COMPETITION TRIBUNAL OF SOUTH AFRICA

Case No: 74/LM/Sep11
013235

In the large merger between:

Life Healthcare Group (Pty) Ltd	**Acquiring Firm**
and	
Joint Medical Holdings Ltd	**Target Firm**

Panel	:	Norman Manoim (Presiding Member) Lawrence Reyburn (Tribunal Member) Medi Mokoena (Tribunal Member)
Heard on	:	21-29 May 2012 18 June 2012
Order issued on	:	24 July 2012
Reasons issued on	:	24 October 2012

Non-Confidential Decision

INTRODUCTION

[1] This is a merger of two hospital groups which impacts specifically on the Durban Central area. The Competition Commission ("Commission") had recommended a prohibition of the proposed merger.

[2] The factual and expert evidence in this merger was heard from 21-29 May 2012 and the last day of closing arguments was 18 June 2012. The Tribunal issued its order on 24 July 2012 unconditionally approving the merger. Our reasons for the approval are set out below.

[3] During the hearing of this matter the Commission called the following factual witnesses:

- Mr Niresh Bechan - hospital manager of the Ethekwini Hospital and Heart Centre
- Mr Glen Passmore - board director of the Hillcrest Private Hospital
- Dr Stan Moloabi – executive, healthcare management for Government Employees Medical Scheme (GEMS)
- Mr Ebrahim Asmal - hospital manager of the Lenmed Shifa Hospital

[4] Professor Alex Van Den Heever, a specialist in the South African healthcare industry, and Mr Simon Pilsbury, an economist from Oxera, were called as the Commission's expert witnesses.

[5] The merging parties' factual witnesses were:

- Mr Matthew Prior - funder manager at Life Healthcare Group
- Mr Kurt Wylie - board member of Life Healthcare Group
- Mr Jonathan Lowick - Group Strategy and Development Executive at Life Healthcare Group

[6] Dr. Nicola Theron an economist from Econex, was called as the merging parties' expert witness.

THE PARTIES TO THE TRANSACTION

[7] The primary acquiring firm is the Life Healthcare Group ("Life" or "LHG"),[1] a wholly owned subsidiary of Life Healthcare Group Holdings. Life Healthcare Group is a public company listed on the Johannesburg Stock Exchange and incorporated in terms of the laws of the Republic of South Africa.[2]

[8] Life is not controlled by any single entity. Some of its main shareholders are Old Mutual Assurance Company South Africa (13.25%), GEPF Equity

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[1] http://www.healthcare.co.za/Default.aspx
[2] Incorporated in the Republic of South Africa under Registration number: 2003/002733/06.

(7.75%), CBNY: International Finance Corporation of South Africa (5.12%), Industrial Development Corporation of South Africa (5.02%) and Mvelaphanda Strategic Investments (Pty) Ltd (3.25%).[3]

[9] Life is currently one of the three largest private hospital groups in South Africa and has facilities which include hospitals, rehabilitation units, occupational health clinics and facilities which care for chronically ill patients.[4]

[10] Joint Medical Holdings ("JMH"), the primary target firm in this merger, owns five hospitals in and around the Durban area, namely; City Hospital, Ascot Park, Maxwell Clinic, Isipingo Hospital and Durdoc Hospital.

[11] Life currently holds a 49.4% shareholding in JMH. The remaining shareholders of JMH are individual medical practitioners or their family trusts, deceased estates or companies controlled by medical practitioners (collectively referred to as 'doctor shareholders') who in aggregate hold 50.6% of the issued share capital of JMH. JMH has approximately 306 doctor shareholders. None of these doctor shareholders individually holds more than 6% of the shares.[5]

THE TRANSACTION AND THE BACKGROUND

[12] In terms of the present transaction, Life seeks to acquire a further 21% of the shares in JMH, thus increasing its shareholding in JMH from 49% to 70%.[6] Post merger, Life will not only assume a greater economic interest in JMH, but *de jure* control as well.

[3] Commission's Report dated 18 January 2012, page 7.
[4] *Ibid.*
[5] Commission's Core Bundle A File 1 page 43-44.
[6] Jonathan Lowick explained during the hearing that the reason Life did not make an offer to go up to 100% was that it believed in having its doctors as shareholders. Transcript 24 May 2012 page 104.

THE RATIONALE FOR THE TRANSACTION

[13] Jonathan Lowick, Life's Group strategy director, stated that the proposed transaction was in line with Life's long-term strategy since it had a long-standing desire to own a majority of the shares in JMH.[7]

[14] For JMH's doctor shareholders the rationale is for them to realise all or part of their investment in JMH.

[15] The more probable, though not expressly articulated reason, is that the merger resolves an impasse in the control situation of the hospital group as we discuss more fully later.[8] Lowick admitted during the hearing that a complaint from a rival hospital network, the National Health Network ("NHN"), to the Competition Commission, alleging that Life was unlawfully negotiating tariffs on behalf of JMH, had exacerbated the need to resolve the control situation.[9] Life, the *de facto* controller of JMH, will now, post merger, become the *de jure* controller as well, whilst its economic interest increases commensurately. This issue is discussed more fully later.

RELEVANT MARKET

[16] Unusually for a competition case, by the time it came to the hearing there was no dispute about the relevant market. Despite some differences both the Commission and the merging parties have accepted the market definition as being the market for the provision of private hospital services in the greater Durban Metro area.[10] If one ignores the pre-merger shareholding that Life has in JMH, then the accretion in market share that the merger brings about would be as follows:

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[7] Transcript 24 May 2012, page 72.
[8] This is implied by the evidence of Lowick who described how Life had been struggling to acquire a majority stake since he had knowledge of the issue. This was from 2009.
[9] See transcript page 102. The complaint was made in October 2010.
[10] The area in which four of the JMH hospitals are located in Durban central also has two Life hospitals, two Netcare hospitals and an independent in close proximity. See Exhibit A, a map of the Greater Durban area, indicating the location of several hospitals belonging to JMH, Life and other groups. Asmal, of Lenmed Nushifa, one of the Commission's witnesses, remarked in an email to a funder that hospitals in Durban were no more than a 5 kilometre radius from one another. See Exhibit G1.

Market shares in Greater Durban market

Firm	**Pre-merger market share**	**Post-merger market share**
Life	34.59	50.08
JMH	15.49	0
Netcare	32.38	32.38
Ethekwini	3.08	3.08
Hilcrest	7.97	7.97
Nu Shifa	6.48	6.48
Total	**100.00**	**100.00**

The post merger HHI would be 3566 representing an increase of 1072.[11]

[17] On this basis the merger brings about an increase in Life's market share of 15.5% in the region; from 34.5% to just over 50%. Life of course has a pre-existing holding of 49% in JMH and a degree of pre-existing control over it. Life argued that this pre-existing shareholding of 49% needs to be factored into the market share calculation on a proportional basis and if allowance is made for this and the fact that it only intends to acquire up to 70% of the equity in the present transaction then its market share accretion in the Greater Durban market would be only 4.65% and its total shareholding would be 45.4%.

[18] The Commission did not accept this approach to determining market share increments.[12] We do not need to decide this issue in the present case. The proper consideration is what is the relevant counterfactual because once this has been identified the proper competition consequences of the merger can be more clearly identified.

[11] The source for these figures is Table 3.2 in the Oxera report prepared by Simon Pilsbury, the Commission's expert.

[12] See comment of Pilsbury in the Oxera report, page 22, where he says he considers this an unusual and inappropriate approach to determining market shares.

APPROACH

[19] We will first decide the proper counterfactual. Having decided that we then go on to consider the various theories of harm advanced by the Commission and the merging parties' response.

THE COUNTERFACTUAL

[20] In merger cases the assessment of the relevant counterfactual is an essential part of the analysis. Essentially this involves a comparison of market outcomes; the market that would prevail without the merger, usually taken as the status quo, compared with the scenario that is likely to prevail post-merger. The difference between the two scenarios informs the threshold question raised by section 12A(1) of the Act viz. – whether the merger would lead to a substantial prevention or lessening of completion. Usually the status quo serves as the proxy for what the market would be like absent the merger, while the post- merger future requires a predictive analysis.[13]

[21] This has been the approach of the merging parties, who argued that Life had, since its acquisition of a 25% stake in JMH, in 1997, exercised *de facto,* albeit not *de jure,* control over JMH. Since *de facto* control suffices as a form of control in terms of section 12(2)(g) of the Competition Act, Act 89 of 1998 ("the Act"), the only difference the merger makes is the establishment of *de jure* control.[14] Since the merging parties argue that the move from *de facto* to *de jure* will have minimal impact on JMH's behaviour for competition purposes, the merger essentially retains the pre-merger competitive status quo.

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[13] See *Mondi Limited and Kohler Cores and Tubes* (Competition Appeal Court (CAC) Case Number 20/ CAC/ June02) at paragraph 38, where the CAC held that the section whilst not permitting speculation lacking an evidential basis nevertheless still,*"... enjoins the Tribunal to make a predictive judgement based on the evidence which has been placed before it."*

[14] We set out the terms of this section in paragraph 30 below."

[22] The Commission's approach is that the facts of this case constitute an exception to the normal approach that the status quo serves as the proxy for the market without the merger. The reason it does so is that whilst Life may control JMH presently in the same way as it might post merger, the question is whether it does so lawfully. If it does not do so lawfully then the status quo should not serve as a proxy for the market without the merger.[15]

[23] In order to decide this we need to review the history of events leading up to this merger as well as evidence on this aspect given in the course of the hearing.

[24] In 1997 Life's predecessor acquired a 25% interest in JMH.[16] The shareholders agreement concluded then is still operative.[17] As far as legal form goes, the agreement gives Life rights to appoint 25% of the directors and to exercise a veto in relation to a number of key operational decisions in JMH. It does not give Life the right to control the board of directors or the majority of votes at an annual general meeting. Although Life acquired a further stake in JMH in 2004, taking its holding to the present one of 49.4%, this did not lead to an alteration of the original shareholders agreement nor to the control situation despite the fact that Life had almost doubled its equity in the company. Whilst it was allowed in practice to appoint another director to the board, Life still did not bring its board representation in line with its shareholding percentage. We are told that immediately prior to the merger Life appointed three directors to the JMH board of eight.[18] As we discuss below this further acquisition was not the subject of a merger filing under the Act.

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[15] In the European Commission's merger guidelines allowance is also made for situations where the pre-merger market counter factual is not the status quo, but also might require a predictive analysis, See *Economics for Competition Lawyers*, Gunnar Niels et al, Oxford University Press 2011, page 338-339.

[16] The predecessor was a company called Presmed which later became Afrox and then, after a restructuring of the shareholding in Afrox in 2005, became Life. Nothing turns on this change in name as the company remained the same throughout and for that reason, to avoid confusion, we will simply refer to Life throughout although this appellation is not historically accurate for the period prior to 2005.

[17] Shareholders agreement, record File A pages 386-410.

[18] See witness statement of Kurt Wylie paragraph 3.2.

[25] Thus to summarise – immediately prior to the present merger Life did not control the majority of votes at either board or general meeting level although the shareholders agreement gave it rights of veto in certain specified instances.

[26] In the present merger, Life contended that despite the absence of *de jure* control, it has *de facto* controlled JMH since 1997.

[27] The witness put up by the merging parties to testify on this aspect was Kurt Wylie who wears two hats – he is both an executive of the Life Healthcare Group and also served on the JMH board from 2006 to June 2011 as one of Life's nominees.[19] He could not testify about the position that pertained earlier than this, but he could state that he was told that the manner in which things worked when he assumed his position on the JMH board was no different from what had prevailed since 1997. Hence, he contended, it was reasonable to assume that the manner in which Life related to JMH from 2006 onwards was no different to the position in the period from 1997 until 2006.

[28] Wylie's evidence was that Life controlled all the major decisions that JMH made.[20] Prior to board meetings agreements on the agenda items were reached between the doctor-appointed directors and Life's executives. Life's views always prevailed. JMH has discovered all its board minutes for the period. Nothing has emerged from a perusal of these that was inconsistent with Wylie's version.[21] This is not to say that there were not differences in strategy between the directors nominated by the doctor shareholders and those of Life. Indeed one internal strategy document authored by Life

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[19] Wylie's witness statement page 2.

[20] See Wylie witness statement paragraph 3. Similar evidence was also given by Matthew Prior, Life's funding manager. See Prior's witness statement at paragraph 2.7 where he stated, *"LHG is by far the largest single shareholder in JMH and, in practice, controlled JMH from before the time that negotiations at a hospital and scheme/ administrator level commenced."*

[21] The Commission did identify minutes where some matters of disagreement arose from time to time between doctor appointed directors and those nominated by Life. But nothing material arose from this indicating that Life could not prevail over the other shareholders when the issue was important enough to it.

executives highlights these differences very clearly.[22] But what the record shows is that to the extent that differences existed, the views of Life always prevailed.

[29] The next event of importance that occurred was Life's 2001 acquisition of Amalgamated Hospitals Limited ("Amahosp"), a firm that managed and owned four hospitals in Kwa Zulu Natal. This merger, as required, was notified as a large merger in terms of the Act in July 2001. In terms of the notification requirements an acquiring firm, in this case Life, is obliged to list all the firms it controls. If Wylie's evidence is accepted then Life controlled JMH in 2001. But the Amahosp merger notification makes no mention of this fact.[23] In another part of the form, the notification describes JMH as a competitor.[24] Market shares of the firms in the greater Durban market are given and there again JMH is listed as a competitor. The only clue of any link between the two hospital groups is the annual financial report of Afrox which, as required by the notification form, is annexed to the filing. In the report there is a list of associated companies. Amongst those listed is JMH, together with a statement that the firm (then Afrox) holds 25% in what is described as an associate.[25]

[30] In terms of section 12(2)(g) of the Act a person controls a *firm* if that person- "*...(g) has the ability to materially influence the policy of a firm in a manner comparable to a person who, in ordinary commercial practice, can exercise an element of control referred to in paragraphs (a) to (f).*"

[31] On Wylie's evidence JMH was controlled by Life by virtue of section 12(2)(g) since 1997. This meant that JMH should have been reflected in the Amahosp filing as an '*acquiring firm*', because in terms of the definition section of the Act, an *acquiring firm* includes all firms directly or indirectly

[22] See Afrox position paper April 2004, Record File B1 1656.
[23] The record of the merger notification, dated 23 July 2001, is contained in Exhibit T1 submitted by the Commission.
[24] Ibid, page 7 paragraph 16.1. See also the competitiveness report which lists competitors and their market shares. In this table JMH is listed as a competitor. See Annexure 2 to the merging parties Competitiveness Report.
[25] See Ibid at Annual Report for Afrox Healthcare Group for year 2000 – page 57.

controlled by another acquiring firm.[26] Since Afrox then was an acquiring firm and controlled JMH at the time, it should have been reflected as such on the form CC4, which is the merger filing form. JMH was not reflected as such and instead, as we noted, the contrary impression was created in the filing that JMH was a competitor of the acquiring and target firms. The Amahosp merger was subsequently approved by the Tribunal unconditionally. Mention is made in the reasons for the approval that amongst the competitors of the merged firm in the market analysis was JMH.[27]

[32] In 2003 Life's attorneys wrote to the Commission requesting an advisory opinion. The attorneys wrote that Life sought to acquire a 49% stake in JMH. Their factual submission was that Life would not be able to control JMH at board or general meeting level and asked if for that reason Life was still required to notify the transaction. In the attorneys' view this was not required by the Act.[28] The shareholders agreement entered into in 1997 was not, it appears, submitted to the Commission. The submission also does not make mention of the fact that Life had had a 25% stake in JMH since 1997. But the most significant omission, if Wylie's evidence in the present case is correct, is the failure to mention that at that time Life already *de facto* controlled JMH. The reader of the letter would have reasonably assumed that Life had no pre-existing stake in JMH and was preparing to acquire, *ex nihilo,* 49%. What is more curious is that the same firm of attorneys had notified the 25% acquisition by Presmed (Life's Predecessor) in 1997 to the Commission's predecessor, the Competition Board.[29]

[33] Despite this submission the Commission took the view that the stake could lead to *de facto* control and advised Life to notify it.[30] It did not do so, nor did it acquire the further 24% stake. Instead, almost a year later, a different firm of attorneys requested an advisory opinion on the subject from the

[26] Section 1(1)(i).
[27] Tribunal Case *Afrox Healthcare Limited and Amalgamated Hospitals Limited* Case Number: 53/LM/Sep01 paragraph 16 page 4.
[28] See record Bundle A File 1 page 411.
[29] See record Bundle A File 1 page 422.
[30] See record Bundle A File 1 page 417.

Commission. This time the 25% stake was revealed as well as the existence of the shareholders agreement. The argument now advanced was that the pre-existing stake had conferred a degree of control by way of the 1997 shareholders agreement, but since that agreement would remain in place the acquisition of the additional 24% would not change the quality of control. It was contended that Life exercised joint not sole, control over JMH.

[34] After an initial objection the Commission was persuaded that this view was correct.[31] In their letter the attorneys relied purely on an interpretation of the terms of the shareholders agreement. Whilst this was a fair reading of the shareholders agreement, no mention was made that the *de facto* situation was that Life controlled JMH despite only holding 25% -- the view that Wylie has propounded in this merger. After receiving the Commission's opinion that notification was not necessary Life proceeded to increase its shareholding in JMH from 25% to 49%.

[35] But there were further intervening events. In April 2004 the Commission concluded a consent order with the Hospital Association of South Africa ("HASA") and its members, amongst which was Life. In terms of that agreement HASA agreed to end centralised industry negotiations regarding the setting of private hospital tariffs with the association that represented private healthcare funders.[32] From then on each hospital or hospital group had to negotiate tariffs separately with each of the funders.

[36] This meant that whilst JMH and Life had charged the same tariff up till then, being that of the industry as the outcome of centralised negotiations, they could not do so thereafter.

[37] The evidence in this case is that in the period for which the witnesses could provide information Life has negotiated tariffs on behalf of JMH at all times

[31] See record Bundle A File 1 page 416 for the initial objection, and page 474 for the subsequent acceptance.

[32] See paragraph 7 of the HASA consent agreement 24/CR/Apr04. A similar consent agreement was entered into with Board of Health Care Funders South Africa which negotiated on behalf of funders. See 07/CR/Feb05.

except for the year 2003.[33] The reason given for the exception in 2003 was that at that time Life held only 25% of JMH and JMH was not on Life's financial systems. Certainly after Life had acquired the shareholding which moved its interest in JMH to 49%, Life negotiated tariffs on behalf of JMH. According to Lowick this was permissible notwithstanding the earlier consent order undertakings because Life had interrogated its ownership of JMH with the Commission and from this process Life had received comfort that it could treat JMH as part of its network for the purposes of establishing tariffs.[34]

[38] Asked specifically if the issue of negotiating tariffs on behalf of JMH had been revealed to the Commission Lowick admitted it had not, but he was not able to explain the reason for the omission as he had not been in his current position at that time.[35]

[39] The Commission argued that this was collusive. Life as a competitor of JMH was not entitled to negotiate tariffs on its behalf. We deal with this contention later.

[40] As we noted earlier, in the current merger Life argues that it has had control of JMH since 1997, including control over the setting of its tariffs, and hence the merger will have no affect on competition.

[41] This position, as we have shown, is inconsistent with the stance that Life took towards the Commission in its Amahosp notification and in its correspondence when seeking an advisory opinion on two occasions in 2003 regarding its contemplated acquisition of a further stake in JMH.

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33 See evidence of Lowick at transcript 24 May 2012 page 84.
34 Transcript 24 May 2012 page 85.
35 Transcript 24 May 2012 page 86. In a later answer he says that the advisory opinion from the Commission gave Life comfort that it could include JMH in its negotiations. See transcript page 91.

[42] This begs the question: which version of the facts regarding control is correct? We queried this with the merging parties during the hearing.[36] No witness gave evidence which dispelled the apparent contradictions.[37]

[43] In correspondence with the Tribunal the merging parties' attorneys offered an explanation.[38] They properly concede that evidence previously submitted by the merging parties or by Life and relied on by the Commission and Tribunal to the effect that JMH was a competitor of Life at the time, was not correct. They state that those responsible for the Amahosp notification are no longer employed by Life and that therefore they have to speculate as to why the Amahosp merger was presented on the basis that it was. They go on to surmise that at the time of the Amahosp notification jurisprudence around control was in its infancy and hence the extent of the concept was not as fully appreciated as it is now.[39]

[44] For the purpose of this case we do not need to decide whether this explanation is credible. What we do have to decide for the purpose of the counterfactual is which version of control is correct: the Amahosp filing version in 2001, the version accompanying the second 2003 request for an advisory opinion, or the version advanced in this merger. The choice is between no control of Life over JMH, (as implied by the Amahosp filing), an attenuated form of joint control (second advisory opinion letter in 2003) or unvarying sole *de facto* control (Wylie's evidence in the present hearing).

[45] On the evidence before us it would appear that the Wylie version is correct. The minutes trail, the document serving before the Life board to approve the deal, are all consistent on this point.[40] Wylie was thoroughly cross-examined on the control issue and in our view answered satisfactorily to issues within his personal knowledge.

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[36] Transcript 21 May 2012 page 3.
[37] Lowick when asked this says, *"I think the focus is on the shareholder's agreement and I don't know why."* Transcript 24 May 2012 page 92.
[38] The present attorneys representing Life in this merger were not involved in either the Amahosp notification or the two applications for an advisory opinion referred to above.
[39] See letter from merging parties attorneys to the Tribunal dated 12 June 2012.
[40] See Record Bundle 1 File A page 360 Life Board paper July 2011 where it is stated, *"Life has no written management contract with JMH, but decided on certain matters relating to the strategy of JMH, particularly its business plan, budget, revenue, capital expenditure and operational costs."*

[46] We therefore find that Life or its predecessors have *de facto* had sole control of JMH since 1997. Whilst legally the doctor shareholders or their nominated directors, acting jointly, may have been able to constrain that control, we have no evidence that they ever did so, certainly in any manner that might be competitively significant. The merger therefore serves to bring the *de jure* situation in line with the *de facto* situation, as Life will now control a majority of the votes at board level and at general meetings.

[47] Having made this finding we must answer the next key question which affects an important counterfactual question. If Life has controlled JMH since 1997 will the merger make any difference to pricing behaviour post merger since Life has controlled JMH's pricing since 2003/4 when central bargaining over hospital tariffs was outlawed?

[48] Behind this question is an important principle of law.

[49] Let us consider the position from first principles. It is a trite proposition that if two competitors had colluded on pricing and then sought to merge they could not rely on that prior collusion to argue that the merger would make no difference to pricing post merger because the counterfactual is a market in which they did not compete. This would be contrary to a precept of public policy that firms cannot benefit from their unlawful conduct.

[50] The merging parties argue that their situation is not analogous to the one outlined above, as they had lawfully acquired joint control in 1997, and joint control must pre-suppose joint pricing, otherwise control is stripped of its essential meaning. However this argument ignores a key provision in our legislation which provides specifically for such situations and in a manner contrary to that contended for by the merging parties.

[51] The Act provides for a regime that discourages horizontal interests in competitors. Whilst not making such holdings unlawful the Act creates a

presumption, when consideration is given to horizontal restrictive practices in which a combination of firms is involved, that an agreement exists between the firms where one of those firms holds a substantial interest in the other or they have directors in common. [41]

[52] The intention of the Act is to facilitate the prosecution of firms in such a situation and thus to discourage such partial forms of control. But at the same time the Act exempts from the provisions of section 4(1) agreements between firms and their wholly owned subsidiaries.[42] This exemption is also extended to firms that constitute part of a 'single economic entity'.[43] The term 'single economic' entity is not given precise definition. But the Act does give some guidance as it states that the exemption applies to the constituent firms of a "*single economic entity*" that is "*...similar in structure...*" to entities in the wholly owned subsidiary –parent relationship.

[53] The use of the word "*similar*" assumes that the subordinate or controlled firm need not be wholly owned by the parent firm (otherwise subsection 5(b) would be redundant), but still seems to suggest that the structure is not far removed from it. What is contemplated by the exemption is not merely firms in a single economic entity. Its meaning is more limited than this since there is an additional requirement that the relationship between the relevant firms must be "*similar in structure*" to the relationship between a parent company and one or more wholly owned subsidiary or sub-subsidiary.

[54] In U.S. law in terms of the so-called '*Copperweld*' doctrine a firm is deemed not to be able to collude with itself.[44] The boundaries of 'self' when located

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[41] Section 4(2) which states "*An agreement to engage in a restrictive horizontal practice referred to sub-section 1(b) is presumed to exist between two or more firms if –*

(a) *any one of those firms owns a significant interest in the other, or they have at least one director or substantial shareholder in common; and*

(b) *any combination of those firms engages in that restrictive horizontal practice.*

[42] Section 4(5)(a).

[43] Section 4(5)(b).

[44] *Copperweld Corp. v Independence Tube Corp.* 467 US 752, 104 Sct (1984).In *Copperweld* a firm and its wholly owned subsidiary were deemed incapable of conspiring with one another for purposes of section 1 of the Sherman Act because they did not represent separate economic interests. The application of *Copperweld* by the district courts in these latter cases has been inconsistent. Consequently there are contradictory judgments, for example in *Novatel v Cellular Tel.*

in separate corporate entities become more tenuous, the less the interest of the holding company in the subordinate company. Neither US law nor European law would extend the notion of 'self' or as in Europe, a single economic entity, to the present one between Life and JMH pre-merger.

[55] If the legislature had intended a partial controller or joint controller of a company to be immune from liability for colluding with it by ordinary operation of law as a consequence of partial or joint control, then it is hard to see why this provision was inserted in the Act. Quite clearly the legislature had no such intention. JMH and Life are therefore not, pre-merger, where on the facts the holding firm does not even enjoy *de jure* control of the subordinate firm, and holds less than 50% of its shares, constituent firms within the same single economic entity.

[56] The only time when a firm can be certain of immunity from the consequences of a section 4(1) prosecution is where it and the subsidiary form part of a wholly owned subsidiary-parent relationship or the type of single economic entity contemplated by section 4(5)(b). Where the relationship between the controlling and the controlled firm falls short of this, such collusion will not be exempt from the consequences of sections 4(1) and 4(2).

[57] Nor does the fact that the controlling firm acquired the substantial interest as part of a previously notified merger entitle it to immunity from section

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Supply (1986) 51% voting control was deemed to be covered by *Copperweld* whereas in *Aspen Title & Escrow v Jeld-Wen* (1987) 75% ownership of the subsidiary was held to be insufficient to qualify for *Copperweld* protection. There is thus no clear approach in the US for cases with partly-owned subsidiaries.

The EU approach is based on the principle that if two or more entities form an economic unit within which the subsidiaries have no real freedom to determine their conduct in the market; the entities essentially form a single undertaking and cannot be expected to compete with each other, thus relations between them are not classified as collusive arrangements (*Viho v Commission* (1995), Case T-102/92, (1995) ECR II-17; upheld on appeal Case C-73/95P (1996) ECR I-5457 at [16-18] *ICI v Commission* (1972), Case 48/69 *ICI v Commission* [1972] ECR 619 at [134 *Ahmed Saeed Flugreisen and Others v Zentrale zur Bekampfung Unlauteren Wettbewerbs* (1989) Case 66/86, [1989] ECR 803. The governing test is therefore whether the subsidiaries enjoy the autonomy to determine their own conduct in the market.

4(1). Where the notified merger contemplates only partial control the acquirer is not entitled to the status of a sole controller unless it notifies the fact of sole control to the authorities. This is because merger analysis is performed on the basis of a merger notification as lodged and not on what might later become the prevailing form of control. For this reason we have held previously that a change from joint to sole control triggers a further notification as does the crossing of a bright line. This was laid down in our *Ethos* decision.[45]

[58] This does not mean that the controller, not contemplated in section 4(5), cannot lawfully exercise some measure of control over the subordinate firm. What it does mean is that control, where firms are in a horizontal relationship, cannot extend to conduct that is unlawful in terms of section 4(1). Where the controlling firm and subordinate firm so act, they do so unlawfully. The relevance of this to the present counterfactual is that Life was not entitled to set prices in conjunction with JMH. To the extent that it did so, this conduct contravened section 4(1)(b)(i) of the Act, which prohibits competitors from jointly fixing the price for their services.

[59] It is not our purpose to make a finding that Life and JMH have in fact colluded on pricing because we are not engaged in a prohibited practice hearing. The only issue relevant to the present proceedings is the merging parties cannot rely on a past history of joint pricing to create a counterfactual that the merger would make no difference to pricing post merger, because they had priced jointly before it.

[60] The correct approach to a counterfactual must be to compare what behaviour by firms would have been lawful competition between them pre-merger, with the post merger scenario. It is not permissible to use unlawful competition as the yardstick of measurement. Where such a lawful counterfactual does not exist in practice, pre-merger, as in this case, the lawful counterfactual must then be the subject of hypothesis. Merging

[45] *ISCOR Limited and Saldanha Steel (Pty) Ltd Case Number 67/LM/Dec01* and *Ethos Private Equity Fund IV and Tsebo Outsourcing Group (Pty) Ltd Case Number 30/LM/Jun03* at paragraphs 18 – 47.

parties cannot benefit from conduct that was, pre-merger, unlawful, to make the comparison with the post merger world seem benign.

[61] We conclude on the counterfactual issue as follows:

1. Life exercised *de facto* control over JMH, pre-merger, but not *de jure* control;
2. The *de facto* control was lawfully acquired in 1997 and existed even before Life increased its stake in 2003 from 25% to 49%;
3. The *de facto* control did not amount to unfettered sole control as it was always subject to challenge at board or general meeting by a voting majority of doctor shareholders or their representatives; for this reason, inter alia, JMH and Life did not constitute part of a single economic entity;[46]
4. Life's *de facto* control did not entitle it to collude with JMH in respect of conduct that would otherwise contravene section 4(1) of the Act; and
5. The correct counterfactual assumes that Life and JMH would, pre-merger, have priced their services independently of one another.

Commission's theories of harm

[62] The Commission has advanced several theories of harm to support its contention that the merger be prohibited and we consider each one separately.

<u>Pricing</u>

[63] There are two issue raised in respect of pricing. First is the effect of the merger on pricing for Life, the second on pricing in respect of JMH. In respect of the first, both Commission and the merging parties are agreed that the merger will not enhance Life's ability to increase its pricing power in

[46] There may be additional reasons why they do not constitute a single economic entity but we consider it unnecessary to detail them.

respect of insured patients who form part of national medical schemes.[47] This is because pricing is negotiated nationally with individual funders and the addition of the JMH beds will have no meaningful effect on Life's negotiating strength. This evidence was confirmed by the representative of the only funder to testify at the hearing, Dr Moloabi, who is an executive director of Gems.[48] The best proof of this contention was the fact that, unbeknown to Gems, Life had negotiated on behalf of JMH when negotiating tariffs with Gems.[49] (We deal later with the two residual issues raised by the Commission in respect of the merger on Life's pricing, namely the effect of the merger on private patients of Life, i.e. patients who are not members of medical schemes, and those who are members of a regional medical scheme.)

[64] The question whether JMH's pricing post merger would increase became an issue during the hearing. Here of course the issue of the proper counterfactual is pertinent. On the merging parties' version this issue was a simple one. They had been negotiating on behalf of JMH pre-merger and so, since JMH was already charging funders Life tariffs, the merger would make no make difference to pricing – the status quo would continue. However, as we have found that this is not the correct counterfactual, we cannot accept this argument.

[65] What then would the proper counterfactual on pricing be, given that there is no factual evidence of the two groups pricing independently of one another? JMH was either pricing as part of the industry's central bargaining together with all other hospital groups that belonged to HASA, including Life, or after 2003, negotiating as part of Life. Fortunately, during the hearing we received evidence of an event that assists us in arriving at the most probable hypothesis.

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[47] See Oxera report paragraph 5.5 and Econex Report page 15.
[48] He stated "... *we do not consider that the addition of a few hospitals to the existing hospitals of a group would affect negotiations substantially*." See Moloabi witness statement, paragraph 19.
[49] Transcript 22 May 2012, page 36. Moloabi conceded that he could not be influenced by something he did not know.

[66] During 2011, whilst Life was negotiating with the doctor shareholders over pricing for their shares as part of the present transaction, a disagreement arose on valuation. Matthew Prior, acting under instruction from chief executive Mike Fleming, wrote a letter to Moloabi of Gems to inform him that as from 1 July that year *"...Joint Management Holdings will no longer participate in the arrangements between the Life Health Care Group and GEMS"* .[50] A similar message was given to JMH's management. JMH proceeded to consider joining an independent hospital grouping known as NHN (the National Hospital Network) which is entitled to negotiate a single tariff with funders on behalf of its members.[51] As it happened the period of JMH's exclusion from the Life network was short-lived. On 28 July 2011 Gems was informed by Life that: *"There has been a change of circumstances regarding the JMH Hospitals and we accordingly withdraw our letter dated 20th June 2011. In the circumstances please reinstate JMH's inclusion in the Life Healthcare arrangements."*[52] What this meant was that Life would again be negotiating on JMH's behalf. It would appear that the negotiating tactic had worked.

[67] There is other evidence apart from this episode that supports the probability that were it to have negotiated independently of Life, JMH would have joined the NHN camp.[53] In 2011, according to a letter written by NHN's Otto Wypkema to an advisor, JMH had approached NHN to join it.[54] Since the merging parties accept this fact as well, this proposition is not contentious. What is contentious however is what this would have meant in terms of pricing to funders. Would JMH's pricing on an NHN tariff be lower to funders and if so, would the difference between the latter tariff and that of Life have been significant?

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[50] Letter from Life to GEMS dated 20 June 2011. See Exhibit D2.See evidence of Lowick on this. Transcript 24 May 2012, pages 96-98.

[51] We are informed that the NHN has received an exemption from the Commission entitling it to do so.

[52] See letter from Life to GEMS dated 28 July 2011. Exhibit D3.

[53] The costs of having the necessary personnel capable of negotiating with funders is not insignificant; Prior estimated that the costs could amount to R3-R4 million rand annually. See Prior witness statement paragraph 2.8

[54] See record pages 1740 to 1741, emails from Bhoola of JMH to Wypkema, and then from Wykema to Wouter Meyer. See also transcript 24 May 2012 page 99.

[68] To answer this we need to appreciate how hospital pricing operates. When hospitals bill funders for services there are three categories of expense. First, there is a tariff for hospital services; for example ward fees and operating theatre fees. Second, the cost of medicines used by the patient. The third category comprises the materials the hospital requires to perform its services for the patient.

[69] All hospitals pass on the same costs for medicines as these prices are now regulated by what is termed single exit pricing. Whilst this does not preclude a hospital or doctor from using a generic equivalent this is an area in which price variances between hospitals is constrained by regulation.[55] How hospitals or doctors may manage the use of drugs is a different matter. It is therefore only the other two categories, namely the fee for services and the charge for consumables that offer a basis for comparing overall hospital costs. Life emphasises, correctly that the issue is not which tariff is lower to funders, but which hospital has lower overall costs i.e. tariffs plus consumables.

[70] This issue was not resolved in the volume of papers that were exchanged prior to the hearing. During the hearing, factual witnesses who were based at independent hospitals testified on behalf of the Commission that in their experience NHN hospitals had lower tariffs to funders than those of Life.[56] However the examples of tariff differences that were given were anecdotal and subject to criticism for this reason by the merging parties.[57]

[71] For this reason during the course of hearing we asked that the Commission and merging parties' experts to perform a more rigorous comparison. The

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[55] See Prior testimony transcript 23 May page 38.

[56] See for example Ebrahim Asmal witness statement paragraph 20 where he alleges that the difference is some 15-20% higher at hospital groups, and Niresh Bechan witness statement paragraph 13 who gives the same figure for the difference in charges.

[57] As an example Asmal alleged that a normal delivery at his hospital would cost R 2500 less than at a Life Hospital. But when challenged whether he knew this for certain he admitted it was just an assumption. See Transcript 23 May 2012 page 22-23.

Commission during its investigation had access to some data from the NHN whilst Life had access to its own data.

[72] This exercise was carried out, but its results proved inconclusive. Simon Pilsbury, the Commission's expert, performed a limited comparative exercise.[58] This exercise relied on the oral testimony of a factual witness (Asmal) to decide which category of procedures to compare. Based on this he selected 10 procedures to compare and then added three more following discussions with the merging parties' expert Dr Theron. Due to availability problems he limited his data to that of one particular fund offered by one funder - Discovery. His conclusion was that the difference in tariffs was marked and varied from **[...]** to **[...]** depending on the weighting given to the respective categories and whether minor surgery was included.[59]

[73] Dr Theron considered the sample too narrow, both as to funder and types of treatment. Instead, she performed what she said was a wider exercise, using other schemes as well as Discovery. Her research revealed that whilst Life was more expensive for Discovery **[...]** it was cheaper for others (for Metropolitan, **[...]** cheaper); it was, if one appropriately weighted for the relevant factors and the schemes in terms of beneficiaries, and if one excludes minor surgery, overall very similar to tariffs for NHN.[60] Unfortunately, Theron did not perform this exercise in conjunction with Pilsbury, but gave him her figures at the moment he was to commence his oral testimony. (Pilsbury testified before her). When he testified he said he had not had time to verify the figures and so could not comment on them. He did not subsequently do so. As a result we were deprived of the benefit of a joint document from the experts on this issue.

[74] We were not satisfied with this outcome and so we decided after hearing final argument that this was sufficiently important an issue for us to attempt

[58] See Exhibit R.
[59] See Exhibit R.
[60] See Exhibit S. Theron also excluded minor surgery as she said this contributed only **[...]** to Life's revenue and noted that Pilsbury's use of Discovery had not taken into account DRG's and the influence of Keycare one of the lower cost Discovery options. See Exhibit G page 4.

to get better evidence. Pricing appeared to us the fundamental competition issue raised, given the counterfactual we had determined. We therefore decided at that stage to explore the feasibility of commissioning evidence on this aspect from an independent expert of our choosing. Given that the experts for the Commission and merging parties had not only come to different conclusions but also adopted different methodologies we sought guidance from the independent expert on the following issues, viz. whether:

(1) either expert had offered a satisfactory comparison of the respective costs to funder;

(2) if not, whether this comparative exercise could be done on a more reliable basis than suggested by these experts which avoided the criticisms made out above or was the information to complex to analyse?

(3) if the answer to (2) was yes, whether he would able to do this exercise or whether he would require more information and if so, what evidence and from whom?

[75] The expert we appointed, Dr David Green of Green West Knowledge Consultants, provided a very valuable methodology for determining the comparison. In fairness to the two other experts, Green's approach points to the complexity of this exercise and the need for data to perform it from willing funders.

[76] In brief, Green's opinion was that the exercise of comparison is highly complex. He illustrated the number of factors that would have to be considered to make the comparison robust. For instance he says that hospital practices that relate to the timing of admission and discharge of patients or their movement within a hospital from wards with different levels of care will have consequences for differences in billing between hospitals. He also highlights a further difficulty, which is that cost comparisons may be bedevilled by the fact that some hospitals attract more complex and hence more expensive cases than others. For this reason he stated that a simple comparison of cost per episode of hospitalisation may not provide a clear indication whether one hospital or group is more expensive than the other.

Further complicating the picture are the attitudes of treating doctors. Hospitals could legitimately argue that they have no control over these. But he also makes the point that hospitals also create the incentives for doctors to make use of technology in which a hospital has invested even where it is not necessary on a clinical basis to use the technology.

[77] His view nevertheless was that the comparative exercise was still possible but it would require obtaining data from at least one open scheme and one restricted scheme, done over the period of one year and should exclude the treatment of the very young and the elderly, as the latter two groups require higher than average costs and may distort the sample.[61]

[78] We decided that the answer to this question was insufficiently probative to the merger to be worth performing in order to meet the rigorous standard that Green suggested. In short, the complexities of the exercise might still have yielded a result that would be subject to methodological quibble, the data set may in any event not have been readily available in the form required, and data may have had to be obtained from less willing sources, thus adding to delay. We also had to have regard to the fact that the exercise, if it was to be performed, was coming at a late stage in what had been a prolonged procedure for the merging parties. Because there was still no certainty that we could reach a robust conclusion and because of the uncertainty over the practicalities of the undertaking, we concluded that the prejudice to all concerned of increased cost and delay outweighed any possible but uncertain benefit.

[79] For this reason we must rely on what evidence we have in the record to come to a conclusion based on the reasonable probabilities.

[80] It is probable that the NHN tariff to most funders is, overall, lower than that of Life. The evidence for this comes from the anecdotal testimony of the several Commission witnesses who are employed by independent private hospitals. The merging parties, apart from the expert testimony of Dr

[61] Greens' full report has been added to the record as Exhibit U.

Theron, did not bring their own evidence to contradict this. But most importantly the Gems episode, described earlier, bears testimony to the fact that both merging parties understand the tariff issue similarly. Life executives understood and JMH managers did too: if the latter were threatened by the former with going to NHN tariffs, they would be worse off. This was the reason why Life adopted the negotiating tactic it did and why after five weeks it succeeded. Life argued that the pressure point was not the threat of lower tariffs but the inconvenience of changing to another negotiator, but we find this unconvincing.

[81] In oral evidence Moloabi was not prepared to commit himself to an answer on this because of confidentiality agreements with hospitals.[62] However, in a written submission provided to the Commission as part of its investigation before the hearing, Gems had stated that its tariffs for independent hospitals were lower than those for Life.[63] In another submission to the Commission, another funder, Metropolitan expressed the view that privately owned independent hospitals tend to charge lower fees than fees charged at a hospital belonging to one of the three main hospital groups.[64]

[82] Moreover, given that Life is larger than NHN and that bargaining takes place nationally, it is likely that this greater size would allow it to negotiate for better tariffs from funders than would NHN.

[83] We find on what evidence we have that it is probable therefore that NHN tariffs are likely to be lower to funders than the Life tariff. This does not answer the question of whether they are less expensive to funders in terms of total cost of hospital services. Tariffs are only part of the cost to funders, as we noted earlier. According to the testimony one of the Life witnesses, Matthew Prior, consumables compromise **[...]** of the cost to funders of private hospital costs.[65] He testified that because its hospitals operate

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[62] See transcript 22 May 2012 page 33-34.
[63] See record file A 3 page 1106 paragraph 8.
[64] See Record page Metropolitan Medical Scheme, p. 1073.
[65] Transcript 23 May 2012 page 39.

several agreements with funders, in particular Discovery, where the cost of consumables is part of the remuneration package, Life's cost to funders is, when consumables are included, lower in practice than that of NHN. This is because of an incentive offered by the funder to pass on to the hospital group some part of any saving achieved by the hospital group on consumables. The funder has its own assessment of what the cost of consumables is and where consumables can be procured at a cost below the funder's expectation, the hospital and funder share in the saving realised, according to a contractually agreed formula.[66] Prior stated that Life was a pioneer in adopting these alternative reimbursement models ('ARM's) in the private hospital sector. His evidence was that **[...]** of Life's income is based on an ARM not a fee for service basis ('FFS').[67]

[84] We were told that, on the other hand, independent hospitals, and this would include the NHN, did not operate on such a formula but charge on a FFS basis and then pass on the cost consumables to the funder at the net acquisition price (NAP). This being so, they have no incentive to lower the cost of consumables to funders. Green also accepts the difficulty of comparing tariff prices in FFS models with those in an ARM model as the ARM model includes a wider range of services than those contained in tariff prices.[68]

[85] This would have been an issue where evidence from funders themselves would have proved invaluable. Van den Heever, the Commission's expert, for instance challenges the notion that ARMs are a result of competition

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[66] There are limits to which hospitals may accept the risk in the cost of treatment.Green points out that many ARM agreements have 'stop loss' clauses, where if the utilisation of services exceeds an agreed level, the hospital can bill the patient on a normal fees for service (FFS) basis. See Green report, exhibit U, paragraph 5.

An example of such an agreement was contained in a contract between Discovery Health and Life where a formula exists based on what is termed the 'DRG rate'. See clauses 5.3 to 5.5 of agreement, record B1 page 1754. .DRG stands for diagnosis related group. DRGs are used to group all charges for hospital inpatient services into a single 'bundle' for payment purposes. (See McGraw-Hill Concise Dictionary of Modern Medicine.) By way of example various forms of a typical treatment .e.g. a caesarean might be classified as having levels of severity and the hospital plan would then set prices for the activity that vary depending on its level. Discovery makes use of DRG's for its Keycare option.

[67] See Prior's witness statement paragraph 4.1 Also transcript May 23 page 44.
[68] Green report, Exhibit U, paragraph 5.

between hospitals and suggests that they exist to smooth risks over a period of time for medical schemes.[69] But he does not have the data to give a view on the comparative issue. Regrettably it was not forthcoming. We are cautious about suggesting that there is significant reluctance amongst funders, who are the best informed consumers of private hospital services, to give evidence, but the experience of several hospital mergers to date would suggest that they are loath to divulge evidence on what may be for them competitively highly sensitive information. Moloabi as we noted earlier testified that confidentiality agreements prevented him from revealing certain information. Not only do the funders want to play off hospital groups against one another but, as importantly, they do not wish rival administrators to know what they have won or for that matter lost at the negotiating table. This reticence came to light in the neutered information gleaned by the Commission in its investigation, and the hesitancy of funders to be more forthcoming does not help the Commission perform its function.

[86] We therefore only have the evidence of Life to rely on when considering whether its costs of consumables are lower to funders than those of NHN hospitals. The Commission's witnesses in general terms accepted this proposition and it also accords with economic likelihood. Life, being a large group with buying power, is probably able to secure lower input costs for itself than NHN.

[87] We are therefore faced with the following conclusions. If JMH was part of NHN its tariffs would be lower to funders but not its consumables. We do not know the extent of the lower tariffs or of the higher costs of consumables. We do know that pre-merger JMH did not procure its consumables through Life but on its own. Thus some saving in this respect, post merger, can be expected. If JMH were a larger group and there were evidence of a greater differential between the tariffs and the costs of consumables this might have been a cause for concern, suggesting a substantial lessening of competition post merger. But the small number of beds which Life will gain from this

[69] Transcript 25 May 2012 page 30.

merger, the fact that the differential in tariffs would be offset by a decrease in the cost to funders of consumables, the move to alternative funding models such as designated service providers ('DSP's'), suggest that the effect of a possible increase in tariffs at JMH would, post merger, as compared to our pre-merger hypothetical, be slight. (Note that in practice the merger will not lead to higher prices to funders as Life has already been setting JMH's prices to funders: we are in this analysis simply pursuing the logic of hypothetically independent pre-merger pricing by JMH.)

Other pricing issues

[88] Pilsbury suggested that the merger would possibly lead to increased prices for non-insured patients. This evidence was of an entirely theoretical nature and we do not consider that the Tribunal is justified in concluding on that tentative hypothesis alone that this concern is warranted. It is common cause that uninsured patients pay higher fees as they do not benefit from the lower tariffs negotiated by funders for their beneficiaries. There was however no empirical evidence as to why this class of patient, thought to presently constitute about **[...]** of the Life patient base, would be worse off post merger.[70] It appears that at Life pricing to private patients is subject to a discretion exercised by individual hospital managers. Managers have the authority to offer discounts up to a ceiling of R 50 000.[71] Wylie's evidence was that post merger JMH would move on to the same policy. It is not clear what the current position is at JMH although Wylie suggests it is similar to that of Life.[72] There is no concrete evidence that the merger will change this behaviour.[73] Whilst uninsured patients face the prospect of very high prices from private hospitals there is no evidence to suggest that this situation will be made worse by the merger. Expressed differently, there is no evidence that JMH offers uninsured patients better terms than does Life and, even if it does, that Life has an incentive to alter these terms. Uninsured patients

[70] Wylie witness statement paragraph 4.6.
[71] Transcript 24 May 2012 page 7.
[72] Transcript 24 May 2012 page 7.
[73] Theron states that there is no reason why the move from 49% to 70% would lead to a change in incentive to charge private patients more and that if it did, they, being more price sensitive, would move elsewhere. Econex report page 35.

appear to be offered rates that depend on hospital-based considerations rather than group-based considerations, local capacity at a hospital appears to drive or at least influence the extent of discounting.

[89] Pilsbury also suggested that Life would not offer discounts to regionally based schemes. Whilst he dealt with this as a pricing issue, we deal with all the competition issues raised by effects on regional schemes together in the discussion of non-pricing issues that follows.

Non-pricing issues

[90] The remaining competition concerns raised by the Commission all constituted theories of harm that might plausibly arise as a result of a hospital merger. The problem was a lack of detail in making the theories relevant to this particular merger and taking them outside the realm of broad competition concerns in private healthcare that are not merger-specific. We therefore do not consider it necessary to deal with them in any detail.

[91] The Commission alleged that that the merger would lead to decreased competition for specialists. It is true that private hospitals compete for the presence of medical specialists in practices located on the hospital premises and these specialists, depending on the funding model, can drive demand to a specific hospital or group of hospitals. It follows that if there are fewer hospitals to choose from this competition would be constrained. However, as JMH has not competed seriously with its major shareholder since 1997, it is a matter of speculation what this competition might have amounted to.

[92] We have evidence that independent hospitals entered this market since 1997, including one, Ethekwini, whose entry was driven by specialists who left a Life hospital because they were unhappy there.[74] A group of

[74] Hilcrest with 137 beds was formed in 2011: Passmore's witness statement paragraph 4. Ethekwini has 250 beds. See Bechan's witness statement paragraphs, 7 and 22.

cardiologists had decided to form their own hospital in July 2008 and have been successful in doing so.

[93] Subsequent to the hearing, on 21 June 2012, the Commission received an email from Mr Asmal in which he attached correspondence between a doctor at his hospital, Nu Shifa, which is an independent, and an administrator at Entambeni, a Life hospital, during June 2012.[75] The Nu Shifa based doctor, a gynaecologist, had asked for admission privileges at Entambeni as that was what his patients had requested. The doctor does not state this, but it appears from other emails that the patients were covered by a designated preferred provider scheme which limited the patients to either a JMH hospital, namely City Hospital, or Entambeni.[76] A reply came back from the hospital manager at Entambeni to say that due to "*...operational challenges*" he was unable to offer the doctor admission rights "*...at this time*".

[94] This incident is again anecdotal. If it is meant to suggest a more generalised exclusionary strategy on behalf of Life to deny facilities to practitioners at other hospitals, the Tribunal would require much more evidence than this single incident gives us. Nor does the incident establish merger specificity. For instance, did JMH routinely give outside practitioners access to its theatres, but possibly, under its new controller Life, be incentivised not to do so? We have no evidence of such a policy existing at either group. Life in any event denied there was such a policy and alleged that at the time of the request there was no capacity to accommodate another gynaecologist.[77] This new evidence does not suffice to support a theory that the merger will lead to additional harm to competition in the quest for specialists.

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[75] This correspondence forms part of an application to lead additional evidence brought by the Commission on 10 July 2012. We explain the context of this application more fully below. This application is Exhibit V in the record.

[76] Ibid page 46,

[77] Letter from merging parties to the Tribunal responding to the Commission application to lead additional evidence, dated 17 July 2012, paragraph 16.2.This letter is Exhibit W.

[95] Another theory of harm advanced by the Commission's expert, Pilsbury, related to the partial ownership of Life in JMH that would eventuate, post merger. The expert testified that post merger Life would have the ability to channel patients and doctors away from JMH to nearby Life hospitals where Life holds a greater economic interest. The problem with this theory is that Life already has this ability pre-merger given its *de facto* control. Post merger its economic interest increases from 49% to 70%. The merger if anything is likely to make 'tunnelling,' as Pilsbury termed this behaviour, less likely than it was pre-merger because Life's economic interest is greater.

[96] Finally, we consider the effect of the merger on regional medical schemes. The Commission argued that given the number of hospitals and concentration that Life had in the greater Durban area post merger, regional medical schemes would be forced to include Life hospitals if they were to construct a network of hospitals to which their members could be directed. The addition of five hospitals to Life's portfolio would make this increasingly difficult. The adverse effect, as we understand the Commission's case, is twofold. The increased footprint available to Life would be exclusionary for other hospitals and would furthermore raise costs for regional schemes since there would be fewer hospitals to bargain with.

[97] Life contended that there were no truly regional schemes in KZN.[78] It provided statistics to show that national schemes with a high proportion of members in the KZN area constituted only a minute portion of Life's total income. When administrators negotiate they do so nationally and national rates are set except in the case of hospital arrangements that are based on the principle of DSPs. Moreover, the medical scheme administrators who undertake these national negotiations typically represent a number of schemes and their outlook and objectives are inclined to be national rather than regional.

[78] See Prior witness statement paragraph 2.19.

[98] The possibility of harm to regional schemes was advanced as a theory by the Commission and was supported by some of the witnesses representing private independent hospital witnesses, but no funder provided such evidence. Whilst such a theory of harm may be correct it was insufficiently advanced on the evidence before us. Much of the oral testimony relied on the assumption that Life had negotiated exclusive deals with funders to the exclusion of other independent hospitals. However the evidence from Life was that these are not exclusive agreements but rather that discounts are offered if certain targets are achieved. It is not clear from the evidence what volume of business in JMH is subject to such schemes. But given JMH's limited size - its five hospitals collectively have fewer beds than Netcare's single hospital in the area - it is unlikely to have impacted on the negotiating power of Life. Again here we have the evidence of Gems as a natural experiment. Gems' Moloabi was unaware that his fund had negotiated with Life on behalf of the JMH hospitals until he learned otherwise during his testimony at the hearing. [79] If JMH had been a significant bargaining chip he would surely have been aware of this.

[99] Life does not negotiate with all funders. Negotiations are time-consuming so the fund would have to be large to make it worthwhile.[80] Similarly large funders do not negotiate with smaller hospitals. Large funders and large hospital groups like Life have their own tariffs that they apply to all those with whom they have not negotiated a different tariff. Given that the probable counterfactual in this case is a negotiation with JMH as part of the NHN network, it is not clear from the evidence before us whether the latter, with the former added to it, would have been more likely to negotiate with individual medical schemes to establish its network. It seems again probable that membership by JMH would not have influenced this possibility.

[79] See transcript, 22 May 2012 page 36. See also Exhibit H Life Health Care Billing document for 2011 page 95 where the JMH hospitals are listed in a schedule as associates.

[80] Lowick in his evidence referred to the fact that when individual negotiations started in 2003 there were 150 odd schemes although some were represented by common administrators. Transcript 24 May 2012 page 84.

[100] We do not know whether, as alleged by some of the Commission's witnesses, funders are excluding their hospitals from the funders' DSP networks because of the superior bargaining power of the large hospital groups which negotiate DSPs in such a way as to ensure the exclusion of independent hospitals or whether the reason for their exclusion is that they are not price-competitive, as suggested by the merging parties. Whilst independents appear to struggle to get on to these networks except where they fill a gap in the footprint that a group-aligned hospital cannot fill, we do not have evidence of exclusionary bargaining by Life. The relevant agreements have been examined by the Commission and whilst they provide for the equivalent of volume-based discounts they do not provide for exclusivity – at least insofar as these agreements have been brought to our attention. The more recent email forwarded as part of the Commission's application to admit new evidence does not take this aspect any further.[81]Whatever the ills of the negotiations that may take place between the hospital groups and the funders to create DSPs it seems unlikely that the merger will make much of an impact on this.

[101] There is thus insufficient evidence before us that the merger is likely to have an effect on bargaining with regional schemes. What may have been more fruitful to explore is why there are no significant regional schemes and if national bargaining is a constraint to their formation. That is a much bigger question than this merger.

[102] It is clear from the evidence in this merger that the most competitively significant events since the abolition of centralised bargaining are the annual negotiations that take place between the three hospital groups which between them represent more than 80 % of the private hospital market in

[81] See Exhibit V. Here the email from Robyn Ambler of the Nimas unit of Metropolitan Health to Wypekema of the NHN, is relied on by the Commission as it purports to show that Metropolitan had excluded an independent hospital from its network in favour of a Life hospital. It does not seem to say anything more than that the hospital was not considered as the scheme already had an existing agreement with Life. This does not take issues at the hearing any further. It does not for instance even show that Life had insisted on exclusivity when this agreement was made apparently in 2009.

the Greater Durban area, and the three largest private administrators which represent approximately 77% of the administration market.[82] According to Prior, Life derives 80% of its income from five schemes or administrators.

[103] Price formation and other benefits for the large number of insured private patients are thus a result of these negotiations. The manner in which the negotiations are conducted is clearly of vital public interest and this case did not offer an opportunity for that topic to be investigated at any depth.

Increased concentration

[104] The Commission also led Professor Van den Heever to advance the thesis that increasing concentration in the private hospital market causes a correlated increase in the real costs of hospital care.[83] The Commission did not persist with this issue in final argument so we do not deal with it at any length although it was the subject of extensive cross-examination from the merging parties' counsel. The problem with the probative value of the evidence was that it is based on an incomplete data set. Theron relying on later data concluded that the market had become less concentrated yet the costs were still increasing. Thus on her evidence there are reasons other than concentration for the above-inflationary increases. Although Van den Heever rejected most of her suggestions, he conceded that omissions in the data available to him were material. [84] We consider that we cannot rely on this aspect of the evidence to come to the conclusion that the merger will lead to an anticompetitive outcome.[85]

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[82] For the hospital figures, see Van den Heever's report, paragraph 9; for the medical scheme figures see the witness statement of Matthew Prior, paragraph 2.11-2.13.
[83] According to Van den Heever, *"... indications are that for every 1% change in market concentration there is a 0.8% real adjustment in hospital costs over and above GDP growth. Based on this reasoning a 3.1% increase in national overall private hospital costs could result from this merger due to the 3,8% change in national concentration."* See Van den Heever report, paragraph 9.15.
[84] Van den Heever's data set omits information for the years 2007, 2008 and 2009. Transcript 25 May 2012, page 9. He conceded that if Theron's data is correct then concentration should have declined (transcript 26) but he was not in a position to persuade us why his data set was more reliable than hers.
[85] See 25 May 2012 transcript page 701.

General comment on the theories

[105] The theories of harm advanced by the Commission are not necessarily misplaced. However they lacked specificity to the facts of this merger. In the final outcome it seems unlikely that the pre- and post merger scenarios will differ materially. This is partly attributable to the limited size of the JMH hospitals relative to the rest of the Life group. Further, even if the merger were prohibited, the fact that Life holds nearly 50% of JHM and that there is no other major individual shareholder, makes it unlikely that JMH would, without the merger, have constituted a competitive threat to Life even if there had been independent behaviour. Regardless of Life's status as a joint controller, third parties dealing with the JMH Group, whether customers in the form of funders or specialists seeking a home for their practices, are likely to view a group halfway in Life's camp as being a Life entity and would interact with it accordingly, thus dulling its competitive potential as opposed to a hospital group that was wholly independent.

Conclusion on theories of harm

[106] For this reason the post merger counterfactual is a more nuanced one than contemplated in argument by either the Commission or the merging parties. Permitting the merger is more competitively significant than suggested by the merging parties who have to wish away the history of a collusive arrangement on pricing. Prohibition of the merger on the other hand would be unlikely to lead to greater competition and would more likely lead to a stalemate since Life is not being divested of its 49% stake, which would remain Life's even if the merger were prohibited. Rather, prohibition would lead to a situation of paralysis; a *de facto* controller not having enough of a stake to provide the incentive to invest further in JMH in order to improve its service offering, and a collection of disparate minorities not having the economic interest or the degree of influence to provide a decisive independent force.

Admission of evidence after the close of final argument

[107] On the 18th June 2012 the Tribunal heard final argument from the Commission and the merging parties. Ordinarily that would have marked the end of the hearing. Two events altered that typical scenario. As we noted earlier the Tribunal decided after the hearing to appoint an expert in the form of Dr Green to provide a report on a particular issue, and the Commission sought to introduce a further item of evidence.[86] The introduction of both Dr Green's report and the further item of evidence from the Commission was opposed by the merging parties and hence we had to rule on the issue. We have decided to admit both items into the evidence. They now constitute Exhibits U and V in the record.

[108] The argument from the merging parties was that as the hearing had terminated after the hearing of final argument, the Tribunal had no discretion to admit further evidence; alternatively that it was unfair and prejudicial for evidence to be admitted at that late stage of proceedings given that the merger had been pending for a considerable time since notification.

[109] As it happens this was a storm in a teacup. Neither item bolstered the case for prohibition. One, Dr Green's report, clarified for the panel the complexities of a comparative exercise between the pricing of Life and NHN. The second, the additional information provided by the Commission, was a submission of email exchanges, open to different interpretation, and insufficiently probative to change our conclusions on the two issues it concerned viz. the effect on competition for specialists and the alleged exclusion by funders of independent hospitals at the behest of Life .[87]

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[86] The Tribunal wrote to all the parties to advise them of this on 27 June 2012. On 29 June 2012 the Commission advised it would be bringing an application to introduce new evidence but first wanted to engage the merging parties. The application was filed on 10 July 2012. The merging parties were given leave by the Tribunal to file their answer by way of a letter instead of an affidavit. This was received on 17 July 2012.

[110] The Commission's application was brought not as its own desire but at the request of two of the witnesses to these proceedings, Messrs Asmal and Bechan. Both forwarded this correspondence to the Commission after the final argument in the hearing.[88] The substance of these two issues has already been dealt with above and does not require further elaboration. We now deal only with the procedural challenge raised by the merging parties as to the Tribunal's entitlement to admit such evidence after final argument had been delivered at the hearing.

[111] The argument advanced by the merging parties is that once closing arguments have been concluded the proceeding has come to an end and no new evidence may be admitted. For this legal proposition several cases involving civil litigation were invoked. That analogy is the problem. This is a merger proceeding, not adversarial civil litigation. Secondly the Tribunal does not sit as neutral referee between sparring litigants, but exercises, as the Act and numerous past decisions have recognised, inquisitorial powers that distinguish it from the function of the passive adjudicator in adversarial civil proceedings. Thus understood the notion that the conclusion of final argument constitutes some termination of proceedings by way of a final curtain that cannot be lifted thereafter to admit highly relevant evidence is unsound.

[112] Indeed, as the Competition Appeal Court recently emphasised in its first decision in the *Wal-mart/Massmart* merger, the Tribunal is not only entitled, but is duty bound, if it considers it does not have sufficient evidence in the record before it, to use its inquisitorial powers to glean the evidence. As the Court there observed "*Merger hearings, the object of which is to determine whether a merger can be approved, should not be stultified by an excess of formalism or of procedures best suited to a trial.*"[89]

[88] The hearing concluded on 18 May 2012. The Commission received the emails on 21 and 22 June 2012 respectively.

[89] *Minister of Economic Development and others v Competition Tribunal and others* (*Wal-mart*) Competition Appeal Court Case No: 110/CAC/Jul11 and 110/CAC/Jun11 page 50 paragraph 85.

[113] This is because in merger cases particularly, as the Court explained, the Tribunal is bound to come to its own conclusion about the merger's consequences. Section 12A, which sets out the substantive issues the Tribunal takes into account in considering mergers, requires the Tribunal to "*determine*" the matter.

[114] This of course does not detract from merging parties' rights to make submissions about their concerns for expeditious conclusion and to express a view as to whether a particular endeavour proposed by a panel to secure more evidence may be misguided. This is precisely how we attempted to manage the use of our independent expert before the merging parties objected to the exercise. Once it was clear that the merging parties objected to this endeavour we proposed a discussion at a pre-hearing on the issue of admission of Dr Green's report and of the new evidence which the Commission sought to place on record. The merging parties then recanted, reversing their original insistence that we rule on the application as a prior step. They chose instead to make submissions by way of a letter to the Tribunal.

[115] The posture of the merging parties proved most counter-productive to their own cause. A matter that could have been resolved expeditiously by way of a pre-hearing and a possible meeting of the respective experts, as the Tribunal proposed, was prolonged and elicited a number of lengthy legal submissions on issues of procedure rather than the merits. Ultimately all that was achieved was a delay in admission of this further evidence.

Contravention of section 4(1) of the Competition Act

[116] The Commission announced at the commencement of the hearing that it was investigating whether the conduct of the merging parties in engaging in joint pricing constituted a contravention of section 4(1) of the Act.[90] We do not in this decision need to comment further on that issue.

[90] See transcript 21 May 2012 page 23.

Lack of proper disclosure to the Commission

[117] In this merger, as noted earlier, we have accepted the version offered by Life that it has *de facto* controlled JMH since its acquisition of its 25% interest in 1997 although this did not amount to *de jure* control. This was the evidence of Mr Wylie and we assume it represented the considered view of Life. This version however is at variance with prior information given to the Commission by Life's predecessor, Afrox, in interactions with the Commission on at least two prior occasions, the noting of the Amahosp merger and the requests for an advisory opinion in respect of the purchase of the further 24% stake by Life in JMH in 2003. These events have been described above in this decision.

[118] These are matters that the Commission needs to investigate. The following provisions of the Act are relevant in this respect. Firstly section 15(1), which provides that the Competition Commission may revoke its own decision to approve or conditionally approve a small or intermediate merger if the decision was based on incorrect information for which a party to the merger is responsible, or the approval was obtained by deceit. This provision must be read with section 16(3) of the Act, which makes it applicable, with the changes required by context, to a large merger. Secondly, section 73(2)(d) which states that a person commits an offence if he or she knowingly provide false information to the Commission.

[119] In addition merging parties are required to comply with section 13(1) of the Act, read with the rules of the Commission, which prescribe the information to be provided with a merger filing. That information includes a list of firms controlled by the merging parties.

PUBLIC INTEREST

[120] There are no public interest considerations in terms of section 12A(3) of the Act arising from this merger that would alter our decision to approve the merger.

CONCLUSION

[121] The merger will not bring about a substantial prevention or lessening of competition for the reasons advanced. There were no substantial public interest considerations raised in this merger. The merger was therefore approved without conditions on 24 July 2012.

N Manoim

<u>24 October 2012</u>
Date

Lawrence Reyburn and Medi Mokoena concurring.

Tribunal Researcher:	Londiwe Senona / Songezo Ralarala
For the merging parties:	D.N. Unterhalter S.C. and G.D. Marriott instructed by Webber Wentzel
For the Commission:	D.I. Berger S.C. and N.J. Jele instructed by the State Attorney