COMPETITION TRIBUNAL OF SOUTH AFRICA

Case No: 122/LM/Dec05

In the matter between:

Phodiclinics (Pty) Ltd
DJF Defty (Pty) Ltd
Medi-Clinic Corporation Ltd
Phodiso Clinics (Pty) Ltd
Phodiso Holdings Ltd — Acquiring firms

and

Protector Group Medical Services (Pty) Ltd (in liquidation)
President Pharmacy (Pty) Ltd
Capstone 177 (Pty) Ltd
Blue Dot Properties 446 (Pty) Ltd
Limosa Investments 93 (Pty) Ltd
Capensis Investments 403 (Pty) Ltd
New Protector Group Holdings (Pty) Ltd (in liquidation) — Target firms

and

Supreme Health Administrators (Pty) Ltd
Network Healthcare Holdings Ltd
Council for Medical Schemes — Intervening parties

Panel : Y Carrim (Presiding Member) M Mokuena (Tribunal Member) and L Reyburn (Tribunal Member)

Heard on : 04-08 September 2006 and 17-20 October 2006

Decided on : 31 October 2006

Reasons released: 21February 2006

Reasons [Non-confidential version**]**

Introduction

1. On 31 October 2006 the Tribunal unconditionally approved the large merger involving the acquisition by Phodiclinics (Pty) Ltd and DJF Defty (Pty) Ltd of the assets of New Protector Group Group Holdings (Pty) Ltd together with assets of the other target companies. The reasons for the Tribunal's order are set out below.

The transaction

2. Phodiclinics (Pty) Ltd ("Phodiclinics") together with DJH Defty (Pty) Ltd ("Defty") are acquiring the assets owned by New Protector Group Holdings (Pty) Ltd ("New Protector"), a company that was placed under provisional liquidation on 2 September 2004.[1] The assets consist of four hospitals: the Medivaal Hospital in Vanderbijlpark, Kathu Hospital in Kathu, Marapong Hopital in Marapong and Kingsley Hospital in Pretoria, and the respective pharmacies that operate within these hospitals, namely Grootgeluk Pharmacy (Marapong), Employees Dispensary Pharmacy (Vanderbijlpark), Ferrochem Pharmacy (Kathu) and President Pharmacy (Kingsley Centre Pretoria).[2] Upon conclusion of the transaction Phodiclinics will control these businesses.

3. Medi-Clinic Investments (Pty) Ltd, a wholly owned subsidiary of Medi-Clinic Corporation Ltd ("Medi-Clinic"), owns 51% of Phodiclinics. The remaining 49% is owned by Phodiso Clinics (Pty) Ltd, a wholly owned subsidiary of Phodiso Holdings Ltd, which is a 94.4% black owned company. Medi-Clinic through its various subsidiaries operates and controls numerous hospitals throughout South Africa. Medi-Clinic

1 New Protector or NPGH was placed in liquidation on 2 September 2004. Its subsidiary companies, in which all of its trading assets were housed, namely Protector Group Medical Services (Pty) ltd and President Pharmacy (Pty) Ltd were placed in liquidation soon thereafter. For a complete list of the primary target firms see File 1, page 127 of the record.

2 The subsidiaries that own the properties upon which the various hospitals are situated are also included in the transaction. These are Capstone 177 (Pty) Ltd, Blue Dot Properties 446 (Pty) Ltd, Limosa Investments 93 (Pty) Ltd and Capensis Investments 403 (Pty) Ltd.

controls Defty in terms of section 12(2) (g) of the Competition Act. Defty owns most of the pharmacies in the Medi-Clinic hospitals and provides pharmaceutical services to and on behalf of the Medi-Clinic hospitals.[3] For ease of reference I will refer to the acquiring firm as Medi-Clinic or Phodiclinics.

Background to the transaction

4. New Protector was established when Glenrand MIB sold its 65% stake in old Protector Group[4] to an empowerment consortium named Tradeworx. Tradeworx consisted of seven black individuals of whom one is Dr Clarence Mini of Supreme Health. The shareholders in New Protector were Tradeworx owning 51% of the shares and Freefall Trading 65 (Pty) Ltd with 49%. The shareholders of Freefall Trading 65 included two directors from the old Protector Group namely Leon van Rensburg and Marc Seelenbinder. The BEE transaction was funded by the IDC and was valued at R130 million.[5] This transaction was approved by the Competition Commission ("the Commission") in June 2004.

5. No sooner had New Protector obtained its approval certificate than it was hit by a series of misfortunes, which led ultimately to its liquidation and its arrival before this Tribunal as the subject of the proposed acquisition.

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3 The structured separation of the hospital and pharmaceutical services offered by private hospitals is prescribed by regulation.

4 The words new and old are used to denote the differences between the Protector group of companies after Glenrand MIB disposed its interests in the group. In that transaction New Protector was formed as a holding company in which Tradeworx and Freefall Trading would be joint shareholders. The operating companies were to be transferred into the new holding company.

5 The Industrial Development Corporation of South Africa ("IDC ") is a self financing, national Development Finance Institution. It was established to promote economic growth and industrial development in South Africa and is a public entity as contemplated in Chapter 6 of the Public Finance Management Act 1 of 1999.

6. On 3 March 2006 the Commission recommended to the Tribunal that the proposed transaction be approved without conditions. A pre-hearing was held on 13 March 2006 during which Network Health Holdings Ltd ("Netcare"), Supreme Health Administrators (Pty) Ltd ("Supreme Health") and the Council for Medical Schemes ("the CMS") indicated to the Tribunal that they wanted to intervene in this matter. The Tribunal granted them leave to intervene on 24 April 2006. A further pre-hearing took place on 9 July 2006 during which a timetable was agreed upon, setting hearing dates for interlocutory applications and the hearing of the main matter.[6]

7. The merger hearing took place on 4 to 8 September 2006 and continued on 17 to 20 October 2006. The CMS,[7] Netcare[8] and Supreme Health[9] opposed the merger on a number of grounds which are dealt with below.

8. The following witnesses were called during the hearing of the main matter:

Witnesses called by the merging parties

1) Mr Johan du Plessis, Head of Workout and Restructuring at the Industrial Development Corporation ("the IDC")
2) Ms Sonja Keulder, Senior Account Manager at the IDC
3) Mr TW van den Heever, Insolvency Practitioner and Managing Director of D&T Trust (Pty) Ltd

6 On 21 August 2006 the Tribunal heard an application for discovery brought by Network Health Holdings Ltd and Supreme Health Administrators (Pty) Ltd in terms of section 54 of the Competition Act.
7 The Council for Medical Schemes is a statutory body established by the Medical Schemes Act to provide regulatory supervision of private health financing through medical schemes.
8 Netcare is a national participant in the private hospital market in South Africa. It is one of Medi-Clinic's main competitors and is also present in the Vaal Triangle.
9 Supreme Health is a BEE controlled, medical aid administrator, whose directors were former shareholders of Tradeworx Clinical and Financial Risk (Pty) Ltd, the BEE majority shareholder of New Protector. Tradeworx and its shareholders were also involved in a number of consortia that bid for the assets of the Protector Group after it was placed in liquidation.

4) Mr G Swiegers, Financial Director of Medi-Clinic Corporation Ltd
5) Dr N Theron of Econex

Witnesses called by Netcare and Supreme Health

1) Dr Clarence Mini, Director of Supreme Health Administrators (Pty) Ltd
2) Ms Petro Bester, Hospital Manager, Vaalpark Hospital

Witnesses called by the CMS

1) Mr Alex van den Heever, Senior Advisor, Council for Medical Schemes
2) Dr Jonathan Bloomberg, General Manager of Strategy and Health Policy at Discovery Holdings Ltd
3) Mr Mbasa Mxenge, Principal Officer of Polmed Medical Scheme

Commission's recommendation

9. The Commission recommended that the transaction be approved unconditionally, on the basis that it was unlikely to lead to a substantial lessening of competition. The Commission noted that New Protector was in liquidation and considered it to be a failing firm for purposes of merger analysis but expressed concern about a likely increase in tariffs at each of the hospitals to be acquired because, post-merger, Medi-Clinic would implement its national tariffs.[10] (The Commission had found that Protector's tariffs were generally lower than those of Medi-Clinic.) The Commission also expressed concern about the increasing concentration occurring in the hospital industry.[11] The Commission

10 It was common cause in this transaction that if Medi-Clinic acquired the Protector hospitals, it would implement its national tariffs, which would result in fee increases at these hospitals.
11 Commission's Recommendation page 30.

however found that the strong countervailing presence of the medical schemes in this industry - 90% of all patients using the Medivaal hospital belong to medical schemes - and the fact that New Protector was a failing company substantially lessened the anti-competitive effects of the transaction. It therefore recommended that the transaction be approved.

Netcare's contentions

10. Netcare and Supreme Health (which we refer to below collectively as Netcare[12]) contended that the transaction ought to be prohibited on several grounds. Netcare argued that the Tribunal should have regard not only to the national market shares of the merged entity but also the local market shares, especially in the Vaal Triangle and Kathu. It submitted, *inter alia*, that Medi-Clinic would become dominant in the Vaal Triangle if it acquired the Medivaal hospital.

11. Such dominance, Netcare contended, would have an adverse effect on the referral patterns of specialists and would provide Medi-Clinic with an incentive to deny patients emanating from Netcare's hospital in Sasolburg access to the ICU facilities at the Medivaal hospital in Vanderbijlpark and access to Medi-Clinic's hospital in Veereniging. Medi-Clinic would also be in a better position to attract specialists away from the hospitals of its rivals at which these specialists had rooms, and thereby attract more patients away from rival hospitals. Furthermore, by acquiring the Protector hospital in Kathu, Medi-Clinic intended to keep Netcare out of the Northern Cape in order to maintain its dominance in that province. Moreover, Netcare contended, the

12 Both parties were represented by the same legal team.

merging parties had failed to discharge the onus identified by this Tribunal previously[13] which falls on those who wish to rely on the failing firm doctrine.

12. Netcare claimed that there were a number of alternative options to the proposed merger, including an acquisition by Netcare itself of the Protector assets, which would lead to a less anti-competitive outcome in the Vaal Triangle and elsewhere.

The CMS' contentions

13. The CMS asserted that the acquisition of the Protector assets by Medi-Clinic ought to be prohibited because, in its view, the extent of concentration in the hospital industry, brought about by progressive acquisitions of independent hospitals by the three large groups, Netcare, Medi-Clinic and Life (previously Afrox), had resulted in an unacceptably high increase in hospital costs over time. The CMS contended that the three major hospital groups had been acquiring independent hospitals in a succession of "creeping mergers" over a number of years. While a particular transaction, or many of these transactions on their own, might not have given rise to any competition concerns, the cumulative effect of these transactions was a high degree of concentration in the private hospital market, with these three players having the lion's share of it. [14] According to the CMS, the three hospital groups enjoyed market power at a national level, and had exercised it. This was evident from the sharp increase in hospital

13 Iscor Ltd and Saldanha Steel (Pty) Ltd, Case No: 67/LM/Dec01.

14 The market shares of the three major private hospital groups in South Africa are:

Netcare	30.4%
Medi-Clinic	24.5%
Life Healthcare	27.7%

costs during the time in which these creeping mergers had occurred. Medical schemes did not have countervailing power. In the CMS' view the three major hospital groups ought not to be allowed to acquire any more independent hospitals.

14. A second argument advanced by the CMS was that the Tribunal should be concerned about local or regional markets in the private hospital market. It argued that regional dominance for a hospital group was important because it provided the group with national leverage in its tariff negotiations with medical schemes. Regional dominance also constrained the ability of medical schemes to negotiate preferred provider agreements.

15. Finally, the CMS argued that even if Protector was a failing firm, which it denied, the Protector hospitals ought to have been sold by the liquidator and the IDC to another independent hospital group[15]. The CMS supported Netcare's definition of the relevant market.

Merging parties' contentions

16. Medi-Clinic contended that, according to its definition of the relevant market, the transaction would not lead to a substantial lessening or prevention of competition at a national level. Nor was it Medi-Clinic's intention to deflect referrals by specialists away from its rivals' facilities in the Vaal Triangle. Medi-Clinic had never denied the use of its facilities to patients referred to them by doctors practising at its competitors' hospitals, and had no intention or incentive to do so in the future. While the transaction would lead to an increase in tariffs at the

15 The CMS contends that the market should be opened up to other players besides the three large hospital groups. Although it does not support Netcare as a less anti-competitive buyer it does seem to favour the notion of a consortium which includes one of the major players as a minority partner buying the target hospitals. See transcript page 1834.

Protector hospitals, this would only affect patients who were not members of medical schemes and these constituted only approximately 10% of all private hospital patients. The tariff increase would be in the region of 10%.[16] A tariff increase would be inevitable if any one of the three major hospital groups acquired the Protector assets because Protector's tariffs were generally lower than those of the three main groups.

17. In the event that the Tribunal found that the relevant market was the local market (as opposed to the national market) and that Medi-Clinic would have a relatively high market share in the Vaal Triangle, this would not lead to a substantial lessening of competition because Protector was a failing firm. After it had been placed in provisional liquidation the liquidator had attempted to obtain as many unconditional offers as possible for Protector's assets as a going concern, but at the date of conclusion of the sale had received only one such offer, namely that from Phodiclinics.

18. The hearing in this matter was preceded by an aggressive discovery process, and encompassed a large amount of documentary evidence and witness testimony.

Tribunal's findings

19. This Tribunal considers that new Protector was a failing firm – or more precisely a failed firm -- within the meaning of the Competition Act, 1998 ("the Act") at the time of the merger transaction, and considers further that the failing firm consideration outweighs any potential loss to competition that may arise as a result of this transaction.

16 See transcript page 880.

20. We have therefore approved the merger. In these reasons for that decision, we find that the merging parties have discharged the onus required Act in relation to what is often called the failing firm defence, also satisfying the criteria applicable in the USA in relation to that defence. Having considered the extent of competitive harm alleged by the intervenors, we have concluded that such harm as exists was overstated by the intervenors, and is outweighed by the failing firm factor.

Competition Analysis

The relevant product market

21. The Commission identified the relevant product market as the market for the provision of private hospital services. These consist of a range of specialist hospital services, also referred to as a cluster of services, such as obstetrics and gynaecology, neonatal intensive care unit, paediatrics, general surgery and urology.[17]

22. In addition to the specialist services above, both parties to the merger provide emergency units, including intensive care, high care, theatre facilities and pharmacies, although, not all of these facilities exist at all of the Protector hospitals .

23. In the case of Protector the above services are offered mainly by the Medivaal hospital, with the Marapong, Kathu and Kingsley hospitals offering limited facilities that can be regarded as catering for primary services rendered by general practitioners. Marapong, Kathu and Kingsley do not have ICU units. At Kathu some minor procedures are rendered by specialists, mostly travelling from Kimberley.

17 For a comprehensive list of specialist services see the Commission's report.

24. It was not contested by any party to the proceedings that the relevant product market was the market for the provision of private hospital services.

The relevant geographic market

25. The Protector hospitals are situated in:[18]

- The Vaal Triangle: Medivaal hospital with 155 beds
- Northern Cape Province: Kathu hospital with 25 beds
- Limpopo Province: Maropong hospital with 12 beds

26. Medi-Clinic owns 44 private hospitals in eight provinces in South Africa. Those closest to the target hospitals are:

- Vaal triangle: Vereeniging Medi-Clinic with 237 beds
- Northern Cape province: Kimberley Medi-Clinic with 234 beds, Upington Medi-Clinic with 40 beds
- Limpopo province: Limpopo Medi-Clinic with 193 beds, Tzaneen private hospital with 64 beds and Curamed Thabazimbi hospital[19] with 19 beds.

27. According to Medi-Clinic, 86% of its income is derived from medical schemes and less than 10% from private patients, the balance being derived from government medical funds. Medi-Clinic has contracts with all of the medical schemes in the country. Tariffs charged by Medi-

18 Kingsley Medical Centre is a day hospital and thus not considered within the same product market.. Netcare indicated in its opening statement that although its main focus was on the effect on competition in the Vaal Triangle it was also concerned about Kingsley and Kathu. These concerns were in relation to certain network effects which came into play as a result of the transaction.

19 This hospital is 51% controlled by Protector and managed by Medi-Clinic. This hospital does not form part of this transaction. The Commission, in its analysis, considered it as part of the Med-Clinic group because of the pre-emptive right that the other shareholders have to acquire the Protector shares. This will be a separate transaction. See Exhibit 8 par 2.6 on page 31.

Clinic vary from one medical scheme to the next. For each medical scheme it has a single tariff that operates nationally. It therefore considers the market serving medical scheme patients to be national. In its view a local market definition is relevant only in the case of patients who are not funded by medical schemes.

28. Hospitals compete with one another at several levels. While they may compete on price (tariffs) at a national level in their negotiations with medical schemes, at a local level they tend to compete for patients on a non-price basis. Hence hospitals may compete on the quality of their facilities, the quality of care provided in these facilities, the location of the hospital, and the nature of the specialist services available at the hospital. The Commission therefore followed a multi-perspective approach in defining the geographic market. It considered the effect of the transaction firstly within a national geographic market and then in a local market.

29. In this analysis, the Commission relied on previous Tribunal decisions, which have held that the market is national, based on the fact that hospital groups adopt a centralised, national pricing policy.[20] At a national level, the Commission found that this transaction would lead to market share accretion of 0.8% for Medi-Clinic and that any price increases following from the merger would be absorbed with minimal premium cost increases by medical scheme patients, who represent 90% of the market.

30. However the Commission was cognisant of the fact that a relevant national market may not adequately address the impact of such a transaction on competition in a local or regional market. According to the Commission, local or regional markets are important because dominance by a particular hospital group in a particular region may

20 See the Commission's Recommendation page 14.

have a negative impact on the ability of medical schemes to negotiate preferred provider agreements with such a group. This would have an impact on pricing and would limit the ability of medical schemes to deliver affordable products to the consumer.

31. The Commission defined local or regional markets by utilising a fixed radius test. This involved taking into account the alternatives available to patients in each area within a fixed radius of 60km ("the fixed radius test"). On the basis of this test the Commission identified the Vaal Triangle as a relevant geographic market in which the merging parties competed.

32. In Kathu, situated in the Northern Cape, the Commission found that 1.7% and 1.9% of all admissions to Kimberley Medi-Clinic and Upington Medi-Clinic respectively were from Kathu. Given the distance of more than 100 km between Kathu and other towns such as Upington, Kimberley, Vryburg and Bloemfontein, the Commission found that there was no geographic overlap between the merging parties in this area on the basis of a fixed radius of 60km.

33. The Commission also concluded that that there was no geographic overlap between Morapong Private Hospital and Limpopo Medi-Clinic because of the distance of more than 200 km between Lephalale and Polokwane, both situated in the Northern province.

34. The merging parties did not accept the Commission's definition of the Vaal Triangle market and argued that they competed in two separate markets, Vanderbijlpark and Vereeniging. Dr Theron of Econex, who gave expert economic testimony on behalf of the merging parties, agreed that the merger had both a national and local dimension but refrained from defining the geographic market conclusively. Dr Theron

utilised a number of tests to determine the relevant market, the primary one being the Elzinga-Hogarty Test ("E-H test") which she applied to patient flow data. [21] She argued that based on both versions of the E-H test, the weaker 75% and the stronger 90% patient flow test, no competition implications arose from this merger. She submitted that if the 75% E-H test is applied then the Medivaal hospital at Vanderbijlpark and the Medi-Clinic hospital at Vereeniging are in separate geographic markets and do not compete. If the 90% E-H test is applied, the Medivaal and the Medi-Clinic hospitals would fall into the same geographic market which should then also include hospitals from areas such as Sasolburg (9% of patients are from Sasolburg), Vereeniging (7% of patients are from this town) and Sebokeng (1% of the patients are from this town).

35. Netcare did not lead an expert witness. However, by cross-examining a number of witnesses, it sought to define the geographic market as the Vaal Triangle – a view it sought to base on the opinions of market participants, internal documents of Medi-Clinic, and the close proximity of the hospitals to each other. Netcare also criticized the use of the E-H test and said that it was not clear that the E-H test could ever be used in hospital merger analysis because of the "silent majority" fallacy.[22] It also pointed out that the economists who developed the E-H test had observed that it was not readily applicable to heterogeneous products such as hospital services.

21 The test was designed to analyse commodity movements or trade flow patters. In hospital mergers this means that the movement of patient X who resides within geographic market A to a facility outside of that geographic area for hospital services is considered an **importation of hospital services** into market A – measured as LIFO ("Little In From Outside"). The movement of patient X who resides outside of geographic market A to a facility inside geographic market A is considered as **exporting of hospital services** outside of A, measured as LOFI ("Little Out From the Inside"). A geographic market is usually described as "strong" if less than 10% of discharged patients from the merging hospitals' area come into or out of the area. If more than 10%, but less than 25% of patients migrate in or out of the hospitals' core geographic area for in-patient services, the market definition is considered "weak".

22 Patient flow does not measure price sensitivity. Patient flow can show existing hospitalisation patterns but offer no insight into what patients will do in response to a price increase by the merged hospital.

36. The CMS argued that the geographic market of a hospital should be defined by considering the hospital's catchment area.[23] It regarded the Vaal Triangle, Marapong, Kathu, Kimberley and Upington as separate catchment areas.

37. Patient flow data has been criticised by some scholars on the basis that it could lead to an overestimation of the geographic market by ignoring relevant factors such as specialist referral patterns. The Federal Trade Commission ("FTC") and the Department of Justice ("DoJ") of the USA, in a joint report on healthcare recommend that the delineation of relevant markets in an industry as complex and differentiated as hospital services should not rely on tests such as E-H test, which are designed primarily for homogenous product markets. Instead, regard should be had to a number of indicators such as the testimony of key witnesses, strategic internal documents of the parties, industry views, and location. [24]

38. Such an approach has been utilised by this Tribunal in other mergers involving product markets with a high degree of differentiation.[25] In our view, there is no need for us to decide whether the E-H test is an appropriate or accurate tool in this transaction. At best, in this matter, it represents an initial and tentative view of the relevant market, which needs to be supported by other tests.[26]

39. In our view the close proximity of the hospitals and documentary evidence as well as the testimony of certain witnesses strongly

23 See File 5 page 94 of the record.
24 See the report by the FTC and the DoJ on "Improving Health Care: A dose of Competition", July 2004.
25 Merger between Massmart and Moresport, Tribunal Case No: 62/LM/Jul05.
26 It may be that the E-H test is useful tool to arrive at a prima facie determination of a relevant market which is supported by other indicia as suggested by Dr Theron. However we make no such finding here.

suggests that Medi-Clinic regards Medivaal as a rival within the same local geographic market.[27] The hospitals are within short distances of each other.[28] Moreover, the hospital manager of Medi-Clinic's Vereeniging Hospital clearly sees his hospital as operating within the Vaal Triangle.[29] Handwritten notes by Mr Heyns also refer to the fact that should Medi-Clinic increase the rates at Medivaal, patients would be able to turn to Midvaal and Vereeniging Medi-Clinic.[30] This leads us to conclude that the relevant local market is the Vaal Triangle.

40. Kathu and Marapong hospitals have limited facilities and are not regarded as significant competitors of Medi-Clinic at a national level. However some competition concerns were raised by Netcare in relation to Medi-Clinic's acquisition of Kathu. We thus accept for purposes of considering Netcare's contentions that Kathu is also a relevant local market.

Market shares

41. Post merger, Medi-Clinic will be the only private hospital group in Kathu.

42. The following hospitals operate in the Vaal Triangle area:

- Vereeniging Medi-Clinic with 165 beds
- Medivaal (Protector) with 155 beds
- Midvaal Vereeniging (independent) with 92 beds
- Netcare Sasolburg with 68 beds

27For example: In a note by Mr Heyns of Medi-Clinic he refers to the options that medical schemes would have should Medi-Clinic increase its prices, namely Midvaal or Vereeniging. See Exhibit 8, handwritten notes, page 325 onwards.
28 The distances between the hospitals range from 5km to 26km.
29 See exhibit 8, page 59 in which he states "*the acquisition would increase our already dominant position in the Vaal Triangle*."
30 Exhibit 8 page 324.

43. In addition to the four listed above, the merging parties had also listed Clinix Private Hospital in Sebokeng. Smaller rivals such as Cormed (a day clinic) were also included in the Commission's list of market participants although the Commission did not regard them as providing the same range of services as those provided by the merging parties.[31]

44. With regard to Clinix in Sebokeng, Dr Theron conceded that she did not have any data indicating that patients living outside Sebokeng would travel to Clinix's hospital.[32]

45. If we were to consider Cormed and Clinix as competitors, then the market shares in the Vaal Triangle would be:[33]

Hospital	No of Beds	Pre-merger Market share	Post –merger Market share
Medi-Clinic (Vereeniging)	237	32%	**53%**
Midvaal (Vereeniging)	92	12%	12%
Vaalpark (Netcare Sasolburg)	68	9%	9%
Clinix (Sebokeng)	160	22%	22%
Cormed (Vd Bijlpark)	20	2%	2%
Medivaal Protector	155	21%	-
TOTAL	732	100	100

31 This was confirmed by Dr Theron under cross examination. See transcript 1115
32 See transcript page 1113
33 We used the number of beds as indicated by Econex on page 20 of Exhibit17 to calculate the market shares in the Vaal Triangle.

46. Excluding Cormed and Clinix, the market shares would be:

Hospital	No of Beds	Pre-merger Market share	HHI	Post-merger Market share	HHI
Vereeniging Medi-Clinic	237	43%	1849	**71%**	5041
Midvaal	92	17%	289	17%	289
Vaalpark (Netcare)	68	12%	144	12%	144
Medivaal (Protector)	155	28%	784	-	-
TOTAL	552	100	3066	100	5474

47. If we exclude Clinix and Cormed on the basis that they were not effective competitors, then, based on the number of beds, the merged entity will, after the transaction, hold a market share of 71% in the Vaal Triangle with an HHI of 5041 and a change in HHI of 3192. A market share of 71%, with an accretion of 3192, will clearly be of concern to any competition agency. Medi-Clinic will by far be the largest player in the Vaal Triangle with its closest rivals having relatively small market shares in comparison. Midvaal Vereeniging, an independent group, will have a market share of 17% and Netcare Sasolburg 12%. The stark figures are however mitigated by a number of factors to which I return later in this decision.

Failing Firm

48. The Act requires this Tribunal to evaluate the competition effect of mergers and acquisitions taking into account a number of factors, one of these being " *whether the business or part of the business of a party*

to the merger or proposed merger has failed or is likely to fail."[34]

49. The Tribunal, in *Iscor Ltd and Saldanha Steel (Pty) Ltd*, Case No 67/LM/Dec01, found that: "*a merger would not be regarded as lessening competition if the conditions laid out in the more stringent EU test can be satisfied.*"[35] However it also considered that one could, depending on the anti-competitive effect of the transaction, use the less stringent US test if a party fell short of the "market share would have gone to us" requirement. The merging parties submit that while they have not been able to discharge the onus of the EU requirement of "market share will go to us", they have been able to discharge the onus pertaining in the US test.

50. The US failing firm defence provides for the following:[36]

"A merger is not likely to create or enhance market power or facilitate its exercise if the following circumstances are met:

1) the allegedly failing firm would be unable to meet its financial obligations in the near future;

2) it would not be able to reorganize successfully under Chapter II of the Bankruptcy Act;

3) it has made unsuccessful good-faith efforts to elicit reasonable alternative offers of acquisition of the assets of the failing firm that would both keep its tangible and intangible assets in the relevant market and pose a less severe danger to competition than does the proposed merger; and

4) *absent the acquisition, the assets of the failing firm would exit the relevant market."*[37]

34 See s12A and s12A (2) (g).
35 See page 15 of the decision.
36 See page 14 of the decision.
37 Paragraph 5.1 of the Revised Guidelines April 8, 1997 issued by the U.S. Department of Justice and the Federal Trade Commission.

51. The Tribunal also pointed out that when the competitive loss is low, one may be less exacting in requiring a showing of all the elements of the traditional failing firm defence. It noted in par 105 of the decision that:

> *"If the failing firm concept was a defence, in the sense that the efficiency defence is, then this type of flexibility would be impermissible and one would have to satisfy all the elements of a test that the legislature had provided before it could be invoked."*

52. Netcare submits that the Protector hospitals, as business units, were not failing but that the Protector group was failing as a result of factors explained in the evidence -- fraud by its erstwhile managers and the loss of its medical scheme administration contract and the losses incurred by its pharmacies.[38] Hence, Netcare contended, the hospitals ought not to have been liquidated at the instance of the IDC. Furthermore, Netcare contended that the merging parties had not discharged the onus described by this Tribunal in Iscor and Saldanha Steel (Pty) Ltd, cited above.

53. Let us consider the circumstances of Protector's failure.

Unable to meet its financial obligations and reorganise successfully

54. On 25 November 2003, the IDC Board approved a leveraged buy-out of Protector Group Holdings (i.e. Old Protector), a holding company with trading subsidiaries, which was owned by Glenrand MIB Ltd, holding 65% and Protector Group Management Company ("Manco") holding 35% of the ordinary shares. As a result of the transaction a new holding company, New Protector Group Holdings (I,e, New

38 This was also argued by the CMS.

Protector) was formed to hold the same trading subsidiaries, with Tradeworx owning 51% and a new Manco, Freefall Trading 65 (Pty) Ltd, holding 49%.

55. The core business of New Protector's subsidiaries comprised 4 hospitals, 34 pharmacies and two medical scheme administration businesses. The funding of the LBO transaction involved R70 million cash in order to purchase the shares and claims of Glenrand MIB and a further R60 million in guarantees. The transaction was hailed as a BEE transaction effected by Glenrand. Marc Seelenbinder, the chief operating officer of the group, and Dr Mini, who had been a member of the Old Protector board, were seemingly the central figures in the transaction.

56. In February 2004, the IDC paid over approximately R70 million, as part of the purchase price, into New Protector's bank account. This money was never seen again. The only persons who had signing powers over New Protector's accounts were the two directors of Freefall, Leon van Rensburg and Marc Seelenbinder, whose whereabouts now seem to be unknown.[39] In July 2004 one of New Protector's subsidiaries lost its administration contract with the Protector Health medical scheme to another administrator, Medscheme, and in doing so New Protector lost its major cash-generating business, then earning revenue of R5.4 million per month.

57. A short time before the IDC-funded transaction was completed, Old Protector had acquired or was in the process of acquiring another entity called The Medicine Chain ("TMC") for R1,00 (one rand) with liabilities of R42 million. The IDC's valuation took into account the possible acquisition of TMC. However, it later emerged that the

39 A forensic and criminal investigation into the disappearance of these funds is ongoing.

acquisition was done without a proper due diligence having been conducted by Old Protector. TMC required additional working capital by way of cross-subsidy from the other business units. New Protector was not able to turn around the businesses in time. On 23 July 2004 the major banks exercised their securities and froze the bank accounts of New Protector and its subsidiaries. None of these banks were willing to extend any further facilities to these companies.

58. New Protector therefore had no cash flow or overdraft facilities available for its subsidiaries' trading operations. It had no money to pay salaries of staff, to buy food or provisions for patients, to pay its rent, or to service its debt. The situation was aggravated by the departure of Messrs Seelenbinder and Van Rensburg,[40] leaving the company with very few, if any, people on its board who were skilled and experienced in the management of a business of that size or nature.

59. New Protector turned to the IDC, its major creditor, for assistance. The IDC settled some debts with the banks, thus increasing its exposure, and then attempted to find a durable solution to New Protector's difficulties.[41] The IDC attempted to facilitate negotiations with Clinix Hospital Group[42] in the hope that Clinix could rescue New Protector. Both the IDC and Tradeworx explored the possibility of bringing in an experienced partner such as Clinix or Medi-Clinic.[43] Attempts were made by the IDC's personnel to engage with the managers of New Protector and its subsidiaries and develop a rescue plan for the group. A rescue plan was proposed by New Protector which contemplated

40 Amidst the fallout caused by the missing funds, Marc Seelenbinder resigned in July 2004. Leon van Rendburg seems to have followed soon thereafter.

41 See Jean Du Plessis' witness statement page 8 par 23 as well as transcript page 170.

42 See IDC 3 page 1280.

43 Some efforts were made by Tradeworx to engage Medi-Clinic as a possible partner in New Protector during this period Prior to the liquidation, Medi-Clinic had been involved in talks with Tradeworx, some information had been exchanged and a limited due diligence had been conducted. The IDC's attempts at bringing in Clinix were unsuccessful.

cost savings in the long run but which in the short term required a capital injection from IDC for retrenchments, the restart of business, and working capital. The extent of this cost had not been calculated but was expected to be high.[44] The rescue plan did not provide for any repayments to the IDC while requiring an increase in exposure for the IDC. The IDC was also expected to take an equity stake in the business, which would have increased its exposure further.[45]

60. In the meantime, the IDC had already advised New Protector that it was seeking to protect its own interests as a creditor and was not willing to increase its exposure any further.[46] During this time, another smaller creditor of New Protector applied for its liquidation. While the company defended the action, the liquidation application, together with the exercise by the banks of their securities, served as a trigger for action by several other creditors. Furthermore New Protector had been evicted from some of the TMC pharmacy premises because it was unable to pay its rent.[47] New Protector was indeed in dire circumstances. Though it seems that the IDC's original intention was to restructure New Protector and assist it in trading out of its financial difficulties[48] this was abandoned because, according to the IDC, it was uncertain that New Protector would be ever able to service the level of additional debt that such a rescue operation required. Events were in any case overtaken by the actions of other creditors.[49]

61. At that point New Protector's major creditors were Nedbank (R59.5 million), ABSA (R27 million), FNB (R23 million), the IDC (R72 million)

44 IDC 1 page 151
45 According to a Business Day report of 8 September 2006 the IDC stated:" *its intention was not to sink the company, but rather to save it by placing it in provisional liquidation, restructuring it, and then pulling it out of liquidation. The IDC together with Tradeworx and other stakeholders are working on a restructuring plan to revive the group*…." See file IDC1 on page 505.
46 IDC1 file, page 453
47 See evidence of the liquidator, witness statement page 3 and IDC 1 page 150
48 The IDC considered placing the company under judicial management as one of the possible options.
49 See evidence of Du Plessis and IDC 2 page 151.

and SARS (R16.86 million). Trade creditors were owed R48.23 million of which R19.37 million was in arrears for 90 days or more. The group's total assets were approximately R35 million while its total liabilities were approximately R250 million. The group employed about 800 people and was unable to pay salaries at the end of August 2004 or buy food and essential provisions for its hospitals.

62. On 2 September 2004 New Protector was placed in provisional liquidation at the instance of the IDC, and liquidation of its subsidiaries followed soon thereafter. The IDC agreed to provide New Protector with a loan of R27 million as liquidation expenses which would in that capacity be secured from other creditors.[50] At the hearing the intervenors suggested that the IDC had placed the company in liquidation simply to protect its R27 million against the claims of other creditors. [51] This does seem to have been a factor that the IDC had in mind when it decided to liquidate the company. But it was not the only one.[52] The evidence clearly indicates that the IDC was not confident that New Protector would be able to repay its existing debts, let alone service any additional funding that it obtained from the IDC. Liquidation proceedings by a number of creditors were pending, none of the banks were willing to extend any further overdraft facilities and there was no money to pay its rent, buy food or pay salaries, it had been evicted from some of its pharmacy premises, it was continuing to trade in insolvent circumstances, and its directors were at risk of incurring personal liability.

63. A liquidator, Mr Theo van den Heever, was appointed on 2 September 2004. He set about trying to assess the extent of the financial distress, conducted a valuation process and ensured that the hospitals

50 See evidence of Mr Du Plessis, witness statement on page 11 par 32
51 The R27m would be secured claim as it was advanced to Protector as liquidation expenses.
52 See evidence of Du Plessis and IDC 1 pages 146-153, IDC 3 pages 1279-1280.

continued operations. He found that the company's financial records were in total disarray. There were no financial statements available after 30 June 2003. Trading results until 28 February 2005 showed a loss for the group of about R8 million. If interest to the IDC, which was owed but not paid, was taken into account then the group had made a loss of R16 million.[53] Moreover, post liquidation rent owed to the IDC but not yet paid over amounted to R22.6million.

64. Continued trading was only made possible by the injection mentioned above of R27 million in cash by the IDC. Moreover, it transpired during an investigation by chartered accountants SAB&T that the sale of Glenrand's 65% stake in Old Protector had initially been made to Freefall, a company owned and controlled by Messrs Seelenbinder and Van Rensburg, and not to TradeWorx, as Glenrand had claimed in press announcements. The investigation also revealed that the shares of the operating companies that ought to have been transferred to New Protector had not in fact been transferred. The effect of this was that New Protector did not have any control over Old Protector or the subsidiary companies in which all the trading assets were held.[54] A transfer of shares could therefore not be effected to any interested buyer, nor could the group pursue any outstanding awards granted to Old Protector without protracted and costly litigation since ownership did not vest in New Protector.[55] The companies in which the hospitals were located were all sureties of each other's and the pharmacies' debts. Hence each of the companies was liable for the accumulated liabilities of the group and a loss in the one would attach to another even if the other was operationally in better financial health.

53 See IDC 3 page 1281
54 See File IDC3, page 1282.
55 Old Protector was awarded a damages claim in litigation arising out the termination of the medical scheme administration contract. However, while it had won on the merits, the amount of damages had not been determined. New Protector was not able to pursue this claim without more costly litigation, and in the end the claim was settled for approximately R6 million. (transcript page 1558)

65. What is evident from the above is that significant efforts were made by the IDC to assist New Protector. The company itself, and its other shareholder, Tradeworx, clearly lacked the experience and expertise to reorganise its structure and operations without the ongoing assistance of the IDC.[56]

66. In our view, there is no doubt that New Proteector was already a failed firm and was unable to reorganise itself successfully by the time it was provisionally liquidated. Subsequent to the liquidation it became apparent that New Protector's finances and ownership structure were in greater disarray than initially anticipated. [57] As the liquidator put it:[58]

> *"So I don't know what the definition is of a failing firm, I just know this company is in liquidation, it is badly in liquidation and post liquidation we are making massive losses because that's just the way it is."*

Good faith effort and reasonable alternatives

67. Netcare argued that the liquidator had not been able to show that good faith efforts had been made to find reasonable alternatives posing a less severe danger to competition than did the proposed merger. According to Netcare there were offers on the table from other interested parties, including Netcare, which were reasonable

56 Netcare and Supreme Health made much of alleged early undertakings by the IDC to Tradeworx that the IDC would rescue New Protector or place it in judicial management in order that it could be refinanced without pressure from other creditors and then taken out of judicial management. Whether or not the IDC made any such undertakings would have been better dealt with in another forum, and that question is certainly not relevant to these proceedings. The fact remains that New Protector was insolvent and in dire straits.

57 See Du Plessis at page 317 where he explains that had there been a rescue plan on the table they would have accepted it.

58 Transcript page 545.

alternatives to the Phodiclinics offer and which would lead to a less anti-competitive outcome. The CMS argued that the liquidator ought to have designed a process, in consultation with the IDC, to find a buyer independent of the three major groups.[59]

68. Let us consider the liquidator's efforts and the offers he received, bearing in mind that New Protector and its subsidiaries were already in provisional liquidation.[60]

69. The liquidator was appointed on 2 September 2004. In accordance with his mandate and with the support of the IDC he embarked on finding a buyer for the assets of the group as a going concern, rather than selling them in a fire sale.[61] He ensured that the hospitals and pharmacies continued trading, using the liquidation funds advanced by the IDC, while he attempted to find a purchaser for the businesses. Information packs were made available on 20 October 2004 and collected by various interested parties, including Medi-Clinic, Netcare and Dr Mini.[62]

70. On 9 December 2004 Phodiclinics submitted a cash offer of R120 million, which was acceptable to the IDC and was subsequently accepted by the liquidator. (Phodiclinics had submitted an earlier cash offer of R90 million through Chestnut Hill, a Medi-Clinic/BEE consortium, for all the businesses dealt with in the information pack excluding the Kingsley hospital and pharmacy, and the liquidator had sought to improve on that offer.)[63]

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59 It was understood by all parties that any potential purchaser would involve a BEE partner.
60 Areeda, in Antitrust Law, Vol. IV page 249 says that:"A failing firm cannot reasonably be asked to canvass any substantial fraction of the entire universe of potential acquirers….Time alone imposes some constraint on the opportunities for search."
61 A fire sale is a sale of assets that are not being used in trading. The liquidator decided to sell the assets as a going concern so as to ensure the highest possible value for the creditors of the company.
62 A copy of the Offer document was given to eleven interested parties. See record File 4 page 400.
63 The "for sale valuation" by Aucor Auctioneers of the Protector group was estimated as R43 million.

71. Prior to that, on 15 November 2004, the liquidator had received an offer from Tradeworx ("the first Tradeworx offer"). Tradeworx offered to purchase the assets for R44 739 076[64] plus 80% of the total stock value. However the structure of this offer required the IDC to provide further funding or guarantees, over and above its current exposure, of approximately R60 million. The liquidator testified that such an offer would not be approved by the Master of the High Court, as the final voice in the liquidation process, unless there was certainty that a majority of creditors would agree to the offer and there was certainty that the condition would be fulfilled.[65] The IDC declined to support the offer as it was not willing to increase its exposure.[66]

72. The merging parties argue that the offer was also unreasonable in that the amount offered was less than half of what had been offered by Phodiclinics. Certainly the cash portion of the offer was approximately that of the fire sale valuation of the assets of the company.[67] Of critical importance, however, was that the offer was conditional upon the IDC's agreement to provide further funding. The offer collapsed when the IDC declined to provide such further funding.

73. On 30 November 2004 Tradeworx submitted a revised offer ("the second Tradeworx offer") in a letter addressed to the IDC directly and not to the liquidator, to purchase, *inter alia*, the IDC's claim of R157 million against NPGH for R90 million, which apparently was later orally

64 An amount approximately equal to the fire sale valuation that had been done by the liquidator.
65 According to Henochsberg on the Companies Act "*The Court must be satisfied that the statutory provisions have been complied with that the classes of creditors or members were fairly represented by those who attended and that the statutory majority approving the compromise or arrangement is acting bona fide in the interests of the relevant class; the compromise or arrangement should also be such as a man of business would reasonably approve… The fact that a majority of creditors or members, as the case may be, has agreed to a compromise or arrangement is of course, an indication that it is fair and reasonable*..." Henochsberg Vol 1 page 622 - 623.
66 See Keulder's evidence, transcript page 358.
67 The "fire sale" value of the company was R43 million.

increased to R95 million in cash and R10 million in preference shares.[68] Although the liquidator was informed of this offer by the IDC, it was never submitted to him for consideration. Of critical importance is that this offer required the IDC to provide an even greater amount of finance to Tradeworx than had the first Tradeworx offer: the IDC was expected to guarantee an overdraft of R16 million and pay R64 million for 49% of the equity.[69] Once again, the offer was conditional upon the IDC providing funding or guarantees which it declined to give. Once again the offer – if it was that – collapsed.

74. Mr van den Heever testified that despite the fact that the liquidation was well advertised no other potential bidders registered any interest in the separate hospitals or the assets as a whole even after he had actively pursued and invited other potential bidders, including Netcare, to submit offers.[70] He informed all the creditors towards the end of November that an offer of R90 million was on the table but that he believed, based on past experience, that this offer could be increased to R120 million.[71]

75. Early in December 2004 Nulane Investments,[72] a Netcare/BEE consortium, submitted an unsigned offer to the IDC ("the Nulane offer") and not to the liquidator, to purchase the claims of the IDC against New Protector and Clinix for R90 million -- not the business of New Protector as a going concern. Clinix was not the subject of the liquidation process. The price of R90 million was not allocated between New Protector and Clinix. Hence the offer was considered

68 See page 399 of File CD1.
69 See IDC2 File, page 847.
70 See transcript of 6 September 2006, page 642. (This part of the hearing was held in camera as the information being aired was confidential.) Also see a letter to the IDC on page 425 of file CD1 where the liquidator gave a synopsis of the communications with potential purchasers.
71 See letter to creditors, page 325, file IDC1.
72 It emerged during the cross examination of Dr Mini that Tradeworx was not part of the Nulane consortium but that Dr Mini (and not Tradeworx) joined the Netcare consortium after the Nulane consortium had submitted its offer. See transcript page 1647.

vague and indeterminable in relation to New Protector.

76. The Nulane offer was also subject to various conditions precedent. It stated that Nulane would only be able to purchase the assets of New Protector it after it had obtained a definitive opinion from its tax advisors on certain matters. No indication was provided by Nulane of the amount which it would be prepared to offer for these assets. Then, it required the IDC to warrant that a dividend on its (the IDC's claim) against New Protector would be at least R90 million, less the realisation costs contemplated in s89 of the Insolvency Act. However, the size of the dividend the IDC would get was dependent on how much Nulane itself was prepared to pay for Protector's assets.

77. Of significance once again was that the offer was conditional upon the IDC's involvement through commitments which the IDC declined to provide. This offer was never submitted to the liquidator for his consideration. Even if it had been, the offer was not capable of being accepted by him since the IDC had refused to grant the undertaking to Nulane on which it was dependent.

78. The IDC, acting on the liquidator's advice, indicated that it would accept an offer of R120 million from Phodiclinics. On 9 December 2004 Chestnut Hill, the Phodiclinics vehicle, increased its offer to R120 million. The liquidator informed Tradeworx of the increased offer but Dr Mini indicated orally to the liquidator that Tradeworx would never offer R120 million.[73] A letter was also sent to Mr Dewald Dempers of Nulane Investments to ascertain if it was still interested in making an offer but he indicated that Nulane was not interested.[74]

73 See transcript page 528

74 Netcare indicated to the Commission in a letter dated 13 December 2005 that is was never interested in making an offer independently. (See File 5, page 76 of the record.)

79. On 20 December 2004 the IDC indicated its acceptance of Phodiclinic's offer of R120 million. However, during February 2005, the IDC invited Nulane Investments and Tradeworx to submit further and final proposals to purchase the assets of NPGH. The IDC embarked on this extended invitation after it had received a letter from Tradeworx complaining about the process that had been followed by the liquidator and referring to an earlier restructuring plan it had suggested to the IDC.[75] The IDC indicated in a letter dated 4 February 2005 that the final proposals had to be submitted by the close of business on 25 February 2005. In the same letter the IDC stated that the proposals should include irrevocable commitments from the offerors' shareholders and financiers for the financing of the proposal. It also stated that should any of the offerors wish to take New Protector out of liquidation and propose a scheme of arrangement, a detailed proposal including offers to creditors should be included in the proposal.[76]

80. The IDC had made it abundantly clear when rejecting all of the conditional offers that it did not wish to increase its exposure, and reinforced this stance by requiring irrevocable undertakings of financing from offerors.[77] It had provided the other two interested parties, Tradeworx and Netcare (whether or not in a consortium) a further opportunity to submit offers and also an opportunity to take New Protector out of liquidation.

81. On 25 February 2005, a restructured offer by Grand Bridge Trading ("the Grand Bridge offer"), consisting of the shareholders of Tradeworx, a BEE healthcare group named Community Hospital Group (Pty) Ltd, and Netcare, was submitted to the IDC. The Grand Bridge offer consisted of a purchase price of R130 million of which R90 million was

75 According to the IDC this process was rejected by management.
76 See IDC 2 file page 925
77 See IDC3 file page 1285, par 2.4.6

a cash portion to be provided by Netcare. The balance of R40 million was to be paid by the IDC by abandoning the R27 million of post-liquidation funding it had provided and abandoning R13 million of any rights to a dividend paid on its claim.

82. This offer too required the IDC to maintain if not increase its exposure. The IDC requested Grand Bridge to guarantee a return of R40 million for the proposed equity stake of 10%, which it declined to provide.[78] In the liquidator's view, this offer was not capable of being accepted because it was conditional upon the IDC paying the balance of the purchase price, which the IDC declined to do.[79]

83. The offers made by Tradeworx, Nulane and Grand Bridge were all conditional upon the fulfilment of a condition that the IDC, in some manner or other, whether through equity, guarantee, cash, abandonment or waiver, contribute towards the purchase of the group by the offeror. None of these offers stated that should the conditions be unfulfilled by the IDC, the cash portion of the offer should be considered as a cash offer for the assets of New Protector. Once the IDC rejected the condition, the offer was no longer capable of being fulfilled and was therefore not capable of being accepted by the liquidator. The offers simply became void.

84. No evidence was led that any of these offerors returned to the liquidator, after being notified of the IDC's rejection of the condition, with a revised offer excluding the involvement of the IDC,[80] even if lower in value than the Phodiclinics offer. Nor did the IDC receive any proposals amounting to a re-organisation of New Protector which would allow it to be taken out of liquidation.

78 See IDC3 file page 1288.
79 See liquidator's witness statement page 12 par 33 and 34
80 Or conditions that may have been more acceptable to the IDC and which did not involve it increasing its exposure.

85. If these offerors intended to make such offers they could have done so easily. There was ample time to do so and they were provided with many opportunities to do so.

86. Instead, the offerors, despite being aware that the IDC wished to limit or decrease its exposure rather than increase it and that it was not willing to accept such conditions,[81] persisted in submitting proposals conditional upon the IDC's involvement and all having the effect of increasing or maintaining the IDC's exposure. Hence there was only one offer capable of being accepted by the liquidator, namely the final Phodiclinics offer.

87. In fact, Mr Du Plessis of the IDC also explained that in the IDC's mind there was only one offer, and that even at the late stage when it arrived the IDC would have welcomed a feasible rescue plan:[82]

> *"Let me repeat myself, we never decided to abandon. We've been waiting for a plan, which we never got and then all that we could do was to look at offers on the table, and there was the cash offer and therefore we proposed that eventually to go with that offer. If at any point in time there was a rescue plan that would've made sense, we would definitely have considered that, but it was never there….."*

88. The liquidator in consultation with the IDC thus decided to accept the R120 million cash offer of the Medi-Clinic consortium on 31 March 2004.

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81 Dr Mini would have been aware of this at the earliest when he received the letter from the IDC advising him that the IDC was acting as a creditor and seeking to protect its interests . This was on 22 September 2004 (see IDC1 file page 550). However, as early as 30 August 2004 Dr Mini was informed at a meeting that the restructuring plan was not acceptable (see IDC1 file page 4530)) and again when the IDC rejected the first Tradeworx offer. Netcare may have been aware of this earlier but at the latest was aware of the IDC's attitude when the Nulane offer was rejected. All of them were aware of the IDC's requirement of irrevocable funding from the letter of 4 February 2005.

82 See transcript page 317.

89. In our view the circumstances explained to us by Messrs Du Plessis and Theo Van den Heever at the hearing, and summarised above, clearly demonstrate that the liquidator took great pains and made more than reasonable efforts in good faith to elicit interest in the sale of the hospitals and to contact all potential buyers he could identify.[83]

Assets will exit the market absent the acquisition

90. According to the Commission a representative of the IDC confirmed in a telephone conversation with it that it was highly likely that the New Protector assets would be broken up and disposed of piecemeal if the merger transaction did not proceed.[84]

91. At the time that New Protector was liquidated it was losing experienced staff and specialists and was facing declining patient admissions.[85] But for the IDC's liquidation funding it would have been unable to pay salaries and rent and provide food for its patients. It had been evicted from some of its pharmacies. Its accrued debts were unpaid. In short, it was unable to run its hospital business. Furthermore, it is clear that New Protector lacked not only the financial resources but also the operational expertise to run a hospital business successfully. Tradeworx and Dr Mini also lacked the requisite experience to turn around the business.[86] The IDC is an investor and is not in the

83 Netcare's attempts to show that the liquidator had manipulated the sale process in order to favour Medi-Clinic are completely unfounded. In fact the liquidator had called whom he considered to be a Netcare representative and other interested parties on more than one occasion to awaken interest and elicit an offer. See transcript 528

84 See Recommendation page 32.

85 As indicated by Dr Broomberg , when specialists turn their back on a hospital, for whatever reason, the hospital might just as well close its doors. Transcript pages 1496 to 1498 and 1504.

86 See in this regard the cross examination of Dr Mini by Mr Rogers, transcript 1621, in which Mr Rogers suggests that Dr Mini, who was a member of the Protector board at the time of the acquisition of the TMC, contributed to the demise of the Group. Dr Mini conceded that he was opposed to that transaction largely because he did not understand how the TMC could be bought for R1,00. He did not realise that Protector was purchasing liabilities of R42million**.**

business of managing the operations of a hospital. It is not surprising, therefore, that the IDC attempted to find an experienced partner such as Clinix to rescue NPGH. When that attempt failed, it sought to find a purchaser on a going-concern basis as a final rescue attempt. The liquidator described the situation as follows:[87]

> *"… so they are not viable as they stand right now. I mean I've been following the argument with regard to the rise in prices if another medical group takes it over. Protector at its current level is not viable and had it not been for the Medi-Clinic in 2004 we would have most probably closed the business down long ago, because its only the fact that we had realised R 80 million more than fire sale value, that has vindicated us in saying let's keep these businesses operational."*

92. The IDC stated on various occasions that it was not prepared to invest more funds in the business or to increase its exposure, and that it was merely keeping the business afloat because it wanted to preserve the hospitals as much as possible, since these were essential services, and only until it found a willing buyer for the businesses as a going concern. The liquidator indicated that he had been willing in the last resort to sell the assets piecemeal or in a fire sale.[88]

93. Medi-Clinic testified that it would have to spend R 14.5 million in order to upgrade the infrastructure and to buy new equipment for the Protector hospitals, of which R 13.71 million related to essential upgrading of medical equipment and infrastructure and a further R800 000 to the adoption and upgrading of IT systems.[89]

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87 See transcript page 544.
88 See evidence of Van den Heever, transcript page652.
89 See page 32 of his witness statement.

94. It is thus reasonable to conclude that, in order to keep these assets in the hospital market and to attract future referrals from specialists, New Protector urgently required operational expertise and a substantial capital injection. Only Medi-Clinic had offered unconditionally to provide both.

95. The CMS argued that if the Tribunal were to prohibit this transaction the IDC would continue to fund Protector through a fresh round of negotiations. However there was no evidence that the IDC would agree to continue funding Protector through any further round of negotiation, let alone the process which the CMS would wish to see, involving the building of consortia in which independent stakeholders would be predominant. Indeed the evidence suggests quite the opposite, namely that the IDC was not prepared to continue funding the company. In his witness statement Mr Du Plessis of the IDC described its position, should the merger be prohibited, as follows:[90]

> "*I do not know whether there would in fact be alternative offers for the businesses if the current merger were prohibited. If there were, and if Netcare were to be involved, I anticipate that merger approval might be contested. I can foresee that the IDC would be reluctant to continue funding the Protector group where the duration and outcome were uncertain. And, of course, there is the risk of staff losses, migration of doctors and loss of patient loyalty.*"

96. The liquidator puts it equally strongly in his witness statement, indicating that it is doubtful that the hospital could be kept afloat for another round of negotiations and competition approval:[91]

90 See page 30 of his witness statement.
91 See witness statement page 19 par 46.21.

"…Upon rejection of the current merger there is a real prospect that the businesses will immediately close down (as they would have done nearly two years ago had the IDC not provided crises funding) and the assets will be sold off piecemeal by the liquidators."

97. In fact the IDC, as early as September 2004, was contemplating whether New Protector should continue trading under the dire circumstances it found itself in or whether the assets should be sold.[92]

98. We are satisfied that, absent the acquisition by Phodiclinics, the assets of NPGH are likely to exit the private hospital market.[93]

99. Counsel for Netcare argued that it would be better for competition had the IDC accepted the Grand Bridge offer.

100. While both Netcare and the CMS urge us to consider alternative scenarios, this Tribunal can only assess this transaction on its own merits. We have found that Protector was a failing firm as contemplated in the Act and that but for the Phodiclinics offer, there were no other offers capable of being accepted by the liquidator. But even if we were to, for arguments sake, consider the Grand Bridge offer as capable of being accepted by the liquidator, from the CMS' point of view the competition outcome would be much the same if any of the three, Medi-Clinic, Netcare or Life, had acquired Protector.

101. In any event this is speculation rather than evaluation. There was no other offer on the table capable of being fulfilled and accepted by the liquidator at the time when the liquidator accepted Medi-Clinic's offer ("the liquidation stage"). This brings us to the proposal or offer tabled by Netcare and Tradeworx in the course of the hearing ("the

92 IDC1 file page 194 and 503.

93 They might continue to exit in other markets such as the market for specialist rooms absent the acquisition but it seems likely that the assets would exit the hospital market absent the acquisition.

competition evaluation stage").

102. At the commencement of the proceedings in September 2006, Dr Mini advised the Tribunal in his witness statement that in the event that this transaction was prohibited, he had with the assistance of Netcare, obtained funding from Imperial Bank of R90 million to purchase New Protector's business. In the course of the proceedings a document was put up to the Tribunal by Netcare indicating that the funding had increased to R100 million. No reasons were provided by either Dr Mini or Netcare why such an offer had not been made to the liquidator at the time when the Medi-Clinic offer was accepted.

103. In our view the existence and the terms of this belated offer are irrelevant to these proceedings[94] and the Tribunal does not regard it as a valid offer existing at the time when the merger transaction was concluded. "Reasonable alternatives" as contemplated in the *Iscor* case must exist at the time when offers are procured by the liquidator and a transaction is concluded, not at some indeterminate time in the future.

104. The EU and US guidelines require that a failing firm demonstrate, at the time when the transaction is being evaluated for competition implications, to the competition authority that it "*has made unsuccessful good-faith efforts".* The word "has" is the singular pr*esent* tense of the word "have". In the context of the requirement that the merging parties prove the elements of the failing firm doctrine, the parties are required to show, *at the time at which they seek approval from the Competition Authorities*, that they "have made" good faith efforts to find reasonable alternatives to the offer they have accepted and for which they seek approval. The Act does not require parties to

94 But serves to confirm that had Netcare and its partners intended to make a cash offer to the IDC at the liquidation stage, they would have been able to do so.

provide an undertaking that they "will continue to make" efforts to find reasonable alternatives. Such an interpretation would lead to an absurdity, since the authority would never be able to approve a transaction to which a party must continuously strive to find an alternative offer.

105. If Netcare and Dr Mini had been desirous of submitting an offer capable of being accepted by the liquidator (and not conditional upon the involvement of the IDC) they had ample opportunity and information at their disposal to do so during the period June 2004 to April 2005. They elected not to do so. Their failure to do so then, linked with the tabling of the belated offer in these proceedings, is nothing more than a cynical attempt to manipulate both the liquidation proceedings and the proceedings of this Tribunal.

106. At the time that the Phodiclinics offer was accepted by the liquidator there was no other offer capable of being accepted by the liquidator on the table, let alone an offer that was a reasonable alternative that would pose a less severe danger to competition than does the proposed merger.

107. We accordingly find that New Protector was a failing firm as contemplated in s 12A(2)(g) of the Act and that the merging parties have discharged the onus as required of them in the US test. We find further that there was only one offer that was capable of being accepted by the liquidator.

Effect on Competition in the Vaal Triangle and Kathu

108. In this section we deal with the concerns raised by Netcare first and thereafter consider those of the CMS.

109. Netcare alleges that Medi Clinic would engage in a number of exclusionary acts which would have an anti-competitive effect on Netcare specifically, as a competitor, and on competition in general in the local markets. We turn to consider each of these concerns.

Closure of Specialised units at Medivaal

110. Netcare submitted that Medivaal Hospital and Medi-Clinic were the only two hospitals in the Vaal Triangle that offered a range of specialised care facilities.

111. Ms Bester on behalf of Netcare explained the concern as follows. There was currently a referral practice amongst specialists in the region by which patients would be referred from a hospital which does not have adequate specialised facilities to another which has these facilities. Many patients from Vaalpark (Netcare) were referred to the Medivaal hospital because of its specialised care facilities and because it was, she testified, 16km closer than Medi-Clinic Vereeniging. Once the merger was implemented, and if the specialised care facilities at Medivaal were closed or rationalised in any way, she was concerned that doctors who currently admitted patients at the Vaalpark Hospital (Netcare) with the knowledge that they could be referred to Medivaal may cease doing so because of the cost and risk of transporting ventilated high care and ICU patients over a greater distance, to Vereeniging. The essential concern seems to be that that Vaalpark would suffer a decline in admissions and will be left out of the loop. Patients would be referred directly to Medi-Clinic Vereeniging.

112. Mr Swiegers on behalf of Medi-Clinic testified that there was no intention to close any facilities at Medivaal. In fact Phodiclinics had already committed itself to upgrading some of the facilities at Medivaal at a cost of R14.5 million.[95] No further evidence was put to us that there was any such intention on the part of Medi-Clinic. Even if Medi-Clinic did rationalise or close down any of specialised units at Medivaal we cannot see how any of the competition concerns raised by Ms Bester would arise. An evaluation of the distances between the hospitals shows that Medi-Clinic is not 16km further from Vaalpark than Medivaal but only 8km.[96] Patients would only be travelling an additional 8km and not 16km from Vaalpark to Medi-Clinic Vereeniging, thus reducing the risk foreseen by Ms Bester by half. In addition, some specialists already refer patients from both Medivaal and Vaalpark to the Medi-Clinic Hospital in Vereeniging.[97] Hence if a specialist decided to leave Vaalpark or Medivaal out of the referral loop he or she could do so now, prior to the merger.

Patient referrals

113. A second concern raised by Ms Bester was that Medi-Clinic would refuse to admit Vaalpark patients who are referred to Medivaal. In our view, there is no basis for such a concern. Medi-Clinic already accepts referrals of patients from Vaalpark to its Vereeniging hospital. There seems to be no commercial rationale for it to refuse referrals to Medivaal in the future. Mr Swiegers confirmed that Medi-Clinic would welcome any referrals since this was a source of revenue for the hospital and it was Medi-Clinic's intention to ensure that Medivaal became a profitable operation on its own.[98]

95 See Swiegers' witness statement page 32, par 53 and transcript page 720.
96 See exhibit 5.
97 See Bester witness statement par 4.13, transcript page 1710 and exhibit 6.
98 See transcript page720.

Refusal to Co-operate

114. Ms Bester's further concern revolved around the impact this merger would have on the extent of co-operation between Vaalpark and Medi-Clinic. She testified that hospitals assist each other in various ways, either by making equipment or nursing capacity available to each other. She was concerned that post-merger Medi-Clinic may refuse to co-operate with or assist Vaalpark. However under cross-examination she could only point to two incidents upon which this concern was based, once when her staff requested a harmonic scalpel and the other when they requested a shaver for an ear, nose and throat procedure.[99] The obstructiveness perceived by Ms Bester in these incidents was credibly dispelled by Mr Swiegers.[100] Interestingly both Ms Bester's and Mr Swiegers' testimony suggests that there is a large degree of co-operation, communication and assistance on a professional level between hospitals in the Vaal Triangle.[101]

115. In response to a question from the Tribunal panel, Mr Swiegers stated that there was no policy within Medi-Clinic to refuse to assist other hospitals on a professional level, and the Tribunal views his testimony as an undertaking that there would be no such refusal, post merger, to assist Vaalpark or any other hospital in times of need.[102]

Competition for specialists

99 See ttranscript page 1703
100 See transcript page 720.
101 Counsel for Netcare was at pains to prevent the Tribunal from viewing such practices as anti-competitive behavior. See transcript page 910.
102 See transcript page 909. At this point Mr Unterhalter tried to argue that Medi-Clinic was obliged to assist Vaalpark with equipment and other requests because it was a dominant player in that region. We do not deal with this issue and make no such finding.

116. Ms Bester explained that at present some specialists had facilities at both Vaalpark and Medivaal. She was concerned that post-merger Medi-Clinic might make it unattractive for specialists to continue having facilities at both Vaalpark and Medivaal.

117. This concern stems from the basis of competition in the private hospital market.[103] Price competition between hospitals is virtually non-existent or, short of a major and focussed enquiry, very difficult to assess. Hospitals tend to compete on non-price factors such as location, quality of care and the range and experience of specialists they can attract to their hospitals.[104] The intervenors argue that the more specialists a hospital can attract to its premises the more likely it is that patients who consult these specialists will be admitted to the hospital at which the specialists practice.[105]

118. However the picture that emerges from cross-examination of Ms Bester, and which is supported by Mr Alex van den Heever's witness statement, shows that specialists in the Vaal Triangle often work at two if not three hospitals.[106] Some specialists even travel between Vereeniging and Sasolburg.[107] No evidence was led by any of the parties that these specialists were prevented by any of the hospitals from working at competitive hospitals.

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103 The basis of competition between hospitals has been a vexed subject in many a merger case, not excluding these proceedings.

104 See CMS' Heads of Argument page 4 par 3.4.6, Afrox Healthcare Ltd and Amalgamated Hospitals Ltd, Tribunal Case No: 53/LM/Sep01, and Business Venture Investments 790and Afrox Healthcare Ltd, Tribunal Case No 105/LM/Dec04.

105 Hospitals may use a number of mechanisms to attract specialists. The nature of the incentives offered by hospitals is somewhat controversial. It has been alleged in various proceedings before this Tribunal and elsewhere that some hospitals may be providing specialists with incentives which encourage them to contravene their professional ethics.

106 See Bester's witness statement page 1, also confirmed by Alex van den Heever's witness statement.

107 See transcript page 1674.

119. Dr Broomberg, on behalf of the CMS, seemed to think that this transaction may, in the long-term, impact on competition for specialists in the Vaal Triangle. However, in his view the impact would be the same whether Netcare or Medi-Clinic acquired the Medivaal hospital.[108] Medi-Clinic is already the largest player in the Vaal Triangle. If Medi-Clinic wanted to discourage any specialists from practising at the hospitals of any of its competitors in the Vaal Triangle, as suggested by Ms Bester, then it could have done so already. There seems to be no reason, commercial or strategic, why it should do so post-merger when it already has the opportunity to do so.

120. Mr Swiegers, on behalf of Medi Clinic, confirmed the competitive dynamics regarding specialists in the Vaal Triangle and provided the Tribunal with assurances that Medi-Clinic would not interfere with the prevailing dynamics post merger but that it would abide by its normal policies of non-interference with specialists.[109]

Effect of transaction on prices

121. A major concern raised by the Commission was that if Medi-Clinic acquired Medivaal there would be an increase in prices (tariffs) because Medi-clinic is in general 10% more expensive than Protector. Medi-Clinic agreed that there would indeed be an increase in tariffs at the Protector hospitals because Medi-Clinic intended to apply its national price strategy post merger. Medical aid members would be not affected since the rates that Medi-Clinic had agreed with medical aid schemes nationally would apply. Only those patients who were not on medical aid, namely private patients, who constituted only 10% of the Medivaal patients, would be affected and only to the extent of between

108 See transcript 1504.
109 See Dr Swiegers' testimony in general, transcript page 909 ff.

NHRPL+19% and NHRPL+20%, not taking into account discounts.[110] However, the parties disagreed on the size of the increase in prices. Netcare attempted to show that the increase would be much larger than that claimed by Medi-Clinic. According to the CMS, an increase in tariffs would occur at Medivaal if any of the three hospital groups acquires the NPGH hospitals.

122. In our view it is unnecessary for us to conclusively decide on the actual size of the increase. We accept that this transaction will lead to an increase in tariffs at the Protector hospitals. For patients who are members of medical schemes this increase is unlikely to affect their contributions since Medi-Clinic's tariffs have been agreed nationally with their respective medical schemes.

123. Even if the increase in tariffs did result in an increase in the premium for some medical aid patients, this increase would be minimal because Protector has less than 1% of the national private hospital market.[111] For private patients, who constitute only approximately 10% of the patient population at Medivaal, an increase in tariffs of at least NHRPL +19% will take place. However these private patients have between three or five hospitals to choose from in the Vaal Triangle.[112]

Barriers to Entry

124. The Commission submitted that barriers to entry in the hospital market were high.

125. The private hospital industry is highly regulated. Prospective entrants

110 See Dr Theron's witness statement page 53. NHRPL is the National Health Price List which is meant to reflect benchmark tariffs for specialists, based on costing studies.
111 See Commission's recommendation, page 33.
112 Depending on whether Clinix and Cormed are included or excluded in the market.

are obliged obtain licenses in order to commence business.[113] The license is specific as to the number of beds that the operator may offer and as to the type of services that the licensee may offer. [114] These authorisations are also associated with specific premises. Hence a licence cannot be transferred from one entity to another without the premises being transferred to the transferee. At present, the Department of Health has placed a moratorium on the issuing of any new licenses. Until this moratorium is lifted the number of private hospitals in the country will not increase. New entrants are only able to enter the market through acquisitions of existing hospitals. The extent of regulation in this industry clearly places a high barrier to entry for new players and contributes to high levels of concentration in the industry. Other factors which contribute to high barriers to entry are the costs involved in constructing hospitals and the operational expertise or specialised skills required to run hospitals successfully.

Countervailing power

126. The CMS alleges that the increase in concentration in the hospital market over the years has removed any countervailing power from medical schemes.

127. A second related argument put forward by both Netcare and the CMS is that that regional dominance by a hospital confers on it national leverage in the bargaining process. If a particular hospital enjoys regional dominance in a particular region, then such region becomes a "must have" for the medical aid scheme (since it is the largest or only hospital in that area) and confers on hospitals greater bargaining power at a national level.

113 The licensing of private hospitals, including the transfer or amendments of such licenses, is regulated by the Department of Health.
114 For example high care, ICU, general services.

128.[Confidentiality claimed but not decided]

129.Over the last few years, some changes have occurred in the landscape for tariff negotiations between medical aid schemes and hospitals. Prior to 2003, tariff negotiations were done by medical schemes through the Board of Healthcare Funders ("the BHF"). The hospitals on their part negotiated as national groups, either as the three large players or through the National Hospital Network ("the NHN"). The BHF was held to be anti-competitive by the Competition Commission and was subsequently disbanded in 2004.

130. The evidence of Dr Broomberg and Mr Mxenge suggests that the negotiation landscape between medical schemes and hospitals has not changed in substance.

131. Large medical schemes and administrators negotiate with large hospital groups on a national basis. Smaller medical schemes negotiate in a group or mandate their administrators to negotiate tariffs. Independent hospitals such as Medivaal negotiate with schemes through the NHN.[115]

132. In our view medical schemes do enjoy some countervailing power. At times the power balance favours the hospitals and at other times the medical schemes. For instance, when Discovery Health and Medi-Clinic could not agree on a tariff increase for 2006, Discovery Health reported as follows in a letter:[116]

> *"In the disappointing event of us not being able to agree on either structure or price, we would assume that Medi-Clinic would choose to increase its tariffs by an amount that it deems appropriate. Discovery would increase its benefit tariffs by an amount that we deem appropriate. Should these two amounts differ, the member would experience a shortfall and Discovery would reimburse the benefit value to the member."*

133. After lengthy negotiations during which Medi-Clinic in return threatened to treat Discovery patients as private patients should the parties not agree on an increase, Discovery concluded the process by informing Medi-Clinic:

115 See the evidence of Dr Broomberg, Mr Mxenge, Mr Swiegers and Mr Alex van den Heever.
116 See the confidential document at page 25 of Exhibit 21.

[confidential]

134. During cross-examination Dr Broomberg, acknowledged that Discovery has some countervailing power:[117]

> *Adv Rogers: ….I would put it to you that the picture that is painted in the limited time we've had available of the negotiations in 2005 and 2006, and the results achieved with the big hospital groups is indicative not of one of the private hospitals [being] dominant and being price setters, but rather that of a balanced negotiation between powerful parties.*
> *DR Broomberg: [confidential.]*

135. We are also not persuaded, as alleged by the CMS, that this transaction will lead to an erosion of the bargaining power of medical schemes at a national level. The market share accretion as a result of this transaction will raise Medi-Clinic's national market share by a mere 0.8%. It is difficult to see how this would confer an increased bargaining power on Medi-Clinic in relation to tariff negotiations with medical schemes. Indeed, as confirmed by Dr

117 See transcript page 1455. [This was held in camera.]

Broomberg,[118] such a small accretion would not impact on existing power relations between medical schemes and the three major hospital groups.

136. Evidence led by Mr Mxenge on behalf of Polmed[119] tends to support a conclusion that smaller schemes are not completely without countervailing power. Mr Mxenge explained that in general smaller schemes do not negotiate separately but negotiate as a group with hospitals.[120] In addition, very few medical schemes negotiate tariffs directly with hospitals. Administrators[121] are mandated to negotiate with hospitals and service providers. The larger the administrator the greater its bargaining power.

137. In our view the evidence led in this matter does not support the contention that the countervailing power of medical schemes will be adversely affected by this transaction, or that the acquisition of the Medivaal hospital in the Vaal Triangle will confer on Medi-Clinic any negotiation advantages with medical schemes, small or large. For all practical purposes the power relations will remain unaffected.

138. As far as national leverage through regional dominance is concerned, Dr Broomberg seemed little concerned about this transaction having an impact of that kind on national negotiations. Indeed, according to him the three larger hospital groups already enjoy regional dominance.[122]

Kathu

118 See below Dr Broomberg's evidence in relation to countervailing power.
119 However, Polmed is actually the third largest scheme n the country, with approximately 145 000 members nationwide.
120 See transcript page 1516.
121 In this case the managed care organization of Medscheme.
122 See transcript 1503.

139. Some documentary evidence presented to the Tribunal during the hearing indicates that one of Medi-Clinic's considerations in acquiring NPGH is the fact that both Kathu and Medivaal hospitals are considered as important referral hospitals. Medi-Clinic is the only private hospital group active in the Northern Cape. It has a hospital in Kimberly and Upington. Netcare argued that by acquiring Kathu the already high barriers to entry in Kimberley and Upington would be raised even higher.[123] It argued that Medi-Clinic's sole rationale for acquiring Kathu was to keep Netcare out of the province.

140. Mr Swiegers, in his affidavit, referred to a report by one of Medi-Clinic's hospital managers in Kimberley, Ms Resa van der Merwe, who urged that Medi-Clinic should consider buying Kathu because of its strategic importance. He pointed out that Ms Van der Merwe was concerned that should Netcare acquire Kathu it would influence referral patterns to favour Netcare's new Bloemfontein facilities, resulting in Medi-Clinic loosing patients:[124]

> "Both Medi-Clinic and Netcare have hospitals in Bloemfontein. Netcare's hospital in Bloemfontein was, as at October 2004, relatively new. The success of these Bloemfontein hospitals is partly dependent on specialist referrals from country areas, including the Northern Cape and North-West. Historically, most referrals from Kathu have taken place in favour of Medi-Clinic's hospitals in Kimberley, Upington and (to a lesser extent) Bloemfontein."

141. Dr Theron argued that although it was important for Medi-Clinic to buy Kathu in order to maintain the levels of referrals to its hospitals in

123 A rival would need to obtain regulatory approval for establishing a hospital and would need to demonstrate that there was a need for an additional hospital. However its decision to enter would also be informed by whether there was sound business case for it.
124 See Witness statement par 35.2, page 22.

Kimberley and Upington, this did not lead to a competition concern since currently specialists *already* refer to Kimberley and Upington. Post merger the current referral patterns would not change. Moreover, since only 2% of the total patients treated at the two large hospitals are from Kathu the merger will not exert any competitive pressure on Upington and Kimberley.

142. The intervenors did not submit any documentary evidence nor were any witnesses led to explain how the referral patterns from Kathu to Medi-Clinic post merger might affect Netcare's ability to enter the Northern Cape successfully.[125]

143. Kathu is roughly 209 km from Kimberley, roughly 195 km from Upington, 184 km from Vryburg and some 400 km from Bloemfontein. It is not surprising that the referrals to Bloemfontein are to a "lesser extent".[126] If we are to assume that Kathu would remain very much as it is and that there was no commercial rationale to justify establishing a fully equipped hospital offering all types of specialised facilities[127] then it is very difficult to conclude, simply on the basis of legal argument, how this transaction will affect referral patterns. It seems unlikely that any doctor who is bound by his or her professional ethics would refer a patient to a hospital some 400km away rather than to a hospital 100km away unless of course the nearer hospital did not provide the required services.

144. But let us for the moment consider the extent of the harm being complained about. In the first instance only 2% of the total patients treated at the three Medi-Clinic hospitals are from Kathu and all of them are currently being referred to Medi-Clinic's hospitals.[128] On

125 Both relied on arguments submitted by their legal representatives.
126 See Econex report page 20.
127 There was no evidence that either Medi-Clinic or Netcare intended to do this post acquisition.
128 Assuming at the time of this transaction there were no Netcare or Life hospitals in the Northern

Netcare's own argument, entry barriers are high in that province. If post-merger the referral patterns would remain the same, i.e. the Kathu patients would still be referred to the Medi-Clinic hospitals, the barriers would remain the same and not be increased, since no change can be expected in the referral pattern.

145. Even if we were to find in favour of Netcare and assume that somehow entry barriers were increased in the Northern Cape by this transaction, the revenue from Kathu referrals that a hospital[129] could lose to Medi-Clinic is only in the region of 2% of patients spread over two or three cities.

Preferred provider agreements

146. The CMS argued that regional dominance of a hospital would affect the ability of medical schemes to conclude preferred provider agreements. Medical schemes conclude preferred provider arrangements with health providers by which a member is obliged to utilise the preferred provider. If a member utilises a non-preferred provider then he or she would become liable for a co-payment. This is one of the managed care mechanisms utilised by medical schemes to manage costs of healthcare and risk to the fund. At the time that the transaction was concluded Medi-Clinic did not have preferred provider agreements with any medical schemes.

147. In the Vaal Triangle, Discovery used to have Medi-Clinic as a preferred provider on its Key Care option. Medivaal, an independent hospital, was never part of this network. At the time of the hearing, Medi-Clinic was no longer on the network. Currently Discovery has preferred

Cape.

129 Whether independent or owned by one of the two other large groups.

provider arrangements with Midvaal, Netcare and Clinix Sebokeng.[130]

148. Evidence led by Dr Broomberg in relation to the Vaal Triangle did not support the concern that this acquisition by Medi-Clinic would lead to any more difficulty for a medical scheme to conclude preferred provider agreements.[131]

149. In relation to Kathu, it would make no difference to medical schemes whether Kathu was owned by one of the three large groups or an independent. There is only one hospital in Kathu.

The level and trends of concentration

150. According to the CMS, consolidation of ownership of private hospitals has increased since 1996 when the three largest private hospital groups only controlled 50.9% of acute hospital beds, compared to the current 82%. This increase in concentration has led to an increase in market power in relation to medical schemes and independent hospitals, which in turn has removed any countervailing power from medical schemes.[132] Furthermore this increase in concentration coincides with a trend break in hospital costs which is detectable from 1998 onwards and which can be attributed to a systematic change in the market power of hospitals in relation to medical schemes from that period onward.[133] The CMS submitted that hospital costs (as a result of increased utilisation) have increased disproportionately to CPI and

130 See transcript page 1408. [Held in camera]
131 In fact Dr Broomberg had very little to say about the impact of this transaction on competition in the Vaal Triangle. Understandably his main concern was the increased national costs of hospital services to medical aid schemes.
132 See our discussion on countervailing power.
133 See figure 8.1 on page 29 of van den Heever's supplementary witness statement dated October 2006.

all other related health costs.[134]

151. Hospital costs are a function of price and utilisation. A significant component of the change in costs results from utilisation and not price.[135] Mr Alex van den Heever, testifying on behalf of the CMS, submitted that over the period of six years, from 1998 to 2004, hospital costs had increased by 67.9%. Over this same period a large number of independent hospitals had been acquired by the three large groups, resulting in a highly concentrated market.

152. In support of its arguments, the CMS relied to a large extent on statistics obtained from the Discovery Health medical scheme. The Discovery Report: *Cost, Quality and Value at Hospitals: 2000 – 2005, Report to the Trustees of Discovery Health Medical Scheme and Discovery In-House Schemes 13 December 2005* was a study conducted by the Discovery Health medical sheme over a period of 5 years into hospital utilisation and costs. [136]

153. The merging parties did not agree with the CMS and asserted that the increase in costs attributable to utilisation could be due to various factors such as an increase in demand for hospital care by an ageing population, increased intensity of care due to acuity of cases and/or increase in co-morbidity, increased burden of disease, the HIV pandemic, improvements in technology, less invasive procedures, better outcomes, and lower risk as specialists are more willing to perform procedures on older patients, and not necessarily to an increase in market power. Increased utilisation could also be attributed to the treatment prescribed by health providers, over which Medi-Clinic

134 For instance such as surgicals,ethicals or doctors fees.
135 See Mr Alex van den Heever;'s witness statement dated 31 August par 13.
136 We refer to it as the Discovery Report.

claims it has no influence.[137] Health service providers are all subject to professional ethical rules and their discretion to prescribe particular treatment for their patients has to be exercised in accordance with those rules. It is doctors who refer patients to hospitals and patients are treated in accordance with the doctors' instructions, whether they relate to prescribed procedures, medication, or duration of stay.

154. However, patient and heath provider behaviour are not insignificant contributors to utilisation. From a medical scheme perspective, both patient behaviour and health provider behaviour, assuming price remains constant, if not managed well, represent enormous risk to the funds. Because members of medical schemes have improved access to healthcare[138] through a common funding pool, schemes run the risk of members and service providers over-utilising the benefits provided by the schemes. Apart from emergency admissions, occupancy in hospitals and utilisation are a function of referrals by specialists and doctors along a vertical supply chain. Doctor networks also provide a source of referrals to hospitals.[139]

155. Medical schemes strive to manage their risk by managing over-utilisation on the part of both patients and service providers. This is evident by the number of managed care mechanisms that medical schemes have put in place to ensure that patients do not engage in over-utilisation and to lower risk to the fund.[140] Mechanisms to ensure that service providers do not over-service patients have also

137 The conduct of health providers is the subject of much debate. The competition for specialists is also a recurring topic in the health sector. See also for instance Prime Cure and Medicross.
138 Funding is provided by the scheme in return for a monthly premium.
139 See Prime Cure and Medicross
140 Most medical aids have savings accounts, require pre-authorisation for hospital admission, and place limits on various costly benefits. Some even require motivations from doctors for certain blood tests to be conducted. Managed care organisations have sprung up everywhere to assist members manage their benefits better so as to reduce risk to the fund.

been put in place by many medical schemes.[141] In their experience, specialists' costs and hospital costs are the most difficult to manage and constitute a large percentage of the cost of heathcare.[142]

156. Indeed Mr Van den Heever himself confirmed that specialists are the key drivers of hospital utilisation and cost.[143] He argued that it is generally assumed that they generate around 70% to 80% of the hospital costs incurred. In his view hospitals and specialists are involved in co-ordinated or collusive relationships which account for such high utilisation rates. He submits that hospitals go to great pains to obtain the favours of specialists. These favours are obtained through the granting of discounted rent for practices, loans, practice support and shares in hospitals. Kickback arrangements also exist but are not practiced by all hospital groups. Moreover, it seems that the three hospital groups have different policies in relation to specialists.[144] It is alleged that some of these groups may provide greater incentives for specialists than the others in order to encourage referrals to their hospitals.[145]

157. The Discovery Report was obtained by the CMS under subpoena. It contains a detailed technical assessment of costs and service quality at the three main hospital groups, identified as hospital A, B and C. The analysis was based on a 100% sample over a six year period from 2000 to 2005. According to Mr Van den Heever, the data collated in the Discovery Report supports the proposition that increased hospital

141 Various options such as capitated medical options aid and preferred provider agreements have been put in place.
142 See evidence of Dr Broomberg. See also evidence of Mr van den Heever of the CMS, page 17 of his witness statement, in which he explains that the Southern JV which was an attempt to form a preferred provider network across the vertical supply chain failed because specialists were reluctant to agree to reduced rates.
143 See paragraph 22 of Mr Van Den Heever's witness statement of 31 August 2006.
144 See in this regard Mr Swiegers' testimony in relation to Medi Clinic's policies in relation to specialists.
145 See Mr Van den Heever's witness statement supra at pages 16-26.

consolidation, coupled with the establishment of financial relationships between hospitals and specialists explains the trend break in hospital costs from 1998 to the present.[146] He also submitted that some hospital practices may also contribute to costs, although referrals by specialists still account for the majority of those costs. Accordingly he argued that the transaction should be prohibited because any acquisition (no matter how small, and irrespective of the circumstances) by any of the three groups will lead to increased utilisation costs.

158. According to the CMS, the trends reflected in the Discovery Report suggest that all of the three large groups are expensive. On the CMS's own version the competition outcome at a national level would be same if any of the three groups acquired the Protector hospitals.

159. At a regional level, Mr Van den Heever computed four different scenarios, based on data obtained from Discovery. While his calculations showed that the worst competition outcome at a regional level would occur if Medi-Clinic acquired the Medivaal hospital, the CMS argued that the "now scenario" in the Vaal Triangle, namely the Medivaal hospital remain in independent hands, was the best outcome for competition.[147]

160. Dr Broomberg was of the view that this transaction would not have any substantial effect on the competitive landscape for specialists at a national or regional level. In any event, according to him, the outcome would be the same if any of the three large groups acquired the Protector hospitals despite the fact that the Discovery Report had ranked Netcare as the most expensive of the three groups.

146 Paragraph 52.4 of witness statement.
147 See Van den Heever's witness statement supra at paragraph 59.

161. A fair amount of econometric evidence was led by both the CMS and the merging parties to demonstrate the effect of age, co-morbidities and pandemics such as HIV on utilisation costs. We find it unnecessary to canvas the various computations and differences between the parties for the reasons outlined below. In any event, it seems that the factors influencing increased utilisation of hospitals and the increases in hospital costs experienced by medical schemes is clearly a topic of such complexity and intricacy that a quantitative analysis on its own, without an extensive and focussed enquiry, going far beyond the confines of this merger hearing, might not provide complete and conclusive answers.

162. Given that the contribution to hospital costs by specialists is assumed to be in the region of 70-80%, and in order to move from the general to the specific - in other words from the industry trend to the specifics of this transaction - we would have expected to hear more about the nature of the relationship between Medi-Clinic and specialists, and the nature of any incentives offered by Medi-Clinic to specialists at both national and regional level. [148] This lack of evidence is hardly surprising and may be symptomatic of the nature of the problem. In an industry, structured as it is with opaque vertical relationships and a guaranteed source of funding from medical schemes, in which the quality of care rendered to a consumer is often a question of life and death, it would be extremely difficult for anybody to distinguish, except in the most obvious cases, between a provider who over-services a patient and a provider who errs on the side of under-servicing.[149]

163. It appears that the question of over-utilisation will continue to persist

148 The quantitative analysis done by Mr Van der Heerden at a regional level does not provide us with sufficient insights into the extent of influence Medi-Clinic has over specialists.
149 This difficulty may be the reason why legislative interventions, rather than anti-trust scrutiny, could be the more appropriate remedy to the possible negative consequences of the vertical relationship between hospitals and specialists.

irrespective of the levels of concentration in the hospital market. Over-utilisation could be due to a specialist who errs on the side of caution. Arguably, even an independently owned hospital in which specialists have vested interests could over-service patients and could contribute to an increase in costs. As long as specialists and hospitals are permitted to exist in an overlapping vertical relationship as they currently do, increased costs as a function of utilisation will continue to be a concern for the CMS, medical schemes and consumers.

164. Mr Van den Heever's impressive review of the many entities, including the Department of Health, which have raised concerns about the vertical relationship between specialists and hospitals does indeed raise the question whether a review of the structure of the industry as a whole is not required with a view to seeking appropriate legislative interventions.[150] Mr Van den Heever himself identified the problem as an "ethical one rather then a competition one" when he stated that specialists should operate independently of hospitals irrespective of the financial arrangements that may be in place between them.[151]

165. Even if we were to agree with the CMS that this merger was likely to lead to an increase in costs due to utilisation, we would have to take heed of Dr Broomberg's view that the anti-competitive outcome of the merger would be relatively low. Moreover, on both the CMS' and Dr Broomberg's version the competition outcome would be the same if any of the three large hospital groups acquired the Protector hospitals.

166. We turn to consider the remedy that the CMS seeks from this Tribunal.

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150 Some interventions of this nature, namely legislation to facilitate the conclusion of preferred provider agreement between medical schemes and hospitals are already in the pipeline,

151 See witness statement paragraph 22. This again supports the notion that anti-trust remedies may not be appropriate in addressing this problem.

167. Counsel for the CMS argued that the liquidator should not have sold the Protectors hospital to any of the three large hospital groups. Instead, he should have embarked on a process by which the assets should have been sold only to an independent hospital group. The CMS argued that the IDC ought to have used this as an opportunity to espouse the formation of another independent hospital group. While the sentiments expressed by the CMS are laudable, this may be easier said than done.

168. The hospital services industry is a highly complex one and it requires expertise to manage hospitals profitably. One only needs to consider the difficulties experienced by hospitals in the public sector to understand the extent of the skills required to manage them successfully. The history of existing independent private hospitals is also replete with such difficulties, the most recent example being that of the Wits University Donald Gordon Medical Centre (Pty) Ltd ("the Donald Gordon Hospital"). The Donald Gordon Hospital was ultimately acquired by Medi-Clinic Investments (Pty) Ltd.[152] In that transaction the hospital required a large capital injection to upgrade certain core facilities and needed experienced operational partners or personnel to return the hospital to profitability. The Board of the hospital attempted to find an independent buyer without success. The only interested party which had the requisite experience and financial resources was Medi-Clinic. This was confirmed by Dr Broomberg in his testimony.[153]

169. In this transaction, the IDC had also, without success, attempted to find a rescue plan for Protector with Clinix, a group independent of the big three players.

170. The trend towards increasing concentration in the private hospital

152 The Tribunal approved the transaction on 12 October 2005.
153 See transcript page 1458, held in camera.

market and the increasing cost of healthcare in this country certainly raise concerns.[154] But the remedy that the CMS seeks, namely that we prohibit any of the three groups to acquire any further hospitals, is one more akin to an industry sector remedy and one which this Tribunal is not empowered to grant.

171. This Tribunal, as an adjudicative body, is required to assess each case on its own merits in accordance with the requirements of the Competition Act. In terms of the Competition Act we are empowered to prohibit or conditionally approve a transaction only if it substantially lessens competition in a relevant market or does not fulfil any of the other requirements of section 12A. We cannot impose blanket prohibitions on specific enterprises in a particular sector. Each case has to be assessed on its own merits and circumstances.

172. In this particular matter, the Tribunal is required to consider, inter alia, the fact that New Protector is a failing firm and that the financial circumstances of the Protector hospitals are indeed dire.

Conclusion

173. This Tribunal has stated in the *Iscor* case that depending on the anti-competitive effect of the transaction, the less stringent US test of the failing firm doctrine would apply if a party fell short of the "market share would have gone to us" requirement.

174. In this transaction we have found that New Protector was a failing firm as contemplated in the Act and as contemplated in the US test, and that the merging parties have discharged the onus as contemplated in the *Iscor* case.

154 And possibly warrants an industry-wide inquiry.

175. In relation to Netcare's concerns regarding possible closure of specialised units at Medivaal, referrals of patients from Midvaal, refusal by Medi-Clinic to co-operate at a professional level and competition for specialists in the Vaal Triangle post-merger, we found no credible incentive for Medi-Clinic to conduct itself in an anti-competitive manner post merger, and only unconvincing evidence to suggest that such concerns have any justification.

176. Moreover we also note the assurances provided to this Tribunal by Mr Swiegers on behalf of Medi-Clinic that post merger, Medi-Clinic will not close down or diminish the specialised facilities at Medivaal Hospital and will not seek to change the competitive dynamics in relation to specialists in the Vaal Triangle. Mr Sweigers also undertook that Medi-Clinic will continue to demonstrate professional comity with the other hospitals in allowing them access in moments of need to surgical equipment and staff, as it has done pre-merger.

177. We found that barriers to entry in the private hospital market were high. However, we found that medical schemes do enjoy some countervailing power. In relation to the national leverage argument and preferred provider agreements, we found no credible evidence to support the theory that this particular acquisition will lead to any significant enhancement of Medi-Clinic's already strong national bargaining position or render it more difficult for medical schemes to conclude preferred provider agreements in the Vaal Triangle.

178. We agree with the CMS that the private hospital market is a highly concentrated one, and that regulatory barriers have contributed to some extent to these levels of concentration. However while we share the concern expressed by the CMS that hospital costs in this country are escalating at an alarming rate, we are unable to conclude, given the absence of evidence by the intervenors about possible anti-

competitive features of the relationship between Medi-Clinic and specialists, that this transaction will contribute to an increase in costs occasioned by an increase in utilisation of hospital services.

179. Even if we are to assume that this transaction would lead to an increase in utilisation and therefore costs, Dr Broomberg was of the view that the consequential anti-competitive harm would be relatively low. The remedy that the CMS seeks, namely to prohibit the three large hospital groups from acquiring any further hospitals and to require the IDC to sell the hospitals to an independent group, cannot be granted by this Tribunal.

180. We accept that this transaction will result in an increase in tariffs at Medivaal. However the impact of that increase to medical aid members and private patients is low relative to the benefits of having the Medivaal hospital continue in business and moreover receive the refurbishment and upgrading to which Medi-Clinic has committed itself in its testimony to the Tribunal.

181. Accordingly we conclude that the competition loss occasioned by this transaction will be low and is outweighed by the failing firm factor.

182. There are no public interest grounds to consider. Save for the issue discussed below, there is also no need for us to deal with any residual arguments put forward by the intervenors such as Medi-Clinic's rationale for the transaction. Accordingly the transaction is approved unconditionally.

183. During the course of the proceedings, and after Dr Broomberg's evidence was led in which he explained the findings of the Discovery Report to the Tribunal, the legal representatives of Netcare requested the Tribunal to stand the matter down. The request itself was not made

in open court but was made by Mr Wilson in camera. Mr Wilson submitted that he wished to stand the matter down in order to take instructions from his client whether or not to bring an application for recusal of one of the Tribunal members. The reason for the application appeared to be some alleged conflict of interest and bias on the part of one of panel members. These are serious accusations indeed.

184. After a brief adjournment this Tribunal refused the application, on the grounds that sufficient time was available to Netcare and its legal representatives to prepare and bring a recusal application, if they wished to proceed with it, on the following day. No such application was brought and nothing about Mr Wilson's allegations was said on the following day (the last of the hearing) by the legal representative then appearing for Netcare.

185. On the last day of the hearing, after all the witnesses had testified and before argument had commenced, Mr Unterhalter sought a postponement of the matter in order to submit expert economic evidence in rebuttal of the Discovery Report. That application was denied. The Tribunal undertook to provide reasons for that decision in this document.

186. These are those reasons. The application was denied because Netcare's legal representatives, led by Mr Unterhalter, had had, in the course of the proceedings, ample opportunity to cross-examine both Dr Broomberg and Mr Van den Heever on the contents of the Discovery Report. Furthermore they were aware, at an early stage of the proceedings, that Mr Van den Heever intended to rely on the contents of the Discovery Report to make the CMS' case. In addition, Netcare itself was aware of the contents of the Discovery Report because Discovery Health had already relied upon it in its tariff negotiations with

Netcare.[155] If, in his or his client's view, there was a need for this Tribunal to hear any further economic evidence in rebuttal of that report, Mr Unterhalter could have filed his rebuttal witness statements at the time when witness statements were exchanged between the parties. At the very latest Necare and its legal representatives could have sought the Tribunal's leave to submit such evidence after Dr Broomberg had testified.

187. Further, we considered that the postponement sought would have resulted in delays to the outcome of the hearing which would have disrupted the orderly truth-seeking process and caused serious prejudice to the merging parties. If we had allowed Mr Unterhalter to file his recently acquired expert evidence, we would have been required to grant the merging parties and the CMS with a proper opportunity to consider and respond to this evidence. We would also have had to recall key witnesses. The uncertainty surrounding New Protector as a firm in liquidation would have continued and would have resulted in further loss of skilled employees and declining admissions at its hospitals. Hence the prejudice caused to the merging parties and the Protector hospitals as a result of us granting the application outweighed any prejudice caused to Netcare by us refusing the application.

188. The behaviour of Netcare's legal representatives, in ventilating serious accusations against a Tribunal member in a closed session and threatening to bring an application for recusal but failing to do so, and thereafter seeking a last-minute disruptive postponement to lead evidence which could have been led much earlier, is concerning. The behaviour amounts, to put it mildly, to the tactics of a spoiler.

189. This Tribunal, in order to fulfil its truth-seeking functions and to

155 See Dr Broomberg's evidence.

enhance the level of information and transparency in its proceedings, has generally taken a generous attitude towards interveners in its proceedings. It is disappointing, to say the least, when intervenors who have ostensibly come to the proceedings in order to provide assistance to the Tribunal, in its truth-seeking task resort instead to tactics of delay and aggression.

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Y Carrim

Presiding Member

Concurring: M Mokuena and L Reyburn

Tribunal Researcher:	R Badenhorst
For the merging parties:	Adv O Rogers SC and Adv A Cockrell instructed by P Krusche (Jan S De Villiers Attorneys)
For the intervenors:	Adv D I Berger instructed by M Ntlha (Cliffe Dekker) on behalf of the CMS Adv DN Unterhalter SC, Adv J Wilson and Adv AG Gotz instructed by A Norton (Webber Wentzel Bowens) on behalf of Netcare and Supreme Health
For the Commission:	A Kalla and M van Hooven