COMPETITION TRIBUNAL OF SOUTH AFRICA

Case No:LM017Apr17

In the matter between:

NETCARE HOSPITAL GROUP (PTY) LTD AND NETCARE PROPERTY HOLDINGS (PTY) LTD	Acquiring Firms
and	
THE AKESO GROUP, CONSISTING OF CERTAIN IMMOVABLE PROPERTY ASSETS	Target Firm

Panel	:	Norman Manoim (Presiding Member)
	:	Yasmin Carrim (Tribunal Member)
	:	Enver Daniels (Tribunal Member)
Heard on	:	26; 28 February 2018; 1 - 9 March 2018; 16 March 2018
Order issued on	:	16 March 2018
Reasons issued on	:	3 May 2018

PUBLIC REASONS FOR DECISION

Approval and background

[1] On 16 March 2018, the Competition Tribunal ('Tribunal') approved the proposed large merger between Netcare Hospital Group (Pty) Ltd, Netcare Property Holdings (Pty) Ltd and the Akeso Group on certain conditions. The conditions consist of a pricing undertaking, an obligation to maintain existing agreements with medical schemes and a divestiture of two Netcare hospitals. The reasons for our decision are set out below.

Background

[2] The merging parties notified the proposed transaction to the Competition Commission ("the Commission") on 17 March 2017. On 18 October 2017 the Commission recommended that the merger be prohibited. The Commission found that there was an overlap in the market for the provision of mental healthcare services and that Netcare would enjoy considerable market power post-merger in this market. In relation to the national market the post-merger market share was calculated as 25-30% with a market share accretion of 20-25%. Of particular concern to the Commission was the Gauteng region in which the post- merger market share was calculated as 40-45% with an accretion of 30-35%.[1]

[3] The merging parties opposed the Commission's recommendation and the matter was set down for hearing.

[4] Prior to the hearing, the merging parties tendered a pricing condition. The Commission however considered this behavioral condition insufficient to address its concerns with the merger and persisted with its recommendation of prohibition.[2]

[5] During the course of the hearing the merging parties tendered revised conditions which included a structural remedy in the form of a divestiture, in addition to the pricing remedy already tendered.

[6] The Commission considered the revised conditions and submitted that, in principle, it agreed that such were sufficient to remedy the theories of harm advanced but that there were certain elements of the conditions which required further clarity.[3] The Tribunal adjourned the hearing on 09 March 2018 to allow the parties to engage further.

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[1] The Competition Commission *Netcare Hospitals and The Akeso Group LM017Apr17 Supplementary Economic Report* ("Commission supplementary report") trial bundle pW275-W276.
[2] Competition Tribunal Transcript of Proceedings *LM017Apr17* ("Transcript") p7 lines 8-11.
[3] Transcript p996 lines 4-6.

[7] The Tribunal reconvened on 15 March 2018. The Commission submitted that its principled agreement with regard to the conditions was unchanged but its engagement with the merging parties had not yielded positive results on the disputed elements of the conditions. The merging parties indicated that such disagreements amounted to mere drafting differences. The Commission requested more time to continue the engagement with the merging parties and the Tribunal adjourned once more, reconvening on 16 March 2018 at which stage the Tribunal afforded the parties the opportunity to make oral submissions on any outstanding disagreements.

[8] The Tribunal thereafter approved the merger subject to the conditions proposed by the merging parties with some amendments.[4]

Parties to the transaction and their activities

Primary acquiring firms

[9] The primary acquiring firms are Netcare Hospital Group (Pty) Ltd ("Netcare Hospital Group") and Netcare Property Holdings (Pty) Ltd ("Netcare Property Holdings") acting jointly. Both firms are ultimately owned and controlled by Netcare Limited, a public company listed on the Johannesburg Stock Exchange. Netcare Limited's stocks are widely held and it is not directly or indirectly controlled by any single entity. As Netcare Limited, Netcare Hospital Group and Netcare Property Holdings act jointly, in these reasons they will hereinafter be collectively referred to as "Netcare".

[10] Netcare operates a private hospital network in South Africa and the United Kingdom. In South Africa it is active in operating a primary care network and medical emergency services.

[11] In its hospital network, Netcare operates a number of general hospitals (also referred to as 'acute hospitals') throughout South Africa. At its general hospitals

[4] Attached to these reasons as Annexure A.

Netcare provides a full range of treatment options such as obstetrics, oncology, neurology, cardiology, gynecology, orthopedic, and general surgery. The treatment offering within each hospital is dependent on a number of factors and may thus differ from hospital to hospital within the network.

[12] A number of Netcare acute hospitals such as Rand[5] and Bell[6] provide mental healthcare services in addition to the general acute services.

Primary target firm

[13] The primary target firm is the Akeso Group ("Akeso"), a group of firms incorporated in accordance with the laws of the Republic of South Africa and ultimately co-controlled in varying degrees by the Tanj and Alo Trusts. The Tanj trust is controlled by Mr. Alon Apteker ("Apteker") and the Alo Trust by Mr. Allan Sweidan ("Sweidan"), the co-founders of Akeso.

[14] Akeso operates a group of 12 in-patient clinics that provide individual, integrated and family orientated treatments for a range of mental health, psychological and addictive conditions. Akeso's mental health hospitals are located throughout South Africa, with five being located in the Western Cape, four in Gauteng, two in Kwa-Zulu Natal and one in Mpumalanga. Akeso does not operate any general care hospitals.

[15] Akeso's facilities are classified as mental health hospitals in terms of the Mental Healthcare Act which states that such hospitals are "*a health establishment that provides care, treatment and rehabilitation services only for users with mental illness*".[7]

Proposed transaction and rationale

[5] Netcare Rand Hospital, situated at 33 Bruce Street, Johannesburg and which is licensed to provide mental healthcare services to 41 beds.

[6] Netcare Bell Street Hospital, situated at the corner of Bell Street and Shannon Road in Krugersdorp, Gauteng. It holds a license to provide mental healthcare services to 51 beds.

[7] Mental Healthcare Act 17 of 2002, as amended.

[16] In terms of the Sale Agreement entered into between Netcare and Akeso, Netcare will acquire sole control of Akeso.

[17] Netcare Property Holdings will purchase those firms in Akeso which control the immovable property of Akeso, with Netcare Hospital Group acquiring the remaining entities. Post-transaction the Akeso group will be wholly owned and controlled by Netcare.[8]

[18] In terms of rationale Netcare submitted that while it provided mental health services through its acute hospitals it did not did not have any dedicated mental healthcare facilities. The proposed transaction would enable it to expand its service offering into an area which is complementary to its principal offering.

[19] Akeso submitted that its shareholders wished to dispose of their interests in the firm.[9]

Industry background

[20] For the purposes of context we turn now to examine certain characteristics of the private healthcare industry.

Healthcare facilities

[21] Healthcare facilities are those facilities which provide healthcare services to consumers. Each healthcare facility operates under a license granted by the relevant provincial government department. This license regulates the number of beds which a facility may operate as well as the 'type' of bed offered i.e. the nature of the services offered to such beds.

[22] A healthcare facility may be licensed as a general or specialist facility. General facilities are licensed to provide a variety of healthcare services. An example of such is the Netcare Linksfield Hospital, which is licensed to offer adult, pediatric,

[8] Transcript p540 line 21.
[9] Transcript p533 lines 3-5.

obstetric, ambulatory, intensive care, high care and mental health services.[10] A specialist facility is one which possesses a license to provide only a particular range or type of service. An example being the Akeso facilities, which are licensed to provide mental healthcare services only. The provision of services relating to the treatment of addiction and substance abuse offered at Akeso facilities are regulated by the provincial Department of Social Development.[11]

[23] Relevant to the proposed merger are licenses for the provision of mental healthcare services.[12]

[24] There are three prominent healthcare facility networks in South Africa, namely Netcare, Life Healthcare, and Mediclinic. Those facilities not controlled by one of the 'big three', such as the Akeso group prior to the merger, are privately owned and run.

[25] The independent healthcare facilities, for the purpose of tariff negotiations (described more fully below), may elect to become members of the National Hospital Network ("NHN"). The NHN is a non-profit company which represents the collective interests of private independent healthcare facilities in South Africa. Prior to the transaction, the Akeso Group formed part of the NHN.

Healthcare funders

[26] Whilst the consumer of healthcare services is the patient, the funders of such services are primarily medical aid schemes, which are legal bodies registered in terms of the Medical Schemes Act.[13] Members of a medical aid scheme pay contributions and in return receive medical cover according to the rules of the scheme and clinical best practice. Schemes offer a range of options for medical cover that will differ in terms of the benefits accruing to and premiums payable by members.

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[10] Gauteng Province Department of Health *Certificate of registration as a private hospital* trial bundle p896.

[11] Gauteng Department of Social Development *RE Netcare Hospital Group and Akeso Group* trial bundle p1451.

[12] Gauteng Department of Health *Submissions RE Netcare Health Group and Akeso Health Group Merging Transaction* trial bundle p1442.

[13] Act 131 of 1998, as amended

[27] In terms of legislation, all medical aid schemes are required to provide all of their members, irrespective of their premium contribution, with prescribed minimum benefits ("PMB's") for a circumscribed list of conditions.[14] Schemes are required to pay in full for the treatment of illnesses covered by PMB's. At the time of the merger, this list contained 11 mental healthcare PMB's.[15]

[28] Medical aid administrators are bodies authorized by the Council of Medical Schemes to perform administrative functions on behalf of medical aid schemes. The Tribunal heard in evidence that the role of an administrator varies depending on the size and nature of the scheme itself as well as the mandate agreement between the scheme and the administrator.[16] Thus in some instances Trustees of a scheme may be involved in tariff negotiations and others not. In general however most administrators negotiate tariffs on behalf of the schemes with health care service providers and render a variety of administrative functions.[17]

Tariffs and tariff codes

[29] A medical aid scheme will only pay a provider of healthcare services for services rendered if the provider holds a valid practice code number which corresponds with the service provided. The practice code numbers are allocated by the Board of Healthcare Funders ("BHF") and are categorized according to the type of facility at which the treatment was provided.[18]

[30] All of Netcare's hospitals tariff codes begin with either a 57 or 58, the prefix ascribed to any acute facility. Items and services dispensed at facilities that provide dedicated mental health treatment exclusively are assigned tariff codes which begin with 55. The Akeso facilities utilise tariff codes with a prefix of 55.

[31] Prior to the merger, although Netcare may have offered certain mental healthcare services, these were billed under a tariff code with a prefix of 57 or

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[14] The list is prescribed by the Minister of Health in Annexure A of the Medical Schemes Regulations in GNR.1262 of 20 October 1999, as amended.
[15] Ibid.
[16] Transcript p148 lines 12-13.
[17] Transcript p181 lines 1-6.
[18] M Bishop *Witness Statement* trial bundle pW134.

58 because such mental healthcare services were being offered at a general or acute facility.[19] Netcare did not have any codes or tariffs with a prefix of 55.

[32] The essential outcome of this difference is that the tariffs for code 57/58 services are generally much higher than those for code 55 services due to the fact that the cost drivers of a 57/58 facility are much higher than those of 55.[20]

Tariff negotiations

[33] Due to the multi-sided nature of the private healthcare industry, prices for services rendered to consumers are determined primarily by a negotiation between owners of healthcare facilities or services and medical aid schemes/ medical aid administrators.[21] Netcare negotiates tariffs with medical aid schemes on behalf of all the hospitals in its network. In the case of pre-merger Akeso, the annual tariff percentage increase was determined through negotiations between medical aid administrators and the NHN for all the 55 facilities within the NHN.

[34] Negotiations occur annually, on a national level and revolve primarily around three components:

34.1. Tariff increases for existing services;

34.2. Tariff setting for new services; and

34.3. The creation of network arrangements.

[35] When speaking to the annual tariff increases for existing services, there was consensus from the witnesses of both the Commission and merging parties, that negotiations took place on a national level, with the previous year's prices for the scheme in question being used as the starting point for the negotiations.[22]

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[19] Bishop Witness statement (n 18 above) pW135 para 5.1.

[20] Transcript p151 lines 14-18; Transcript 331 lines 13-19; *Competition Commission of South Africa Merger report: Netcare Hospital Group and Netcare Property Holding and The Akeso Group LM017Apr17* trial bundle pW49, para 130.

[21] Discovery Health Medical Scheme *Submissions RE Proposed Transaction Between Netcare Hospital Group (Pty) Ltd and the Akeso Group* trial bundle p1332 para 4(b).

[22] Transcript p302 line 15.

[36] Mark Bishop ("Bishop"), a factual witness for the merging parties, indicated that in negotiations the single most important figure for both sides was the annual increase for 57/58 tariffs. This is because these services comprised the largest portion of medical aid scheme spend.[23]

[37] Tariffs for new services were the product of negotiation between hospital networks and medical aid schemes. In these negotiations, the parties would be constrained by the their relative bargaining dynamics and the amount charged for the new services by any different/ previous/third party service provider.[24]

[38] It was common cause that the Netcare 57/58 tariffs were higher than the Akeso 55 tariffs.[25]

[39] Turning then to the creation of network arrangements, the evidence was that medical aid schemes compose a network of hospitals at which they may fully cover any PMB or for the purpose of creating a low cost product for members on which a particular selection of hospitals are selected to form part of its designated network. This network of hospitals is also known as the Designated Service Provider ("DSP") network. Tariffs charged by services providers on a network are generally lower by 10-15%.[26] Should a member opt to attend a different hospital outside of the DSP network, that member may be liable for co-payments.

[40] Apart from networks, medical schemes also seek to negotiate alternative reimbursement models in an effort to manage expenditure and risk. Typically services are reimbursed on a fee for service ("FFS") basis where each item or service utilized in the treatment of a patient is billed individually and separately to the scheme. In an alternative remuneration model ("ARM") the billing may vary from scheme to scheme, but may include such models as a *per diem* rate, whereby the medical aid scheme pays a fixed rate per day of treatment, or a

[23] Transcript p289 lines 14-18.
[24] Transcript p15-19.
[25] The Commission, in its initial report at page 49, paragraph 130, calculated that Netcare's 57/58 Tariff was 28-32% higher than the NHN 55 Tariff. Pederson, under cross examination indicated that the difference was 'material' at Transcript p179 lines 4-5.
[26] Transcript Page 263 line 14.

bundle/ episode fee, whereby the medical aid scheme pays an agreed fixed amount for the treatment of a particular episode.

[41] With this context, we now turn to assess the merger.

Analysis

[42] As mentioned above the Commission had recommended that the merger be prohibited on the basis that were the merger to be approved, Netcare would enjoy considerable market power in the market for the provision of mental health care services.[27]

[43] On the basis of this finding the Commission advanced two theories of harm. First, it submitted that the market share accretion in the market for the provision of mental healthcare services at a regional (Gauteng) level would confer on Netcare the ability to increase the tariffs in Akeso mental healthcare hospitals post-merger. In other words the merger would enable Netcare to raise the lower Akeso 55 tariffs up to the 57/58 level. The second theory of harm postulated by the Commission was that the acquisition by Netcare of additional hospitals in the Akeso group would confer on it a larger footprint nationally which would shift the relative bargaining power in favour of Netcare in negotiations with medical schemes. Thus Netcare would be able to extract higher tariffs overall.[28]

[44] The merging parties disputed the Commission's theories of harm, but nevertheless tendered conditions seeking to address its concerns. In the conditions tendered by the merging parties initially, Netcare undertook to (i) maintain the Akeso base tariff at Akeso facilities post-merger; (ii) tie the annual price increases at the Akeso facilities to the annual increases negotiated between any medical aid scheme and Netcare for 57/58 tariff line items for a period of seven years; and (iii) respect any pre-existing ARM agreements in place.

[27] Commission supplementary report (n 1 above) pW275.
[28] Commission supplementary report (n 1 above) pW252 para 12-13.

[45] During the course of the hearings and after the evidence of the Commission's economist, Netcare tendered a revised set of conditions which included an undertaking to divest of two of its acute hospitals which were operating beds licensed to provide mental health services.

[46] The Commission accepted the conditions tendered by the merging parties at the level of principle and by implication accepted by and large (apart from the few disputed items) that such addressed the theories of harm it had advanced. In the circumstances we found it unnecessary to pronounce finally on the harm postulated by the Commission. Instead we arrived at our decision after considering whether the tendered conditions would address the Commission's theories of harm on the assumption that these were likely.

[47] We thus turn to examining the Commission's first theory of harm which related to unilateral effects.

Unilateral effects

[48] The Commission found an overlap in the activities of the parties insofar as both provided mental healthcare services as licensed by the Department of Health. It therefore defined the relevant market as the market for the provision of mental healthcare services specifically including voluntary treatment of patients (under 18 years), voluntary treatment of patients (over 18) and adult assisted treatment for patients in private healthcare facilities, with the relevant geographic market being both national, as tariff negotiations occur nationally and local, as competition between hospitals occur locally within a 40km radius of the target hospitals in Johannesburg, Gauteng.

[49] On the Commission's national market share analysis, calculated using number of beds licensed for the provision of mental healthcare, Netcare would control 25-30% of the mental healthcare beds in South Africa, with an accretion of 20-25% post-merger.[29] In the regional market (Gauteng) using the same

[29] Commission supplementary report (n 1 above) pW275.

calculation, the Commission submitted that Netcare would control 40-45% of the market share post-merger, with an accretion of 30-35%.[30] The Commission was of the view that the proposed transaction would thus bring about a structural change in the relevant market.

[50] On the Commission's theory of harm, the structural change in the Gauteng market would afford Netcare an unconstrained bargaining position at negotiations with medical aid providers.

[51] It became apparent through submissions to the Tribunal that a hospital network derives its bargaining strength from (i) the diversity of the services it is able to offer as a network; (ii) the number of beds it is able to offer as a network and (iii) the geographic placement of such beds across the country.

[52] The Commission's theory ran that Netcare already enjoys the largest market share in the market for the provision of acute hospital services, as well as a strong position in the market for the provision of mental healthcare at acute hospitals. So increasing the market share percentage of mental healthcare beds controlled by Netcare in Gauteng, noted as being the geographic area in which the demand for mental healthcare services was highest,[31] would unduly strengthen Netcare's bargaining power in all three of the areas mentioned above.

[53] Anthony Pederson ("Pederson"), the CEO of Medscheme, called by the Commission, illustrated the Commission's theory of harm by indicating that:

> *"MR PEDERSEN: The nature of our concern is that the negotiating strength of Netcare would increase through having an increased market share in many disciplines so the ability for a single group to negotiate tariffs across all of its disciplines is clearly stronger in those circumstances. So clearly I can't say it is a certainty but we believe it is a possibility."*[32]

[54] NHN, the hospital network to which Akeso belonged pre-merger, supported these concerns, indicating that not only will Netcare obtain market share through

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[30] Commission supplementary report (n 1 above) pW276.
[31] Transcript p150 lines 16-19; p298 lines 9-13.
[32] Transcript p178 lines 16-21.

this acquisition, but this would be at the expense of NHN, a competitor to Netcare. Dr Elsabie Conradie ("Conradie"), the CEO of NHN, called by the Commission, commenting on the competitive landscape post-transaction indicated that:

> *"DR CONRADIE… the balance of the power will be with Netcare and we* [NHN] *will have less bargaining power to proper negotiate tariffs with the medical schemes. And that will definitely harm them.*
> *Also our DSP networks, the current networks won't be there anymore. We will lose that because of the footprint. Medical schemes look at geographically spread, where the members are situated, which facilities are available and how they can then assist the members, because they want to provide obviously as much services than they can.*
> *And with the Akeso merger, should that go through, it will obviously benefit Netcare, but it will harm NHN tremendously".*[33]

[55] To address this concern, the merging parties tendered the divestiture of two of its hospitals in Gauteng, Netcare's Bell Street Hospital ("Bell") and Rand Hospital ("Rand"). Bell was licensed to provide mental healthcare services to 51 beds, and Rand to 41 beds.

[56] In accepting the divestiture conditions, the Commission accepted that the loss of beds, as tendered, would reduce Netcare's bargaining power which it would otherwise enjoy post-merger vis-à-vis the medical aid schemes and other hospital groups during negotiations. We see no reason to differ from this acceptance.

[57] We turn now to assess the Commission's second theory of harm which related to pricing.

Pricing effects

[58] The Commission's theory was that the structural change in the market would afford Netcare market power, which it could use to increase prices. The

[33] Transcript p41 lines 3-15.

mechanism of this price increase could be two-fold. Firstly, as a result of its market power, Netcare would be able to extract a greater overall annual increase from medical aid schemes at annual tariff negotiations. Secondly Netcare would be able to implement a higher base tariff at the newly acquired Akeso facilities. It would be able to do so because Netcare did not have a 55 tariff file pre-merger. The Commission noted that Netcare's comparable tariffs are higher than those of NHN prior to the merger and extrapolated that Netcare would be most likely to charge higher rates than the Akeso NHN rates when establishing its 55 tariff file.

[59] Pederson indicated that:

> *MR PEDERSEN:* … [redacted].[34]

[60] In a submission to the Commission, the Government Employees Medical Scheme (GEMS) submitted:

> [redacted]."[35]

[61] The merging parties again disputed this theory of harm, but tendered conditions which: (i) would ensure that the 55 base tariff charged at Akeso facilities would be retained post-merger;[36] and (ii) the annual percentage price increase for all Akeso 55 tariff would be the same as that agreed for 57/58 tariffs for a period of seven years.[37]

[62] Included in the condition was a clause which stipulated that, in the event that an agreement could not be reached between Netcare and any relevant medical aid

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[34] Transcript p251 lines 21-23.

[35] Government Employees Medical Scheme *GEMS SMC input on the acquisition of Akeso by Netcare* trial bundle p1315 para 25.

[36] Competition Tribunal *Order and Conditions LM017Apr017* clause 3.1

[37] Order (as above) clause 3.2.

scheme with regard to the annual price increase, Netcare would apply a tariff increase of Consumer Price Inflation ("CPI") plus one to the Akeso facilities.[38]

[63] The Commission accepted as sufficient the conditions insofar as they addressed the base price and annual increase of Akeso tariffs, but opposed the implementation of the clause regulating events when no agreement was reached between Netcare and the relevant medical aid scheme. We deal with each of these issues in turn below.

[64] On the issues of base price and annual increase regulation, we see no reason to differ from the Commission's acceptance of the conditions.

[65] Submissions made by the Commission indicated that whilst the Netcare base tariff may be higher in certain instances, the annual increase Netcare is able to extract from medical aid schemes is, on the average of the examples provided, lower than that of NHN increases (under which the Akeso facilities negotiated).[39] The proposed conditions therefore which retain the lower Akeso 55 base tariff and limit annual increases to that negotiated between Netcare and medical schemes appear to place medical aid schemes in a better position in relation to the 55 tariff increases at Akeso facilities.

[66] This position was indeed supported by Perderson:

"*MR WILSON:* *So let me just put the example to you. If, the day after the transaction or whenever your next annual negotiation takes place, I understand you're not there but let's outline the proposition, and Mr Bishop says to your negotiator 'henceforth, leaving aside one-size-fits-all inflators, I am going to move all of Akeso's 55 tariffs up to a 57/58 level', you would not stand for that?*

MR PEDERSEN: *Clearly not; we would not reach agreement on that.*

MR WILSON: *And indeed (intervention).*

MR PEDERSEN: *I think maybe what I am suggesting is that we would favour that protection as part of the transaction.*

MR WILSON: *In other words, you would like to have a guarantee that that won't happen?*

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[38] Order (as above) clause 3.3.

[39] Merger Report (n 20 above) pW46 table 13 & 14.

MR PEDERSEN: *That would be ideal.*"[40]

The condition was put to Pederson and the following exchange ensued:

"MR WILSON: *Is that the kind of guarantee you had in mind?*

MR PEDERSEN: *Yes, it is."*[41]

[67] Pederson's testimony was instructive on two issues. The first was that from a medical aid scheme's point of view, the pricing protection would be beneficial. Second it indicated that if Netcare were to seek to unilaterally increase its base tariff for 55 facilities, there would be push-back from the medical aid schemes to the extent that the schemes would refuse to come to an agreement on the matter, which would not be desirable for Netcare.

[68] Turning then to the issue of the clause establishing a protocol to be put in place for the instances in which an agreement between the schemes were not reached. Prior to the tendering of the divestiture condition that the Commission raised two concerns. The first was that this condition would act as a signal to the market indicating what the competition authorities considered an acceptable annual increase.[42] The second was that such a condition would offer comfort to Netcare in the instances where it could not reach agreement with medical aid schemes, allowing it to more readily walk away from negotiations.[43]

[69] However subsequent to the tendering of the divestiture conditions the Commission seemed to have taken comfort from the fact that the condition was drafted so as to suggest a cap only in the event of a failure to reach agreement during negotiations.

[70] The evidence of Bishop was that the failure to reach agreement was unlikely. He could point to only one instance in which a scheme and a healthcare provider had failed to reach agreement and the disastrous consequences for them.

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[40] Transcript p197 lines 16- p198 line 9.
[41] Transcript p200 lines 4-5.
[42] Transcript p750 lines 10-14.
[43] Transcript p749 lines 25- p750 line 3.

[71] The example was that of Life Healthcare and the medical fund Bonitas. In 2016/2017 Bonitas was unable to strike a favourable deal with Life healthcare for tariffs across all of Life Healthcare's facilities and, for that reason, 14 Life Healthcare facilities were removed from the Bonitas DSP network. This meant that members would need go to other network hospitals in the area or pay a 30% co-payment if admitted to one of the excluded hospitals. In response, Life Healthcare waived the 30% co-payment applicable for Bonitas members at the hospitals Bonitas had excluded from its DSP.

[72] Bishop also submitted that in negotiations the parties seldom achieved CPI and that the cost of walking away for each side was too high to warrant a breakdown. This was supported by Dr Caffara,[44] who submitted that if, on the Commission's theory of harm, Netcare would post-merger, by virtue of its size, enjoy relatively stronger bargaining power and would be incentivized to walk away from negotiations, the converse was equally likely. Netcare, as a result of having a larger footprint would also stand to lose more from failure to reach agreement and thus would not be incentivized to walk away.

[73] Considering the effects of the divestiture on the post-merger structure of the Gauteng market, as well as the degree of countervailing power held by medical aid schemes during negotiations, we agree that the harms raised by the Commission are adequately addressed by the merging parties' conditions.

DSP Network agreements

[74] During the course of the hearing, the Commission began developing a theory of harm related to network agreements. The Commission submitted that Netcare may use its market power acquired to abandon certain network placement agreements entered into whilst Akeso was part of the NHN.

[75] Discovery Health, in a submission to the Commission indicated that:

[44] Dr Christina Caffara of Charles River Associates, in her capacity as an expert witness called by the merging parties.

"we therefore support the merger but strongly recommend that a condition of the merger should be that Netcare is obliged to maintain the current ARM agreements between Akeso and DHMS after the merger"[45]

[76] Netcare, in its conditions has undertaken to fulfill any network agreement obligation until such an agreement expires.[46] The Commission accepts this condition as addressing its concern. We agree. This theory of harm is an extension of the market structure harm we see as remedied by the divestiture condition and, in any event, Netcare would be bound in terms of contract law to honour existing agreements of the target firms.

[77] We therefore concluded that the Commission's concerns relating to the change in market structure are addressed by the divestiture conditions. Further any effect that may have come about by the structural change are also addressed through pricing conditions.

Public interest

[78] The merging parties submitted, which was confirmed by the Commission that the proposed transaction will not have a negative effect on employment, given that there will be no duplication of facilities with Netcare's existing facilities as a consequence of the proposed merger.

[79] The proposed transaction further raised no other public interest concerns.

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[45] Discovery Health (n 21 above) p1339 para 22(b).
[46] Order (n 36 above) clause 3.5.

Conclusion

[80] In light of the above, we concluded that the proposed transaction was unlikely to substantially prevent or lessen competition in any relevant market. In addition, no public interest issues arose from the proposed transaction. Accordingly, we approved the proposed transaction subject to conditions.

Ms Yasmin Carrim

03 May 2018
Date

Mr Norman Manoim and Mr Enver Daniels concurring.

Tribunal economist	:	Karissa Moothoo-Padayachie
Tribunal case manager	:	Alistair Dey-van Heerden
For the merging parties	:	Adv W Trengove SC; Adv J Wilson SC; Adv G Marriot *instructed by* Nortons Inc.
For the Commission	:	Candice Slump