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Draft Statement of Issues

Market Inquiry into the Private Healthcare Sector

30 May 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 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 draft 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 of healthcare services (including facilities[3] and practitioners[4]), and

[1] The Notice as well as the Terms of Reference was published in the Government Gazette, Volume 581, No. 37062, on 29 November 2013.
[2] Healthcare financing refers collectively to Medical Schemes, Medical Scheme Administrators, Managed Care Organizations and Healthcare Insurers.
[3] Healthcare facilities include hospitals, day clinics, sub-acute, specialized care centers 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

consumables. The Panel is required to evaluate 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 health 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".[5] This will include 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 draft Statement of Issues, the Panel sets out a framework for approaching the investigation 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. The Panel invites comments on this framework. What must be emphasised is that the points raised in this statement are intended to be topics for investigation and do not represent any settled views or findings of the Panel. As the inquiry progresses further, the Panel may add issues for investigation. If the parties consider that there are additional issues that the Panel should consider, they are invited to identify them and to explain why these are relevant to the investigation.

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); and includes pharmacists as registered by the South Africa Pharmacy Council (SAPC); and nurses and midwives as registered with the South African Nursing Council (SANC).

[5] Terms of Reference at p 85 (paragraph 4).

The general task of the Panel

7. 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.[6] 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.

8. 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". In calling for comments on this draft Statement of Issues, the Panel would welcome comments on the appropriate approach to be adopted in interpreting and applying these concepts in the context of private healthcare.

Assessing Competition

9. 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.

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

10. 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. The Panel believes likewise that these theories of harm – or others that participants might propose in comments on this draft statement or in their eventual submissions – will help in the identification of the most important issues to be addressed and enable more efficient concentration on relevant information.

11. 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. In addition, their identification 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. 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.

12. When commenting on the appropriateness or otherwise of using the theories of harm identified in this draft statement, or in proposing others, participants should provide reasons for their views and, if possible, suggest an alternative methodology or approach for use in the conduct of the inquiry.

Rationale for the inquiry

13. Private healthcare provision takes place within the context of a constitutional commitment to the provision of universal healthcare services to all South Africans.

14. 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.[7] Prices across key segments are also rising above headline inflation. These increases in prices and expenditure frame the decision to initiate the inquiry.

15. The Panel notes the rationale and accordingly wishes to evaluate 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, 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.

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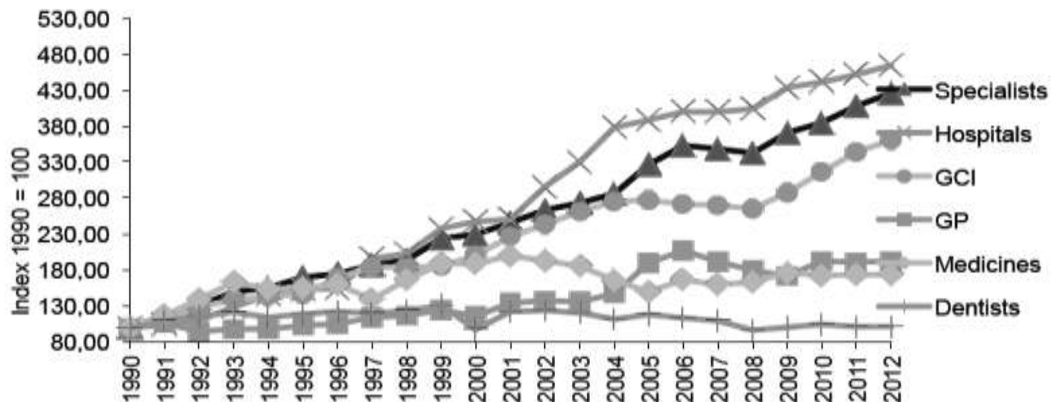
[7] Figure 1 on page 83 of Government Gazette No 37062, reproduced below, presents indicative trends in private healthcare expenditure from 1990 to 2012 compared to gross contribution income per beneficiary (index = 100 in 1990).



Source: Council for Medical Schemes: Annual Reports from 1991 to present

16. The inquiry will evaluate the various explanations for costs, 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.

II. FRAMEWORK

17. Many explanations have been suggested for observed increases in costs and expenditure in the private healthcare sector. These include increased utilisation; the introduction of new technologies; changes in the demographic profile of patients; market power abuses and other restrictions on competition; and imperfections in information adversely affecting the incentives and decisions of various role players.

18. Given the scope and complexity of the above-mentioned factors, the Panel is mindful that it is neither practical nor feasible to attempt to cover all ground and explore every possible factor that may play a role in driving outcomes in the sector. Therefore, it will be important for the Panel to prioritise its work.

19. Criteria the Panel will apply in prioritising its work are:

    Criteria related to substance -

    a) Relative importance in explaining costs, affordability, access, innovation and quality;
    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.

20. 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 preliminary and subject to revision and refinement based on the review of submissions received in response to the Statement of Issues. The Panel invites comments on the framework and on the application of the framework in order to prioritise further.

Consumers

21. The ability of consumers to make optimal decisions is affected by their needs, the quality of information at their disposal, and the incentives and actions of the various actors with whom they interact.

22. Among the initial decisions that consumers must make is which medical scheme to select and, within the scheme selected, what products and services to purchase. The Panel wishes to understand 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 wishes to understand 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.

23. The Panel wishes to understand the nature of competition among medical schemes and other providers of health insurance in the South African market and the impact of this on the affordability and quality of the products and services that consumers purchase.

24. 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, the patient is even less likely to play any role in decisions regarding their own treatment. The Panel wishes to understand how decisions made by and/or on behalf of patients are affected by prevailing incentives, availability of information, 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 wishes to understand the extent to which interests of patients and interests of providers are aligned with good healthcare outcomes. The Panel seeks to understand whether there are any factors bringing about a misalignment in this regard.

25. 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. Patients are therefore less likely to be constrained in making decisions about the affordability of services than they would be if they had to pay directly for services. The Panel wishes to understand how this affects both the incentives of patients and competitive outcomes in the sector.

26. 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. Specifically, consumers may select schemes based on their terms and conditions regarding out-of-pocket payments. The Panel wishes to understand the circumstances under which a system of out-of-pocket payments has arisen in South Africa, what this means for the welfare of consumers, and the effect, if any, of out-of-pocket payments on competition.

Financing of Healthcare Services

27. Financing of healthcare services encompasses products and services provided by medical schemes (closed 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.

28. The Panel wishes to understand 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.

29. Administrators 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. What are 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? Further, what is 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 wishes to understand 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.

30. Administrators and/or medical schemes 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 wishes to understand these trade-offs, if any, the role of standardisation (or lack thereof), and the impact of regulatory intervention on competitive outcomes.

31. 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 wishes to understand the extent to which these are used, the effectiveness thereof, and the alignment of these interventions with good healthcare outcomes.

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

33. 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 less likely to become ill and are thus low risk. The Panel wishes to understand how risk pooling arrangements, risk equalisation, other risk sharing mechanisms and the rules governing them affect competitive outcomes in the sector. The Panel also seeks to understand how the demographics of scheme membership influence the costs of private healthcare.

34. In addition, the Panel will inquire into the role and impact on competition and sustainability of the sector of health insurance

products of financial service providers that are not medical schemes and are not subject to the rules for medical schemes set out above.

Providers of Healthcare Products and Services

35. Healthcare services include those provided by healthcare facilities and by practitioners. Facilities include various health care institutions providing patient treatment by specialised staff and 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 facilities, unless the context indicates otherwise. Healthcare practitioners encompass general practitioners, dentists, specialists, emergency services and supplementary service providers.

36. The private hospital sector consists of three large hospital groups, in addition to an association of independent hospitals and some independent hospitals not affiliated to the association. The Panel wishes to understand 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 inquiry seeks to understand 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.

37. The Panel wishes to understand the level and structure of prices and underlying costs for key services offered by facilities. The Panel seeks to understand 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.

38. The sector consists of a number of different kinds of practitioners offering a variety of services and specialising in different disciplines. If the inquiry is to be focused and manageable, it will be necessary to identify criteria for identifying which types of practitioners to prioritise and which disciplines to focus on for further evaluation. At the outset, the Panel wishes to identify general practitioners (GPs) as a priority because of their important gatekeeper role in directing patients through the healthcare pathway. With respect to specialists, however, the Panel may identify areas of focus based on factors like contribution to overall costs, the rate of cost increases and frequency of use. The Panel invites submissions on appropriate prioritisation criteria and welcomes any proposals on what the focus areas should be.

39. With regard to GPs and specialists, the Panel seeks to understand 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 Counsel of South Africa (“HPCSA”) on competition; and the impact of any skewed distribution of practitioners in different areas.

40. 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 wishes to understand the trade-offs that must be made between the need for coordination in organising and reporting information and maintaining competition and rivalry among practitioners.

41. The Panel wishes to understand the relationship between practitioners and hospitals. Practitioners operate out of hospitals, but HPCSA rules prevent practitioners from being employed by hospitals. However, practitioners may own shares in hospitals. The Panel wishes to understand the rationale and the implications of these rules 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.

42. 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 seeks to understand the components of costs, the drivers of those costs, the determination of profits, and whether profits are consistent with a competitive and sustainable sector.

43. The consumables market includes pharmaceutical products and other medical consumables. Pharmaceuticals form a considerable part of consumables and operate within a highly regulated market through the Single Exit Pricing (SEP) regime, and are affected by efforts to facilitate generic competition. The Pharmacy Council of South Africa oversees ethical conduct by pharmacists. The other noteworthy part of the consumables market includes the market for medical technology and devices. The Panel wishes to understand the impact of consumables on costs and competition in private healthcare.

The Role of the Public Healthcare Sector

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

45. The Terms of Reference exclude the public sector as a focus area of this inquiry. However, the Panel considers it important to understand how the public and private healthcare sectors interact and what, if any, constraints exist between the two that affect competitive outcomes in the private health sector. For example, there may be areas of excellence in the public healthcare sector, like academic hospitals, which may pose some competitive constraint on private hospitals. The Panel wishes to understand the extent of this.

46. 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 outcomes, competition, costs, prices, and expenditure in the private health sector rather than issues pertaining to outcomes in the public sector.

Techniques for Defining Markets and Analysing Competition

47. 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 the technical theory and methods of competition economics. While a discussion of these techniques may not be of interest to everyone, it will nevertheless be important for stakeholders and their appointed experts to engage on this issue.

48. The definition of the relevant product and geographic markets is an important first step in the assessment of the competitive constraints in competition matters. The purpose of undertaking this step is to delineate the market so that instances of market power can be identified and the relevant competitive constraints isolated and their strength assessed.

49. As indicated above, distinct features of the healthcare market set them apart from conventional commodity markets. This may influence the application of standard techniques for defining markets and analysing competition and may necessitate the need for alternative techniques.

50. The Panel will consider standard approaches and alternative techniques for defining relevant markets and analysing competition. The Panel will select appropriate methods based on their applicability to the theory of harm under evaluation and the characteristics of the market being assessed. These techniques represent a broad spectrum of methods that are characterised by different degrees of theoretical soundness, complexity, data requirements and the extent to which they have been tested empirically or have established precedent. Pragmatic considerations will also be taken into account including, for example, data limitations, resource requirements, and practical applicability.

51. Stakeholders are invited to make submissions on the appropriate techniques to be employed. The Panel will in due course engage with its own experts and those of the affected stakeholders in order to explore alternative techniques with a view to deciding on the methods most appropriate and practical for purposes of this inquiry.

III. THEORIES OF HARM TO COMPETITION

52. 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 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. 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. The theories of harm may thus evolve during the course of the inquiry.

53. Based on the framework discussed above, the Panel proposes the following theories of harm to assess competition in private healthcare:

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.

54. The Panel notes that, at this stage, the theories of harm to competition are stated in broad terms. After consideration of the submissions made in response to this draft Statement of Issues and upon further research, the Panel may refine the theories of harm.

55. The effects arising in relation to each of the theories of harm may be higher costs, higher prices (including premiums), impaired access, as well as less innovation, and lower quality of service. In addition, public interest issues affecting employment, small and medium-sized enterprises and the spread of ownership in the economy could arise. As the inquiry progresses, the Panel will seek to understand these effects in more precise terms, informed by facts at hand.

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;
- 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;
- The relationship between brokers, medical schemes and consumers; and
- The relationship between providers of healthcare finance and suppliers of consumables.

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

59. 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.

60. 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.
- Market power of healthcare facilities over patients (including self-paying users) in local markets.
- Market power arising from healthcare facilities that offer specialised treatments.
- The relationships between practitioners and healthcare facilities.
- The relationships between healthcare facilities and suppliers of consumables.

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 anticompetitive manner relating 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 consumables.

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.

Barriers to entry and expansion in healthcare facilities

63. 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 into healthcare financing

64. 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
- Contractual arrangements between medical schemes and/or administrators and providers.

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 the HPCSA); and
    - Contractual arrangements between medical schemes and/or administrators 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 compromise the following decisions and processes:

    - Patients' ability to choose the best 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 are, understandably, numerous regulations that govern 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 wishes to understand the current regulatory framework 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 intends to conduct a review of previous interventions by competition authorities into the healthcare sector in order to understand their effects on the market.

[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 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. The Panel invites stakeholders and all those who wish to participate to make submissions on this draft Statement of Issues. Submissions must be received by no later than 30 June 2014.

72. The submissions may be hand-written or typed and must be sent to the Panel by fax, email, post or hand delivery to the following addresses:

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