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COMPETITION TRIBUNAL OF SOUTH AFRICA

Case No: LM124Oct16

In the matter between:

Mediclinic Southern Africa Proprietary Limited	Primary Acquiring Firm
And	
Matlosana Medical Health Services Proprietary Limited	Primary Target Firm

Panel	: Norman Manoim (Presiding Member) : Yasmin Carrim (Tribunal Member) : AW Wessels (Tribunal Member)
Heard on	: 28, 29, 31 May 2018; 1, 4 – 7, 11 – 13 June 2018; 26 September 2018; 12 December 2018; and 15 January 2019
Order issued on	: 29 January 2019
Reasons issued on	: 22 March 2019

REASONS FOR DECISION

PROHIBITION

[1] On 29 January 2019, the Competition Tribunal ("Tribunal") prohibited the large merger involving Mediclinic Southern Africa Proprietary Limited ("Mediclinic"), the primary acquiring firm, and Matlosana Medical Health Services Proprietary Limited ("MMHS"), the primary target firm, hereinafter collectively referred to as "the merging parties".

[2] The reasons for prohibiting the proposed transaction follow.

EXECUTIVE SUMMARY

[3] Mediclinic intends acquiring a controlling shareholding in MMHS. Mediclinic will post merger own *inter alia* Mediclinic Potchefstroom and MMHS' Wilmed Park Private Hospital and Sunningdale Hospital, all multi-disciplinary private hospitals located in the North West province. MMHS is a member of the National Health Network ("NHN"), a non-profit company which *inter alia* negotiates tariffs and other benefits with medical schemes on behalf of a range of independent hospitals

[4] The robust, common cause evidence in this matter was that the proposed transaction will result in a significant increase in tariffs at the target hospitals (Wilmed and Sunningdale) when their tariff files change from the current NHN tariff files to the Mediclinic tariff files. This is because Mediclinic has been able to achieve higher tariffs to date than the NHN.

[5] It was also common cause that the tariff, which comes about as a result of national negotiations between hospital groups and medical schemes, is the major component of the total cost to a patient for hospital services, sometimes referred to as cost per event or CPE. The differences in tariff must be given a weighting with other factors such as the cost of ethicals and surgicals to arrive at a final CPE which is the relevant figure for assessing the pricing effects of the proposed merger. It was also common cause as we discuss later how this weighting was to be applied.

[6] It was also common cause that after applying the appropriate weighting, there would, post merger, be an increase of approximately [redacted]% in the customers' overall hospital bill at Wilmed and Sunningdale.

[7] The vast majority of medical aids raised concerns in relation to the anticipated effects of the proposed transaction on competition - specifically in relation to tariff effects.

[8] The further clear, undisputed evidence was that MMHS grants significantly larger discounts to uninsured patients than Mediclinic and on both sets of fees, i.e. theatre and ward fees. Mediclinic's discounts to uninsured patients are

smaller and are furthermore [redacted] of the hospital bill. Bearing in mind that Mediclinic's tariffs are significantly higher than that of the target hospitals as quantified above the proposed transaction will thus have a significant adverse tariff effect on the uninsured patients, as was confirmed in the merging parties' own strategic documents. The due diligence document regarding MMHS records *"MMHS's Private Tariffs are [redacted]% lower than Mediclinic"*.

[9] We have concluded that the proposed transaction will remove the lower tariffs that are available to uninsured patients at the target hospitals and given the significant differences in these tariffs, the proposed merger will significantly affect the uninsured patients by limiting their ability to negotiate and switch to cheaper hospitals in the form of the target hospitals. These uninsured patients do not have the benefit of a medical scheme negotiating on their behalf and from a public interest perspective this group is thus important and significant. They are vulnerable when one considers consumer welfare and the importance of private healthcare in South Africa.

[10] The merging parties argued that the above common cause tariff effects would be offset by certain claimed efficiencies that Mediclinic could post merger achieve in the merged hospitals. Mediclinic argued that it was able to achieve *inter alia* procurement and utilisation efficiencies at hospitals because it ran them as a group. NHN is a loose alliance of independent hospitals which (previously) only had an exemption to bargain tariffs collectively and not to procure collectively. Mediclinic argued that the relevant counterfactual to the proposed merger is the status quo and the actuaries based their calculations on this being the case.

[11] Nevertheless, between the end of the hearing of oral testimony on 13 June 2018 and final argument on 12 December 2018 and 15 January 2019 a new development occurred which changed the relevant counterfactual. This was that the Competition Commission in November 2018 published its decision to conditionally approve an exemption application of the NHN (of which MMHS is a member) to undertake collective or centralised procurement on behalf of its members. We shall refer to this as "the exemption counterfactual". Given the

relative size of the NHN and the large volumes of surgicals and ethicals that it will procure on behalf of its members after the exemption, we have concluded that it can be expected that the procurement costs of Wilmed and Sunningdale will significantly reduce absent the proposed transaction. This neutralised the merging parties' efficiency claims relating to the post merger cheaper procurement by Mediclinic of surgicals and ethicals for the target hospitals. The merging parties furthermore failed to demonstrate that other likely, merger-specific, timely efficiencies would result from the proposed merger that would outweigh the likely adverse tariff and other anticompetitive effects.

[12] Certain medical schemes raised concerns in relation to increased concentration and regional dominance and its effects on Mediclinic's bargaining position in negotiations. This included concerns received from Discovery that initially was going to be a customer witness of the merging parties, but never testified, and seemed to have changed its views in its latter submissions on the anticipated effects of the proposed transaction.

[13] We have also found other concerns relating to the proposed merger.

[14] The merging parties will post merger be the dominant player in the market for the provision of private multi-disciplinary acute inpatient hospital services in the "MaJB" area consisting of the Ditsobotla, City of Matlosana and JB Marks local municipalities with a combined market share of approximately 63% - a market share that dwarfs that of the next largest competitor.

[15] We have concluded that given the merging parties' dominant position in the relevant market and the fact that post merger the combined Mediclinic Potchefstroom, Wilmed and Sunningdale can provide a medical scheme wanting representation in the relevant geographic area with a complete coverage and range of services, the medical schemes would find it difficult to exclude the merged entity when constructing networks, including Designated Service Providers ("DSPs"). The proposed merger will make medical schemes' (and patients when considering non-price factors) outside options much less attractive, giving the merged firm the ability to offer lower or no discounts on DSPs (and deteriorate non-price factors) in the relevant market. The medical

aid members on the various low-cost options collectively are an important group from a public interest perspective since they are particularly vulnerable to the increasing costs of private healthcare in South Africa. If the patients on the low-cost options could no longer afford private healthcare, this would put further constrains on the public healthcare sector in South Africa.

[16] We further heard evidence that Mediclinic has in the past attempted to leverage its dominance in one geographic region, where it does not face much competition, to require medical schemes to increase their utilisation of hospital facilities in a geographic region where it does face competition. Discovered correspondence in this case revealed that the attainment of a dominant position in one geographic area / market can be leveraged to restrict members' choice of hospitals in a different geographic area / market. Since in competition law restricting choice is also considered to be an anticompetitive effect, the proposed merger may potentially also have adverse effects on consumers outside of the defined relevant geographic market. The correspondence revealed that this possibility exists.

[17] From a non-price competition perspective, we concluded that the proposed transaction will likely lead to a deterioration in patient experience at the target hospitals if the merger is implemented.

[18] In the course of the proceedings, the merging parties submitted a continual iteration of different behavioural conditions, all of limited duration, to address the competition concerns. This included a pricing remedy in the form of a post merger discount off the Mediclinic tariffs.

[19] However, after extensive engagement with the merging parties on potential remedies, and taking into account the concerns raised by medical schemes, we have found that the proposed behavioural remedies offered by the merging parties did not address the source of the competitive harm, were limited in duration and were also inappropriate or inadequate in a number of other respects, including that the Commission would not be able to effectively monitor and enforce the various proposed behavioural conditions.

[20] We also found that the adverse effects of the proposed transaction are not confined to the post merger prevention or lessening of competition but also extend to public interest grounds that must be considered by the Tribunal in terms of the Competition Act, No. 89 of 1998, as amended ("the Act"). In particular section 12A(3)(a) of the Act, which requires the Tribunal to consider the effects of a merger on "*a particular industrial sector or region*". Both sector and region are adversely affected by this merger.

[21] Private hospitals provide services in the health care sector. That this is a sector of public interest significance can hardly be disputed. Indeed, Section 27 of the Constitution affords everyone the right to have access to "healthcare services". It is trite that there are serious concerns about private health care inflation in South Africa, a concern shared by the merging parties themselves, and that there is a need to curb escalating costs.

[22] The proposed transaction will have a significant effect on the health care costs of both insured and uninsured patients living in a specific region – the rural Potchefstroom / Klerksdorp region, given that the target hospitals have significantly lower tariffs than Mediclinic. Moreover, the uninsured patients in this area, which are a vulnerable group, will have less choice of cheaper hospitals post merger and this will adversely affect their ability to switch between cheaper options. As indicated above, the robust, common cause evidence was that the proposed transaction will significantly increase the tariffs at the target hospitals for both the insured and uninsured patient market segments.

[23] The proposed merger thus leads to an adverse public interest effect with no countervailing positive public interest ground advanced to mitigate this.

PARTIES TO THE PROPOSED TRANSACTION

[24] The primary acquiring firm is Mediclinic.

[25] The Mediclinic group is a private hospital group with 48 private hospitals across South Africa. Mediclinic provides primarily acute care multi-disciplinary private hospital services. Of specific relevance to the assessment of the proposed

transaction is Mediclinic's hospital in Potchefstroom in the North West province, known as Mediclinic Potchefstroom, which is a multi-disciplinary private hospital.

[26] Mediclinic Potchefstroom has 197 licensed beds, 135 of which are operational; four operational theatres and two newly upgraded theatres that they said will be operational by the end of 2018; an emergency centre; eleven consulting rooms which are let to specialists, and one additional session room.[1]

[27] The primary target firm is MMHS, a private company.

[28] MMHS's current controlling shareholder, as to 74%, is Cold Creek Investments 22 Proprietary Limited ("Cold Creek"). Cold Creek represents a group of individual medical practitioners and individuals. Cold Creek is not controlled by any single person or firm. The remaining non-controlling 26% of MMHS is held by Crimson King Properties 408 Proprietary Limited, which is a historically disadvantaged person.

[29] MMHS owns and manages two multi-disciplinary private hospitals in the North West province, Wilmed Park Private Hospital ("Wilmed") and Sunningdale Hospital ("Sunningdale"), collectively referred to hereinafter as "the target hospitals". It also owns a psychiatric hospital, Parkmed Neuro Clinic ("Parkmed") and a nursing school in Klerksdorp in the North West province.

[30] In these reasons we shall focus on Wilmed and Sunningdale since the Competition Commission ("Commission") did not raise any competition concerns in relation to Mediclinic's proposed acquisition of either Parkmed or the abovementioned nursing school.

[31] Wilmed has 185 operational beds (and 144 licensed beds);[2] six theatres; 27 consulting rooms which are let to specialists; and an emergency unit.[3] Sunningdale has 62 licensed and operational beds; two theatres; and twelve

[1] Van Aswegen's Witness Statement, Bundle B, pages 105 and 106, paragraph 10.
[2] See Steenkamp, Transcript, page 902, lines 4-10, where he explains that the Minister of Health has in a letter approved the additional beds, but the hospitals' licence has not yet been amended.
[3] Steenkamp's Witness Statement, Bundle B, pages 58 and 59, paragraphs 9-11.

consulting rooms.[4] According to the final motivation for approval of the proposed transaction management has indicated that [redacted] specialists have consulting rooms in either Wilmed or Sunningdale.[5]

[32] As indicated above, MMHS is a member of the NHN, a non-profit company which *inter alia* negotiates tariffs and other benefits with medical schemes on behalf of a range of independent hospitals. After the latest exemption granted to the NHN it will also be able to do collective procurement. The NHN centralises data through MediKredit.

[33] Prior to argument of the matter, a significant new development took place in that the Commission granted the NHN a conditional exemption for central or collective procurement on behalf of its members. This exemption has a grace period of two years applicable to all NHN members, where after each individual NHN member will have to meet certain qualifying criteria to be part of the exemption. The exemption is of importance since it affects the procurement efficiencies that the target hospitals could achieve absent the proposed transaction, given that MMHS currently is a member of the NHN. We shall refer to this in these reasons as "the exemption counterfactual".

PROPOSED TRANSACTION AND RATIONALE

[34] The proposed transaction will result in Mediclinic owning at least 50.01% of the entire issued shares in MMHS, meaning that Mediclinic will post merger control *inter alia* three acute multi-disciplinary hospitals in the Potchefstroom / Klerksdorp area in the North West province, i.e. Mediclinic Potchefstroom, Wilmed and Sunningdale.

[35] Mediclinic submitted that it wants to expand its Southern African footprint and network of hospitals in an area, Klerksdorp, which is expanding and developing.

[36] MMHS submitted that its shareholders wish to realise the value of their shares.

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[4] Steenkamp's Witness Statement, Bundle B, page 59, paragraph 12.
[5] Bundle D, page 69, paragraph 9.

BACKGROUND

[37] On 29 September 2016 the merging parties notified the large merger to the Commission. On 28 June 2017 the Commission recommended to the Tribunal that the proposed transaction should be prohibited since it raises significant competition concerns in the Commission's defined relevant market.

[38] The Commission argued that the proposed transaction will likely lead to a substantial lessening of competition in the relevant market since healthcare costs are likely to rise as a result of the proposed transaction. It also said that the incentive to improve non-price factors of competition, such as patient experience and quality of healthcare, is likely to diminish after the proposed transaction.

[39] The merging parties, on the other hand, argued that the Commission has failed to establish that the proposed merger is likely to cause a substantial prevention or lessening of competition and that the proposed merger should therefore be approved. However, they submitted that should the Tribunal find a substantial prevention or lessening of competition as a result of the proposed transaction in any market, that lessening of competition would be addressed by their tendered merger conditions.

Witnesses

[40] The Commission called the following factual witnesses:

- Ms Susanna Catarina Van Reenen ("Van Reenen"), the hospital manager of Mooimed Private Hospital ("Mooimed"), a multi-disciplinary hospital located in Potchefstroom;
- Ms Elizabeth Stephanie (Elsabé) Conradie ("Conradie"), the recently appointed CEO of the NHN. We note that Conradie did not complete her cross-examination due to personal reasons and the merging parties submitted a note on points that they dispute in Conradie's witness statement;
- Dr Vuyo Gqola ("Gqola"), the Chief Healthcare Management Officer at the Government Employees Medical Scheme ("GEMS"); and

- Mr Kenneth Clive Marion ("Marion"), the COO of Bonitas Medical Fund ("Bonitas").

[41] The Commission submitted an actuarial expert report by Alexander Forbes Health Proprietary Limited ("Alexander Forbes") and called Mr Zaid Saeed ("Saeed") as actuarial expert witness. The Commission further called Dr Liberty Mncube ("Mncube"), the Commission's Chief Economist, as economics expert.

[42] We note that the merging parties in argument raised the criticism that Saeed is only a student actuary.[6] This was however an unfair criticism because it was not raised with him in cross-examination, which is necessary if the expertise of the witness is to be challenged. We further note that Saeed was not the only person at Alexander Forbes who did the actuarial analysis and compiled the various reports. From the filed expert reports it is clear that they were produced by co-authors.

[43] The merging parties called the following factual witnesses:

- Mr Roland Theodore Buys ("Buys"), the recently retired head of Fund Relations at Mediclinic;
- Mr Hendrik Steenkamp ("Steenkamp"), a director of MMHS. He is also a trustee of the trust which owns and operates Wilmed and Sunningdale and is the general manager of Wilmed;
- Mr Blake van Aswegen ("Van Aswegen"), the hospital manager at Mediclinic Potchefstroom; and
- Dr Marthinus Stephanus Smuts ("Smuts"), the Chief Clinical Officer for Mediclinic.

[44] The merging parties submitted an actuarial expert report by Insight Actuaries and Consultants ("Insight") and called Mr Barry Childs ("Childs") as actuarial expert, and Prof Nicola Theron ("Theron") of Econex as economics expert.

[6] Transcript, page 122.

Tendered remedies, Tribunal directives and other developments

[45] The Tribunal engaged extensively with the merging parties regarding potential remedies to address the Commission's and customers' competition concerns. The merging parties, over a period of months, made different remedy proposals under different scenarios. We explain this below.

[46] The merging parties did not propose any remedies during the Commission's investigation period or prior to the Commission's referral of the matter to the Tribunal. We mention this to point out that no potential remedies were tested with customers, i.e. medical schemes, during the Commission's investigation period. Various medical schemes did however prior to referral make submissions to the Commission on the likely effects of the proposed transaction on competition and we shall refer to those submissions in these reasons.

[47] Prior to the commencement of the hearing, the Tribunal on 22 May 2018 directed that if the merging parties wanted to tender any structural or behavioural remedies, they must file that with the Tribunal by no later than 25 May 2018 in order for any potential remedies to be tested with the factual witnesses and commented on by the economics experts during the forthcoming hearing.

[48] On 28 May 2018 the merging parties submitted their first proposed behavioural remedy[7] based on the target hospitals' pre- and post merger so-called cost per event or CPE[8]. However, this remedy proposal was later, after it had been tested with the witnesses, abandoned by the merging parties themselves and replaced with a different remedy proposal. Since the merging parties replaced this remedy with another proposed remedy, we do not deal with it in any detail.

[49] The evidence of the factual witnesses on the abovementioned abandoned remedy, in summary, was that it was impractical since it would be difficult to

[7] The proposed remedy read as follows: after the implementation of the merger, and for a period of three years, if any Medical Scheme which is reimbursed on a fee for service basis is shown to have paid, in respect of the target hospitals, a CPE which exceeds the target hospitals' CPE prior to the merger by more than 1%, Mediclinic will compensate the affected Medical Scheme by the difference.
[8] CPE and how it is defined in an acute multi-disciplinary hospital context will be discussed in detail below.

implement, likely result in disputes and would place an inappropriate administrative and cost burden on certain medical schemes, specifically the smaller schemes, and the Commission to monitor and enforce it. Gqola, for example, confirmed that there are differences in the way CPE is calculated by different medical schemes and hospital groups and that hospitals may claim to see more efficiencies than what the medical schemes see.[9] Where a clear, agreed and universal formula for the calculation of CPE does not exist, monitoring by the Commission of this proposed condition would be cumbersome, if not impossible. As stated, the merging parties themselves abandoned this remedy during the proceedings.

[50] The merging parties' first remedy proposal furthermore excluded any pricing remedy in relation to uninsured patients i.e. patients that do not have medical insurance. It also excluded any proposed remedy relating to non-price competition issues *inter alia* quality of service and patient experience at the relevant hospitals. These shortcomings of the proposed remedy were made known by the Tribunal to the merging parties through questions posed to the factual witnesses.

[51] On the eve of argument set down for 26 September 2018 the merging parties submitted an entirely different remedy proposal ("the September remedy proposal").

[52] At the hearing on 26 September 2018, the Tribunal expressed dissatisfaction that the merging parties' September remedy proposal had been furnished only on the eve of the hearing. The merging parties attempted to shift the blame for this on the Commission's actuarial expert since they argued that they required a certain calculation from him. However, this calculation affected only the insured patient tariff element of the proposed remedy and not the potential concerns relating to uninsured patients and non-price issues. The merging parties could have put up a different in principle tariff remedy for insured patients much sooner, subject to the final figures of the actuarial experts. The

[9] Transcript page 526, line 15-21.

merging parties furthermore did not alert either the Tribunal or the Commission to the fact that a new remedy proposal will be forthcoming.

[53] The Commission should not hesitate to ask for the postponement of merger proceedings where merging parties put up remedies late in the day, specifically in situations such as this where the proposed behavioural remedies had not been tested in the market with a sufficient number of customers.

[54] We stress that we cannot assess whether or not proposed remedies would address the potential concerns, if they have not been thoroughly explained to and canvassed with customers.

[55] Given the abovementioned eleventh-hour development, the Tribunal had no choice but to postpone the hearing of argument and directed as follows:

(i) the medical schemes that provided comments during the Commission's investigation of the proposed transaction must be afforded an opportunity to provide comments on the merging parties' new set of proposed behavioural conditions;

(ii) the Commission should canvass the views of the market in relation to a potential alternative pricing remedy similar to that imposed by the Tribunal in *Netcare Hospital Group (Pty) Ltd, Netcare Property Holdings (Pty) Ltd and The Akeso Group*[10] ("the Netcare-type remedy");

(iii) the Commission should submit a report dealing with the above issues as well as the merging parties' proposed conditions in relation to uninsured patients; and

(iv) the Commission and the merging parties should address the Tribunal on any public interest considerations that would impact upon the proposed merger.

[56] In relation to the abovementioned Netcare-type remedy we point out that the Tribunal in that matter imposed a combination of a structural, i.e. divestiture, remedy and a behavioural, i.e. pricing remedy. In this matter there was no structural remedy proposal and only a proposed pricing remedy.

[10] Tribunal Case No.: LM17April17.

[57] Given these developments, the Tribunal further directed both parties to file supplementary heads of argument once the customers' comments on the remedies had been obtained.

[58] On 8 October 2018 the Commission sought the comments of thirteen medical schemes in respect of the merging parties' September remedy proposal. Nine schemes responded to the Commission's request. We shall refer to these comments in these reasons.

[59] The Commission submitted its remedies and public interest report as required by the Tribunal on 7 November 2018. The Commission further submitted updated heads of argument on 19 November 2018 and the merging parties on 27 November 2018.

[60] Based on the comments received from customers, the Commission submitted that the merging parties' proposed remedies were unlikely to effectively address the identified competition concerns. The merging parties disputed this and argued that their proposed conditions were adequate to address any potential harm to competition.

[61] In the Commission's updated heads it brought a new development to the attention of the Tribunal – the abovementioned grant of a conditional exemption to the NHN for *inter alia* central or collective procurement on behalf of its members. The Commission commented on the likely impact of this on the competition assessment, specifically the likely effects of the proposed transaction, i.e. the efficiency comparisons performed by the actuaries.

[62] This prompted a dispute over the relevant counterfactual absent the proposed transaction i.e. the likelihood of the target hospitals' achieving (better) procurement efficiencies absent the proposed transaction because of the exemption. The Commission argued that the current procurement efficiencies of the target hospitals will significantly increase as a result of the conditional NHN exemption as to neutralise any procurement efficiencies claimed by the merging parties as a result of the proposed transaction. The merging parties disputed this and argued that the target hospitals might achieve only some

procurement efficiencies absent the proposed transaction as a result of the conditional exemption. We note that the actuaries did not take the exemption counterfactual into account in their efficiency comparisons.

[63] On 12 December 2018 the Tribunal directed the merging parties to submit their final proposed remedies in a proper format, including monitoring provisions. On 7 January 2019 the merging parties submitted two alternative sets of final proposed remedies. We note that these remedies were different in certain respects to the abovementioned September remedy proposal that the Commission tested with customers.

[64] The two final sets of remedy proposals differed in relation to the proposed pricing remedy for the insured patients' segment of the market. They were:

(i) a remedy based on the tariff "*for all other Mediclinic hospitals*"[11] discounted by 3%[12]. We shall refer to this as the "the Mediclinic minus remedy"; and

(ii) a remedy based on a tariff that "*shall not exceed by more than 3%*" the tariff in respect of services at the target hospitals.[13] We shall refer to this as "the MMHS plus tariff remedy".

LEGAL FRAMEWORK

[65] The Competition Appeal Court ("CAC") in *Imerys*[14] set out the legal framework in merger cases, specifically those where remedies have been tendered, as follows:

"*[38] Given the Tribunal's inquisitorial powers, it may not strictly be accurate to say that the Commission bears the burden of proving likely SLC. It is nevertheless so that, if on all the evidence before the Tribunal, a likely SLC cannot be found, the Tribunal must approve the merger unless the public interest override is operative. And in that respect I do not think it matters whether the Tribunal is dealing with an intermediate or large merger (a question*

[11] Other than the target firms, post merger.
[12] See paragraph 3.1.1 of the proposed remedy.
[13] See paragraph 3.1.1 of the proposed remedy.
[14] Imerys South Africa (Pty) Ltd and another v Competition Commission [2017], CPLR 33 (CAC).

left open in Oceana Group Limited and another v Competition Commission [2014] 2 CPLR 372 (CAC) paragraphs 48-51).

[66] As explained above, the Tribunal has used its inquisitorial powers in this matter, specifically in relation to directing that potential remedies must be tested with customers.

[67] In relation to the public interest, we note that the merging parties did not contend for any positive public interest factors justifying the proposed merger. The Commission, on the other hand, contended that the proposed transaction would adversely impact the public interest given the significant competition concerns and the importance of the private health care sector in South Africa. We shall deal with this under the public interest.

[68] The CAC further said: *[39] The position is less clear-cut where the Tribunal determines that the merger is likely to cause an SLC, that there are no likely pro-competitive gains outweighing the likely SLC and that there are no overriding public interest grounds justifying the merger. In this situation there are two potential outcomes, prohibition and conditional approval. To the extent that an onus rests on the Commission to establish a likely SLC, the Commission would in such a case have discharged the onus. The Tribunal's determinations pursuant to section 12A would give it the jurisdiction to exercise its powers of prohibition and of conditional approval.*

[69] As we have noted above, the Tribunal extensively explored the possibility of potential remedies with the merging parties. This shall be dealt with further under remedies.

[70] [40] Where, in the situation just mentioned, the Tribunal is asked to approve the merger with conditions rather than prohibit it, the choice of remedies is in the nature of a discretion. I reject the proposition that the Commission bears the burden of proving that the proposed conditions will not adequately address the likely SLC. The Tribunal has the power to prohibit the merger if it is not satisfied that the conditions will adequately remedy the likely SLC. And regardless of where the onus lies in respect of proposed conditions (if it is accurate to speak

of onus at all), I do not think that the Tribunal is obliged to approve a merger just because it finds it more probable than not that the conditions will neutralise the likely SLC. One should bear in mind, in this regard, the real problem in such cases will not necessarily be competing views as to the probable future state of the market but an inability to make reliable predictions at all. I think it is permissible for the Tribunal to reason thus: "The merger will likely give rise to an SLC. Although the proposed conditions are more likely than not to remedy the likely SLC, there is a reasonable possibility that they will fail to do so. Therefore we prohibit the merger" (emphasis added).

[71] *[41] Particularly where the uncertainty about the adequacy of the conditions concerns the likely duration of the SLC rather than the nature and content of the SLC, prohibition has this advantage over conditional approval: it does not necessarily represent the final word. If the merger is conditionally approved and the conditions turn out to be inadequate to neutralise the SLC, the harm cannot be reversed. If, on the other hand, the merger is prohibited and with the passing of time it becomes clear that the merger will no longer give rise to SLC, the transaction can be renewed.*

[72] *[42] I do not say that the Tribunal would be obliged to reject conditional approval just because there was a reasonable possibility (falling short of a preponderance of probability) that the conditions would fail to remedy the likely SLC. The Tribunal might properly exercise its discretion in such a case to give conditional approval.*

[73] The CAC went on to comment on what the Tribunal might take into account in exercising its discretion whether or not to accept a remedy: *In exercising its discretion, the Tribunal could be expected to take into account, on the one hand, the precise likelihood and extent of the SLC; and, on the other, the precise extent of the risk that the conditions will fail to remedy the likely SLC. The public interest may also enter into the balancing exercise, particularly the public importance of the markets which would be directly or indirectly prejudiced if the conditions failed to remedy the likely SLC"* (emphasis added).

COMPETITION ANALYSIS

Background to the acute multi-disciplinary hospital sector

Relationship between hospitals, patients, general practitioners, specialists and medical schemes

[74] The inpatient private hospital services sector has several role players – hospitals, general practitioners, specialists, medical schemes and patients – that engage in a multifaceted relationship.

[75] The majority of end customers, i.e. patients, have medical insurance plans provided by medical schemes, but there is also a group of uninsured patients that do not have any medical insurance. The medical schemes provide funding for healthcare services and establish hospital and doctor networks by which they channel patients. We shall in these reasons discuss the likely effects of the proposed transaction on both these groups of customers.

[76] The first call for a patient is generally the general practitioner. Depending on the complexity and severity of the condition / illness at hand, the general practitioner may refer the patient to a specialist and the specialist will if necessary admit the patient to a specific hospital.[15] The hospital provides the facilities required by general practitioners / doctors and specialists in order to treat their patients.

[77] It was common cause that competition between multi-disciplinary acute hospitals occurs at more than one level; they compete for *inter alia* patient admissions,[16] the inclusion on medical scheme network arrangements, specialists[17] and in terms of quality of service. Hospitals thus also compete on non-price features to attract patients to their facilities - that is by offering better quality of care, amenities, convenience and patient satisfaction than their competitors.

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[15] Van Aswegen's Witness Statement, Bundle B, page 107, paragraph 16.
[16] For example see Van Aswegen, Transcript page 827, line 6.
[17] For example see Van Aswegen, Transcript page 827, lines 7-8.

[78] The medical schemes negotiate with hospitals to determine the reimbursement rates and the terms of services provided to health plan members. Changes in the reimbursement terms negotiated between a hospital and a medical scheme, including increases in reimbursement rates, significantly impact the medical scheme's health plan members. One of the issues that we had to assess is if and how the proposed transaction is likely to affect these (traditionally annual) negotiations between the various medical schemes and Mediclinic, specifically in relation to the schemes' low-cost options where discounts are an important feature.

[79] To become an in-network provider a hospital negotiates with a medical scheme and, if mutually agreeable terms can be reached, enters into a contract, for example, a national tariff arrangement or a DSP and/or preferred service provider ("PSP") arrangement. The financial terms (i.e. discounted tariffs) under which a hospital is reimbursed for services rendered to a medical scheme's members are a central component of those negotiations, regardless of the payment method.

[80] The acute multi-disciplinary hospital sector in South Africa is dominated by three large corporate hospital groups (i) Life; (ii) Mediclinic; and (iii) Netcare, as well as the NHN (as a collective of all the individual NHN members). There are also independent hospitals which do not fall under the NHN.

Market delineation

Relevant product market

[81] The Commission and the merging parties agreed that the relevant product market, where there is a service overlap between the merging parties' activities, is the provision of private multi-disciplinary acute inpatient hospital services.[18] Inpatient private hospital services are a cluster of services that require admission to a hospital, typically overnight or for more than 24 hours.

[18] Minutes of Economic Expert Meeting of 8 June 2018, paragraph 1.1. Econex, Bundle C, pages 386-387, paragraphs 14 and 15.

[82] The distinct inpatient hospital services generally are not substitutes for each other. Consequently one could delineate each individual inpatient hospital service as a separate relevant product market. However, doing so would be burdensome and therefore, for analytical convenience, we do not follow that approach in this case.

[83] It was common cause that outpatient services are a separate relevant product market.[19] Outpatient services are not substitutable with inpatient hospital services and are offered by a different set of competitors under different competitive conditions.[20]

[84] The economics experts further agreed that specialised hospitals which offer only one discipline, such as inpatient psychiatric services, are part of (a) separate relevant product market(s).[21] Psychiatric services are offered by a different set of competitors under different competitive conditions.[22] As indicated above, there is no need for us to analyse the Parkmed aspect of the transaction (see paragraphs 29 and 30 above) since the Commission did not raise any competition concerns relating to inpatient psychiatric services.

[85] The economics experts also agreed that traditional day hospitals or day clinics, which offer a limited set of procedures and do not compete with the bulk of services provided by a multi-disciplinary hospital, are excluded from the relevant product market under consideration.[23]

[86] Theron stated, "*We agree with the CC that day clinics cannot be said to compete with the bulk of services provided by a hospital and therefore do not form part of the relevant market. However, they do pose a competitive constraint to a subset of services offered at multi-disciplinary hospitals*".[24]

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[19] Minutes of Economic Expert Meeting of 8 June 2018, paragraph 1.2.
[20] Exhibit G, Mncube, slide 2.
[21] Minutes of Economic Expert Meeting of 8 June 2018, paragraph 1.3.
[22] Exhibit G, Mncube, slide 2.
[23] Minutes of Economic Expert Meeting of 18 May 2018, Bundle C, page 472, paragraph 1.6; also see Mncube, Transcript, page 1083.
[24] Econex, Bundle C, page 390, paragraph 31, and page 391, paragraph 37; Also see Buys, Transcript page 675.

[87] Mediclinic in the notified acquisition of shares in *Intercare* lists the differences between multi-disciplinary hospitals and day clinics as *inter alia*: (i) smaller, short-stay, less acute cases are typically treated at day clinics, day clinics offer a limited set of procedures, and patients cannot stay overnight; (ii) the tariffs charged for procedures at day clinics are perceived to have been generally lower due to cheaper cost structures, meaning that day clinics have been perceived to be able to be more affordable from a patient / scheme perspective; and (iii) there are different licensing requirements which apply to day clinics on the one hand and traditional multi-disciplinary hospitals on the other hand.[25]

[88] We concur that the providers of only day care services cannot provide the bulk of inpatient multi-disciplinary hospital services because of the licences, facilities and expertise required to provide inpatient multi-disciplinary private hospital services.

[89] The economics experts however disagreed on one aspect of the relevant product market - whether what is classified as the 'day case' services of acute multi-disciplinary hospitals should be included in or excluded from the relevant product market.[26]

[90] We note that Mediclinic and the target hospitals have different approaches to their respective definitions of day cases, which in one instance includes cases which may involve an overnight stay. This resulted in various disputes and complicated the actuaries' comparisons of the Mediclinic and target hospitals.

[91] The Commission contended that the day case services of acute multi-disciplinary hospitals must be excluded from the relevant product market. It argued that whether a patient receives inpatient services, day care services or outpatient services is a clinically driven decision i.e. it is a decision based upon medical considerations and not price.[27] The Commission further argued that it was common cause between the economics experts that outpatient services

[25] Exhibit D: Competitiveness report filed by Mediclinic in the intermediate merger with Intercare Group Hospital Holdings (Pty) Ltd, page 15, paragraph 5.3.6. Also see Buys Transcript page 671, line 11, to page 674, line 20.
[26] Minutes of Economic Expert Meeting of 18 May 2018, Bundle C, page 472, paragraphs 1.4 and 1.5; Mncube, Transcript page 1083.
[27] Mncube, Transcript, page 1083, lines 1-6.

are not substitutable for inpatient services and similarly the day care services of acute multi-disciplinary hospitals are not substitutable for inpatient multi-disciplinary services.[28]

[92] The merging parties' economics expert argued that the services that involve admission but not an overnight stay in the multi-disciplinary hospital, referred to as 'day cases', should be included in the relevant product market. The merging parties in closing argument however contended that not much turns on this dispute over the inclusion or exclusion of the day cases of acute multi-disciplinary hospitals since their assessment of the likely competitive effects of the proposed transaction does not significantly differ between the two approaches.

Assessment

[93] In support of the merging parties' contention, they argued that since all the acute multi-disciplinary hospitals (which fall within the geographic market as defined by the Commission) include day case services among their various services which they provide, and as part of the offering by which they compete for specialists, specialist admissions and inclusion in scheme networks, this should be part of the relevant product market. However, this is not the correct test for including products / services in a relevant product market, as explained by Mncube: "*a firm that has a monopoly for product X, the fact that it also produces another product Y for which it [faces] competition does not affect its monopoly for product X. In this case product Y would be the day care cases and it will also be the outpatient cases. It does not matter as well that medical schemes and hospitals negotiate a single contract that includes tariffs that are applicable for inpatient hospitals, day care cases and outpatient cases.*"[29]

[94] Furthermore, Theron accepted that outpatient services are properly excluded from the relevant product market and does not include them in her analysis, notwithstanding that post merger they will still be provided by the merged firm.[30]

[28] Transcript page 1234, lines 1-4.
[29] Transcript page 1237, lines 4-11. Exhibit G, Mncube, slide 8.
[30] Bundle C, pages 386-387, paragraphs 14 and 15.

[95] Theron also accepted that the standard approach to competition analysis is that once the relevant market is identified, one analyses the competition effects in that defined market.[31]

[96] We concur with the Commission that the day care services of the hospitals under consideration are not substitutable for inpatient multi-disciplinary services.[32] A medical scheme or uninsured patient cannot substitute an inpatient service for a day care service of an acute multi-disciplinary hospital in response to a price increase or quality reduction in inpatient services. Put differently, a hypothetical monopolist of inpatient multi-disciplinary private hospital services could profitably raise prices by a small but significant amount or degrade non-price factors without the risk of substitution to the day care services of the hospitals.

[97] The day case services must be analysed separately because the market dynamics, including constraints, differ between the day case services and the non-day services. Buys in his testimony confirmed that the day care services are offered under different competitive conditions by a different set of competitors to inpatient private hospital services.[33]

[98] Buys for example indicated, "*The reality is that there's a MediCross facility in Potchefstroom that has I think ten beds. They will be doing a huge amount of the day cases, specifically the smaller, the gastroscopies etcetera, etcetera and so if you look at another town where there's no such competition, …*".[34] Netcare MediCross situated in Potchefstroom is a medical and dental centre which offers day surgery in limited disciplines including dentistry, ophthalmology and orthopaedics. The merging parties conceded that Netcare MediCross only competes with the multi-disciplinary acute hospitals in particular disciplines which do not require an overnight stay.[35]

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[31] Transcript page 1323, lines 7-11.
[32] Mncube, Transcript page 1234, lines 1-4; page 1232, lines 3-18. Exhibit G, Mncube, slides 3 and 8.
[33] Buys, Transcript page 666, line 1, to page 679, line 7.
[34] Transcript page 678, lines 17-21.
[35] Merging parties' Heads of Argument, paragraph 54.

[99] The Commission's counsel took Buys to a Mediclinic document related to an acquisition of shares in *Intercare*,[36] which lists the various differences between the services of day clinics and acute multi-disciplinary hospital services, and we highlight the following extract from that document: "*Traditional multidisciplinary hospitals are able to provide a type of medical service, characterised by overnight care and accessibility to a centrally located variety of services that cannot be provided by day clinics due to the acuity of the patients' condition, (i.e. patients who required this level of acute care cannot take advantage of the services of a day clinic)*".[37] Buys confirmed "*there are procedures that you can do in a day clinic that you don't need to have a multidisciplinary hospital but the quid pro quo is there those procedures can also be done in a multidisciplinary hospital provided the tariff is correct*".[38] This is illustrative of asymmetric constraints among different providers of inpatient and day care hospital services.

[100] Buys further confirmed that there are separate rates for the day cases performed in the multi-disciplinary hospitals: "*... we have the separate rate, we have the significant rate that goes with the day case, the day clinic case, so the normal day rate would be X, the day clinic rate for day cases in a multidisciplinary hospital is X minus* [redacted]*%, so there's a price difference for day cases that are being done in a 57 and a 58 hospital, in a multidisciplinary hospital*".[39] These different prices are a further indication that the day cases of multi-disciplinary hospitals, from a substitution perspective, are not in the same product market as the inpatient services.

[101] Mncube gave a good summary of the factors to be considered and the asymmetric constraints that exist and must be considered. He noted, "*For example in a town like Potchefstroom there are many day case service providers in that town that include Mediclinic Potchefstroom, MooiMed and Netcare MediCross whereas if you are just looking for inpatient services in a*

[36] Exhibit D: Competitiveness report filed by Mediclinic in the intermediate merger with Intercare Group Hospital Holdings (Pty) Ltd, page 15, paragraph 5.3.6.3. Buys, Transcript page 671, line 11, to page 674, line 20.
[37] Buys, Transcript page 671, line 11, to page 674, line 20.
[38] Buys, Transcript page 674, lines 16-20.
[39] Buys, Transcript page 675, lines 1-6.

town like Potchefstroom you will only have two providers of inpatient services";[40] "*you also have day case only providers such as day clinics and these providers are readily capable of providing outpatient services and day case services*";[41] "*Whether one looks at inpatient, day case or an outpatient service it is appropriate to remember that for a patient this is a clinical decision it is determined based on medical considerations and not price or non-price considerations*";[42] "*a day clinic can offer a short stay typically for a day and you are discharged and it also has a different tariff structure that relates to day clinics. There are also different licensing requirements for a day clinic as compared to a multidisciplinary hospital*"; [43] and "*hospital providers do not view day case facilities as competitors for inpatient services but only for day care case services*".[44]

[102] There clearly are asymmetric constraints among different providers of inpatient and day care hospital services.

[103] Given all the above, we define the relevant product market as the market for the provision of private multi-disciplinary acute inpatient hospital services excluding the day case services of these hospitals.

[104] However, even if one includes the day case services provided by private multi-disciplinary acute inpatient hospitals in the relevant product market, our conclusions regarding the effects of the proposed transaction on competition do not change.

[105] We note that the above approach to market delineation is consistent with that followed in other jurisdictions. In the *Ashford St Peter's NHS Foundation Trust / Royal Surrey County NHS Foundation Trust* merger inquiry,[45] the UK CMA

[40] Transcript page 1232, lines 20-25.
[41] Transcript page 1233, lines 6-9.
[42] Transcript page 1233, lines 15-18.
[43] Transcript page 1234, lines 12-15.
[44] Transcript page 1234, lines 20-22.
[45] *Ashford St Peter's NHS Foundation Trust / Royal Surrey County NHS Foundation Trust merger inquiry*, UK CMA 2015. https://www.gov.uk/cma-cases/ashford-st-peter-s-nhs- foundation-trust-royal-surrey-county-nhs-foundation-trust#reference-decision.

distinguished between outpatient, day-case and inpatient services for the purposes of market definition and said the following:

"*5.20 In summary, consistent with the decision at phase 1, we consider there to be asymmetric constraints among different providers of inpatient, day-case and outpatient care for each specialty. We therefore consider that these treatments settings are distinct product markets.*

5.21 Providers of inpatient care generally compete with a wider set of providers, including day-case-only and outpatient-only providers, in the provision of day-case and/or outpatient care. However, this is unlikely to be the case across the full range of day-case and outpatient treatments, where day-case-only and outpatient-only providers cannot provide certain services. This may be because some day-case activity may have to take place at inpatient providers because of the equipment or capability required, and patients attend outpatient appointments at the provider at which their inpatient or day-case treatment has taken or will take place.

5.22 In our analysis, we distinguish between outpatient, day-case and inpatient services where this is possible and take into account the extent of competition that the Parties face from each other and other providers" (Emphasis added).

[106] Although one has to be cautious of adopting the market delineations of other jurisdictions in South Africa since different circumstances may exist in different countries, the merging parties did not advance any reasons why the South African market is different to that of the UK in relation to asymmetric constraints among different providers of inpatient and day case care. As indicated above, the merging parties' own factual witnesses have confirmed these asymmetric constraints.

Relevant geographic market

[107] As indicated above, Mediclinic Potchefstroom is situated in Potchefstroom in the North West province and Wilmed and Sunningdale are situated in Klerksdorp. Potchefstroom and Klerksdorp are just under 50 kilometres apart and the travelling time between Mediclinic Potchefstroom and Wilmed /

Sunningdale is approximately 41 minutes.[46] This travel distance in a rural setting was relevant to our ultimate conclusion on the relevant geographic market, as explained below.

[108] The only other multi-disciplinary acute hospital in Potchefstroom is Mooimed. As background: Mediclinic Potchefstroom has more beds and theatres than Mooimed and an emergency unit and MRI which Mooimed does not have.[47] Mooimed has 83 beds[48] and five consulting rooms of which one is for a specialist. All the other specialists in Potchefstroom in private practice are based at Mediclinic Potchefstroom.[49]

[109] The only other multi-disciplinary acute hospital in Klerksdorp is Life Anncron. Of the three hospitals in Klerksdorp (Wilmed, Sunningdale and Life Anncron) only Wilmed offers neurosurgery and oncology, whilst Life Anncron was said to soon be introducing the only Cath Lab in the Klerksdorp and surrounding areas.

[110] The Commission and merging parties' economics experts disagreed about the scope of the relevant geographic market.

[111] The Commission contended that the relevant geographic market is (no broader than) the "MaJB" area consisting of the Ditsobotla, City of Matlosana and JB Marks local municipalities. In terms of acute multi-disciplinary hospitals this area includes Mediclinic Potchefstroom and Mooimed (both situated in Potchefstroom) and Wilmed, Sunningdale and Life Anncron (all situated in Klerksdorp).[50]

[112] The Commission's MaJB candidate geographic market was constructed based on the location of the hospitals by including:

(i) only multi-disciplinary private hospitals;

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[46] Source: http://www.distancecalculator.co.za.
[47] Van Aswegen's Witness Statement, Bundle B, pages 105 and 106, paragraphs 10.1, 10.2, 10.3, 13.1 and 13.2; Transcript page 772, lines 7-9.
[48] Van Reenen, Transcript page 53, lines 12-19.
[49] Van Reenen, Transcript page 35, line 25, to page 36, line 6.
[50] Exhibit G, Mncube, slide 9.

(ii) hospitals with at least one percent share of the total number of patients in the areas from which Mediclinic Potchefstroom, Wilmed and Sunningdale attract patients; and

(iii) hospitals that overlap with (that is, draw patients from the same areas) as Mediclinic Potchefstroom, Wilmed and Sunningdale rather than those that overlap with just one.

[113] Mncube submitted that the Commission then applied the hypothetical monopolist test, which identifies where within the area of competitive overlap, the effect of the merger on competition will be direct and immediate. This is an area in which consumers can practically turn for alternative sources of the service and in which the merging parties face competition.[51]

[114] The merging parties, on the other hand, from a geographic market perspective submitted that private hospitals compete with each other on (i) a national level; and (ii) at a local level.

[115] In relation to a potential national geographic market, the merging parties submitted that tariffs for more than 95% of private patients are determined at the national level and therefore price competition takes place nationally. They further submitted that private hospitals also compete at a national level to attract specialists. They disputed that regional factors or regional dominance affects price negotiations between the medical aids and hospital groups.

[116] The merging parties submitted that the market for patient admissions is local because patients prefer to attend hospitals close to where they reside. They contended for a very narrow local geographic market such that each of Potchefstroom and Klerksdorp constitutes separate relevant geographic markets i.e. the acute multi-disciplinary hospitals situated in Potchefstroom do not at all compete with those situated in Klerksdorp.[52] They also contended that the relevant geographic market in respect of non-price competition is the local market in only Klerksdorp or only Potchefstroom.

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[51] Exhibit G, Mncube, slide 9.

[52] Bundle C, *inter alia* page 407, paragraph 76.

[117] The one argument advanced by the merging parties for their very narrow take on the scope of the local geographic market is current limited patient flows between Potchefstroom and Klerksdorp.[53] Relying on pre-merger admissions data, the merging parties submitted that a relatively low number of patients of Mediclinic Potchefstroom currently specifically come from Klerksdorp itself; the same applies to Wilmed and Sunningdale in that pre-merger a relatively low number of patients from Potchefstroom itself visit these two hospitals in Klerksdorp.[54] The merging parties argued that there is no expectation for Mediclinic Potchefstroom to compete for patients in Klerksdorp and vice versa in the case of Wilmed and Sunningdale.[55]

[118] To further substantiate their narrow local geographic market delineation, the merging parties indicated that medical schemes are required to provide reasonable access to DSPs within reasonable proximity to their beneficiaries, which is stipulated as a distance of 50 kilometres. We shall discuss this aspect in more detail below.

[119] The merging parties also argued that medical schemes currently appoint DSPs in both Potchefstroom and Klerksdorp, which makes it unlikely for there to be a competitive dynamic between hospitals in Potchefstroom and Klerksdorp.[56] However, the fact that medical schemes may currently appoint DSPs in both Potchefstroom and Klerksdorp, does not tell us anything about the relevant geographic market because medical schemes also often appoint two different hospital groups as DSPs in the same town. It would make no sense to suggest that for example Klerksdorp constitutes of two separate geographic markets given the appointment of two DSPs in the same town.

[120] The merging parties further argued that if a (broader) geographic market encompassing both Klerksdorp and Potchefstroom were to be considered, the relevant geographic market would also have to encompass the areas to the east of Klerksdorp and to the west of Potchefstroom from which the hospitals

[53] Bundle C, *inter alia* pages 406-407, paragraphs 76-77.
[54] Bundle C, *inter alia* pages 406-407, paragraphs 76-77.
[55] Bundle C, pages 409-410, paragraphs 86-89.
[56] Bundle C, page 410, paragraph 89.

in Klerksdorp and Potchefstroom, respectively, before the proposed merger, draw their patients.[57]

[121] The Commission argued that its answer to the above contention is dispositive: "*[The] argument misses the point of geographic market definition altogether. The purpose is not to identify a market capturing every competitor, but to identify a market within which a hypothetical monopolist could profitab[ly] impose a SSNIP. Thus, a properly defined geographic market often excludes some substitutes to which some customers might turn in the face of a price increase even if such substitutes provide alternatives for those customers. Under the hypothetical monopolist test there is no reason to consider additional competitors once the hypothetical monopolist test is satisfied*".[58]

Assessment

[122] The general approach to delineating geographic markets in competition analysis was common cause between the economics experts. Theron agreed conceptually that the hypothetical monopolist test is the appropriate way of identifying the relevant geographic market.[59] This she agreed must be applied considering all the available evidence, including the merging parties' strategic documents.[60]

[123] In the context of the hypothetical monopolist test we want to determine the (smallest) geographic area over which a hypothetical monopolist could impose and sustain a small but significant non-transitory increase in price (otherwise known as a SSNIP) or effect a deterioration in non-price factors. The ambit of the relevant geographic market thus depends on the distance that patients would be willing to travel in the case of a hypothetical SSNIP or a deterioration in non-price factors at say one of the target hospitals.

[124] Although medical aids are the direct customers in the case of insured patients, patient preferences are still important since medical schemes care about the

[57] Econex, Bundle C, page 407, paragraphs 77 and 78; pages 409-410, paragraphs 86-89.
[58] Bundle C, page 162, paragraph 26.
[59] Transcript page 1316, line 6, to page 1319, line 4.
[60] Transcript page 1316, line 6, to page 1319, line 4.

demand for their products, which is determined by employers' preferences and the preferences of their employees. As we shall indicate below, the medical aids were especially concerned in this case about the significant tariff differences between Mediclinic and the target hospitals. Tariffs are extremely important to the medical aids since it affects their costs.

[125] Historic patient flow analysis, unfortunately, does not answer the above question - it suffers from the significant defect that it is only backward looking and therefore is not a reliable and appropriate method for defining geographic markets in hospital mergers.[61] It does not capture the willingness of patients to travel in the event of a hypothetical SSNIP or a service quality deterioration at a specific hospital.

[126] Theron conceded the abovementioned weakness of historic patient flow analysis.[62]

[127] Professor Elzinga (who co-developed the Elzinga-Hogarty test) has explicitly acknowledged that in hospital cases the test is inconsistent with the merger guidelines' hypothetical monopolist test.[63] As indicated above, the hypothetical monopolist test asks what customers would regard as an alternative hospital, if any, in the case of a SSNIP or a quality deterioration at a specific hospital. Given that historic patient flow analysis is an unreliable method of defining geographic markets in hospital mergers, we give little weight to this analysis.

[128] Rather, in determining the scope of the relevant geographic market we have given weight to what the merging parties' own strategic documents reveal about the parameters of the geographic area in which they compete and who their competitors are in that "catchment" area.

[129] The first strategic document that shed light on this issue is a motivation by Van Aswegen in February 2015 that sought approval from the Mediclinic

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[61] Bundle C, pages 159-161, paragraphs 13, 14, 17 and 20; Econex Report dated 30 April 2018, page 395, paragraphs 44-45.
[62] Transcript page 1316, line 6, to page 1317, line 2.
[63] See Kenneth G Elzinga and Anthony W Swisher, "*Limits of the Elzinga-Hogarty test in Hospital Mergers: The Evanston Case*" 18 Antitrust Bulletin 45 (2011).

International Board for an expansion of beds and theatres at Mediclinic Potchefstroom. This document, which was confirmed by Van Aswegen during his evidence, states "*Due to the shortage of beds, doctors practicing from consulting rooms at Mediclinic Potchefstroom frequently admit their patients to other hospitals in the city or refer patients to Klerksdorp, 50 kilometres away*"[64] (emphasis added). The document describes the planned expansion as of strategic importance "*to retain patient volumes, specialist support, as well as to have a competitive advantage over other competitors in the catchment area*" (emphasis added). Under the heading "*Competition*" the document lists the "*competitor hospitals*" in "*the broader catchment area*" as the following hospitals:

(i) Mooimed (Potchefstroom);

(ii) Wilmed Park (Klerksdorp);

(iii) Life Anncron (Klerksdorp);

(iv) Sunningdale (Klerksdorp);

(v) Fochville Private Hospital[65] (Fochville);

(vi) Duff Scot Hospital (Stilfontein), but indicated as "*bankrupt*"[66] (also see paragraph 213 below);

(vii) The mine hospital – Lesley Williams; and

(viii) MediCross Day Hospital.

[130] Duff Scot Hospital in Stilfontein is bankrupt. In relation to the "mine" hospital Lesley Williams, Van Aswegen conceded that MMHS did not compete with it for admissions.[67] As indicated above, MediCross provides day care and not acute multi-disciplinary care (see paragraph 98).[68] As conceded by the merging parties MediCross competes only with the day care cases of the acute multi-disciplinary hospitals. Fochville Hospital (Pty) Ltd ("Fochville Hospital")

[64] Bundle D, page 660.
[65] This hospital is approximately 60 kilometres from Mediclinic Potchefstroom and more than 100 kilometres away from the target hospitals.
[66] Also see Bundle D, page 69, paragraph 10, where the bankruptcy of the 104-bed Duff Scott Hospital in Stilfontein is confirmed in the motivation for final approval of this proposed transaction.
[67] Transcript, page 882, lines 13-14.
[68] Also see Transcript page 825, line 9, to page 827, line 25. Buys tried to give a different slant to the document, but he did not author it and further said that he could not answer certain questions since he was not the hospital manager. See Transcript pages 687-693.

submitted to the Commission that it does transfer patients to Mediclinic Potchefstroom since it does not have residing specialists or an ICU. It further submitted that the proposed transaction will have no influence on it with regards to patients because the merging parties' hospitals are not near its catchment area.[69] We note that this hospital falls outside of the radius of approximately 50 kilometres that we regard as a reasonable distance for patients to travel in a rural setting as per the factual testimony discussed below.

[131] As is evident from the above, three of the competitor hospitals identified by Mediclinic itself, other than Mooimed in Potchefstroom, and listed in the 2nd, 3rd and 4th place, are all situated in Klerksdorp. Since this document was not prepared for these merger proceedings, it is a good indicator of the true competitors of Mediclinic Potchefstroom in what it itself regards as its broader catchment area.

[132] A motivation dated November 2015 to the Mediclinic International Investment Sub-committee for final approval of the proposed acquisition of MMHS describes the catchment area of the target hospitals as "*amongst others, "Hartbeesfontein, Orkney and Stilfontein, all being part of the larger Klerksdorp district as well as Ottosdal, Wolmaranstad, Bothaville, Lichtenburg, Potchefstroom, Mafikeng and Viljoenskroon*"[70] (emphasis added).

[133] The same document identifies the "*competitor hospitals*" of the target hospitals in the "*broader catchment area*" as just three hospitals:

(i) Life Anncron Clinic (in Klerksdorp; stated as 3 kms away from Wilmed Park);

(ii) Mediclinic Potchefstroom (stated as 50 kms away from Wilmed in Potchefstroom); and

(iii) Vryburg Private hospital – indicated as having 44 beds and 221 kms from Wilmed.[71]

[69] Email from Fochville Hospital to the Commission dated 7 December 2016; Bundle AC, page 170.

[70] Bundle D, page 68, paragraph 8. Transcript page 958, line 1, to page 959, line 6.

[71] Bundle D, page 68, paragraph 10.

[134] From the above it is clear that the merging parties themselves regard Mediclinic Potchefstroom as a competitor in the target hospitals' broader catchment area. We note that Vryburg (more than 200 kilometres away) is so far outside of the parameters of the distance that customers would be willing to travel in the case of a SSNIP or quality deterioration - which we regard as approximately 50 kilometres in a rural setting - that we do not consider Vryburg as a potential competitor.

[135] The same document under risks states: "[redacted]".[72]

[136] The above document also gives us Mediclinic's view of how it sees Klerksdorp. It describes Klerksdorp as "*expanding and developing*" and "*positioned as a notable medical, retail and educational centre for North West Province and Northern Free State*".[73] Under the heading "*Bed requirement*" the document states that there are an estimated 223 000 medical aid beneficiaries in the catchment area which extrapolates to a total bed need of 905 and a shortfall of 188 private beds.[74]

[137] Steenkamp at the hearing tried to distance himself from the above and testified that Wilmed does not regard Mediclinic Potchefstroom as a competitor "*at all*".[75] However, we have given weight to the merging parties' own strategic documents which we regard as the most reliable source since they were prepared based on the commercial realities at the time and not for purposes of the merger proceedings.

[138] In summary, the merging parties' contention that there is no competitive dynamic between the acute multi-disciplinary hospitals located in Klerksdorp and Potchefstroom is contradicted by their own strategic documents.

[139] It is recognised that patients strongly prefer to receive inpatient hospital services as close as possible to their homes and families since both the patient

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[72] Bundle D, page 116.
[73] Bundle D, page 68, paragraph 7.
[74] Bundle D, page 68, paragraph 8.
[75] Transcript page 957, line 25.

and his / her family members must travel to the hospital. Buys said that from a patient and willingness to travel perspective "*the market is not just a question of beds it's also a question of the dynamics of travel, the ability to get there quickly etc.*"[76] We have already indicated that Potchefstroom and Klerksdorp are just under 50 kilometres apart with a travel time of approximately 41 minutes between them.

[140] The question then is how far patients and their families will be willing to travel in the case of a SSNIP or quality deterioration at for example one of the target hospitals. We specifically considered what medical aids said in relation to this, as well as certain regulations that are applicable in relation to travel distances.

[141] GEMS submitted that in a more rural setting such as the North West province, travelling up to 50 kilometres to access healthcare is not untoward and as such the degree of competition should not be underestimated.[77] Gqola testified that a 50 kilometre radius is not an unreasonable distance for patients to travel in a rural area, "*if you look at a rural setting, it's very common for patients, or members, to move from one hospital to another. So, for example, a 50 kilometre radius, isn't an unreasonable distance to travel in a rural area, as opposed to an urban area where there's a lot more hospitals. This is a region with very few hospitals in that region.*"[78]

[142] Steenkamp conceded that patients who live within a 50 kilometre radius between Klerksdorp and Potchefstroom could go to hospitals in either Klerksdorp or Potchefstroom.[79]

[143] We further considered the Council for Medical Schemes' ("CMS") so-called unreasonable distance rule for purposes of DSPs. Medical schemes are mandated by the Medical Schemes Act, No. 131 of 1998, to provide access to DSPs within "reasonable proximity" to their beneficiaries. Medical aids must pay in full (i.e. no co-payment or deductible may be levied) if beneficiaries obtain

[76] Transcript page 558, lines 12-13.
[77] GEMS' submission to the Commission dated 24 November 2016, Bundle AD, pages 94-95, paragraph 3.
[78] Transcript page 523, lines 1-6.
[79] Transcript page 1013, line 22, to page 1014, line 8.

prescribed minimum benefits ("PMBs") from non-DSPs involuntarily.[80] A beneficiary obtains the service involuntarily if no DSP is located within reasonable proximity to his / her place of personal residence or ordinary place of business.[81]

[144] Buys confirmed that a rule within the Medical Schemes Act says that you need to be in reasonable distance of a hospital and that is given as 50 kilometres.[82] He elaborated, "*when an option is put together and you reduce the number of hospitals that a member has access to you have to keep in mind that there are certain basic requirements that are required in terms of the Medical Schemes Act. The first one is that there must be a reasonable distance to the facility and it's normally considered to be 50 kilometres*"[83] (emphasis added).

[145] Gqola explained how GEMS would apply this rule in practice, "*the concept of a geographic filler is if you get a region where there is no network hospital within reasonable distance, and by reasonable distance we use 50 kilometre radius, then we use a filler hospital from a group that is outside of the network. And members then would not be penalised. However, if there is no hospital at all within a 50 kilometre radius, then members would essentially utilise any hospital, regardless of, well, that would be a non-network hospital, and that would be involuntary use of a non-network hospital. So, those members would not be penalised, as opposed to members who voluntarily use a non-network hospital when there is a network hospital within a reasonable distance, then those members would be penalised, or we would incur a R10 000.00 co-pay upon admission*"[84] (emphasis added).

[146] We conclude that in a rural setting such as the areas of Potchefstroom and Klerksdorp, a distance of just under 50 kilometres will be a reasonable distance for patients to travel in the event of a SSNIP or quality deterioration at say the target hospitals.

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[80] Regulation 8, sub-regulation (2)(b).
[81] Regulation 8, sub-regulation (3)(c).
[82] Transcript page 558, lines 5-7.
[83] Transcript page 579, lines 1-6.
[84] Transcript page 516, lines 5-23.

[147] We further had regard to whether or not the medical schemes that provided comments anticipated adverse competition effects from the proposed transaction. As we shall discuss in more detail below, several medical schemes voiced their concerns about the effects of the proposed transaction on competition. If Mediclinic Potchefstroom and the two target hospitals indeed were spacial monopolies as contended for by the merging parties, i.e. each operating in their own narrow geographic market for patient admissions, then the medical aids would hardly have raised these competition concerns.

[148] Based on the merging parties' own strategic documents and what they reveal about the catchment area of the relevant hospitals and their competitors, what the medical aids and CMS regard as a reasonable distance to travel between hospitals in a rural setting, the fact that Potchefstoom and Klerksdorp are just under 50 kilometres apart, as well as the views of customers that likely anticompetitive effects will result from the proposed transaction, we concur with the Commission's approach to defining the relevant geographic market as (no broader than) the "MaJB" area.

[149] We shall below discuss how regional dynamics affect network discounts.

Theory of competitive harm

[150] Before we discuss market concentration, potential entry, price effects, non-price competition and other issues we first summarise the Commission's theory of harm and the merging parties' response thereto.

[151] The Commission submitted that the current competition between Mediclinic Potchefstroom and the target hospitals results in lower prices and improved non-price factors such as higher quality and better patient experience. It said that the elimination of this competition will post merger likely lead to an increase in prices. Faced with higher prices and other less favourable terms, medical schemes will be forced to pass on the higher health care costs to the employers and their employees in the form of increased premiums, co-payments and other out of pocket expenses.

[152] The Commission further contended that the proposed merger would increase the merging parties' bargaining leverage in respect of network discounts as a result of the regional dominance that their combined acute multi-disciplinary hospitals will enjoy in the MaJB area. The Commission submitted that this increased bargaining leverage will also lead to higher health care costs. The Commission further argued that at present Mediclinic Potchefstroom and the target hospitals compete for the inclusion in medical schemes' hospital networks, but post merger it would be difficult for medical schemes to market a health plan to employers with employees that live and/or work in the MaJB area, or to construct their networks in the MaJB area, without the merging parties' hospitals.

[153] The Commission further contended that the merged hospitals will have a diminished incentive to improve its non-price factors such as quality of care or patient experience. It said that when considering non-price factors the proposed merger makes medical schemes' and patients' outside options much less attractive, giving the merged firm the ability to deteriorate non-price factors in the MaJB area.[85]

[154] The merging parties argued that the proposed transaction will not in any way affect the tariffs for the so-called "richer" medical scheme options given the national tariff negotiations between medical schemes and hospital groups. They said that on the richer medical scheme options the medical schemes prefer to offer their members a greater choice and include all the hospitals of the groups.

[155] The merging parties further contended that Mediclinic's post merger market share (in a geographic area encompassing Klerksdorp and Potchefstroom) will not influence a medical scheme's determination of national anchor groups for its networks, including its low-cost options, and the only instance in which local issues will have relevance is the appointment of "filler" hospitals in particular areas.

[85] Exhibit G, Mncube, slide 27.

[156] The merging parties submitted that even if some effects were identifiable, the demographics in Klerksdorp and Potchefstroom render it highly unlikely that any effects could amount to a substantial prevention or lessening of competition. They argued that in the North West province the percentage of members of medical schemes is very small since the North West has only about 3.5% of the acute beds in South Africa. They averred that in negotiating discounts these very small numbers could hardly be said to be material in any decision made by a medical scheme or a hospital group.

[157] In relation to the low-cost options, the merging parties argued that the proposed transaction will affect a very small percentage of insured patients nationally and a significantly smaller number of insured patients in the North West province. They used the example of Bonitas having about 700 000 insured lives, of which approximately 50 000 are on the *BonCap* low-cost option and approximately 3.5% of the 50 000 BonCap members live in the North West.[86]

[158] Mncube's response to the aforementioned BonCap example was that one cannot isolate one medical scheme and look at those effects in isolation. He said "*It all depends on what's happening everywhere else. It's not just about one scheme*"[87] and "*... capacity related to number of beds, but it's beyond one scheme option. It's about the patients and their options. There's also capacity in relation to services and that will play itself differently. You've taken me to estimates that Mr Marion has given, but I think it's a small, it's not the full picture ...*".[88]

[159] We agree with the Commission that one cannot reach conclusions based on isolated examples. One must consider the likely effects of the proposed transaction on balance on all customers including the insured and uninsured and further consider both price competition and non-price factors, i.e. clinical quality and patient satisfaction / experience.

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[86] Marion, Transcript page 376, line 6, to page 377, line 11.
[87] Transcript page 1383, lines 12-13.
[88] Transcript page 1383, line 22, to page 1384, line 3.

[160] Furthermore, we note that the robust, common cause evidence during these proceedings were that:

(i) there is a significant difference between the tariffs of Mediclinic and the target firms, with the target firms having significantly lower tariffs;

(ii) the target firms provide significantly better discounts to uninsured patients than Mediclinic and on more tariff items; and

(iii) the majority of medical aids were concerned about the effects of the proposed transaction on competition, specifically on tariffs.

Effects of the proposed transaction on tariffs

[161] We shall first consider the effects of the proposed transaction on tariffs paid by insured patients and thereafter the effects on discounts provided to uninsured patients.

Tariff effects on insured patients

[162] It was common cause that for a medical scheme or patient tariffs are the major cost item of the overall hospital bill.

[163] Tariffs are however not a complete reflection of the customer's overall hospital costs. The overall costs are referred to in the industry as cost per event or CPE, which encompasses a number of components of the overall hospital bill - tariffs, ethicals and surgicals. CPE is made up of:

(i) the cost of theatre time;[89]

(ii) the cost of ward accommodation;[90]

(iii) the cost of ethical items;[91]

(iv) and the cost of surgical items.[92]

[164] Van Reenen explained that the tariff pertaining to CPE is tariffs on theatre time and ward fees. CPE further considers various cost categories, including surgicals, ethicals and prosthesis.[93] Marion said that the overall hospital costs

[89] Tariff multiplied by minutes.
[90] Tariff multiplied by days.
[91] Price multiplied by volume.
[92] Price multiplied by volume.
[93] Transcript page 47, lines 10-25.

include "*accommodation, it's the length of stay, it's the price, it's the theatre time, surgicals, ethicals, prosthesis*".[94]

[165] It was common cause between the experts that the proposed transaction will result in a post merger increase in tariffs at the target hospitals. The actuaries agreed that there will be an automatic increase in tariffs at the target hospitals when their tariff files change from the current NHN tariff files to the Mediclinic tariff files,[95] and that the approximate increase will be [redacted]%.[96] Ward and theatre tariffs are the largest portion of the overall hospital bill for a customer. Childs calculated the tariff portion for the target hospitals as approximately [redacted]% of the overall bill.[97]

[166] Childs' abovementioned [redacted]% figure, which we accept as the minimum effect on tariffs, is based on a tariff price comparison across Mediclinic and NHN based on the NHN tariff basket and includes the tariff costs of 16 individual medical aids.[98]

[167] Thus, in pure price terms, the Mediclinic tariffs are [redacted]% higher than the target hospitals' tariffs, and since tariffs account for [redacted]% of the overall hospital bill, its overall impact on CPE is approximately [redacted]%. The Commission did not dispute this figure.

[168] The significant average tariff differential between Mediclinic and the target hospitals of [redacted]% is consistent with the views on tariffs expressed by the medical schemes in their submissions to the Commission. Although each medical aid would be affected differently and some more than others, all medical aids anticipated negative post merger effects on the tariffs of the target hospitals, as summarised below:

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[94] Transcript page 410, line 27, to page 411, line 2.

[95] Insight, 3 October 2017, page 294, paragraph 1.3; Alexander Forbes, 4 April 2018, page 52.

[96] This is based upon the finding by Childs that Mediclinic's tariffs are on average [redacted]% higher than NHN's tariffs using the basket of tariffs on NHN facilities (*inter alia* Insight's Report of 3 October 2017, page 294, paragraph 1.3).

[97] Exhibit I, Childs, slide 7; Transcript, page 1111, lines 2-4.

[98] See various Insight Reports, *inter alia* the report of 31 August 2016, Bundle C, pages 184-185.

- Barloworld stated that on average the MMHS tariffs are 17% lower than the Mediclinic tariffs for acute hospitals for Barloworld.[99]
- Omsmaf submitted that that on average the MMHS tariffs are 6.5% lower than the Mediclinic tariffs for acute hospitals for Omsmaf.[100]
- Bankmed confirmed that currently NHN provides better tariff deals than Mediclinic. However, since Bankmed has changed its administrator it expects to in future be able to negotiate better tariffs with Mediclinic.[101]
- Polmed confirmed that the MMHS tariff price is cheaper, and in a teleconference with the Commission quantified the MMHS tariff as being between 3% and 4% lower than the Mediclinic tariff.[102] It however said that MMHS's overall CPE is higher than that of Mediclinic as a result of longer lengths of stay, high utilisation of tariffs for theatre and higher surgical consumable prices.[103]
- AngloGold, a major employer in the relevant geographic area, that raised a concern specifically regarding tariffs for births, indicated that the Mediclinic fixed fees for the same birth procedures are 76% higher for natural births and 26% higher for caesarean births than the NHN fixed fees.[104]
- GEMS submitted that Mediclinic's tariffs are significantly in excess of that of the NHN, though this is partially offset by current better non-tariff procurement by Mediclinic.[105] Gqola testified that a tariff differential of 7% to 8% between Mediclinic and the NHN "*would sound about right*".[106]
- Bonitas noted that if Wilmed and Sunningdale are moved onto the Mediclinic tariff file, there will be a significant increase in tariff costs for

[99] Barloworld's submission to the Commission dated 30 March 2017, Bundle AD, page 166, paragraph 5.
[100] Omsmaf's submission to the Commission dated 13 April 2017, Bundle AD, page 190, paragraph 5.
[101] Bankmed's submission to the Commission dated 21 April 2017, Bundle AD, page 211, paragraph 5.
[102] Teleconference between the Commission and Polmed of 17 November 2016, Bundle AD, page 15, paragraph 1.
[103] Polmed's submission to the Commission dated 14 November 2016, Bundle AD, page 8, paragraph 13.
[104] AngloGold's submission to the Commission dated 18 November 2016, Bundle AD, page 78, paragraph 11.
[105] GEMS' submission to the Commission dated 24 November 2016, Bundle AD, page 97, paragraph 7.
[106] Transcript page 531, lines 1-16.

these hospitals and thereby a deterioration in these hospitals' cost efficiencies. This will have an impact on the scheme's hospital expenditure going forward.[107]

[169] Furthermore, Buys confirmed "*we've been told by Discovery, GEMS and every single other medical aid that NHN's tariffs are lower than ours*".[108]

[170] In the absence of any efficiency gains, a merger of two firms under the same ownership and management implies that their pricing decisions will be coordinated to maximize the total profit. This implies that prices will increase post merger. Given that the Mediclinic tariffs are [redacted]% higher than the target hospitals' tariffs, and since tariffs account for [redacted]% of the overall hospital bill, the proposed transaction's overall adverse impact on customers of the target hospitals will be approximately [redacted]%.

Tariff effects on uninsured patients

[171] Uninsured patients are not members of any medical scheme and pay their hospital bills directly from their own pockets. They thus are not protected by the agreements on tariffs, Alternative Reimbursement Models ("ARMs") and networks that the various medical aids have with hospitals for the insured market segment.

[172] The evidence showed that MMHS grants significantly larger discounts to uninsured patients than Mediclinic and on both sets of fees, i.e. both theatre and ward fees. Steenkamp confirmed "*we have a separate file for or a tariff file for uninsured patients*" which is not an NHN file.[109] He also confirmed that the hospital managers at the target hospitals can grant discretionary discounts of up to [redacted] percent to uninsured patients[110] and that the discount applies to [redacted][111] - as opposed to Mediclinic, which limits this to [redacted].

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[107] Bonitas' submission to the Commission dated 7 December 2016, Bundle AD, page 154, paragraph 2.16.
[108] Transcript page 695, lines 25-26.
[109] Transcript page 906, lines 16-19.
[110] Transcript page 906, lines 7-22.
[111] Transcript page 966, lines 4-18.

[173] Van Aswegen confirmed that Mediclinic gives its hospital general managers a certain discretion to provide discounts to uninsured patients. This discretionary limit is a discount of up to 4% [redacted] of the hospital bill, with the proviso that discounts over 4% are permitted, but any deviance from the 4% must be declared to the Mediclinic regional office.[112] In order to qualify for a discount at Mediclinic the uninsured patients must furthermore pay Mediclinic in full upfront.[113]

[174] Buys said that its "*exceptionally difficult to give a quote to someone [an uninsured patient] that could be materially wrong. So we tend to be over cautious with quotes …*".[114] He further said that Mediclinic therefore is "*moving to a fixed fee system. It probably will be in place within a year. But we would be happy to consider any arrangement where we take our fee structure and come up with a form of discount or some form of structure which is acceptable to both parties. It's a small part of the business.*"[115]

[175] We shall below indicate what remedy the merging parties ultimately offered in relation to uninsured patients. We note however that although Buys made this commitment to uninsured patients, the merging parties nonetheless limited the duration of the remedy offered to uninsured patients to only five years.

[176] The above significant tariff differences for uninsured patients between Mediclinic and the target hospitals are confirmed in the merging parties' own internal documents, including the due diligence report prepared for the proposed transaction. Their internal motivation for approval of the proposed transaction indicates that "*NHN tariffs are applied at all three facilities. MMHS's private tariffs are [redacted]%-[redacted]% lower than Mediclinic private tariffs. Higher tariffs may affect private patient volumes.*"[116] This is also reflected in the due diligence

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[112] Transcript page 850, line 13, to page 851, line 24.

[113] Van Aswegen's Witness Statement, Bundle B, pages 112-113, paragraphs 40.3 and 40.4; Transcript page 821, lines 13-19; Bundle D, page 886.

[114] Transcript page 663, lines 15-19.

[115] Transcript page 663, lines 19-23.

[116] Bundle D, page 82.

document regarding MMHS which records "*MMHS's Private Tariffs are* [redacted]*% lower than Mediclinic*".[117]

[177] Steenkamp could furthermore not confirm that MHHS will post merger retain this discount structure in relation to uninsured patients. He had the following exchange with the Chairperson:
"*CHAIRPERSON: I understand your rationale at present but how do you know that the new owners Mediclinic will take the same view that you have now, have they given you any undertaking in that respect?*
MR STEENKAMP: I do not know".[118]

[178] The merging parties contended that uninsured patients will benefit from the cost efficiencies which they will post merger introduce at the target hospitals, irrespective of the discounted tariff which they pay. We shall deal with the exemption counterfactual and alleged efficiencies below but note that this statement is misleading. Pre-merger Mediclinic's tariffs for uninsured patients are much higher than that of the target hospitals despite them being a much larger group than MMHS with claimed procurement efficiencies due to volume. The merging parties furthermore made no commitment in their proposed remedies of the pass-through of any alleged efficiencies to uninsured patients. Neither did they put up any evidence to show that any past potential efficiencies resulting from Mediclinic's history of acquisitions of hospitals have been passed through in full or even partially specifically to uninsured patients. We have already noted that the remedy in relation to uninsured patients was tendered only for a limited period of five years.

[179] The merging parties further submitted that a failure to offer appropriate discounts to uninsured patients would result in a loss of uninsured patient business to competitors such as Life Anncron. This argument however ignores the fact that the uninsured patients will have less choice post merger in the context of significant discounts being offered by the target firms (as borne out in the merging parties' own due diligence document). This affects their ability to

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[117] Bundle D, page 143, paragraph 2.1.3. Also see Buys, Transcript, page 698, line 22, to page 699, line 9.
[118] Transcript page 907, lines 13-16.

switch and bargain prices down. It further ignores the reaction of a competitor such as Life Anncron to reduced competition in the relevant market as a result of the proposed transaction.

[180] The merging parties also submitted that the uninsured patients make up a "miniscule" proportion of the business of the target hospitals (no more than 2% to 3% in any of the Mediclinic hospitals, 2% at Wilmed and 4% at Sunningdale) and according to Theron a very small part of the market. [119] The merging parties argued that it is unlikely that any increase in the prices which uninsured patients might pay in respect of services at the target hospitals could result in a substantial lessening of competition.

[181] We disagree with the merging parties' above contention that the effects on this group is meaningless from a substantial effects perspective.

[182] First, from the above figures it is evident that the price differences between Mediclinic Potchefstroom and the target firms are very significant in relation to uninsured patients.

[183] Second, given that this group of customers does not have a medical aid to negotiate lower hospital costs on their behalf, it is extremely important that they have sufficient choice of cheaper hospitals in the relevant geographic market as their only means to reduce their overall hospital costs. Econex stated that the uninsured patients, since they pay for the services themselves, are expected to be more sensitive to price differences.[120] Thus although this group is relatively small in comparison to the insured group as a whole, it is vital that this group has the ability through choice of cheaper hospitals to reduce their hospital costs. The target firms represent these cheaper options.

[184] Third, since the uninsured patients do not have the benefit of a medical scheme negotiating on their behalf, this group of patients from a public interest perspective is important and significant. They are the most vulnerable when one considers consumer welfare and the importance of healthcare (section 27

[119] Buys, Transcript, 663, lines 11-12; Theron, Transcript, 1096, lines 16-24.
[120] Econex, Bundle C, page 391, paragraph 37.

of the Constitution). The same applies to the insured patients on the medical schemes' low-cost options. Providing consumers (including these consumers of private health care services) with competitive prices and product choices is an explicitly stated object of the Act (section 2(b)). It is trite that legislation, including the Act, must be interpreted and applied to achieve its purposes.[121]

[185] We conclude that given that the discounts that the target hospitals offer to the uninsured patients are significantly higher than that available at Mediclinic and extend to both sets of tariffs i.e. theatre and ward fees, the proposed transaction will likely lead to lower discounts being available post-merger to the uninsured patients. Given these significant tariffs differences, the proposed merger will significantly affect the uninsured patients. The proposed transaction will limit the uninsured patients' choice of alternative cheaper hospitals and thus their ability to negotiate prices down since it will eliminate the current available significantly cheaper option in the form of the target hospitals.

Customers' views on the proposed transaction's effects

[186] We next consider what customers' views were in relation to the anticipated effects of the proposed transaction on competition. Various medical aids made submissions to the Commission. The Tribunal furthermore ordered the Commission to do a proper market investigation to test if and the extent to which the merging parties' proposed behavioural remedies may address the concerns raised by customers.

[187] The Commission called a representative of Bonitas, Marion, as a customer witness.

[188] The merging parties however did not call any customer as a witness to support their contention that the proposed merger would have no negative effects on competition. Although the merging parties initially were going to call Discovery as a factual witness, they in the end, for reasons unknown to us, did not call a representative of Discovery to testify. As we shall discuss below, Discovery appears to have changed its view regarding the effects of the proposed

[121] *Cool Ideas 1186 CC v Hubbard and another* 2014 (8) BCLR 869 (CC) paragraph 28.

transaction between its first and later submissions, which were made by two different Principle Officers of Discovery.

[189] As we have already indicated above, contrary to the merging parties' views that the proposed transaction will have no adverse effects on competition, several medical schemes raised concerns in relation to the effects of the proposed transaction. We summarise below the customer responses that the Commission received.

[190] Bonitas which currently has hospital networks for its BonCap, Standard Select and Bonfit options,[122] submitted that the proposed transaction will increase concentration, reduce competition and further strengthen Mediclinic's negotiation power.[123] Bonitas is administered by Medscheme Holdings (Pty) Ltd ("Medscheme").

[191] Barloworld Medical Scheme ("Barloworld"), also administered by Medscheme, made similar submissions.[124]

[192] Old Mutual Staff Medical Aid Fund ("Omsmaf"), also administered by Medscheme, said that it had significant concerns regarding the proposed transaction and gave the same reasons for that than Bonitas and Barloworld.[125]

[193] Bonitas also submitted that the proposed transaction will further strengthen Mediclinic's regional dominance and consequently this will strengthen Mediclinic's negotiation power. It said that the proposed transaction will also impact the ability to get hospital network discounts as typically Mediclinic does not offer hospital discounts where it has regional dominance. It submitted that in contrast, the NHN's stance on network discounts does not preclude network

[122] Bonitas' submission to the Commission of 7 December 2016, Bundle AD, page 151, paragraph 2.8.
[123] Bonitas' submission to the Commission of 7 December 2016, Bundle AD, page 155, paragraph 2.17.
[124] Barloworld's submission to the Commission dated 30 March 2017, Bundle AD, page 169, paragraph 12.
[125] Omsmaf's submission to the Commission dated 13 April 2017, Bundle AD, pages 192-93, paragraph 12.

discounts where it has regional dominance.[126] We shall discuss this in more detail below under regional dominance and network effects.

[194] The current industry practice of negotiating tariffs at a national level has also been raised as a concern. Barloworld[127] and Omsmaf submitted that Mediclinic and NHN currently are unwilling to negotiate regionally. Medscheme has raised this as a concern in its submission to the Health Inquiry and recommended that this practice be investigated.[128]

[195] The merging parties attempted to make something of the fact that Bonitas and Fedhealth in response to the Commission's market inquiry on the proposed remedies made the same comments about the proposed transaction, presumably because the same administrator, Medscheme, furnished both sets of comments. However, we have no reason to doubt that the various submissions of the medical schemes administered by Medscheme represent the medical aids' views of the effects of the proposed transaction. Medscheme is after all involved in the negotiations.

[196] AngloGold Ashanti ("AngloGold") that employs in excess of 10 000 people in the Klerksdorp area, submitted that should the discounted tariff for the category 4 to 8 employees[129] which is currently in place with the NHN, be terminated due to the proposed transaction, it will negatively affect AngloGold as it will increase the cost of providing healthcare services to these employees. Furthermore, it indicated that there are currently fixed fees for births in place at Wilmed and Sunningdale, and should this be terminated after the merger, this will have a negative effect on costs and on these employees.[130]

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[126] Bonitas' submission to the Commission dated 7 December 2016, paragraph 2.16.
[127] Barloworld provides Medscheme with a mandate to negotiate on its behalf.
[128] Barloworld's submission to the Commission dated 30 March 2017, Bundle AD, page 166, paragraph 7.
[129] AngloGold has appointed an administrator to administer the health care claims for the category 4 to 8 employees.
[130] AngloGold's submission to the Commission dated 18 November 2016, Bundle AD, page 78, paragraph 9.

[197] GEMS submitted that the immediate concern is that the proposed transaction will culminate in higher tariffs. This is because the new entity will pursue the more favourable of the two existing tariff files.[131]

[198] Bankmed submitted that its (only) concern with the proposed transaction would be its impact on the hospital network of its Basic Plan and whether Mediclinic would retain the MMHS hospitals on the network at favourable tariff rates.[132]

[199] Discovery[133] initially in November 2016, in a submission of Mr Milton Streak ("Streak"), the then Principal Officer of Discovery, submitted that the proposed transaction will not pose any "*immediate threat*" to it.[134] Streak however in the same submission suggested that the incremental increase in the market shares of the three large listed hospital groups, Mediclinic, Netcare and Life Healthcare, should be closely monitored by the Commission. In other words, the Commission should be aware of creeping mergers in the hospital sector in South Africa.[135]

[200] In a later submission of 24 October 2018, a different principal officer, Dr Nozipho Sangweni ("Sangweni"), raised concerns regarding the proposed transaction. Discovery now submitted that it is concerned about the impact of the proposed transaction on its ability to manage future utilisation of hospital services and said that the merging parties' proposed conditions do not at all cater for this concern.[136] Discovery again raised issues regarding creeping acquisitions and said that increased consolidation in the hospital market will jeopardise not only Discovery's future negotiation power, but the negotiation

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[131] GEMS' submission to the Commission dated 24 November 2016, Bundle AD, page 97, paragraph 7.
[132] Bankmed's submission to the Commission dated 21 April 2017, Bundle AD, page 211, paragraph 7.
[133] We caution that Discovery, because of its relative size in the health insurance industry, is not necessarily in the same position as the other (smaller) medical schemes when negotiating with the large hospital groups.
[134] Discovery's submission to the Commission dated 15 November 2016, Bundle AD, page 51, paragraph 15.
[135] Discovery's submission to the Commission dated 15 November 2016, Bundle AD, page 51, paragraph 15.
[136] Discovery's submission to the Commission regarding potential remedies dated 24 October 2018, paragraphs 3.2 and 4.

power of all other medical schemes in the industry, to the detriment of medical scheme members.[137]

[201] Discovery also submitted, in reaction to the Commission's market enquiry on potential remedies, that a discount level of no less than 7% would be required to limit the adverse consequences of this merger for it based on both the risk of a tariff increase and the risk of utilisation increases as well.

[202] The South African Police Service Medical Aid ("Polmed") gave a mixed response to the anticipated effects of the proposed transaction saying that the hospital market is already concentrated and that the proposed transaction may have both positive and negative effects. The negative element being that it will provide Mediclinic with stronger negotiating power for hospital pricing and may negatively impact smaller and independent groups of hospitals, but it may also have positive effects if it increases competition between the three large hospital groups.[138] In a later teleconference with the Commission Polmed suggested that the Commission should look at effects on negotiating power on price and if consumer choice will be affected.[139]

[203] Hosmed Medical Scheme ("Hosmed") submitted that it currently has no direct relationship with MMHS, and the only effect will be the differences between the Mediclinic and NHN rates.[140]

[204] Two schemes raised no concerns. Selfmed Medical Scheme ("Selfmed") submitted that it currently has no arrangements with MMHS and therefore raised no concerns.[141] Medihelp[142] submitted that it has no concerns with the proposed transaction.

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[137] Discovery's submission to the Commission regarding potential remedies dated 24 October 2018, paragraph 3.4.
[138] Polmed's submission to the Commission dated 14 November 2016, Bundle AD, page 9, paragraphs 14 to 17.
[139] Teleconference between the Commission and Polmed, 17 November 2016, Bundle AD, page 17, paragraph 12.
[140] Hosmed's submission to the Commission dated 5 December 2016, Bundle AD, pages 135 and 136, paragraphs 4 and 9.
[141] Teleconference with Commission of 28 November 2016, Bundle AD, pages 82 and 83, paragraphs 1 and 7.
[142] Medihelp's submission to the Commission, Bundle AD, page 25, paragraph 16.

Market concentration in the relevant market

[205] The market shares of Mediclinic Potchefstroom and the target hospitals in the relevant market are approximately 31% and 32% respectively.[143] The merging parties do not dispute these figures. The merging parties will therefore be the dominant player in the relevant market with a combined market share of approximately 63%.

[206] The merging parties' post merger market share furthermore dwarfs that of the next largest competitor. The two competitors' market shares will be: Mooimed, approximately 13% and Life Anncron, approximately 24%.

[207] The merging parties contended that the effect of the proposed transaction on (national) concentration is minimal since the current beds from the NHN will simply move to Mediclinic post merger.[144] However, this argument ignores the fact that the NHN hospitals (such as the hospitals owned by MMHS and Mooimed) are individually owned and managed and that they each determine their own internal policies and strategic objectives, as demonstrated by the evidence of Van Reenen as the manager of Mooimed and Steenkamp as the general manager of Wilmed. The individual NHN hospitals have different approaches to, for example, discounts to uninsured patients, use of generics, theatre time usage, managing of patient expectations and satisfaction and many other factors.

[208] We conclude that the proposed transaction significantly increases concentration in the relevant market and leads to a highly concentrated relevant market.

[209] We shall also assess below how Mediclinic's regional dominance affects negotiation dynamics, specifically Mediclinic's willingness to provide network discounts to medical schemes on the low-cost options.

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[143] Exhibit G, Mncube, slide 22. Transcript page 1085, lines 7-10.
[144] Theron, Transcript page 1088, lines 7-12.

Barriers to entry and potential new entry

[210] The economics experts agreed that barriers to entry in the acute multi-disciplinary market are high, including regulatory barriers and high construction costs for hospital facilities.[145] An acute multi-disciplinary hospital cannot enter the market without the necessary regulatory approvals, including a licence from the Department of Health,[146] which can be a very lengthy process. Entry is furthermore highly capital intensive since it involves the construction of wards, operating theatres, consulting rooms and all other ancillary and specialist facilities associated with multi-disciplinary hospitals, as well as the purchasing of equipment to perform the various medical functions.

[211] In relation to licensing, Buys suggested "*it's just our opinion that independent hospitals are really being given licenses far more easier than we have*".[147] However, this was not the experience of Mooimed, as testified by Van Reenen.

[212] Van Reenen of Mooimed explained the lengthy time that it took Mooimed to enter the multi-disciplinary hospital market and to expand its facilities. She said Mooimed "*went through several years of applications it's not about the fact you just open up a multi-disciplinary hospital you have to be licensed. We had applied for expansion several times in this 20 years and in 2010 we became a multi-disciplinary hospital and already have an additional application through to Mmabatho for additional beds. That took us nine years, lots of struggle but eventually in 2015 we've been granted additional theatre and beds to become an 83-bed multi-disciplinary hospital*".[148] She later expanded, "*It's extremely difficult to get [a] licence. Not being a group to start off with, in terms of, we call it … (indistinct) they have legal teams that can really give momentum, I would believe, to Government or the Department of Health … And once Mediclinic Potchefstroom's licence came through, and granted the 17 additional beds, we pushed for our licence to be granted too. And we used an external legal*

[145] Minutes of Economic Expert Meeting of 8 June 2018, paragraph 7.
[146] In this case the Department of Health of the North West,
[147] Buys, Transcript, page 662, lines 14-15.
[148] Van Reenen, Transcript, page 22, lines 1-10.

company to just enquire about our pending licence for nine years. And then it was granted to us".[149]

[213] The Department of Health of the North West province confirmed that in the last five years only two (potential) new entrants can be identified in the private hospital market in the North West province. However, both these facilities are currently not operating, they are (i) Duff Scott Hospital in Klerksdorp (2015) (also see paragraph 129); and (ii) Multi Care in Potchefstroom (2015), a sub-acute psychiatry facility.[150]

[214] There was no evidence suggesting that future entry or expansion by competitor hospitals in the relevant market would be likely, timely and sufficient.

[215] We conclude that entry barriers in the relevant market are high and new entry is highly unlikely.

Closeness of competition

[216] The Commission argued that Mediclinic Potchefstroom and the target hospitals are close competitors.

[217] The merging parties, on the other hand, argued that Wilmed and Sunningdale are not close competitors of Mediclinic Potchefstroom. They argued that Mediclinic Potchefstroom and the target hospitals do not constrain each other's pricing as pricing is determined nationally and that Mediclinic will not acquire any regional dominance which would enable it to exert increased bargaining leverage in respect of scheme networks. They also argued that they do not constrain one another in respect of quality or patient experience, as there is currently very limited patient flow between them.

[218] We have already dealt with these issues under the geographic market section above where we found that the merging parties' own internal documents, produced in the ordinary course of business and not for these merger proceedings, indicate that they regard each other as competitors for acute

[149] Van Reenen, Transcript, page 501, lines 3-13.
[150] Submission to the Commission dated 18 January 2017; Bundle AE, page 17, paragraph 8.

multi-disciplinary hospital services. As indicated under the market concentration section above, the merging parties will be the dominant provider of inpatient multi-disciplinary hospital services in the relevant market and will post merger dwarf the market share of the next competitor.

[219] We further concur with the Commission that merging parties need not be each other's closest competitors in order for a merger to give rise to anticompetitive effects. A merger is likely to have unilateral anticompetitive effects if the acquiring firm will have the incentive to raise prices or reduce quality after the acquisition, independently of competitive responses from other firms. We have dealt with the likely effects of the proposed transaction on tariffs above. We shall next deal with the other components of CPE i.e. ethicals and surgicals, as well as with non-price competition factors i.e. clinical quality and patient experience / satisfaction.

Other components of CPE (other than tariffs)

[220] Mncube and Theron agreed that in theory CPE is a better indicator of the overall cost differences between multi-disciplinary hospitals, i.e. one should have regard to the efficiency adjusted price.[151] However, the economics experts left the CPE calculations to the actuaries. CPE comparisons between hospitals are by no means straightforward and the results can differ significantly depending on the selection of hospital(s) that the comparisons is based on.

[221] Before we consider what factors affect overall CPE, we first give a general overview of CPE in an acute multi-disciplinary hospital context.

[222] The factual evidence showed that the CPEs of individual hospitals vary considerably. Even within Mediclinic's own stable of hospitals there is a significant degree of variance in the CPEs of the individual hospitals. Marion explained, "*we would take the entire range or list of Mediclinic facilities and perform an analysis on those and the results will be available and yes there would be inefficient as well as efficient facilities across the group*";[152] and "*the*

[151] Transcript page 1092, lines 1-3.
[152] Transcript page 343, lines 20-24.

Mediclinic hospital that sits in the 25th percentile in terms of cost efficiency is 20% more cost efficient than the hospital that sits in the 75th percentile."[153]

[223] The fact that CPE differs even within the same hospital group means that it is influenced by hospital specific conditions, including factors such as doctor behaviour and management, as further explained below.

[224] We had to consider whether or not the common cause tariff differences between Mediclinic and the target hospitals (as discussed in paragraphs 165 to 167 above) will post merger be offset or reduced by Mediclinic having lower costs for ethicals and surgicals than (each of) the target hospitals pre-merger.

[225] The proportions that ethicals and surgicals represent of the target firms' total basket of costs (i.e. all tariffs, ethicals and surgicals) were not in dispute. Childs using actual cost figures[154] calculated that ethicals make up approximately [redacted]% of the total cost at the target hospitals and surgicals make up approximately [redacted]% of the total cost.[155]

[226] To give context to the above we first consider how hospitals price ethicals and surgicals. Buys gave a good explanation of this.

[227] In relation to ethicals, Buys explained that because the price in respect of listed medicines is the Single Exit Price (SEP), which is a fixed price, cost efficiency in respect of ethicals can be achieved only by using generic equivalents or alternative cheaper products.[156] He explained "*efficiency on that side would be do we use generic equivalents or do we use other products that would be cheaper, that would be the basis that you get an efficiency on the medicine part. You really can't compete on the price part as it were*".[157]

[228] Buys quantified the pharmaceutical basket in terms of the total hospital account as follows: "*if a hospital account is 100 then the pharmaceutical basket will be*

[153] Transcript page 344, lines 1-4.
[154] He weighted each of the three elements (tariffs, surgicals and ethicals) by the actual percentages that they contribute in the MMHS hospitals to arrive at a pure price effect for each on overall CPE.
[155] Exhibit I, Childs' slide 7.
[156] Transcript page 551, line 18, to page 553, line 8.
[157] Transcript page 552, lines 14-17.

roughly 28% of that, of that about 10 or 11% will be the SEP products. So by far the biggest component, about two-thirds of the component which we classify generally as pharmaceutical is surgical products. Surgical products are a whole range of things like sutures, bandages and all sorts of other things that are used within the hospital but for which there is no standard equivalent."[158]

[229] Van Reenen explained "*There's a lot of generics, especially in ethicals. And the procurement of surgicals is really a matter of seeking the best price at the best supplier, at the best quality*".[159]

[230] The merging parties argued that cost savings will be achieved in the target hospitals post merger since Mediclinic is more efficient than the target hospitals in respect of the procurement, selection and utilisation of surgical and ethical items. They contended that this will offset the abovementioned tariff increase as a result of the proposed transaction.

[231] The Commission disputed this *inter alia* based on the exemption counterfactual, as discussed below. The Commission argued that the exemption counterfactual disposes of the entire efficiency debate since it neutralises the merging parties' cost efficiency claims.

[232] We first consider ethicals and then surgicals below.

Ethicals

[233] With regards to ethicals, it was common cause that that the differential between Mediclinic and the target hospitals would be nil because of the SEP legislation. Childs confirmed that ethicals have no impact on overall CPE because there is no pure price difference. He testified, "*ethicals are governed by a single exit pricing and so even though there's a small observable difference in the data it's very small it's less than 1% so we've left it there at zero*"[160] (also see paragraph 227 above). He went on to say "*even though the prices are the same, we would expect the ethical prices, because of the items selected, a different basket of*

[158] Transcript page 553, lines 11-18.
[159] Transcript page 506, lines 10-12.
[160] Transcript page 1110, line 24, to page 1111, line 1.

items, to go down also in the order of 30, just over 30%".[161] The merging parties on this basis argued that considering utilisation by Mediclinic, ethicals making up approximately [redacted]%[162] of the overall CPE basket of the target hospitals, would contribute approximately [redacted]% to efficiency.

[234] The target hospitals' procurement efficiencies absent the proposed transaction will be dealt with under the exemption counterfactual below.

[235] We shall also analyse the use of generics instead of original medicines under efficiencies below. In relation to utilisation we conclude there that this is not a merger-specific efficiency and that the target hospitals can, absent the proposed transaction, improve their efficiencies by improving the management of the use of generics by the doctors / specialists (see paragraphs 368 to 374 below). We conclude that the alleged post merger cost savings at the target hospitals due to the increased use of generics rather than original medicines can be replicated by the target hospitals and is not specific to the proposed merger. This therefore does not decrease or offset the tariff effects of the proposed transaction as discussed in paragraph 165 to 167 above.

Surgicals

[236] With regards to surgicals, based on pre-merger data (thus without considering the exemption counterfactual i.e. the above-mentioned conditional NHN exemption) Childs submitted that surgical consumables are [redacted]% cheaper at Mediclinic, and since surgicals contribute [redacted]% of the overall MMHS hospital account, its impact is a reduction of [redacted]% in overall costs.[163] The merging parties argued that this [redacted]% reduction due to the post merger more efficient procurement of surgicals by Mediclinic at the target hospitals will entirely offset the weighted [redacted]% tariff effect. Childs submitted "*yes tariffs will go up but as soon as Mediclinic are able to stock at their prices in those hospitals and bill at their, the prices that they procure at, there's an offset of* [redacted]% *on surgical*

[161] Transcript page 1112, lines 2-6.
[162] Transcript page 1111, lines 2-4.
[163] Childs, Transcript, page 1110, line 20, to page 1111, line 4; page 1112, lines 2-3.

consumables, which is about [redacted]*% of the bill. And so, those effects overall, on a weighted average basis, roughly even out*".[164]

[237] However, as already noted above, Childs' [redacted]% figure does not consider the exemption counterfactual absent the proposed transaction, i.e. the recent conditional exemption that the Commission has granted to the NHN to procure collectively on behalf of its members. The Commission submitted that this exemption and the procurement efficiencies that it will bring to the target hospitals, render the actuarial calculations relating to surgicals and ethicals largely irrelevant.

[238] We next discuss the exemption counterfactual i.e. the NHN exemption.

Exemption counterfactual

[239] As already indicated, the counterfactual debate was triggered by the Commission's recent conditional exemption granted to the NHN to procure collectively on behalf of its members. The relevance of this is that given that MMHS is a member of the NHN, the conditional exemption could affect Wilmed's and Sunningdale's procurement efficiencies of surgicals and ethicals absent the proposed transaction.

[240] On 2 November 2018 the Commission published its conditional approval of the NHN's exemption application to undertake *inter alia* collective or centralised procurement.[165] It is a five-year exemption from 1 November 2018 to 31 October 2023, subject to a grace period of two years and further qualifying requirements after that. In terms of the grace period granted by the Commission the individual NHN members must within a period of 24 months from the grant of the exemption qualify as either "*small businesses*" or "*firms owned or controlled by historically disadvantaged persons*" as contemplated in section 10(3)(b)(ii) of the Act or will automatically be excluded from the exemption.

[164] Transcript page 1111, lines 7-11.
[165] Notice in terms of section 10(7) of the Act, published in Government Gazette No 42010, dated 2 November 2018.

[241] The Commission argued that given the above the relevant counterfactual absent the proposed transaction is a likely significant improvement in the procurement efficiencies of Wilmed and Sunningdale and that this must be considered in the analysis. The Commission further submitted that given the relative size of the NHN compared to Mediclinic, it is appropriate to assume that the NHN will after the exemption be able to match all of Mediclinic's procurement advantages / savings.[166]

[242] The merging parties, on the other hand, contended that the recently granted NHN exemption will not give rise to guaranteed and immediate procurement efficiency savings at the target hospitals. They contended that the Tribunal must predict that the target hospitals will, absent the proposed transaction, because of the exemption only be able to achieve half (50%) of the procurement efficiencies that Mediclinic would achieve if the merger is approved.

[243] The merging parties further alleged that MMHS does not currently meet the criteria to qualify as a "*small business*" as defined in section 1 of the Act, nor is it a business "*controlled or owned by historically disadvantaged persons*" as described in section 10(3)(b)(ii) of the Act.

[244] The Commission argued in relation to MMHS potentially complying with the BEE criterion after the grace period in two year's time, that [redacted] firms were shortlisted as potential purchasers of an interest in MMHS and that the [redacted] parties other than Mediclinic may meet the exemption's BEE requirement.[167] It contended that there is therefore the likelihood of a qualifying investor / shareholder in terms of the BEE requirement. The Commission further argued that the merging parties had not responded to this argument and that it is thus unchallenged.

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[166] See Commission's Report on the Remedies and Public Interest, Box 2, page 34.
[167] Bundle D at page 242 (Internal Summary of Indicative Offers) and pages 244 and 245 (Minutes of the MMHS Board of 8 April 2015).

[245] We are not at present in a position to assess the BEE aspect, other than to say that the MMHS would, absent the proposed transaction, have an incentive to meet the qualifying criterion in terms of BEE in two years time.

[246] We likewise cannot comment at this stage on what the criteria would be to qualify as a "*small business*" in the context of the private acute multi-disciplinary hospital market. MMHS may or may not meet the qualifying criteria depending on the criteria adopted by the Commission.

[247] We therefore focus our assessment on what the likely effects of the exemption would be on the procurement efficiencies of the target hospitals absent the proposed transaction over the next two-year grace period, as provided for in the exemption.

[248] In relation to the NHN's exemption application before the Commission at the time of the hearing, Van Reenen and Conradie testified that the exemption application included a request to do central procurement and that this would allow the NHN hospitals to improve CPE efficiency above current levels.[168] Conradie explained that the NHN's exemption application includes an additional request to address the centralised procurement and/or handling of both surgicals and ethicals.[169] She said the rationale for the NHN's exemption application was to centrally procure on behalf of all of its members and that the individual NHN members currently cannot get the prices they would get through bulk buying.[170]

[249] The NHN exemption permitting collective or centralised procurement at least for the next two years, must be seen in the same light as the merging parties' averments regarding economies of scale that lead to procurement cost efficiencies. Steenkamp acknowledged that there was likely to be an effect on the costs of procured items for the target hospitals should the exemption be granted, due to the ability to leverage off larger purchase volumes. He had the following exchange with the Commission's counsel in this regard:

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[168] Transcript page 72, lines 15-22; page 226, lines 9-18.
[169] Transcript page 162, lines 1-4.
[170] Transcript page 161, line 25, to page 162, line 15; page 226, lines 9-18; and page 243, line 4, to page 244, line 15.

"*MR MAENETJE: And if that [the NHN exemption] happens, that would have an impact on price – on cost as you say, because you're a smaller group you are not able to get the efficiencies on cost due to size and volume.*
MR STEENKAMP: It should have an effect. I've said that it's common sense that volume matters".[171]

[250] Steenkamp also gave his view of the main reason for the NHN exemption application: "*it is common sense that volume matters and we cannot compete with the bigger groups or the three groups in terms of procuring at the same prices. I am certain that that is one of the reasons or the main reason why NHN is applying for the exemption on behalf of its members*".[172]

[251] Marion testified that volume or buying power has a significant impact on the procurement of ethicals and surgicals. He had the following exchange with the merging parties' counsel:
"*MR BUTLER: The other two elements, surgicals and ethicals, on the other hand, would you agree with the proposition that, certainly as far as procurement is concerned, Mediclinic with its significantly large buying power, is likely to have a significant impact on those two items?*
MR MARION: They would."[173]

[252] It was also common cause between the economics experts that centralised or collective procurement would result in a lower CPE.[174]

[253] We also note that the Commission does not lightly grant exemptions in terms of the Act and follows a process of assessment that includes allowing all stakeholders to make submissions regarding the application. After consideration of the NHN's exemption application the Commission found overall that the pro-competitive gains that would arise from the grant of the exemption would enable members of the NHN to compete more effectively

[171] Transcript page 969, lines 10-24.
[172] Transcript page 898, lines 20-25.
[173] Transcript page 392, lines 23-27.
[174] *Inter alia* Mncube, Transcript page 1287, lines 14-16; Theron, Transcript page 1282, lines 14-20, where she talks about the efficiencies that Mediclinic can achieve as a result of centralised procurement.

since it will allow the NHN to undertake collective or centralised procurement on behalf of its members.

[254] The merging parties however contended that a lack of alignment of the individual NHN members, unlike Mediclinic, will prevent them from achieving the procurement efficiencies. This argument is however undermined by the fact that in the group Mediclinic has not achieved uniform CPE despite the alleged alignment (see paragraphs 222 and 223 above). Furthermore, the NHN already has experience in collective bargaining on behalf of its members with medical schemes and thus understands the dynamics of the market(s) and already provides feedback / data to the individual members, as will be discussed below. We do not see the alleged lack of alignment as a serious obstacle to the NHN achieving volume discounts after the exemption.

[255] The merging parties further contended that the possibility of increased bargaining by the MMHS as a result of the exemption may lead to a NHN tariff increase. This however was entirely speculative and contradicts the merging parties' main stance that the MMHS will not achieve (at all or not all possible) procurement efficiencies as a result of the procurement exemption and their own contention that their alleged procurement efficiencies as a result of the proposed transaction will benefit customers.

Conclusion on the relevant counterfactual

[256] Our predictive judgement is that given the relative size of the NHN[175] compared to Mediclinic, with national pre-merger market shares of approximately 25% and 20% respectively,[176] the conditional exemption to procure collectively will, absent the proposed transaction, significantly lower the procurement costs of Wilmed and Sunningdale for the next two years. The fact of the matter is that the NHN will procure collectively as a single economic unit with the associated benefits, as agreed by the factual witnesses, of reduced procurement costs as a result of the ability to procure in bulk / large volumes.

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[175] When the individual NHN hospitals are taken as a collective.
[176] See merging parties' Heads of Argument, paragraph 167 for these national market shares based on share of beds.

[257] Given the NHN's relative size on a national scale that exceeds that of Mediclinic, there is no reason to believe that the NHN through its collective procurement would not be able to match the post merger procurement efficiencies of Mediclinic. The exemption application thus offsets or neutralises any potential post merger procurement efficiencies in favour of Mediclinic. This then leaves the weighted approximately [redacted]% overall increase in CPE due to the tariff differential between Mediclinic and the target hospitals (see paragraphs 165 to 167 above).

[258] The above conclusion on the counterfactual rendered the actuaries' overall CPE calculations largely irrelevant, but we nevertheless discuss this below.

Actuaries' CPE methodologies and results

[259] The actuarial experts, Saeed and Childs, calculated the pre-merger differences in the CPEs of Mediclinic Potchefstroom, Wilmed and Sunningdale, using different methodologies in the sense that they used different hospitals as comparators to each of or a combination of the merging parties' hospitals. They produced several iterations of their calculations, the most recent of which were contained in their reports of 4 and 8 September 2018. For convenience, a table was collated containing the ultimate figures produced by Alexander Forbes and Insight for comparison.[177] This is the report dated 21 September 2018.

[260] Alexander Forbes, on instruction from the economists for the Commission, compared the pre-merger CPE of Mediclinic Potchefstroom individually with (i) Wilmed; and (ii) Sunningdale. Alexander Forbes submitted that this was guided by the Commission's definition of the relevant geographic market and Mediclinic Potchefstroom was geographically the closest hospital to the two target hospitals.[178] Second, Mediclinic Potchefstroom represented a similar demographic profile, in that "*the patrons that would be serviced [at] Mediclinic Potchefstroom are likely to be similar, from a demographic profile point of view,*

[177] See merging parties' core bundle for argument, pages 24-26.
[178] Transcript page 1137, lines 1-6.

to those who would be patrons of Sunningdale and Wilmed".[179] Third, relevance depends on the closeness of competition. Saeed said, "*relevant in this context is really defined as a hospital that you consider a close competitor to the two target hospitals that are under consideration*".[180]

[261] Childs of Insight did his comparative CPE analyses based on seven Mediclinic hospitals[181] that he selected out of the total Mediclinic group. In other words, he compared the target hospitals not to Mediclinic Potchefstroom, but to seven selected hospitals in the group. He submitted that he selected these seven hospitals on the basis that they have similar admitting disciplines and facilities relative to the target hospitals, as well as on geographic location, i.e. he used a radius of between 35 and 250 kilometres from Johannesburg and Pretoria. The merging parties on this approach argued that Mediclinic's overall CPE is lower than the average CPE of the combined target hospitals.

[262] Each side criticised and rejected the methodology on selecting comparatives followed by the other side in doing the CPE calculations. We assess this below.

[263] Furthermore, the actuaries could not agree on how to treat the day cases of the acute multi-disciplinary hospitals in their analyses. The merging parties accused Alexander Forbes of comparing apples with oranges by stripping out the day cases using different rules, supposedly in the one instance using the rules of MMHS (for the MMHS hospitals) and in the other using the Mediclinic rule. The Commission on the other hand argued that Childs in his supplementary report of 4 September 2018 ignored the request from the Tribunal to re-calculate CPE based on a rule agreed between the economists. The Commission said that the economists agreed on six scenarios, which they alleged did not appear to be represented in Childs' analysis.

[264] From the wide variation in individual hospitals' CPEs, even within Mediclinic's

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[179] Transcript page 1137, lines 6-10.
[180] Transcript page 1136, lines 15-25.
[181] These were: Mediclinic Brits (North West province); MC Emfuleni (Gauteng); MC Ermelo (Mpumalanga); MC Highveld (Mpumalanga); MC Potchefstroom (North West province); MC Vereeniging (Gauteng); and MC Secunda (Mpumalanga).

own stable of multi-disciplinary hospitals (see paragraphs 222 and 223 above), it is evident that the comparison of the CPEs of Mediclinic, Wilmed and Sunningdale will be significantly affected by the hospital(s) that one selects to compare each of these hospitals to. In other words, the CPE outcomes of the actuaries can potentially be manipulated through the selection of comparator hospitals.

[265] The danger of the above is that one can compare the CPEs of hospitals that are not comparable, for example in terms of the relative size of the hospital. This is an important factor to keep in mind when we consider the two actuaries' selections of hospitals in their comparative CPE analysis. We note that Childs himself in his report stated that his seven selected Mediclinic hospitals as the comparator "*are among the most efficient hospitals in the broader Mediclinic stable*", but averred that the hospitals were not selected on the basis of their efficiencies. This does however raise some questions about his methodology of selecting comparator hospitals, that we shall analyse further below.[182]

[266] The merging parties recognised that the actuaries' CPE calculations depend on several factors, including:

(i) the hospitals selected for comparison; and

(ii) whether the day cases of acute hospitals are included or excluded from the analysis. The merging parties however argued that in the end nothing material turned on this.

[267] The CPE comparisons in the final analysis however also depend on another factor - what one regards as the relevant counterfactual absent the proposed transaction given the conditional exemption given by the Commission to the NHN to procure collectively, as already discussed above. We noted that the actuarial experts did not consider this in their analyses. At the stage that they did their analyses the NHN exemption was not yet decided by the Commission.

[182] Bundle C, page 205 (Insight Report of 21 November 2016).

[268] With the above in mind, we next consider the methodologies of the actuarial experts in selecting comparators.

[269] Turning to Childs' methodology of selecting comparator hospitals, he explained that including certain "super-specialist" Mediclinic hospitals such as Donald Gordon and Sandton Mediclinic in the comparative analysis, which have an atypical selection of specialists / procedures, would not make for a 'like for like' comparison in terms of representivity.[183] We agree with excluding these "super-specialist" hospitals from the analysis but this however still does not explain the exclusion of all the other Mediclinic hospitals from his comparative analysis.

[270] In response to Alexander Forbes' methodology, Childs submitted that a comparison to just one hospital (i.e. Mediclinic Potchefstroom) is unreliable since you may include idiosyncrasies of that particular hospital in the analysis and there may be inherent volatility in that one hospital over time.[184] We note that Alexander Forbes in an attempt to address this criticism considered more than one year of data to see if the results differ per year.

[271] The merging parties further criticised Alexander Forbes' analysis because it compares the larger Mediclinic Potchefstroom with the much smaller Sunningdale. This the merging parties argued is not sensible. We concur with this criticism. Discovery for example pointed out that Mediclinic Potchefstroom and Wilmed are hospitals of similar size, while Sunningdale is a much smaller hospital.[185] Childs also conceded that the target hospitals differ in size (see paragraph 274 below).

[272] The merging parties ultimately argued that we should disregard all Alexander Forbes' CPE permutations because it is not appropriate to compare either Mediclinic Potchefstroom or Childs' 'Mediclinic seven' with only one of the target hospitals.[186]

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[183] Transcript, page 1109, line 23, to page 1110, line 5.
[184] Transcript, page 1109, lines 15-22; page 1128, lines 6-11; page 1137, lines 19- 22.
[185] Discovery submission to the Commission dated 6 December 2016, Bundle AD, page 64; and its submission of 13 January 2017, Bundle AD, page 73.
[186] Transcript of 12 December 2018, page 119, lines 7-9.

[273] In relation to the size of the comparator hospitals, Saeed queried the inclusion by Childs in his CPE analysis of two smaller hospitals in the selected seven Mediclinic hospitals – MC Ermelo and MC Secunda.[187] Saeed said that Alexander Forbes did a sensitivity analyses and if you exclude these two smaller regional hospitals and Sunningdale (as a smaller hospital), the results do shift quite noticeably.[188]

[274] In response to this criticism Childs contented that the two target hospitals vary in size (Wilmed being a larger hospital than Sunningdale) and therefore he argued that it was beneficial that some smaller Mediclinic hospitals were "*caught in the net*" as it were, because that supported comparability between the two datasets.[189]

[275] However, the merging parties have to live with their own criticism that it is wrong to compare the CPEs of hospitals that significantly differ in size (see paragraph 271 above). Childs should have compared the CPE of the smaller Sunningdale with hospitals only of a similar size; lumping small and larger hospitals together in one dataset distorts the analysis and the results.

[276] The merging parties in argument, with regards to the final table comparing the actuarial results, submitted that we should only have regard to the comparison of Childs' selected seven Mediclinic hospitals to MMHS, because that compares "*greater data with greater data*".[190] This however is a misleading argument based on a flawed approach. One must, as a first principle, compare apples with apples and more data of inappropriate comparators do not cure this flawed approach.

[277] Saeed said that although more data could improve statistical stability, relevance still is the key consideration to adding data. He said, "*the more hospitals you add in the analysis, the more statistically stable your results, but that has to be … (indistinct) against the relevance of the hospital that you're adding. And our view is that adding additional hospitals, should be done with the relevance of*

[187] Transcript page 1139, lines 13-22.
[188] Transcript page 1139, lines 16-22.
[189] Transcript page 1139, line 24, to page 1140, line 3.
[190] Transcript page 1406.

that hospital in mind"[191] (emphasis added). We concur with this; adding data for the sake of having a larger data set is meaningless if one does not compare like with like. A methodology that compares apples with pears remains a flawed approach and adding more data cannot cure this.

[278] Furthermore, Childs conceded that his analysis does not account for regional differences when selecting hospitals.[192]

[279] Childs further conceded that he did not at all consider the competitive landscape when selecting hospitals for his comparative CPE analysis. He stated that "*no, we didn't consider the competitive environment*".[193]

[280] Childs' methodology of selecting comparator hospitals and his CPE results are furthermore questionable when they are compared to the medical aids' views on the relative efficiencies of Mediclinic Potchefstroom and the target hospitals since some of their views deviate significantly from Childs's ultimate conclusions.

[281] We next summarise the available information on how the medical schemes view the cost efficiencies of Mediclinic, Wilmed and Sunningdale. The Commission asked the customers to explain which of Mediclinic or MMHS they generally consider to be cheaper. What is again clear from the medical aids' responses is that the results are significantly influenced by what one regards as the appropriate "comparator" hospital(s). However, apart from Discovery's submissions, we have no detail regarding what each medical aid regarded as the appropriate comparator hospital(s) in giving their views.

[282] Bonitas submitted that both Wilmed and Sunningdale are cost efficient for direct hospital costs as well as CPE. It said that comparatively only 3 out of 13 Mediclinic hospitals in the regions identified are noted to be efficient in both hospital costs and CPE. It was of the view that "*on average, including allowances for efficiencies, the Mediclinic costs are approximately* [redacted]*% higher between the comparator group of Mediclinic hospitals and Wilmed and* [redacted]*%*

[191] Transcript page 1136, lines 19-22.
[192] Transcript page 1139, lines 6-8.
[193] Transcript page 1142, lines 1-5.

higher for Sunningdale.[194] Marion testified "*The average cost efficiency (cost efficiency takes into account both price and utilisation and is case mix adjusted) of all the Mediclinic facilities on a cost per admission basis was* [redacted]*% higher than Wilmed's cost efficiency and* [redacted]*% higher than Sunningdale's cost efficiency in 2016.*"[195]

[283] Marion further said that subsequent to (a more recently adopted) multi-year agreement (that ends at the end of 2019) Mediclinic's average cost efficiency is similar to that of Wilmed, but Mediclinic Potchefstroom is [redacted]% less cost efficient than Wilmed.[196]

[284] Gqola said that GEMS, based on its claims data (excluding outliers), compared the cost efficiency or CPE of the two target hospitals and of Mediclinic and found that the NHN hospitals were about [redacted]% more efficient than Mediclinic in 2016 and [redacted]% more efficient that Mediclinic in 2017.[197] She agreed that the NHN wins the battle on tariff (see paragraph 168 above), but Mediclinic wins the battle on efficiency.[198] GEMS further quantified what it would cost it if the efficiencies (i.e. cost per admission or CPE) of Wilmed and Sunningdale would post merger deteriorate by 0.5%. This he quantified as about R400 000.00 per annum.[199]

[285] When comparing hospitals of similar size, Discovery[200] concluded that Wilmed seems to treat patients with similar cost efficiency to Mediclinic hospitals of comparable size. It included seven Mediclinic hospitals in this comparison, i.e. Stellenbosch, Vereeniging, Medforum, Paarl, Potchefstroom, Emfuleni and Hermanus.[201] We note that this selection of comparable hospitals is different to

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[194] Bonitas' submission to the Commission of 7 December 2016, Bundle AD, page 154, paragraph 2.15.
[195] Transcript page 340, lines 17-24.
[196] Transcript page 340, line 25, to page 341, line 18.
[197] Exhibit G, Mncube, slide 32. The cost efficiency estimates provided by GEMS indicate that Mediclinic Potchefstroom is 5.8% less efficient than Wilmed and 19.7% less efficient than Sunningdale. Table 13 on page 17 of GEMS SMC Report dated 16 March 2018.
[198] Transcript, page 531, lines 21-24. Gqola's Witness statement, Bundle B, page 41, paragraph 15.
[199] Transcript page 517, line 1, to page 521, line 9.
[200] Discovery submitted that its graphs were calculated using complete datasets, proper casemix adjustments and statistically relevant truncation. See Discovery's submission to the Commission dated 13 January 2017, Bundle AD, page 72.
[201] Discovery's submission to the Commission dated 15 November 2016, Bundle AD, page 50, paragraph 13.

that used by Childs, with only Vereeniging, Potchefstroom and Emfuleni as the common comparator hospitals.

[286] Discovery further concluded that Sunningdale seems to be slightly less cost efficient than Mediclinic hospitals of comparable size. It included four Mediclinic hospitals in this comparison, i.e. Lephalale, Thabazimbi, Klein Karoo and Ermelo[202] - a totally different selection of comparable hospitals to that used by Childs, with only Ermelo as the common element.

[287] In a later submission, when specifically comparing Mediclinic Potchefstroom to the target hospitals, Discovery submitted that "*Mediclinic Potchefstroom and Wilmed are hospitals of a similar cost efficiency*", while "*Sunningdale is roughly 21% cheaper than both hospitals [Mediclinic Potchefstroom and Wilmed], in line with Mediclinic hospitals of a similar size*".[203] This efficiency it said can be attributed to the differences in size and nature of the hospitals.[204]

[288] In its last submission in October 2018, in reaction to the Commission's market enquiry on potential remedies, Discovery submitted "*a discount level of no less than 7% would be required to limit the adverse consequences of this merger for DHMS based on both the risk of a tariff increase and the risk utilisation increases as well*".[205]

[289] It is clear that Discovery's above ultimate conclusion on the anticipated effects of the proposed transaction are totally out of sync to that of Childs. Unfortunately Discovery did not testify as a witness of the merging parties since it was not called (also see paragraph 188). We note that the merging parties throughout the hearing punted Discovery as the correct measure to apply in respect of medical scheme comments on the likely effects of the merger. Their cross-examination of the Commission's witnesses bear testimony to this.

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[202] Discovery's submission to the Commission dated 15 November 2016, Bundle AD, page 50, paragraph 13.
[203] Discovery's submission to the Commission dated 13 January 2017, Bundle AD, pages 73 and 74. Also see Transcript page 1359. Exhibit G, Mncube, slide 31.
[204] Discovery's submission to the Commission dated 13 January 2017, Bundle AD, page 74.
[205] Discovery's submission to the Commission dated 24 October 2018, paragraph 7.

[290] Medihelp submitted that for some procedures Mediclinic is more cost effective and for other procedures MMHS is more cost effective.[206]

[291] Polmed submitted that MMHS's overall CPE is higher than "Mediclinic" due to longer lengths of stay, high utilisation of tariffs for theatre, high utilisation of surgical consumables with higher surgical consumable prices.[207]

[292] When it was put to Buys that the medical schemes Discovery, GEMS and Bonitas all have stated in the documents that form part of the record that Sunningdale and Wilmed are already doing better on CPE compared to Mediclinic, especially Mediclinic Potchefstroom, he replied, "*Yes that may be so.*"[208]

[293] As already noted, apart from Discovery, we do not know how the medical aids did their efficiency comparisons and specifically what hospitals they used as comparators, except where they compare each of the target hospitals specifically to Mediclinic Potchefstroom. The views of Bonitas, GEMS and Discovery however cast serious doubt on Childs' final results when he compares his selected seven Mediclinic hospitals to the two MMHS hospitals.[209]

[294] We conclude that both actuaries' methodologies of selecting comparators are open to significant criticism and cannot be relied on. Childs' CPE comparison based on his seven selected hospitals is flawed for all the reasons explained above. Saeed's comparison of Sunningdale to Mediclinic Potchefstroom is equally flawed because of the significant differences in the sizes of these hospitals. Saeed's comparison of Wilmed to Mediclinic Potchefstroom may include the idiosyncrasies of that particular hospital in the analysis.

[295] Furthermore, the actuaries' pre-merger CPE calculations are a static comparison of the current CPEs of the respective hospitals in a representative

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[206] Medihelp's submission to the Commission, Bundle AD, page 24, paragraph 13.
[207] Polmed's submission to the Commission dated 14 November 2016, Bundle AD, page 8, paragraph 13.
[208] Transcript page 725, lines 8-12.
[209] See merging parties' core bundle for argument, pages 24-26.

historical year or period based on the data provided, i.e. they are only backward looking. It is not indicative of likely post merger CPEs considering factors such as a potential increase in market / bargaining power.[210] More to the point, a proper assessment of the impact of a merger on prices requires taking into account the consequence of the merger on the reactions of competitors and ultimately on the post-merger equilibrium prices.

[296] Furthermore, as already noted, the actuaries' CPE calculations do not consider the exemption counterfactual, i.e. they do not tell us whether Wilmed or Sunningdale would have different CPEs absent the proposed transaction given the NHN's exemption to procure collectively.

[297] As noted above, the actuaries' CPE calculations are largely irrelevant given our conclusion in relation to the exemption counterfactual.

[298] For all the above reasons, we attach no weight to the actuarial experts' CPE comparisons performed for this case. The only robust evidence is the significant tariff differences between Mediclinic and the two target hospitals for insured patients, as per paragraphs 165 to 167 above, as well as the significant differences in the discounts provided to uninsured patients, as per paragraphs 172 to 176 above.

Non-price competition

[299] The Commission argued that the merging parties' regional dominance in the relevant market will likely result in a post merger deterioration of non-price factors.

[300] The merging parties argued that the proposed merger will not cause any deterioration of clinical quality or patient experience in the target hospitals. They submitted that when Mediclinic's comprehensive and globally benchmarked systems are introduced to the target hospitals, both clinical quality and patient experience are likely to improve.

[210] Alexander Forbes, 8 September 2018, Bundle C, page 479, paragraph 1.

Assessment

[301] The factual witnesses agreed that quality is an important metric of competition between hospitals and that quality is a function of *inter alia* clinical quality, outcomes and patient experience.[211] Van Aswegen said "*quality we define at Mediclinic as clinical indicators, so clinical outcomes, plus the patient experience in the hospital*".[212] Steenkamp confirmed that patients care about clinical quality and about their experience in the hospital.[213] Marion said that from a quality perspective one needs to look at "*each facility individually. It could be simply driven by provider behaviour, over-servicing, unnecessary length of stay etc. So there's a combination of factors, and you would have to look at it individually per facility*".[214]

[302] The factual witnesses however cautioned that some clinical quality benchmarks are not necessarily in the best interest of the patient. For example, we noted above that Polmed submitted that MMHS has longer lengths of stay than Mediclinic and high utilisation of tariffs for theatre (see paragraph 291 above). This is not necessarily bad from a patient perspective. Van Aswegen explained that as a hospital manger one must try to balance costs, clinical outcomes and patient experience; "*from my perspective as a hospital manager, it's important to chase cost, and I do chase cost. However, I'm not going to do it at the cost of poor clinical outcomes and a poor patient experience. So I've got to try and balance all three of these things ...*".[215] Van Reenen cautioned that certain cost cutting measures of hospitals such as reducing length of stay and theatre time are not always in the best interest of the patient. She said "*We try not to go to length of stay. The patient has the right to recover in full, and then discharged. So, that would be our least options*".[216]

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[211] Transcript, Marion, page 419, lines 11-15; page 419, line 23, to page 420, line 8; Van Aswegen, page 878, line 21, to page 879, line 16; Steenkamp, page 967, lines 8-25; Van Reenen, page 496, line 22, to page 497, line 23.
[212] Transcript page 858, lines 20-21.
[213] Transcript page 967, lines 22-25.
[214] Transcript page 420, lines 4-9.
[215] Transcript page 858, lines 22-25.
[216] Transcript page 51, lines 10-12; page 52, lines 5-7.

[303] Van Reenen further explained that quality - from a patient experience perspective - encompasses a host of factors including "*how was the reception of the hospital, how was the nursing staff, how was the cleanliness, how was the catering, how was information regarding your treatment, was it explained to you when administered with medication, what was your impression of management involvement, have you seen the Matron, all those kind of questions are extremely important to the medical aid*".[217]

[304] In relation to objective measures for quality, the factual witnesses confirmed that there is no standard measure of clinical outcomes or of patient satisfaction / experience in South Africa.[218] Both Buys and Smuts said that there are no standardised measures in South Africa for comparison on clinical quality and patient experience as between South African hospitals.[219] We shall get back to this important fact when we discuss remedies below, specifically the ability to monitor and effectively enforce potential non-price behavioural conditions given that there are no standardised measures in South Africa.

[305] Buys further said that Mediclinic "*started to publish quality reporting in the last ten or 15 years at a national level. We have not got to the place yet where we publish hospital quality indicators on, in a transparent manner in the website, but we are publishing national numbers.*"[220]

[306] Bonitas indicated that some hospital groups recently started to share quality metrics and patient experience results, but this is mostly limited to a high level, does not include any benchmarks and is user unfriendly.[221] Marion commented that Bonitas is making progress in that regard with Mediclinic, but "*We're not necessarily at the point where we want to be, but we are moving in that direction.*"[222]

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[217] Transcript page 497, lines 7-20.

[218] *Inter alia* Marion, Transcript page 302, lines 7-13; Van Reenen, page 497, lines 22-23; Van Aswegen, page 878, line 21, to page 879, line 16.

[219] Buys, Transcript, page 652, lines 1-8; Smuts, page 1032, line 20, to page 1033, line 1.

[220] Transcript page 629, lines 21-25.

[221] Bonitas' submission to the Commission of May 2017, Bundle AD, page 160, paragraph 2.4.

[222] Transcript page 420, lines 14-17.

[307] In the context of the merging parties' initial proposed remedy that simply addressed tariff issues and included no remedy for a potential deterioration in quality, Marion noted that this would be a concern.[223]

[308] Van Reenen submitted that Wilmed and Mooimed are known for their quality care.[224] She said that the fact that Wilmed offers quality care, like Mooimed, attracts doctors.[225]

[309] Van Reenen in relation to patient surveys said, "*quality care, and being rated by medical aids in terms of feedback from experience from their members, that would be a very high indication of whether your service is just average, or extraordinary*".[226]

[310] Steenkamp in relation to comparisons of patient experience said that currently only Discovery does patient experience surveys.[227] He confirmed that Wilmed has since 2015 for three years in a row been ranked in the top 20 of the Discovery patient survey.[228] Mediclinic did not dispute this.

[311] Steenkamp also confirmed that "*Wilmed Park won the PMR Africa Award for best hospital in the Northwest Province for 8 consecutive years*".[229] He said that the latter award relates to what business people think of your institution.[230]

[312] We have limited evidence on the differences between the quality of service of Mediclinic Potchefstroom and the target hospitals, but the available evidence that we do have on balance suggests that MMHS is currently performing better than Mediclinic in relation to patient experience or satisfaction. This leads us to conclude that, from a non-price competition perspective, the proposed transaction will likely lead to a deterioration in patient experience at the target hospitals if the merger is implemented.

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[223] Transcript page 420, line 14.
[224] Transcript page 36, lines 9-14.
[225] Transcript page 62, lines 9-10.
[226] Transcript page 52, lines 7-10.
[227] Transcript page 981 lines 15-18.
[228] Transcript page 984 lines 7-9; page 984 lines 20-25.
[229] Transcript page 959, lines 12-16.
[230] Transcript page 960, lines 10-11.

Role of reginal dominance in negotiations and scheme network effects

[313] We have above discussed the effect of the proposed transaction on concentration at a regional level, i.e. in the relevant geographic market, and indicated that the merging parties will post merger have a dominant position in that market.

[314] One must be extremely cautious of drawing conclusions based only on national market shares in the relevant product market since the market dynamics, specifically the negotiations between medical aids and the large hospital groups, are complex and are influenced by regional factors. As borne out by the factual testimony that will be discussed below, regional dynamics affect those negotiations - specifically in relation to discounts provided to medical schemes with regards to their low-cost options.

[315] To provide context to the above, we next provide a broad overview of how the large hospital groups are represented in various regions of the country.

[316] The geographic spread of hospital ownership between the three major corporate hospitals groups and the NHN[231] differs between regions, suggesting that there could be a regional dynamic to the product market. The regional distribution of acute hospitals across South Africa shows interesting patterns between the major groups, with certain hospital groups being totally absent in certain geographic areas and certain hospital groups having a relative advantage in specific geographic parts of our country. For example:

- Mediclinic has no hospitals in the Eastern Cape (zero acute beds of a total of 1821 acute beds), but has the largest number of hospitals in the Western Cape (17 hospitals and 2449 acute beds out of a total of 5004 acute beds);
- Netcare and Life Health are absent in the Northern Cape;
- Netcare is absent in Mpumalanga;
- Life Health is absent in Limpopo; and

[231] Collectively looking at the individual NHN members.

- The individual NHN hospitals collectively have the largest number of hospitals in KwaZulu-Natal (but Netcare has the highest number of acute beds) and in the Free State (but Mediclinic has the highest number of acute beds).[232]

[317] It was common cause that in relation to the medical schemes' low-cost options, only one or two hospital groups are appointed as a network "anchor" and other hospitals are nominated as so-called "filler" hospitals where the anchor hospital group does not have a hospital within a reasonable distance. In respect of these low-cost options, discounts are particularly important.

[318] We have rarely in the past in hospital mergers had good insight into the dynamics at play in negotiations between medical schemes and the large hospital groups and how this is affected, if at all, by regional dynamics or regional dominance. A submission by Dr Jenni Noble ("Noble"), General Manager: Strategic Advisory Unit at Medscheme, supported by discovered correspondence between Mediclinic and Medscheme / Bonitas regarding Bonitas' low cost options, and the factual testimony, provided valuable insight into this.

[319] Noble submitted that Mediclinic wields its negotiating power *inter alia* through its demographic exclusivity in several areas. She said that if an agreement is not reached, Mediclinic will typically threaten to charge members cash upfront at private rates. In an effort to minimise any access or financial impact on its members the scheme may have to back down to Mediclinic demands in these circumstances.[233]

[320] Marion of Bonitas testified that one of the important factors for a medical scheme is the quantum of the discount that hospitals offer in exchange for participation in the scheme's network. He said "*any group which has a regional or geographical dominance is also more likely to be included in the network simply because of the accessibility of facilities which the Fund needs to provide*

[232] See merging parties' core bundle for argument, pages 2 and 3.
[233] Bonitas' submission to the Commission dated 7 December 2016, paragraph 2.10.

to its membership base".[234] This he contended gave regionally dominant hospitals bargaining leverage in relation to the discounts that they will offer to medical schemes.[235] He said "*regional dominance does influence unfortunately higher tariffs*".[236]

[321] Marion gave a practical example of how in Bonitas' negotiation with the Mediclinic group, Mediclinic played off its regional dominance against the level of discounting it was prepared to give: "*that would be the Mediclinic Group, it would relate to the network which we implemented for the low cost option which is the BonCap option and in regions where there was regional, in instances rather where there was regional dominance there was no agreement reached on any reduced tariffs or discounts and we had to accept or we were – there was no room to negotiate for any discounts rather*".[237] He explained: "*In 2012 Mediclinic indicated [in] the letter dated 7 December that it would be prepared to offer discounted tariffs to the following hospitals if they were added to the BonCap network:* [redacted] *However, it further indicated that* [redacted] *the Mediclinic facilities on the BonCap Hospital network list. This included facilities in areas that Mediclinic had regional dominance such as* [redacted], *amongst* others. *In Mediclinic's response to the BonFit and Standard Select RFP for our hospital network dated 20 July 2015 it stated that the proposed discount was* [redacted] *on the network*".[238]

[234] Transcript page 307, lines 4-7.
[235] Transcript page 307, lines 3-20; pages 311 and following.
[236] Transcript page 307, lines 7-8.
[237] Transcript page 307, lines 15-20.
[238] Transcript page 308, line 1, to page 309, lines 9.

[322] We below consider, in more detail, the correspondence exchanged between Mediclinic and Medscheme / Bonitas that Marion based his evidence on:

[323] Mr Guy D'Elboux ("D'Elboux"), Manager: Funder Relations and Contracting of Mediclinic, in a letter to Noble of Medscheme dated 7 December 2012 regarding the BonCap low cost option stated: "*In reviewing the network, we note that the Mediclinic facilities that are on the network are in areas* [redacted]."[239] D'Elboux further links any potential discounts to Bonitas [redacted]. He stated "*if Bonitas expects a reduction in the tariff for BonCap, then Mediclinic would like to see* [redacted] in the letter. He also demanded "*If the* [redacted].[241] He went on to say that Mediclinic is prepared to offer a reduction of [redacted] in the letter.

[324] In later correspondence of 19 December 2012 D'Elboux stated, "*Mediclinic has indicated on more than one occasion to Medscheme and Bonitas that we are prepared to engage on the issue of low cost options on the basis that we see* [redacted]"[242] (emphasis added).

[325] Marion explained that Bonitas was requested by Mediclinic [redacted] on that particular option.[243] He further said that if all Mediclinic's demands were not met "[redacted]. *In other words there would be* [redacted]".[244]

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[239] Bundle G, page 36, paragraph 2 of the letter.
[240] Transcript page 605, lines 16-18. Bundle G, page 36, paragraph 4 of the letter.
[241] Transcript page 607, lines 6-8. Bundle G, page 36, paragraph 5 of the letter.
[242] Transcript page 609, lines 3-10. Bundle G, page 47, paragraph 2 of the letter.
[243] Transcript page 312, lines 2-8.
[244] Transcript page 314, lines 3-6.

[326] Marion further gave the example of Mediclinic's proposal in 2015 for Bonitas' Efficiency Discount Option ("EDO") where Mediclinic made its discount [redacted] as the hospital network for the EDO option.[245]

[327] Marion further testified that it would post merger be difficult to exclude Mediclinic in the Klerksdorp and Potchefstroom area in constructing low-cost networks.[246] Van Reenen held a similar view and said that it would be unlikely for Mooimed to post-merger have DSP status in the geographic area. She explained, "*DSP's normally are signed up for a three year period, and the aim is to have a one stop service. Having the post-merger [entity] on our doorstep, Mr Chairman, MooiMed Hospital would definitely not be considered a DSP at all. We cannot offer that full extent of service that would be offered by [the] post-merger [entity]*".[247]

[328] Fedhealth in response to the Commission's remedies questionnaire summarised its view on how the proposed transaction given Mediclinic's post merger dominance in the geographic area will affect networks and discounts: "*The proposed conditions do not address the issue of networks. Hospitals offer good discounts in lieu of increased volumes; in this scenario the merging parties will not gain much in additional volumes, as the only other close competitor in the area is Life Anncron Clinic in Klerksdorp and, to a minimal extent Mooimed Private Hospital. Mediclinic's stance on network discounts has historically been that they will offer minimal if any network discount for hospitals in areas where they do not stand to gain in volumes. It is therefore anticipated that this merger will result in Mediclinic offering poor network discounts, but Fedhealth would be obliged to include these hospitals on their networks for member access, which can impact member contributions.*"[248]

[245] Transcript page 316, line 4, to page 318, line 20. Bundle G, page 41, paragraph a.
[246] Transcript page 409, lines 19-24.
[247] Transcript page 44, lines 10-19.
[248] Fedhealth's submission to the Commission of 24 October 2018, paragraph 3.1.3.

[329] Buys confirmed that regional considerations are one of the features in network negotiations.[249] He furthermore confirmed that Mediclinic does not give discounts in areas [redacted].[250]

[330] Mncube, relying on the above correspondence and the factual testimony, explained the relevance of this from an effects perspective. He said that Mediclinic "*In an area where they'd have a monopoly, they do not offer a deep discount. They will put a condition that you add areas where there is competition for them to offer that discount .... They have spoken it, about discounts in relation to whether they will increase their patient numbers, which, as I understood, was code for competition. So, in areas, the only area that they were able to increase numbers, are areas where they are facing competition. So, currently they are facing a lot of competition. Post-merger, they'll face less competition.*"[251]

[331] What the above correspondence further shows is that Mediclinic has in the past attempted to leverage its dominance in one geographic region, where it does not face much competition, to require medical schemes to increase their utilisation of hospital facilities in a geographic region where it does face competition. If a medical scheme has members in both regions (the one where Mediclinic has a dominant position and the other where it faces competition) it may have to choose between forgoing a discount on the tariff in the dominant region or restricting members' choice of hospitals in the other region to achieve the discount. Thus the correspondence reveals that the attainment of a dominant position in one geographic area / market can be leveraged to restrict members' choice of hospitals in a different geographic area / market. Since in competition law restricting choice is also considered to be an anticompetitive effect, the proposed merger may potentially also have adverse effects on consumers outside of the defined relevant geographic market. The correspondence reveals that this possibility exists.

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[249] Transcript page 679, line 8, to page 681, line 4; page 682 lines 3-8.
[250] Transcript page 602, lines 13-17; page 605, lines 3-10; page 607, lines 6-10; page 609, lines 3-21; page 683, lines 4-14.
[251] Transcript page 1260, lines 16-25; Buys, Transcript pages 683-684.

[332] Post merger the merging parties will have a dominant position in the relevant market and can provide a medical scheme wanting representation in the area with a complete coverage and range of services. Given its dominance and the access that the merged entity would offer to the medical schemes, the schemes would find it difficult to exclude the merged entity when constructing networks, including DSPs. Because the medical schemes would not be able to effectively market networks in the relevant market without one of the merging parties' hospitals, Mediclinic would post merger have more bargaining leverage with the medical schemes than either firm has separately. Thus, the merged entity will acquire a bargaining power that currently does not exist in respect of low-cost networks – because it can post merger include the target hospitals in its offering and provide full coverage.

[333] Other hospitals in the area such as Mooimed and Life Anncron will be relegated to filler status. It is not an answer that the other hospital groups would be offered filler status because that is not a desirable status. This will ultimately adversely impact on the filler hospitals' competitiveness.[252] Mediclinic itself complained in a letter to Bonitas that it did not want to see Mediclinic hospitals being used to fill gaps: "*Regarding BonCap we reiterate that we are willing to participate however we wish to be part of the* [redacted]".[253]

[334] We disagree with the merging parties' aforementioned approach (see paragraph 157 above) of considering individual medical aids' low-cost options and concluding that the numbers do not suggest a substantial lessening of competition or a public interest concern. The medical aid members on the various low-cost options collectively are an important group form a public interest perspective since they are particularly vulnerable to the increasing costs of private healthcare in South Africa. If the patients on the low-cost options could no longer afford private healthcare, this would put further constrains on the public healthcare sector in South Africa.

[252] Van Reenen, Transcript, page 45, lines 9-23.

[253] Transcript page 601, line 19, to page 602, line 2.

[335] Medical aids are continuously looking at even cheaper health insurance options to attract new clients that currently do not have healthcare insurance. The willingness of hospital groups to give discounts in all geographic areas are vital in making these options a success. An example of this is Bonitas launch of the Standard Select option around 2016, with the intention "*to provide new and existing members with the same benefits as the Standard option, but at a lower premium. Also being created with the purpose of stopping potential membership loss of privately funded members due to affordability issues. It's intended that this EDO will be offered at a reduced premium …*"[254]

[336] We conclude that the proposed merger makes medical schemes' (and patients when considering non-price factors) outside options much less attractive, giving the merged firm the ability to offer lower or no discounts on DSPs (and deteriorate non-price factors) in the relevant market.

Conclusion on competition effects

[337] The robust evidence was that the proposed transaction, in relation to insured patients, will result in an increase in tariffs at the target hospitals. In pure price terms, the Mediclinic tariffs are [redacted]% higher than the target hospitals' tariffs, and since tariffs account for [redacted]% of the overall hospital bill, its overall impact on customers will be an increase of approximately [redacted]% in the total hospital bill. These significant tariff effects were also confirmed in the submissions of the medical aids.

[338] We have found that these likely post merger tariff increases at the target hospitals, which were common cause between the parties, are not offset by any post merger efficiencies related to surgicals and ethicals, specifically when the exemption counterfactual is taken into account.

[339] Furthermore, with regards to uninsured patients there are also significant differences between the tariffs of Mediclinic and the target hospitals. Moreover, MMHS grants discounts to uninsured patients on [redacted] like Mediclinic. The due diligence

[254] Transcript page 610, lines 10-20.

document regarding MMHS records "*MMHS's Private Tariffs are* [redacted]% - [redacted]% *lower than Mediclinic".* We concluded that the proposed transaction will remove the lower tariffs that are available to uninsured patients at the target hospitals. Given the significant differences in the discounts provided to uninsured patients between Mediclinic and the target hospitals this will significantly affect the uninsured patients. The proposed transaction will limit their ability to bargain and switch between hospitals since it will eliminate the current available significantly cheaper option in the form of the target hospitals.

[340] With regards to non-price factors we have concluded that the proposed transaction will likely lead to a deterioration in patient experience at the target hospitals if the merger is implemented.

[341] Furthermore, the merging parties will post merger have a dominant position in the relevant market and can provide a medical scheme wanting representation in the area with a complete coverage and range of services. Given its dominance and the access that the merged entity would offer to medical schemes, the schemes would find it difficult to exclude the merged entity when constructing networks, including DSPs. The merger makes medical schemes' (and patients when considering non-price factors) outside options much less attractive, giving the merged firm the ability to offer lower or no discounts on DSPs (and deteriorate non-price factors) in the relevant market.

[342] The discovered correspondence further showed that Mediclinic has in the past attempted to leverage its dominance in one geographic region, where it does not face much competition, to require schemes to increase their utilisation of hospital facilities in a geographic region where it does face competition. If a medical scheme has members in both regions (the one where Mediclinic has a dominant position and the other where it faces competition) it may have to choose between forgoing a discount on the tariff in the dominant region or restricting members' choice of hospitals in the other region to achieve the discount. Thus the correspondence revealed that the attainment of a dominant position in one geographic area / market can be leveraged to restrict members' choice of hospitals in a different geographic area / market. Since in competition law restricting choice is also considered to be an anticompetitive effect, the

proposed merger may potentially also have adverse effects on consumers outside of the defined relevant geographic market. The correspondence revealed that this possibility exists.

[343] Given all the above, we conclude that the proposed transaction will substantially prevent or lessen competition in the relevant market.

[344] We next consider whether there are merger-specific efficiencies that would outweigh the likely adverse effects on competition.

MERGING PARTIES' ALLEGED EFFICIENCIES

[345] The merging parties argued that cost efficiencies at the Mediclinic hospitals are driven by a range of measures and that this will be implemented at the target hospitals post merger and will ensure, at the very least, that the cost efficiency of the target hospitals will not decline post merger. They averred that the target hospitals' CPEs will not increase post merger, since the agreed tariff increase arising from the implementation of Mediclinic's higher tariff file will be offset by cost reductions as a result of improved cost efficiencies at the target hospitals.

[346] They submitted that Mediclinic's cost efficiencies in respect of surgicals and ethicals are driven by (a) an effective, centralised procurement system; (b) a ranking system to ensure cost-efficient choices of pharmacy items; and (c) measures aimed at containing the volumes of pharmacy items utilised. They argued that the target hospitals, in contrast, do not have cost efficiency measures in place that are comparable to the Mediclinic measures. They further submitted that the target hospitals do not acquire or keep the data necessary to effectively assess cost efficiencies, nor do they actively engage with specialists on these issues. They further said that the target hospitals cannot access peer-equivalent data to assess the detailed performance of individual specialists. Furthermore, due to their size and volumes, they are limited in their ability to procure pharmacy items at favourable prices.

[347] The Commission argued that the merging parties failed to provide information that would allow for the verification of the likelihood and magnitude of each

asserted efficiency claim, how and when each claim would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each efficiency would be merger specific. It said that most of the claimed efficiencies are not merger specific since they can be realised by the target firms without the merger.

[348] The Commission further submitted that it is difficult to determine on a probabilistic basis that the merging parties claimed efficiency outcomes will be achieved timeously in order to overcome the competition concerns. The reason for this the Commission said was because much of the claimed efficiencies and their timely realisation depend upon utilisation (based upon clinical decisions) and doctor behaviour, as well as management.

[349] The Commission further submitted that the relevant counterfactual, i.e. the NHN exemption, renders the debate on potential post merger procurement efficiencies irrelevant.

[350] We first deal with the merging parties' claimed procurement efficiencies.

Alleged procurement efficiencies

[351] Mediclinic submitted that all their pharmacy items are procured centrally, through the group procurement manager, and the price, volume, and quality are centrally controlled and monitored before and after purchase. This and the large volumes purchased significantly reduces Mediclinic's costs.[255] They submitted that MMHS, on the other hand, manages its own procurement of pharmaceuticals and does not enjoy the size or volumes to achieve meaningful advantages in the procurement of ethical or surgical items since its purchasing power is limited to only three hospitals, and it therefore cannot achieve the economies of scale enjoyed by the big hospital groups.[256] This they argued has a significant impact on the target hospitals' cost.[257]

[255] Buys' Witness Statement, Bundle B, page 89-90, paragraphs 62 and 63.
[256] Steenkamp's Witness Statement, Bundle B, page 66, paragraph 56.
[257] Steenkamp's Witness Statement, Bundle B, page 67, paragraph 62.

[352] The merging parties argued that a large component of the purported efficiencies that Mediclinic would bring to the table is the collective procurement of surgical items. Buys said that there is a strong likelihood that 5% savings in pharmaceutical purchasing and utilisation would be passed through immediately.[258] They argued that the post merger procurement of ethical and surgical items to be deployed at the target hospitals will result in an improvement in CPE and relied on Childs' quantification of this.[259] We have already dealt with this above.

[353] Van Reenen, testifying regarding Mooimed's experience, said it is not impossible to procure efficiently. When asked how a relatively small hospital like Mooimed achieves savings on surgicals, Van Reenen gave a very practical and simple solution, "*Mr Chairman, you pick up the phone, you phone a supplier, and you request a price. And you get the price.*"[260] She elaborated, "*We purchase surgicals through our Pharmacy, and we have access to the suppliers, point blank. So, I believe any independent hospital can do the same, and buy cheaper. So, MooiMed does buy cheaper*".[261] However, she also said that procurement efficiencies will improve further if the NHN exemption is granted by the Commission given the combined buying power that the NHN will then enjoy.[262]

[354] As already indicated above, Childs' analysis was a static backward analysis that ignored the exemption counterfactual. We have concluded that the exemption counterfactual, given the relative size of the NHN, on a probabilistic basis, neutralises the merging parties' claimed procurement efficiencies for at least the next two years. There is thus no need to deal with this any further.

[355] We next discuss the merging parties' other efficiency claims.

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[258] Buys, Transcript, page 725, line 24, to page 726, line 4.
[259] Childs, Transcript page 1111, line 22, to page1112, line 7.
[260] Transcript page 48, lines 5-9.
[261] Transcript page 48, lines 19-22.
[262] Transcript page 48, lines 9-15 and 22-25.

Alleged efficiencies with regards to ethicals and other factors influenced by doctor behaviour

[356] In relation to doctor efficiency measures, Mediclinic emphasized its CPE trend analyses for doctors, which analyse individual doctors' CPE relative to other doctors who practise within the same specialisation in the Mediclinic group, thus comparing each doctor to all her / his peers in all Mediclinic hospitals. [263] Mediclinic further submitted that it produces CPE trend reports for every Mediclinic hospital, but that the target hospitals do not generate CPE reports, nor do they have clinical committees routinely monitoring efficiency.[264]

[357] The merging parties alleged that although the hospital managers at the target hospitals will consider the NHN reports, the data in those reports do not enable them to make any meaningful changes in hospital efficiencies.[265]

[358] Steenkamp confirmed that specialists at the target hospitals are generally afforded freedom of choice in respect of pharmacy items, equipment, length of stay and theatre time.[266] He further suggested that the data required for engagement with specialists regarding their relative efficiency is not available to MMHS and he therefore had not engaged regularly with specialists. He said, "*we have not engaged with the specialists on a regular basis concerning their efficiencies because we do not have the necessary figures to do so and specialists are afforded the freedom of choice to use and prescribe to the patients what they believe is the best for their patients*"[267] (emphasis added).

[359] The discovered NHN reports suggest that Wilmed was particularly inefficient in respect of its utilisation of patent or original branded medicines instead of generic medicines.[268] A GEMS report also reflected excessive use at Wilmed of patents or original branded medicine rather than generics.[269]

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[263] Transcript pages 636-637.
[264] Steenkamp's Witness Statement, Bundle B, page 67, paragraphs 60-61.
[265] Steenkamp, Transcript, page 919, line 5, to page 920, line 11.
[266] Steenkamp's Witness Statement, Bundle B, page 67, paragraph 60.
[267] Transcript, page 900, lines 6-10.
[268] Bundle D, page 1305.
[269] Steenkamp, Transcript, page 932, line 8, to page 933, line 2.

[360] The Commission's assessment of these claimed efficiencies was that they are not merger specific since they can be realised by the target firms without the proposed merger and furthermore, even if they could be achieved, they would not be achieved timeously.

Assessment

[361] Steenkamp confirmed that the target hospitals indeed do receive NHN efficiency reports and that they are aware that they are currently not functioning at an optimal level of cost efficiency.[270]

[362] As indicated above, Steenkamp averred that the efficiency data provided by the NHN are generalised and aggregated and does not contain sufficient detail to effectively engage with specialists.[271]

[363] However, Steenkamps' version of not being able to engage with specialists due to a lack of sufficient data was negated by the evidence of Van Reenen regarding her effective utilisation as the hospital manager at Mooimed of the data sources available to Mooimed.

[364] As indicated above, the NHN centralises data through MediKredit. Conradie confirmed that MediKredit reports are available to the NHN members. She said that the NHN "*receive monthly reports from the medical schemes as well as from MediKredit and then we submit those reports to our individual hospitals. When we talk about benchmarking it is within the NHN Group so we indicate to a particular hospital how they performed in terms of the rest of the hospitals within that particular group say for example acute hospitals, how they perform comparing with the other NHN hospitals.*"[272] Conradie further explained, "*there are individual agreements between MediKredit and the independent hospitals. So they [the hospitals] receive line item data, that means for each and every single item used in a particular hospital whether it's for*

[270] Transcript page 898, lines 18-20.
[271] Transcript page 919, line 24; page 920, line 1.
[272] Transcript page 162, line 25, to page 163, line 5.

treatment or whatever".[273] She said, "*the hospitals themselves they get the detailed data so that they can determine exactly where inefficiencies may occur and how they can address those then*".[274]

[365] Van Reenen confirmed that the NHN, since at least from April 2017, provides its members with adequately constructed efficiency reports to assist its members to manage and improve their efficiencies.[275] She said, "*I believe every NHN hospital has got this information to some extent. It's a matter of using it or not using it*".[276]

[366] She further explained that MediKredit provides the NHN members with sufficient disaggregated data to identify inefficiencies in their hospitals. She testified "*You have direct access to MediKredit in terms of determining your efficiency, that's the first statement. The second statement is that is what gives me the information to engage with our specialists in order to bring them in line with efficiency*".[277] She was candid in explaining to the Tribunal how she uses different available sets of information to effectively improve efficiencies at Mooimed.[278]

[367] Steenkamp's version was furthermore contradicted by his own anecdotal evidence of effectively engaging with a doctor regarding efficiency. He told the Tribunal of a recent instance when he used the NHN data for the purpose of meeting the requirements of the Discovery Global Fee, which took some effort, but could be done.[279]

[368] Steenkamp confirmed that he can at least identify the source of inefficiency using the currently available information.[280] For example, the NHN reports with regards to Wilmed signal that efficiencies can be improved by using more generic medicines. There is no justifiable

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[273] Transcript page 163, lines 20-24.
[274] Transcript page 176, lines 6-9.
[275] Transcript page 64, lines 5-25.
[276] Transcript page 64, line 25, to page 65, line 2.
[277] Transcript page 446, line 25, to page 447, line 4.
[278] Transcript *inter alia* page 440, line 20, to page 447, line 21.
[279] Transcript page 924, line 20, to page 926, line 7.
[280] Transcript page 977, lines 2-16.

reason why Steenkamp could not confront this problem by engaging with the pharmacy manager at Wilmed and then with specialists. The reason he has not done so is not because of the deficiencies in the data available to NHN members or directly from the pharmacy manager, but his approach to doctor freedom at the target hospitals.

[369] Steenkamp in relation to questions from the Tribunal on the utilisation of generics confirmed that Wilmed has an antibiotics stewardship committee and a procurement pharmacist, and further conceded that the better utilisation of generics is a management issue and within his hands as the general manager of Wilmed.[281] He further said: "*And to be honest with you the medical aids pay for the medicine so we did not in the past engage the pharmacists in looking at what do the doctors dispense which they believe is too much original medicine*".[282]

[370] Steenkamp furthermore did not argue with the fact that Van Reenen could effectively use NHN and MediKredit data to engage with specialists:
"*MR MAENETJE: .... what she [Van Reenen] explained is you can utilise the, with the NHN report you can utilise MediKredit, or access to the MediKredit system to get a daily, even monthly information on, and Doctor spend, and that will allow you to see which Doctor might be responsible for spending which is an outlier on, say, ethicals.*
MR STEENKAMP: If she said so, I believe that she could do it."[283]

[371] Steenkamp also confirmed that Wilmed had not, as a member hospital of the NHN, raised any shortcomings with regards to the quality of the NHN's reporting with the NHN.[284]

[372] When Steenkamp was pertinently asked if the proposed transaction is needed to further improve efficiencies at Wilmed he said, "*That's very* [redacted] *the merger to improve*".[285]

[281] Transcript page 1017, line 7, to page 1018, line 25.
[282] Transcript page 935, lines 1-4.
[283] Transcript page 976, line 20, to page 977, line 1.
[284] Transcript page 977, lines 17-21.
[285] Transcript page 980, line 23, to page 981, line 5.

[373] We have no reason to doubt Van Reenen's evidence in relation to the ability to achieve efficiencies utilising the current information available to members of the NHN. She was a candid, helpful witness and from her evidence it was clear that the driving of efficiencies in hospitals depends largely on the will, dedication and determination of the specific hospital manager to improve efficiencies by actively intervening inter alia to change doctor behaviour. This she can do at Mooimed with existing data sources. There is no reason why dedicated hospital managers and staff at the target hospitals could not do the same with the existing data sources at their disposal.

[374] We conclude that the merging parties claim that certain efficiencies cannot be achieved at the target hospitals due to a lack of sufficient data / information to engage with specialist is unfounded. The claimed efficiencies therefore are not merger specific.

Timeliness

[375] We next consider if the merging parties claimed efficiencies could potentially be achieved timeously.

[376] Childs submitted that in order for the (alleged) CPE efficiencies to be realised, Mediclinic's operational procedures, systems and procurement will need to be fully deployed at the target hospitals.[286] Smuts agreed that in setting up systems at the target hospitals much is dependent upon whether "*the data collected by the acquired hospital conforms with the content and the format required in Mediclinic's databases; whether the volume of historical data is sufficient to analyse and establish trends in CPE indicators*".[287]

[377] Smuts further said that the due diligence conducted at the target hospitals was of a limited nature and could he not say whether or not Wilmed has captured data that is highly matchable and of sufficient volume to be transferred into Mediclinic's archives to generate meaningful CPE reports within the desired

[286] Insights' Report dated 3 October 2017, Bundle C, pages 308, paragraph 9.
[287] Transcript page 1050, lines 5-14.

time frames. This can only be properly investigated after the proposed merger is implemented.[288]

[378] The merging parties' witnesses also agreed that doctor behaviour, i.e. how doctors at the target firms post merger respond to Mediclinic's procedures, systems and procurement choices, would affect the time frame for achieving efficiencies at the target hospitals.[289] Buys said that getting doctors to understand the complexities of CPE and other indicators "*does however take time because one has to build a relationship with the doctor of trust to understand that he believes the data that he has*".[290] He said that specifically "*your older doctors who for them this is a very new concept find it very difficult to understand what they consider to be interference in their clinical process. But I think after time they in fact also adjust or are prepared to adjust*".[291]

[379] We further note that Steenkamp, as confirmed by Buys,[292] will post merger be staying on at Wilmed as hospital manager and it is unlikely to expect that he would undergo a sea change and change doctors' behaviour since he has up to date largely given specialists at Wilmed freedom of choice (see paragraph 358 above).

[380] We conclude that the merging parties and their experts did not provide clear timelines of when each of the claimed efficiencies are likely to be achieved post merger. The debate between the Tribunal and Theron on what is required to realise the claimed efficiencies was on point.[293] Theron confirmed that "*the length of stay, the theatre time and the ethical would require some time to implement yes*".[294] She also agreed that "*you would need the right people to implement that [the efficiencies]*".[295] She also said that it was her understanding that Steenkamp will remain as hospital manager post merger.[296]

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[288] Transcript page 1051, line 18, to page 1052, line 17.
[289] Buys, Transcript page 723, line 16, to page 724, line 25; Van Aswegen, page 810, line 18, to page 811, line 10.
[290] Transcript page 723, lines 16-18.
[291] Transcript page 724, lines 1-5.
[292] Transcript page 725, lines 1-7.
[293] Transcript page 1334 lines 7-24.
[294] Transcript page 1334, lines 7-12.
[295] Transcript page 1334, lines 14-21.
[296] Transcript page 1334, lines 22-24.

Alleged ARM efficiencies

[381] The merging parties claimed that efficiencies will arise from the implementation of ARMs (also see paragraph 171 above). ARMs refer to models designed to reimburse hospitals and specialists for a specific procedure according to a set fee. They seek to share the risk of inefficiency. Discovery explained, "*These innovative models have enabled the Scheme to transfer a certain amount of risk to the providers, resulting in the providers focusing on managing cost and quality, rather than simply on maximising revenues*".[297]

[382] The merging parties contended that Mediclinic has superior data and systems, and for that reason its ability to agree to and implement ARMs is superior to that of the target hospitals. They contended that the medical schemes will derive significant benefit as a result of the proposed merger (in respect of prices and utilisation) from the increased ability of the target hospitals to provide ARMs.

Assessment

[383] From the evidence of Buys it appeared that ARMs are not as prevalent in Mediclinic's business as to justify the efficiency claims made.[298] Buys said that "*most of the schemes are gradually moving away to what I would call a fifth generation ARM, which is managing the cost per event. If you have a proper cost per event system in place, you actually don't need to go to all that kind of detail in terms of billing, but you can manage the actual risk that you have without getting into all of that kind of work*".[299]

[384] There have furthermore been transparency and other issues with Mediclinic's implementation of ARMs.[300] Bonitas submitted that it established that Mediclinic's ARM model was more expensive than its fee-for-service ("FFS") equivalent. This was not previously identified since Mediclinic refused to share

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[297] Bundle AD, page 47.
[298] Transcript page 703, line 5, to page 704, line 11.
[299] Transcript page 703, lines 15-20.
[300] Marion's Witness Statement, Bundle B, page 18, paragraph 15.

the line item data for the ARM with Bonitas. Consequently, Bonitas reverted to FFS from 2015.[301]

[385] The evidence was furthermore that the NHN hospitals are also capable of implementing ARMs and are indeed doing so.[302] For example, Discovery confirmed that it has ARMs with both Mediclinic and the NHN (MMHS).[303] Marion said that the NHN has lagged in ARMs but only until about 2015 and that the NHN has improved in that regard.[304] He also confirmed that Bonitas has implemented ARM agreements with the NHN early in 2018.[305]

[386] We conclude that the merging parties exaggerated the claims of post merger efficiencies relating to ARMS and furthermore the claimed efficiencies are not merger-specific since the NHN hospitals are clearly capable of and have in fact successfully concluded ARMs.

Conclusion on efficiencies

[387] The merging parties claimed procurement efficiencies as a result of the proposed transaction are offset by the exemption counterfactual, i.e. the conditional exemption given to the NHN to, for at least the next two years, procure collectively. The merging parties have furthermore not demonstrated that there are other likely, merger-specific, timely efficiencies resulting from the proposed merger that would outweigh the likely adverse effects on competition.

POTENTIAL REMEDIES

[388] We have above described the extensive engagement of the Tribunal with the merging parties to see if there potentially could be appropriate conditions that would remedy any competition or public interest concerns.

[389] The merging parties submitted that their final proposed remedies deal with any possible concerns that the proposed merger may raise. The Commission said

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[301] Bonitas' submission to the Commission dated 7 December 2016, Bundle AD, page 153, paragraph 2.14.
[302] Conradie, Transcript pages 217-221; Marion, Transcript pages 328-329.
[303] Bundle AD, page 49.
[304] Transcript page 398, line 27, to page 299, line 6.
[305] Transcript page 408, line 25, to page 409, line 7.

that the merging parties' proposed remedies do not address the competition and public interest concerns resulting from the proposed transaction and would be difficult if not impossible to effectively monitor.

[390] As we have indicated under the legal framework above, the CAC in *Imerys* found that where the Tribunal is asked to approve a merger with conditions rather than prohibit it, the choice of remedies is in the nature of a discretion. The Tribunal has the power to prohibit the merger if it is not satisfied that the conditions will adequately remedy the likely SLC.[306]

[391] The CAC said that in exercising its discretion, the Tribunal could take into account, on the one hand, the precise likelihood and extent of the SLC; and, on the other, the precise extent of the risk that the conditions will fail to remedy the likely SLC. It said that the public interest may also enter into the balancing exercise, particularly the public importance of the markets which would be directly or indirectly prejudiced if the conditions failed to remedy the likely SLC.[307]

Customer responses to September remedy proposal

[392] Before we consider the merging parties' ultimate remedy proposals, we first consider how customers i.e. the medical schemes responded to the Commission's information request on potential remedies. Recall that on 8 October 2018 the Commission sought the comments of thirteen medical schemes in respect of the merging parties' September remedy proposal and nine schemes responded to the Commission's request.

[393] Seven of the nine medical aids that responded, submitted that the merging parties' September remedy proposal[308] was inadequate. Their comments are

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[306] At paragraph 40.
[307] At paragraphs 42.
[308] This proposed remedy read as follows: "*After the implementation of the merger, and for a period of three years, Mediclinic shall ensure that the base tariff which it applies in respect of services at the target hospitals for each Medical Scheme which reimburses Mediclinic on a fee for service basis, shall be the base tariff which it applies in respect of those services at all other Mediclinic hospitals for that Medical Scheme, discounted by 0.9%*" (emphasis added). The basis for this discount was the difference between the [redacted]% pure tariff differential between Mediclinic and the target hospitals, as calculated by Childs, and a [redacted]% cost saving as calculated by Childs which the merging parties claimed will be implemented at the target hospitals as a result of Mediclinic's pharmacy procurement efficiencies.

summarised in the Commission's remedies report.[309] Although only Bonitas suggested that the merger should be prohibited outright, certain other medical schemes submitted that the proposed remedies did not address all their concerns or did not address the lessening of competition as a result of the proposed merger. Certain customers furthermore raised concerns specifically regarding the period for which any behavioural remedy would have to be imposed. The comments received included the following:

- Bonitas submitted that the proposed conditions will not adequately address the issue of increased levels of concentration, likely lessening of competition or strengthening of Mediclinic's regional negotiation power;[310] Fedhealth made similar submissions;[311]
- Bankmed said that the tariff remedy was totally inadequate, raised the issue of creeping acquisitions in the private hospital sector and said that the proposed remedies do not address the issue of (potential) increased utilisation of hospital services in the relevant market;[312]
- Medihelp was satisfied with the proposed conditions, but said that the tariff condition was insufficient;[313]
- Momentum Health submitted that it is doubtful if the proposed conditions will be sufficient, specifically in relation to the proposed tariff condition;[314]
- Polmed submitted that the proposed conditions are not sufficient and do not address all concerns. It further said that there is no doubt that the proposed transaction will result in the elimination / lessening of competition;[315]
- Discovery raised concerns about the impact of the proposed merger on the future utilisation of hospital services, said that the proposed tariff remedy is inadequate and raised concerns about creeping mergers;[316] and
- Bestmed said that the tariff remedy should lead to a cost neutral situation as far as funders are concerned and found the proposed pricing remedy sufficient.[317]

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[309] Commission's Remedies and Public Interest report pages 11 and 12, paragraphs 22 and 23.
[310] Bonitas' submission to the Commission of October 2018, paragraph 2.1.
[311] Fedhealth's submission to the Commission of October 2018, paragraph 3.1.1.
[312] Bankmed's submission to the Commission of 24 October 2018, paragraphs 2, 3 and 7.
[313] Medihelp's submission to the Commission of 9 October 2018.
[314] Momentum Health's submission to the Commission of 29 October 2018, paragraph 13.1.
[315] Polmed's submission in relation to proposed remedies, paragraph 2.
[316] Discovery's submission in relation to proposed remedies dated 24 October 2018, paragraphs 3, 5, 7, 8 and 10.
[317] Bestmed's submission in relation to proposed remedies dated 23 October 2018, paragraph 13.1.

Merging parties' final proposed remedies

[394] As indicated above, on 7 January 2019, the merging parties submitted two sets of final behavioural conditions using two different approaches in relation to a pricing condition applicable to the insured market segment: (i) the Mediclinic minus remedy proposal; and (ii) the MMHS plus tariff remedy proposal.

[395] We first deal with the MMHS plus tariff remedy proposal.

Proposed MMHS plus tariff remedy

[396] The MMHS plus tariff remedy proposal for insured patients was based on the existing tariffs of the target hospitals plus up to 3% added to that tariff: It reads: "*Following the Implementation Date, and for the remainder of that calendar year, Mediclinic shall ensure that the tariff which it applies in respect of services at the Target Hospitals for each Medical Scheme (or particular option, as the case may be) that reimburses Mediclinic on a fee for service basis, shall not exceed by more than 3% the tariff which at that stage applies to those services at the Target Hospitals in respect of that Medical Scheme (or option, as the case may be) in terms of the NHN 57/58 Tariff Schedule*"[318] (emphasis added).

[397] The merging parties indicated that they do not support this pricing remedy (which we have asked them to consider as an alternative) since it does not take CPE differences between the hospitals into account. They also submitted that introducing the NHN tariff files in the Mediclinic system would be an unfair administrative burden since it would result in a significant increase in the number of tariff files that Mediclinic would have to maintain post merger.

[398] The NHN said that the NHN members have access to negotiated tariff information with all medical schemes and administrators. These members however have to sign confidentiality and non-disclosure agreements since the

[318] See paragraph 1.1.1. of the proposed remedy.

tariff files contain price sensitive information and intellectual property in the form of *inter alia* designated ARMs and reimbursement structures with funders.[319]

[399] Concerns were raised by the NHN and certain medical aids in relation to the use of the NHN tariff files as basis for a pricing remedy since the NHN tariff files are confidential intellectual property. It was argued that using this as the basis or starting point of the remedy would result in Mediclinic obtaining access to NHN's confidential tariff files as it pertains to each option negotiated with all medical schemes in South Africa, which could have both competition and proprietary implications. Conradie explained the consequences of a remedy that would allow Mediclinic to know and use the NHN negotiated discounted tariffs, including discounts that may have been offered in the context of the DSP, relating also to certain procedures.[320]

[400] On 15 January 2019 Mr Mornè Myburgh ("Myburgh"), the legal advisor and company secretary of the NHN, made oral submissions to the Tribunal and said that the NHN will not give its consent to Mediclinic having access to and using the NHN's confidential tariff files. He said that the NHN Board considered the issue that the NHN confidential tariff file may be utilised as part of a potential remedy in this merger and decided that it "*should take all steps available to try and prevent that*".[321] He explained that at the moment the NHN member hospitals enjoy access to the tariff file via a portal, and if it so happens that this merger is approved, the NHN can simply stop access to that portal, whereas if the NHN tariff file should be utilised as part of a remedy, that tariff file itself will have to be made available to the IT technicians of Mediclinic to use that as part of their system.[322] He also confirmed that Mediclinic (apart from its legal advisors and experts) had not at all had access to the confidential NHN tariffs.[323]

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[319] Submission by Bouwer Cardona on behalf of the NHN to the Commission dated 30 January 2017, Bundle AE, page 7.
[320] Transcript page 227, line 10, to page 232, line 26.
[321] Transcript page 1399, line 20, to page 1400, line 6.
[322] Transcript page 1400, lines 19-24.
[323] Transcript page 1401, lines 2-3.

[401] Given the objections raised by the NHN to Mediclinic post merger using its proprietary tariff-related information, we conclude that a remedy that would require Mediclinic post merger having access to the NHN tariff files is not a practical and implementable remedy. It involves a third party, the NHN, that will not allow Mediclinic to use its tariff information.

[402] Given the above, we do not discuss this remedy proposal any further in these reasons.

[403] We however note that we do not agree with the up to 3% that the merging parties suggested could be added to the target hospitals' tariffs in the proposed remedy, but since we regard this remedy as impractical we do not need to discuss this any further.

[404] We next discuss the merging parties' Mediclinic minus remedy proposal.

Proposed Mediclinic minus tariff remedy

[405] This remedy proposal was one in terms of which the base tariff in respect of services at the target hospitals which are reimbursed on a fee for service basis, would be the Mediclinic base tariff discounted by a percentage (calculated by the merging parties) representing the difference between the pure tariff differential between Mediclinic and the target hospitals and the cost savings which the merging parties claimed will be achieved at the target hospitals as a result of Mediclinic's efficiencies (as calculated by Childs). The remedy in relation to insured patients reads as follows:

"*Mediclinic shall ensure that the tariff which it applies in respect of services at the Target Hospitals for each Medical Scheme (or particular option, as the case may be) that reimburses Mediclinic on a fee for service basis, shall be the tariff which it applies in respect of those services at all other Mediclinic hospitals for that Medical Scheme (or option, as the case may be) in terms of Mediclinic's 57/58 Tariff Schedule, discounted by 3%*"[324] (emphasis added).

[324] See paragraph 1.1.1. of the proposed remedy.

[406] The merging parties explained the proposed 3% discount - as opposed to the common cause weighted [redacted]% tariff differential between Mediclinic and the target hospitals - as follows: they submitted that the pre-merger cost differences in surgicals between Mediclinic and the target hospitals, ignoring the NHN exemption, is approximately [redacted]%[325] (see paragraph 236 above) of the overall CPE basket and that offsets the agreed tariff differences of approximately [redacted]% (see paragraph 167 above). The merging parties submitted that it is not possible to mathematically compute their suggested 3% discount in the proposed remedy, but what Mediclinic is effectively proposing is that the target hospitals be given some credit for the possibility of exploiting the NHN exemption (absent the proposed transaction) and therefore they dropped the pin for that at 3%. In other words, the merging parties assume that the MMHS will achieve approximately [redacted] of Mediclinic's procurement savings after the exemption.[326]

[407] We disagree with the merging parties' abovementioned assumption and their 3% discount figure. In our view, as explained above, the NHN given its relative size compared to Mediclinic, and since the overall NHN procurement volumes will drive the procurement efficiencies of the target hospitals, can be expected to yield the same procurement advantages as Mediclinic during the two-year guaranteed exemption period i.e. the grace period of the exemption. This leaves us then with the (common cause) approximately [redacted]% weighted tariff differential.

[408] However, the proposed remedy is not only inappropriate in terms of the size of the discount off the tariff, it is also flawed in principle because it does not address the source of the competitive harm. It does not take the likely post merger change in bargaining dynamics as a result of the proposed transaction into account and does not address the issue of post merger regional dominance in the relevant market. Since the proposed behavioural remedy fails to address the source of the competitive harm resulting from the proposed transaction, at

[325] Insights calculation based on 2015 data, see merging parties' core bundle for argument, page 28.
[326] Transcript page 1411, line 7, to page 1413, line 12. Also see Transcript of 12 December 2018, page 124, line 24, to page 125, line 10.

a principle or absolute level, even without considering the further elements, we find that the proposed remedy is not appropriate.

[409] The proposed behavioural remedy is also inappropriate for two other overarching reasons: (i) its limited duration of a finite five-year period; and (ii) serious doubts regarding the Commission's ability to effectively monitor and enforce the proposed pricing and non-price behavioural conditions. We discuss this next, starting with duration.

Duration

[410] The medical schemes' views on the appropriate duration of a potential behavioural remedy varied with Medihelp (which had no concerns with the proposed transaction) suggesting a minimum 3 year period;[327] Bestmed a 3-5 year period;[328] GEMS, Bonitas and Momentum Health a minimum of 5 years;[329] Polmed a 7 year period;[330] and Discovery, Bankmed and Fedhealth submitting that the remedy should apply permanently / in perpetuity or until such time as a new competitor enters the relevant market.[331]

[411] The Commission, as the party that ultimately would be responsible for the monitoring and enforcement of the tendered behavioural remedies, submitted that behavioural remedies can only be appropriately used on a temporary basis and therefore argued that the merging parties' proposed behavioural conditions are inappropriate.

[412] We have indicated above that it was common cause between the economics experts that barriers to entry into the acute multi-disciplinary hospital sector are high. Furthermore, future entry of new acute multi-disciplinary hospitals in the relevant geographic market is highly unlikely. Therefore any behavioural remedy would need to endure in perpetuity since the market conditions /

[327] Scheme comments, Medihelp, page 71, paragraph 13.1 and 17.
[328] Scheme comments, Bestmed, page 156, paragraph 14.3, paragraph 17.
[329] Scheme comments, GEMS, pages 15 and 16, paragraph 2.5; Bonitas, page 38, paragraph 2.9.3.; Momentum, page 86, paragraph 14.3
[330] Scheme comments, Polmed, page 101, paragraph 2.
[331] Discovery, page 120, paragraphs 6-7; Bankmed, page 53, paragraph 6; Fedhealth, page 143, paragraph 3.3.3.

dynamics that necessitate *inter alia* discounted tariffs are unlikely to change in the future. However, behavioural conditions in perpetuity would be unpractical and undesirable and would put an inappropriate administrative burden on the Commission.

[413] Furthermore, the health care sector in the affected geographic region (as discussed under the public interest below) would be substantially prejudiced by behavioural remedies that only cure the likely harm to competition for a (short) period of time.

[414] We conclude that on the basis of the limited duration of merging parties' proposed behavioural remedies alone, they are inappropriate and do not address the harm resulting from the proposed transaction.

[415] We next discuss the proposed remedy relating to uninsured patients.

Proposed remedy for uninsured patients

[416] The merging parties offered the following remedy in relation to uninsured patients:

"3.2.2 *Upon the Implementation Date, and for a period of 5 (five) full years thereafter, Mediclinic shall ensure that in respect of uninsured patients at the Target Hospitals:*

3.2.2.1 the base tariff which it applies shall be the base tariff which is currently applied in respect of uninsured patients at the Target Hospitals, escalated at the commencement of each calendar year by no more than CPI; and

3.2.2.2. discounts on the base tariff referred to in paragraph 3.2.2.1 above shall be offered in accordance with the discount policy which is currently applied in respect of uninsured patients at the Target Hospitals" (emphasis added).

[417] Similar to the discussion above on duration, this remedy proposal is inappropriate due to its limited duration.

[418] The Commission argued that the proposed remedy for uninsured patients would furthermore be ineffective for the following reasons:

(i) It does not address the underlying cause of the discrepancy in pricing behaviour for uninsured patients, because the Mediclinic discount policy, which is adopted at a corporate level, is unlikely to change at the head office level after the five-year period; and

(ii) once the remedy has expired, it is expected that uninsured patients are likely to suffer the effect of the increase in prices resulting from the proposed transaction.

[419] We concur with the above.

[420] The other concern raised by the Commission related to misgivings about the practicality of the proposed condition. The Commission's misgiving was that the remedy would involve the complication of deciding in each case / procedure what discount would have been chosen by the target firm' hospital manager "*before and after the merger*". It is of course impossible to ascertain how hospital managers would exercise their discretion in respect of discounting in any particular case.

[421] The Commission further submitted that effective monitoring of the proposed condition to address the real risk of circumvention would require the services of independent auditors and actuarial experts as it does not possess these skills inhouse. The complexities will increase the risk of the proposed remedies being ineffective.

[422] We conclude that the concerns regarding the limited duration of the proposed remedy remain and make it inappropriate. A finite remedy does not address the future harm to uninsured patients, whilst an infinite remedy will place an inappropriate administrative burden on the Commission to monitor. It is further highly doubtful if this proposed remedy could ever be effectively monitored by the Commission.

[423] For all the above reasons, we conclude that no appropriate behavioural remedy in relation to uninsured patients has been tendered.

[424] We next discuss the proposed remedy relating to non-price factors.

Proposed remedy for non-price factors i.e. quality and patient experience

[425] The merging parties in their final remedy submission offered the following behavioural remedy in relation to non-price factors:
"*Mediclinic shall ensure that all of its initiatives in respect of clinical quality and patient experience, which apply across its group of hospitals in South Africa, will be implemented in the Target Hospitals post-merger*".[332]

[426] We have already indicated that there is no standard measure of clinical quality and outcomes in South Africa (see paragraph 304 above). Van Aswegen conceded that it would be difficult to find a remedy that would address potential post-merger quality deterioration concerns since there is no uniform standard in the industry for quality parameters.[333]

[427] We further note that the CPEs of the individual Mediclinic hospitals in the group differ significantly and thus the current initiatives for the group, that will be the basis of the proposed remedy, do not seem to be applied equally or working equally in the individual hospitals.

[428] Furthermore, there is no evidence that Mediclinic's initiatives referred to in the proposed remedy are the same or better than those of the target hospitals, specifically in relation to patient satisfaction. We have on the limited available evidence concluded that MMHS is currently performing better than Mediclinic in relation to patient experience or satisfaction. The proposed remedy does not address this.

[429] From a monitoring perspective the medical schemes pointed out that the merging parties provide no detail in the proposed remedy regarding Mediclinic's initiatives in respect of clinical quality and patient experience, which would make it difficult for the Commission to verify whether or not the proposed condition would be adhered to. The medical schemes further suggested that effective monitoring would require that Mediclinic should be required to provide the Commission and medical schemes with hospital-specific quality reports and

[332] See paragraph 3.3.1. of the proposed conditions.
[333] Transcript page 878, line 21, to page 879, line 16.

patient experience reports on a quarterly basis. Mediclinic however resisted this.

[430] We conclude that since there is no standard measure of non-price factors such as quality and patient experience for acute multi-disciplinary hospitals in South Africa, the measurement of quality is highly subjective making it difficult if not impossible for the Commission to effectively monitor and enforce any behavioural remedy.

[431] The same comments as above on duration apply regarding the limited duration of this tendered remedy.

[432] For all the above reasons no appropriate remedy has been tendered for non-price factors.

Supply-induced demand

[433] Bankmed and Discovery raised concerns about the impact of the proposed transaction on their ability to manage future utilisation of private hospital services. They referred to this as utilisation-related risks. Discovery noted the health market inquiry's provisional observation that supply-induced demand is a key driver of healthcare inflation.[334] To address this concern, Discovery and Bankmed suggest that certain conditions should be imposed on the merging parties to post merger control (i) an increase in the number of beds at the target hospitals; and (ii) the ability of Mediclinic to convert current hospital beds to higher acuity beds.

[434] The merging parties argued that this concern is not merger specific. They said that the risk of an increase in beds or the conversion of beds applies whether or not the merger proceeds. The merging parties further contend that supply-induced demand was not among the theories of harm proposed by the Commission.

[334] Scheme Comments, *inter alia* page 119, paragraph 3.2; page 120, paragraph 4.

[435] We have no evidence relating to the merged entity's future plans regarding bed numbers or bed conversions. We cannot assess if the proposed merger will for example make bed conversions more likely. Since we have for a number of other reasons found the tendered remedies to be inappropriate, there is no need to discuss this any further.

Conclusion

[436] We have found that the proposed transaction is likely to result in a substantial prevention or lessening of competition in the relevant market, with significant price and non-price effects that would be harmful to customers. The merging parties' proposed behavioural remedies do not address the source of the competitive harm, are limited in duration and inappropriate or inadequate in a number of other respects, including the Commission's inability to effectively monitor and enforce the various proposed behavioural conditions. Furthermore, as we shall indicate under the public interest below, the private hospital market is of public importance in South Africa with serious concerns about rising private health care costs in our country and will be prejudiced if the proposed behavioural conditions failed to remedy the likely SLC.

[437] For all the above reasons we conclude that the merging parties tendered no appropriate behavioural remedies to address the concerns resulting from the proposed transaction.

[438] We note that, as the CAC said in Imerys,[335] should market conditions change, the proposed transaction may still be presented for investigation by the Commission and possible approval. The door would not be permanently shut to the merging parties by this prohibition.

[439] Furthermore, a portion of the proposed transaction, i.e. that relating to the proposed acquisition of MMHS' psychiatric hospital, Parkmed, and the nursing school in Klerksdorp (see paragraphs 29 and 30 above), does not raise competition concerns. This portion of the transaction can be implemented, if so

[335] At paragraph 41.

desired by the merging parties, if it can practically be severed from the acute multi-disciplinary hospitals Wilmed and Sunningdale.

PUBLIC INTEREST

[440] The merging parties raised no positive public interest arguments in support of approving the proposed transaction.

[441] The Commission's main contention on the public interest was that the private hospital sector is already highly concentrated and that this proposed transaction will significantly increase concentration levels in the relevant market. The Commission highlighted the impact that Mediclinic's post merger regional dominance will have on bargaining dynamics in negotiations for discounts in respect of specifically DSP and/or PSP networks. The Commission further argued that the private healthcare sector is a particular and important industrial sector as contemplated in section 12A(3)(a) of the Act. It said that the sector serves an essential public good, which the Constitution[336] protects under section 27.

[442] The Commission furthermore identified two other issues which it submitted are issues of public interest:

(i) the danger of creeping mergers in the context of already high concentration levels; and

(ii) the impact of the merger on competition for specialists, in particular the danger of "perverse incentives" being introduced at the target hospitals post merger.

[443] We discuss each of these issues.

Creep

[444] In relation to creep, the Commission noted that the provisional findings of the health market inquiry identified creeping mergers as one of the main drivers of the continuing increase in concentration in the private healthcare sector. The

[336] Constitution of the Republic of South Africa, 1996.

high levels of concentration are *inter alia* the result of the three large corporate hospital groups acquiring smaller independent hospitals over time.[337]

[445] The Commission said that the proposed merger must be evaluated in the light of creeping mergers, which it described as a series of acquisitions over time that individually do not raise competition concerns, but when taken together, have a significant impact on competition. It submitted that the large corporate hospital groups have acquired market share incrementally, leading to greater concentration in their hands.

[446] In terms of the numbers of Mediclinic acquisitions, the Commission said that the current transaction continues a series of fourteen Mediclinic acquisitions since 2002, including eight facilities between 2014 and 2018. The present transaction will bring this number to ten facilities (excluding Parkmed).[338] The merging parties responded by saying that at least seven of these acquisitions were associated with a change from joint control to sole control.

[447] The merging parties also indicated that in a national acute multi-disciplinary hospital market the HHI will post merger decrease marginally and the position pre- and post-merger in respect of national market shares will remain more or less the same. They submitted that Mediclinic's pre- and post merger national market shares measured by beds are respectively 19.77% and 20.38%.[339]

[448] However, as indicated above, Mediclinic's market share in the defined relevant market changes dramatically as a result of the proposed transaction to a post merger market share of approximately 63%.

[449] We concur that creep is an issue that should be carefully considered in any hospital merger in South Africa given the already concentrated character of the market(s). Creep is an issue that equally applies to the competition assessment.

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[337] Commission's Remedies and Public Interest report, pages 38 and 39, paragraphs 86 and 87.
[338] Commission's Remedies and Public Interest report, page 39, paragraphs 88-89.
[339] Econex Second Report, Bundle C, page 414, Table 7, revised as set out in the supplementary Econex report.

[450] We however do not have information on how each of Mediclinic's previous acquisitions of acute multi-disciplinary hospitals have impacted concentration levels and the regional and national competitive landscape. The Commission should in future hospital merger cases analyse this aspect and include it in their theory of harm, if appropriate.

[451] As the Commission has correctly pointed out, creep is relevant when an individual transaction does not raise significant competition concerns, but where more than one acquisition over time raise significant competition concerns. This is not such a situation since this proposed transaction on its own raises significant competition concerns. We therefore saw no need in requesting further information from the Commission and the merging parties with regards to each of Mediclinic's past acquisitions of acute multi-disciplinary hospitals and their effect over time on competition in South Africa, regionally or nationally.

Competition for specialists

[452] As indicated, the Commission also raised concerns regarding the "*perverse incentives*" that may post merger exist between Mediclinic and doctors / specialists. The Commission *inter alia* pointed to Van Reenen's claim that there is a clause in the Mediclinic Potchefstroom specialist rental agreements requiring specialists to do the bulk of their business in that hospital.[340]

[453] The health market inquiry provisional report[341] records, "*some of the existing arrangements [offered to practitioners] are not in the best interest of competition and consumer welfare and do not curb increasing utilisation and expenditure*".[342] The incentives which were of a concern were *inter alia* those which "*set volume targets for practitioners*"; urged practitioners to use underutilised capacity; monitored practitioners and set penalties for low utilisation.[343]

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[340] Van Reenen, Transcript, page 127, line 23, to page 129, line 9.
[341] The section headed "Relationships between facilities and practitioners" pp 210 ff.
[342] Paragraph 269.
[343] Paragraph 261.

[454] We lack sufficient information to come to any conclusion on this issue. Potential perverse incentives however appear to be a broader industry issue that should be addressed at a sector level.

Effects on a particular sector or region

[455] The competition effects of any hospital merger should be considered in the context of the private healthcare sector as "*a particular industrial sector or region*" contemplated in section 12A(3)(a) of the Act. We concur with the Commission that this sector serves an essential public good, which the Constitution[344] protects under section 27. The proposed transaction will have a significant effect on the health care costs of both insured and uninsured patients living in a specific region – the rural Potchefstroom / Klerksdorp region, given that the target hospitals have significantly lower tariffs than Mediclinic. Moreover, the uninsured patients in this area, which are a vulnerable group, will have less choice of cheaper hospitals post merger and this will adversely affect their ability to switch between cheaper options.

[456] The merging parties themselves submitted that it is trite that there are serious concerns about private health care inflation in South Africa, and that there is a need to curb escalating costs. They however submitted that there is substantial debate as to precisely what the drivers are of such escalations.[345]

[457] Discovery in its submissions also highlighted the high rates of healthcare inflation in South Africa, stating that it is almost double that of CPI. It further noted that the health inquiry's provisional report (July 2018) identified the affordability of medical scheme membership as a significant concern and that this is a threat to the long-term sustainability of the private healthcare funding industry.[346]

[458] The undisputed, robust evidence in this matter was that there will be an increase in tariffs at the target hospitals when their tariff files change from the

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[344] Constitution of the Republic of South Africa, 1996.
[345] Merging parties' Supplementary Heads of Argument, paragraph 61.
[346] Discovery's submission to the Commission regarding potential remedies dated 24 October 2018, paragraph 3.2.

current NHN tariff files to the Mediclinic tariff files, and that the increase will be approximately [redacted]%, which is a weighted [redacted]% in terms of the overall costs for customers. Furthermore, the tariff discounts given to uninsured patients are significantly better at the target hospitals than at Mediclinic and the proposed transaction will therefore limit the uninsured patients' ability to bargain and switch between alternative hospitals since it will eliminate the current available significantly cheaper option in the form of the target hospitals. This must be seen in the context of the abovementioned serious concerns about private health care inflation in South Africa and a need to curb escalating costs.

[459] It is in this public interest context that we have assessed the merging parties' tendered remedies and have found them to be both inadequate and inappropriate and not a permanent solution to the concerns arising from the proposed transaction.

CONCLUSION

[460] In light of the above, we conclude that the proposed transaction is likely to substantially prevent or lessen competition in the relevant market. Since no appropriate remedies were tendered that would effectively address the competition concerns, we prohibit the proposed transaction.

22 March 2019

Mr AW Wessels **Date**

Mr Norman Manoim and Ms Yasmin Carrim concurring

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