm" that it proposes to test in the course of the Inquiry. A theory of harm refers simply to a hypothesis about how harm to competition might arise in a market to the detriment of consumers and to the detriment of efficient and innovative outcomes in that market.

13. These theories of harm, and the process of testing them against facts, will help the Panel remain focussed as it develops its understanding of the markets involved and evaluates the information gathered.

14. The Panel wishes to emphasise that these preliminary theories of harm are not findings of harm but serve only as a starting point in the analysis. Their identification does not in any way imply that the Panel has reached views on whether or not they apply. The identification of theories of harm in this statement does not preclude the Panel from finding harm to competition on other grounds. The theories of harm may thus evolve during the course of the Inquiry. Seen in this context, they are tools that guide the Inquiry. They are questions that the Inquiry will explore through various mechanisms. Furthermore, the theories of harm are not mutually exclusive; the markets that make up the private health sector are interlinked and so are these theories of harm. Those making submissions to the Inquiry are not restricted to dealing with these theories of harm, but are invited also to provide factual information and analysis bringing to light other causes of harm to competition which they can identify, as well as other factors which may be restricting access to affordable and high quality private healthcare.

Rationale for the Inquiry

15. Private healthcare provision takes place within the context of a constitutional commitment to the provision of healthcare services to everyone and a recognition of freedom of trade. However, in conducting the Inquiry, the Panel is limited by the Terms of Reference to the private healthcare sector.

16. In the Terms of Reference, it is stated that prices in the private healthcare sector are at levels that only a minority of South Africans can afford. Further, the Terms of Reference state that various concerns have been raised about the functioning of private healthcare markets in South Africa due to rising healthcare expenditure. Prices across key segments are rising above headline inflation. These increases in prices and expenditure informed the decision to initiate the Inquiry.

17. The Panel notes this rationale and accordingly wishes to inquire into the level of prices, expenditure and costs in the sector as well as the reasons for the above-inflation increases in prices in private healthcare. Given the large number of possible explanations for these increases, which may or may not be related to the state of competition in the sector, there is a need for a thoroughgoing Inquiry into the factors that drive the observed increases in private healthcare expenditure and prices in South Africa. The Panel invites submissions commenting on the probable causes of these increases in costs, expenditure, and prices.

18. The Inquiry will evaluate the various explanations for cost, prices, and expenditure increases in the private healthcare sector and will identify competitive dynamics at play. This will provide a factual basis upon which the Panel can make evidence-based recommendations that serve to promote competition in the interest of a more affordable, accessible, innovative and good quality private healthcare.

19. The Panel appreciates that access to healthcare services is a constitutional right and that this right also informs the competition assessment that it must undertake. The Panel also understands that healthcare markets are distinctive; there are various features that set them apart from conventional commodity markets. This will be borne in mind in the conduct of this Inquiry.

II. FRAMEWORK

20. The Panel is mindful that it is neither practical nor feasible to attempt to cover all ground and explore fully every possible factor that may play a role in driving outcomes in the private healthcare sector. Therefore, the Panel will prioritise its work and prioritisation will be informed by substance and practical considerations.

21. The Panel will apply the following criteria in prioritising its work:

Criteria related to substance -

a) Relative importance in explaining costs, affordability, access, innovation and quality; and
b) Contribution to promotion of competition and sustainability in the sector.

Criteria related to practical considerations -

c) Resource requirements; and
d) Availability of data and information.

22. As an initial step in the prioritisation process, the Panel has identified a number of focus areas. These fall within the following categories: consumers; providers of healthcare financing; and providers of healthcare products and services. The issues identified under these focus areas are set out below. These issues are subject to revision and

refinement based on the information the Panel receives in the course of the Inquiry.

Consumers

23. The Panel will evaluate any features of the private healthcare sector that may limit consumers' access to private healthcare. At the same time it will consider the extent to which the inequality of consumers' resources, by limiting their access to the market, may also constrain the ability of the private healthcare sector to meet consumers' needs.

24. It is generally accepted that the ability of consumers to make decisions is affected by their needs and resources, the quality of information at their disposal, and the incentives and actions of the various actors with whom they interact.

25. Among the initial decisions that consumers must make is whether they can afford private healthcare, which medical scheme to select and, within the scheme selected, what products and services to purchase. The Panel invites submissions on the factors influencing consumers' choices, and whether consumers have sufficient information regarding selection of medical schemes and the purchase of products and services of medical schemes. The Panel also invites submissions on how other health insurance products, such as those provided by financial services firms that are not medical schemes, influence consumers' choice of schemes and scheme products.

26. The Panel invites submissions on the nature of competition among medical schemes and other providers of health insurance in the South African market, as well as the impact of this on the affordability and quality of the products and services that consumers purchase.

27. Patients are often less well informed about matters such as diagnosis and treatment than the providers who make these decisions. In cases where urgent medical care is required, patients are even less likely to play any role in decisions regarding their own treatment. The Panel invites submissions on how decisions made by and/or on behalf of patients are affected by prevailing incentives, availability of information, resources available, power relations between patient and provider, and the fact that payment for treatment is often made by medical schemes on behalf of patients. In particular, the Panel invites submissions on the extent to which interests of patients and interests of providers are aligned with good healthcare outcomes.

28. A distinguishing feature of the private healthcare sector is that there is often a third party, such as a medical scheme or an insurance company, who makes payments on behalf of patients. In these circumstances, patients may not be concerned about the cost of services, than if they had to pay directly for services. The Panel invites submissions on how this affects both the incentives of patients and competitive outcomes in the sector.

29. The requirement to make out-of-pocket payments may arise when patients are required to make co-payments, when a patient's scheme savings or benefits are exhausted, or when a patient has no scheme or insurance cover at all. The requirement to make co-payments, or the extent and level of co-payments, will influence consumer choice. The Panel invites submissions on the circumstances under which a system of out-of-pocket payments has arisen in South Africa, what this means for accessibility and affordability of private healthcare, and the effect, if any, of out-of-pocket payments on competition.

Financing of Healthcare Services

30. Financing of healthcare services encompasses products and services provided by medical schemes (closed/restricted and open), medical scheme administrators, managed care organisations and other healthcare insurers who are not registered as medical schemes. Intermediaries like brokers are also included.

31. The Panel invites submissions on the relationship between medical schemes and administrators of medical schemes and its impact on competition. The Panel is also interested in the boundary lines between administrator and medical scheme; regulations governing this; the impact of various risk sharing arrangements; and the impact of possible market power of administrators.

32. Administrators seemingly play an important role in negotiating tariffs and reimbursement mechanisms with providers of healthcare services. They are confronted with a fragmented market and must negotiate with disparate providers. The Panel invites submissions on the implications of the relative sizes of medical schemes and/or administrators on this negotiating process, on market structure, on competition and sustainability of the sector, and on bargaining outcomes. Submissions should also address the impact of the complexity inherent in the sector on the ability of medical schemes and/or administrators to make comparisons and informed decisions about the price and quality of various services during the negotiation process. The Panel invites submissions on the effect of the availability of information on competitive outcomes as they pertain to the role of medical schemes and/or administrators in the bargaining process.

33. Medical schemes and their service providers design benefits, negotiate tariffs, and process claims for a wide variety of services and a large number of providers. They need good quality information to do this effectively. Should there be trade-offs between, on the one hand,

coordination in organising and publishing this information and, on the other, competition and rivalry among providers and medical schemes? The Panel invites submissions on these trade-offs, if any, the role of standardisation (or lack thereof), and the impact of regulatory intervention on competitive outcomes.

34. There are various mechanisms available to administrators and other intermediaries aimed at managing costs. These include managed care, alternative reimbursement mechanisms, and generic substitution. The Panel invites submissions on the extent to which these are used, whether they are effective, and the relationship between these interventions and good healthcare outcomes.

35. Brokers play a potentially important role in guiding consumers in choosing healthcare financing. The Panel invites submissions on whether the incentives of brokers and medical schemes, administrators, and/or other insurers are aligned with the interests of consumers.

36. The Medical Schemes Act 131 of 1998, protects consumers from catastrophic healthcare expenditure, while preventing schemes from discriminating against high-risk members or cherry picking members who are relatively healthy and are thus low risk. The Panel invites submissions on how risk pooling arrangements, risk equalisation, other risk sharing mechanisms and the rules governing them affect competitive outcomes in the sector. The Panel also invites submissions on how the demographics of scheme membership influence the costs of private healthcare.

37. In addition, the Panel invites submissions on the role and impact of health insurance products that are not medical schemes on competition and sustainability of the sector. In this regard, the impact of regulation on the financing of private healthcare will also be considered.

Providers of Healthcare Products and Services

38. Healthcare services include those provided by healthcare facilities and by practitioners. Facilities include various health care institutions providing patient treatment by specialised staff and using specialised equipment such as hospitals, day clinics, and sub-acute facilities. Where the term "hospitals" is used in this document, it should be understood to include all health care institutions, unless the context indicates otherwise. Healthcare practitioners encompass general practitioners, dentists, specialists, emergency services and supplementary healthcare service providers.

39. The private hospital sector consists of three large hospital groups, an association of independent hospitals, and some independent hospitals not affiliated to the association. The Panel invites submissions on the impact, if any, of hospital concentration and possible market power at national, regional and local levels. In particular: are there features that harm competition among private hospitals; does market power arise from possible unilateral conduct and/or coordination of private hospitals; what is the impact of possible market power on bargaining between hospitals and medical schemes/ administrators; and what is the impact of possible market power on costs? Further, the Panel invites submissions on how hospitals compete with regard to investment in technology and attracting practitioners to their respective hospitals, the regulatory requirements affecting entry and expansion, and the implications of these for competitive outcomes.

40. The Panel wishes to understand the level and structure of prices and underlying costs for key services offered by facilities. The Panel invites submissions on the components of costs, the drivers of those costs, and the determination of profits and whether these levels of profitability are consistent with a competitive and sustainable sector.

41. The sector consists of a number of different kinds of practitioners offering a variety of services and specialising in different disciplines. In order for the Inquiry to be focused and manageable, it is necessary to prioritise and select disciplines to focus on for further evaluation.

42. The Panel will inquire into the potential gatekeeper role that general practitioners (GPs) may play in directing patients through the healthcare pathway. With respect to specialists, the Panel will start with a broad evaluation of all practitioner groups and invites submissions on all specialities. The Panel may narrow its focus based on information received during the Inquiry.

43. With regard to GPs and specialists, the Panel invites submissions on how they make decisions on directing patients through the healthcare pathway; the impact of scarcity of specialist skills on competitive rivalry; the impact of the rules and requirements of the Health Professions Council of South Africa ("HPCSA") and Allied Health Professions Council of South Africa ("AHPCSA") on competition; and the impact of any skewed distribution of practitioners in different areas.

44. The Panel seeks to understand whether any concerns arise from possible coordination in tariff setting and adoption of coding systems. Do imperfections of information in the sector, if any, have an impact on the incentives and actions of practitioners? The Panel invites submissions on the trade-offs that must be made between the need for coordination in organising and reporting information and maintaining competition and rivalry among practitioners.

45. The Panel wishes to understand the relationship between practitioners and hospitals. While practitioners operate out of hospitals, HPCSA and AHPCSA rules prevent practitioners from being employed by hospitals.

In addition, practitioners may own shares in hospitals. The Panel invites submissions on the rationale and the implications of these rules and practices for the incentives and actions of practitioners, the relationship between hospitals and practitioners, and whether these incentives and actions are harmful to costs, prices and quality of treatment provided and to competition.

46. As with the provision of healthcare facilities, the Panel wishes to understand the level and structure of prices and underlying costs for key services offered by practitioners. The Panel invites submissions on the components of costs, the drivers of those costs, the determination of profits, and whether profits are consistent with a competitive and sustainable sector.

47. Medicines and medical devices are integral to the provision of healthcare services. The Terms of Reference refer to "consumables" as including pharmaceuticals, medical devices and other consumables. For the purposes of this Inquiry, the Panel interprets "consumables" to include "medicine(s)" and "medical device(s)" as defined in the Medicines and Related Substances Control Act, no 101 of 1965 (as amended). Manufacturers and suppliers of medicines operate within a regulated market through the Single Exit Pricing (SEP) regime, and may be affected by efforts to facilitate generic competition. The Panel invites submissions on the impact of medicines and medical devices on costs and competition in private healthcare.

The Role of the Public Healthcare Sector

48. Parallel to the private healthcare market is the public sector, largely servicing uninsured consumers.

49. Whilst the Act, and accordingly the Terms of Reference, do not permit the Panel to inquire into the public healthcare sector, the Panel

nevertheless considers it important to consider how the public sector affects competition and access in the private health sector.

50. The Panel welcomes any submissions that stakeholders may wish to make in this regard, but wishes to stress that these should be related to issues that have a bearing on access, affordability, competition, costs, prices, and expenditure in the private health sector, rather than issues pertaining solely to the functioning of the public sector.

Techniques for Defining Markets and Analysing Competition

51. In order to establish a sound analytical and factual basis for the findings of the Inquiry, the Panel wishes to ensure that methods and tools used in the Inquiry support rigorous analysis and are consistent with best practice. Various techniques are available which are based on theory and methods of competition economics.

52. The process for selecting methods for defining markets and analysing competition will be developed during the Inquiry. The choice of methodology will be informed by pragmatic considerations such as data limitations, resource requirements, and practical applicability of the methodology. Stakeholders are invited to address these issues in their submissions.

III. THEORIES OF HARM TO COMPETITION

53. The concept of theories of harm is a best practice tool adopted in competition analysis globally and in South Africa. As explained in the introduction, it is merely a tool for the Panel to remain focussed as it develops its understanding of the markets involved. These preliminary theories of harm are not findings of harm, but serve as a starting point in the analysis. Their identification does not in any way imply that the Panel has reached views on whether or not they apply. At this stage, the theories of harm are intended to indicate to stakeholders the issues that

the Panel seeks to address and as a guide to stakeholders to provide the relevant information to the Panel. The theories of harm may thus evolve during the course of the Inquiry.

54. The theories of harm, which are not exhaustive, must be understood as applying to competition issues. They may not necessarily address all factors that have an impact on access and affordability. Submissions should therefore not be confined to addressing only the theories of harm indicated here.

55. The Panel proposes to assess competition in private healthcare according to the following theories of harm:

i) Theory of harm 1: Market power and distortions in healthcare financing.
ii) Theory of harm 2: Market power and distortions in relation to healthcare facilities.
iii) Theory of harm 3: Market power and distortions in relation to healthcare practitioners.
iv) Theory of harm 4: Barriers to entry and expansion at various levels of the healthcare value chain.
v) Theory of harm 5: Imperfect information.
vi) Theory of harm 6: Regulatory framework.

Theory of harm 1: Market power and distortions in healthcare financing

56. This theory of harm relates to demand and supply of healthcare financing. It hypothesises that there are providers of healthcare financing that may have market power and use this power in a manner that harms competition.

57. Market power may arise because of the dominance of individual firms or of coordination. In this market, lack of coordination might also create

distortions to the detriment of competition and ultimately consumers. Other distortions could include a misalignment of incentives between providers of healthcare finance and consumers.

58. These market power relations and distortions could include the following:

- Market power of medical schemes and other health insurance providers over members or policyholders;
- Market power of medical scheme administrators over medical schemes, or *vice versa*;
- Market power of medical schemes and administrators over providers of healthcare facilities;
- Market power of medical schemes and administrators over healthcare practitioners;
- The relationship between not-for profit medical schemes and for profit administrators; and
- The relationship between brokers, medical schemes and consumers.

59. Market power may arise because of dominance and/or coordination. Distortions of competition and market power relations could include:

- Market power of healthcare facilities during negotiations with medical schemes and/or administrators. National and local market dynamics may be considered; and
- Market power of healthcare facilities over the relationship between providers of healthcare finance and suppliers of medicines and medical devices.

Theory of harm 2: Market power and distortions in relation to healthcare facilities

60. This theory of harm relates to demand and supply of healthcare services through facilities. It asks whether healthcare facilities have market power in relevant geographic markets or in certain types of specialisation and whether this market power is exercised in a manner that harms competition.

- Patients in local markets;
- Market power arising from healthcare facilities that offer specialised treatments;
- The relationships between practitioners and healthcare facilities; and
- The relationships between healthcare facilities and suppliers of medicines and medical devices.

Theory of harm 3: Market power and distortions in relation to healthcare practitioners

61. This theory of harm relates to demand and supply of healthcare services by various healthcare practitioners. It hypothesises that healthcare practitioners in relevant geographic markets may behave in an anti-competitive manner in relation to patients and/or healthcare facilities. The evaluation of market power or distortions could include the following areas of Inquiry:

- The effectiveness with which healthcare practitioners direct patients along the healthcare pathway;
- The scarcity of skills and absence of local rivalry;
- Possible coordinated conduct among healthcare practitioners;
- Market power of practitioners during negotiations with medical schemes and administrators. National and local market dynamics will be considered as well as the role played by practitioner groupings and networks during negotiations; and
- The relationships between healthcare practitioners and suppliers of medicines and medical devices.

Theory of harm 4: Barriers to entry and expansion at the various levels of the healthcare value chain

62. Entry or merely the threat of entry may be expected to play a significant role in the competitive outcomes of the private healthcare sector. This theory hypothesises that there are both structural barriers, which are inherent to the market, and behavioural barriers to entry and expansion in the healthcare value chain that could harm competition. Potential barriers arising from relationships between various parties, contractual or otherwise, will also be evaluated.

Barriers to entry and expansion into healthcare financing

63. Barriers to entry and expansion into healthcare financing may include:

- Economies of scale and large financing requirements associated with the need to attract beneficiaries and pool risk;
- Reserve ratios and other regulatory requirements and constraints; and
- Contractual arrangements between medical schemes and/or administrators and providers.

Barriers to entry and expansion in healthcare facilities

64. Barriers to entry and expansion into the healthcare facilities may include:

- Substantial investment and sunk costs;
- Licensing and other regulatory requirements; and
- Contractual or informal arrangements between existing healthcare facilities and practitioners.

Barriers to entry and expansion for healthcare practitioners

65. Barriers to entry and expansion for healthcare practitioners may include:

- Rules and regulations impacting healthcare practitioners, such as promulgated by the HPCSA and National Department of Health;
- Contractual arrangements between medical schemes and/or administrators and practitioners; and
- Agreements and arrangements between facilities and practitioners.

Theory of harm 5: Imperfect Information

66. It is generally accepted that many healthcare markets are characterised by imperfect information. This theory of harm considers the extent to which imperfect information distorts outcomes in the healthcare markets and harms competition.

67. Imperfect information could, for instance, compromise the following decisions and processes:

- Patients' ability to choose the most appropriate provider to deal with their condition;
- Members' choice of medical schemes;
- Healthcare funders' ability to compare cost and quality when contracting providers;
- Patients' lack of information available to healthcare facilities and funders on the use-value of treatment and technologies, which may lead to inappropriate use.

68. Another form of imperfect information arises as a result of the third party payer mechanism. This may distort the incentives of the consumer and/or the provider, giving rise to adverse selection and moral hazard.[8]

Theory of harm 6: Regulatory Framework

69. Globally, regulatory intervention is used to ensure safety and effectiveness of healthcare services and products. There is, understandably, a regulatory framework that governs the healthcare sector in South Africa. Possible deficiencies and unintended consequences in the regulatory framework may distort competition, raise barriers to entry and expansion, and maintain and/or create positions of market power. The Panel invites submissions on the current regulatory framework how it is implemented and enforced, and how it affects competitive outcomes.

70. The Panel would also like to understand the role that competition law and policy plays in this sector. In order to do this, the Panel invites submissions on previous interventions by competition authorities into the healthcare sector in order to understand their effects on the market. In addition, the Panel intends to inquire into the impact of the regulatory framework (including various statutes, regulations and rules) on competition in private healthcare. Stakeholders are invited to comment on the impact of statutes, regulation, or rules on competition and to provide a full motivation for any views expressed.

[8] Moral hazard arises, for example, when insured patients are tempted to consume unnecessary quantities of healthcare goods and services due to the fact that they are not paying directly for services. Adverse selection arises, for example, when people who are ill, and are expecting to incur costs, only then seek coverage while healthy people choose to remain uninsured. This may raise costs and reduce accessibility to healthcare insurance.

Conclusion

71. In the Call for Submissions, published simultaneously with this Statement of Issues, the Panel invites all those who wish to participate to make submissions on the issues identified in this Statement of Issues, read with the Terms of Reference. Stakeholders are requested to assist the Inquiry by making full submissions at the outset. It should not be assumed that those who withhold information and argument at the outset will be afforded an opportunity to supply it later, as and when they choose.

72. Submissions should be as detailed as possible and any views or opinions expressed should be substantiated as far as possible. The most helpful submissions will be those that provide verifiable facts to support specific arguments.

73. The closing date for full submissions is 31 October 2014.

74. The submissions may be hand-written or typed. Anyone unable to write or type their submission themselves may approach the Inquiry Director for assistance in doing so, and in filling in Form “HI1”.

75. Submissions, accompanied by a completed form “HI1” available on the Inquiry website (www.healthinquiry.net) must be sent to the Panel by email, post or hand delivery to the following addresses:

Attention: Mr Clint Oellermann
Inquiry Director
The Market Inquiry into the Private Healthcare Sector

Physical Address:
Trevenna Campus,
Block2A,

Fourth Floor
70 Meintjies Street,
Sunnyside,
Pretoria

Postal Address:
The Competition Commission
Private Bag x23
Lynwood Ridge, 0040
South Africa

Email: submissions@healthinquiry.net
Contact number: +27 (12) 762 6900