In sickness and in health: Competition law in the healthcare sector

Competition legislation and policy – can it cure the perceived ailments in the private hospital market?*

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* Kindly note that this paper is an academic research exercise reflecting observations in the healthcare sector and does not necessarily represent the views of Edward Nathan Sonnenbergs Inc.
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1. **Introduction and background**

Ralph Waldo Emerson once said: “The first wealth is health”\(^1\). It is arguable that for those for whom health is not a concern, wealth is typically associated with illusions of grandeur and prosperity, an evaluation in which the state of one’s health does not often feature. Illness is often a limitation to the attainment of wealth in that those who are unwell are unable to perform at their peak and may subsequently be obliged to relinquish certain opportunities to the healthy. On the other hand, the rising costs of healthcare have resulted in the fact that health is a scarce and expensive commodity – without wealth, it is increasingly more difficult to achieve and hold onto.

Citizens of affluent, developed countries are often fortunate in that their wealth is automatically credited with access to quality healthcare services at a limited cost. For instance, in the annual survey conducted by the World Health Organisation (the “WHO Study”\(^2\)), it was estimated that annual healthcare costs (including public, private and external costs) paid per person in Luxembourg\(^3\) amounted to approximately US$ 8 262 in the 2009 year.\(^4\) Similarly, the United Kingdom’s National Health System (“NHS”\(^5\)) (the world’s largest publicly funded healthcare system) covers almost all healthcare costs of its 62 million strong population, save for some costs associated with certain prescriptions, eye and dental care.\(^6\)

In contrast, populations of developing countries are often not afforded access to healthcare services. Characterised by high costs of hospital care, limited medical supplies, poor facilities, ever-burgeoning populations and the spread of pandemic diseases, health has become a privilege, and not a right, in such countries. In the WHO Study\(^7\), it was recorded that the minimum annual per capita healthcare spend by developing countries ought to total a mere US$ 44 to equip its population with the basic tools to battle pandemic diseases such as HIV, tuberculosis and malaria. The WHO Study estimated Eritrea’s healthcare spend per person to total US$ 11 for the 2009 year as compared to the US$ 8 262 in Luxembourg.\(^8\) The disparity between the healthcare spend of developed and developing countries is even more apparent when one considers that 29 developing countries were unable to pay the recommended minimum healthcare spend of US$ 44 per capita per annum.\(^9\)

Whilst South Africa is also characterised by attributes similar to certain other developing jurisdictions, government has committed to affording its population access to quality healthcare services. Access to healthcare is one of the basic human rights acknowledged in the Constitution of South Africa\(^10\). The Department of Health records as its ultimate priority the attainment of a “long and healthy life for all South

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3. Luxembourg’s healthcare expenditure was the highest in the WHO Study and does not represent the average standard for developed countries.
4. Additional information to contextualise this spend is provided hereunder.
6. For more information regarding the United Kingdom’s NHS kindly see section 5.2 hereunder.
7. Supra n2.
8. Supra n2.
9. Supra n2.
10. Section 27(a) of the Constitution of South Africa, No. 108 of 1996.
Africans”, which it pledges to achieve by taking measures to increase life expectancy, decrease maternal and child mortality, combat Human Immunodeficiency Virus (“HIV”) and Acquired Immunodeficiency Syndrome (“AIDS”), decrease the burden of disease from tuberculosis and strengthen the health system effectiveness.\(^\text{11}\)

Although there is still work to be done to achieve these goals, one must be mindful of South Africa’s progress to date in the public healthcare sector despite its relevant infancy as a constitutional and democratic state. Since the advent of our constitutional dispensation, equality to healthcare services in South Africa has been furthered. President Nelson Mandela implemented various initiatives during his term as president, the effects of which are already somewhat demonstrable. Some of the strategies for which he was responsible include the introduction of primary healthcare for pregnant women and children under the age of 6, the establishment of an essential drugs programme, the promulgation of the Choice on Termination of Pregnancy Act\(^\text{12}\) and various anti-tobacco legislation, the introduction of a community service programme for newly-graduated health professionals, improved immunization programmes, hospital revitalisation programmes and the like.\(^\text{13}\)

Notwithstanding the progress which has already been made, there is a burden in covering the healthcare costs of a population exceeding 50 million\(^\text{14}\), especially in a country in which pandemic diseases are prevalent.

Given such economic realities, the healthcare system in South Africa has mutated into a two-tiered scheme – the private and the public healthcare systems.

Simplistically, the South African public healthcare sector offers various healthcare services to the percentile of the population unable to afford private healthcare services. Funded primarily by government, an estimated 14% of annual government expenditure was dedicated to the public healthcare system during 2010.\(^\text{15}\) The main impediments of the public healthcare sector have been described as poor management coupled with a lack of funding, appropriate facilities and human resources.\(^\text{16}\)

In contrast, the private healthcare sector is funded mainly by contributions from those able to afford it in the form of medical insurance premiums.\(^\text{17}\) The service offering of most medical schemes (of which there were 100 as of 2010)\(^\text{18}\) includes a variety of options, tailored to suit the budget of its customers. In most instances, an entry level medical aid package bestows upon the recipient a “hospital plan”, which

\(^{12}\) Choice on Termination of Pregnancy Act, No 92 of 1996
\(^{16}\) These and other impediments afflicting the healthcare system in South Africa are discussed in more detail in section 2 hereunder.
\(^{17}\) Supra n15.
contemplates the admission and servicing of that customer by a private hospital in South Africa.\textsuperscript{19} If such an option is selected, all other day-to-day healthcare costs would be for the personal account of the individual. Consequently, the insurance package selected by an individual will affect the degree to which that individual is insured.

The Competition Tribunal (the "Tribunal") has previously expressed its view on the healthcare system in South Africa\textsuperscript{20}:

"The provision of adequate health care to all the citizens of the country is clearly an important plank in the government’s efforts to tackle poverty and inequality. High and middle income South Africans (and this would include a significant proportion of those in employment) receive healthcare through South Africa’s sophisticated private healthcare system comprising the full gamut of general practitioners, specialists, hospitals and pharmacies. Private healthcare is funded by an array of medical schemes serviced by the administration companies, data processing companies and managed care companies that are an integral part of South Africa sophisticated ‘first world’ private healthcare system.

However, the majority of the population – and this includes a significant number of those in the lower reaches of formal employment – rely on the public health system for meeting its needs. The reality – and possibly the only agreed certainty in the fraught debate surrounding the provision of healthcare in South Africa – is that the private healthcare systems, and most notably, although not exclusively, the private hospital network, is characterised by significant excess capacity, while the public healthcare system is simultaneously resource-constrained and increasingly unable to cope with the demands made of it. A major thrust of government’s efforts to improve healthcare provisioning is thus to utilise the excess capacity in the private healthcare system, the better to reduce the demands on the public healthcare system, to, in other words, move a strata of those presently reliant on public healthcare over to the private healthcare system."

Of course, and as is expressed by the Tribunal above, the most apparent barrier to the provision of private healthcare services is wealth. It is estimated that approximately 13 million South Africans live on less than R10 per day.\textsuperscript{21} With this meagre income, such individuals are unable to afford the monthly premiums charged by medical schemes in exchange for private healthcare services. For this reason, the public healthcare system is overburdened. As of 2008 it was estimated that approximately 40 million South Africans utilised the services of the public healthcare system, with the number of individuals serviced by the private sector (approximately 7 to 8 million people) having remained stagnant since or about 1993.\textsuperscript{22} 23 24

The transference of some public patients to the private healthcare system, would relieve (to a certain extent) the burden on the public healthcare system, such that the sector would be less resource-constrained and better able to offer quality healthcare services to each of its patients.\textsuperscript{25}

\begin{flushleft}
\textsuperscript{19} For instance, medical aid schemes such as Discovery, Momentum, KeyHealth Medical Aid, Pathfinder Medical Aid and Selfmed all offer entry level hospital plans.
\textsuperscript{20} Medicross Healthcare Group (Proprietary) Limited and Prime Cure Holdings (Proprietary) Limited, Case No. 11/LM/Mar05, paragraph 52 and 53.
\textsuperscript{21} Living Social Justice, <livingsocialjustice.com> (accessed 3 August 2012).
\textsuperscript{22} Johnson (2009) supra n13 at pages 24 and 25.
\textsuperscript{23} Supra n11.
\textsuperscript{24} Supra n13 at page 24 and 25.
\textsuperscript{25} Supra n20.
\end{flushleft}
One possible method for the aforementioned transference to occur, is to confine the cost of private healthcare services to competitive levels to ensure as great a percentage of the population as possible is able to afford such services. This paper reviews the role that competition policy can play in attaining this. In this regard, the lessons learnt as regards competition in the market for private hospital services\textsuperscript{26} can be equally applied to other healthcare markets in general.

With the above noted, this paper seeks to identify and elucidate upon the perceived ills in this relevant market, with a view to assessing some of the factors that potentially serve to increase the cost of healthcare services in South Africa. In addition, this paper will consider the evolution of competition law intervention in the healthcare sector in South Africa, focussing on the market for the provision of private hospital services, and what the impact of such intervention has been. Finally, by considering the position in certain international jurisdictions, the paper will consider instances in which competition law and other public policy instruments have been used to achieve improved healthcare outcomes.

2. **Perceived ills in the healthcare sector**

It is estimated that South African expenditure on healthcare in 2012 approximated 8.6% of GDP with the public sector health accounting for 4.2% and private healthcare 4.4% of total healthcare expenditure\textsuperscript{27}. While the split between the private and public healthcare systems seems almost equal it is important to note that only approximately 16% of the population has access to private healthcare\textsuperscript{28}. This places a greater burden on public sector healthcare expenditure as the majority of the population is unable to self fund.

In 2010 medical aid membership totalled approximately 8 million people with the South African mid-year population reaching an approximate 50 million.\textsuperscript{29} Using medical aid membership as a proxy for private healthcare access it is estimated that approximately 16% of the population can afford what is perceived to be high quality healthcare in the private sector.\textsuperscript{30} The South African Competition Commission submission to the Organisation for Economic Development and Co-Operation ("OECD")\textsuperscript{31} states that low levels of private medical insurance have prevailed in South Africa over the past decade\textsuperscript{32} as the number of medical schemes’ beneficiaries, including principal members and dependents, has increased from 6.7 million in 2000 to only 8 million in 2010\textsuperscript{33}. By the same token, the population grew from 45 million in 2001 to approximately 50 million in 2011\textsuperscript{34, 35}. As such a large portion of the population relies on the public health system for healthcare services. This burden on the public healthcare system is aggravated by the notable quality problems

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\textsuperscript{26} Due to restrictions on the length of this paper its scope has been limited to the market for the provision of private hospital services.
\textsuperscript{28} Own calculations as discussed further below.
\textsuperscript{30} Council of Medical Schemes Annual Report 2011.
\textsuperscript{31} Competition Commission South Africa (2012). Submission to the OECD Roundtable on Competition in Hospital Services.. 13 February, Paris, France.
\textsuperscript{32} Ibid.
\textsuperscript{33} Council of Medical Schemes Annual Report 2011.
\textsuperscript{35} Supra n13 at page 24 and 25.
including, *inter alia*, cleanliness, safety and security of staff and patients, long waiting times, staff attitudes, infection control and drug stock-outs. McIntyre *et al* (2009) states that even though the public health system has been transformed into an integrated, comprehensive national service, leadership failures coupled with a weak management system and a substantial human resources crisis have led to the inadequate implementation of what are often good policies. Given such quality problems in the public healthcare system the common practice in South Africa has been, and continues to be, a general preference for the private healthcare system.

The cost of private healthcare in South Africa has been an issue of concern going as far back as the 1990’s. Given that the public healthcare system is generally over-burdened it was hoped that affording South Africans access to quality private healthcare services at competitive prices, could be of some assistance in relieving this burden.

The pricing of private healthcare services and some of the related concerns about such, find their origination in the historical operation of this sector. It is common that prior to 1993 the private healthcare sector in South Africa was regulated by the government through the National Health Act 61 of 2003 and the Medical Schemes Act of 1967 (subsequently named the Medical Schemes Act 131 of 1998). These two pieces of legislation covered a number of aspects pertaining to the healthcare industry, including the tariffs charged by healthcare providers and reimbursement tariffs for medical schemes. In addition, the legislation allowed for and promoted collective bargaining and co-operation between the medical schemes and various healthcare providers under the auspices of their respective industry associations. These industry associations were the Representative Association of Medical Schemes (now known as the Board of Healthcare Funders (“BHF”)), the Medical and Dental Associations (now split into the South African Medical Association (“SAMA”)) and the Hospital Association South Africa (“HASA”).

During the 1990’s the private healthcare sector underwent a deregulation process. Notwithstanding this, the practice of collective bargaining and publication of jointly determined tariffs continued unhindered until its curtailment by the intervention of the Competition Commission (the “Commission”), the first of which took place in or about 2002. The premise for the Commission’s intervention was that the collective bargaining and publishing of tariffs by these associations amounted to price fixing in breach of the provisions of the Competition Act.

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38 Dr Manto Tshabalala-Msimang (Minister of Health). Briefing to the Portfolio Committee on Health, Tuesday, 26 February 2008.
41 ibid.
42 The impact of this collective bargaining on the market for private hospital services is discussed in more detail in section 2 hereunder.
43 Supra n39.
44 Supra n42.
45 Competition Act No. 89 of 1998, as amended. See section 4 for more detail in this respect hereunder.
Such intervention by the competition authorities, as discussed further below, altered the competitive landscape in the sector with the most prominent outcomes being shifts or changes in the countervailing power dynamics between healthcare providers and medical schemes. Alongside the enforcement action by the competition authorities was a stream of mergers and acquisitions\(^{(46)}\), particularly in the market for the provision of private hospital services that culminated in three major hospital groups accounting for approximately 80% of the private hospital market in South Africa\(^{(47)}\). This, it is argued\(^{(48)}\), has enabled the private hospital groups to pass and sustain high price increases.\(^{(49)}\) Similarly, consolidation in the medical schemes market somewhat strengthened the countervailing power of the schemes or administrators, even though the extent to which all schemes are able to exercise their countervailing power is subject to debate\(^{(50)}\). Despite this, the bilateral negotiations between the medical schemes and private hospitals, given the highly concentrated private hospital market and what is perceived to be a fragmented medical schemes market, did not yield, and have not subsequently yielded desired pricing outcomes\(^{(51)}\).

Instead the result is a pricing regime with stark differences between the tariffs charged by the healthcare providers and the rates the medical schemes were prepared to pay, leaving a greater gap for the insured to either self or co-pay\(^{(52)}\). In addition it is alleged that many healthcare providers struggled to set their tariffs at appropriate levels given the absence of a recommended tariff list and a lack of knowledge of individual costs.\(^{(53)}\) To resolve this, medical schemes introduced the practice of co-payments which requires that patients who are members of medical schemes make additional payments out of pocket to cover the difference between the tariff charged by the healthcare provider and the rate of cover determined by the medical scheme.\(^{(54)}\).

This state of affairs led to the Department of Health, through the Council of Medical Schemes ("CMS"), publishing what was termed a "National Health Reference Price List" from 2004 onwards.\(^{(55, 56)}\) The objective was to establish a price schedule based on independently and objectively determined costs. This system was, however, not successful in eliminating co-payments as healthcare providers could conceivably deviate from this list and charge higher tariffs, resulting in the practice of co-payments persisting in the sector\(^{(57)}\). Further, there were allegations that the system did not adequately take into account the medical schemes' budgetary constraints nor did it address the healthcare providers' costing exercises.\(^{(58)}\) The concerns by both

\(^{(46)}\) As indicated above, this paper focuses on the market for the provision of private hospital services in South Africa.
\(^{(47)}\) For more information regarding the concentration levels in the market for the provision of private hospital services, kindly see section 4 hereunder.
\(^{(48)}\) This argument has been, inter alia, raised by the Council for Medical Schemes, which is discussed in more detail hereunder.
\(^{(49)}\) Supra n31, supra n39.
\(^{(50)}\) Supra n31, supra n39.
\(^{(51)}\) Dr Manto Tshabalala-Msimang (Minister of Health). Briefing to the Portfolio Committee on Health, Tuesday, 26 February 2008
\(^{(52)}\) Submissions to the Department of Health's National Health Reference Pricelist Process.
\(^{(53)}\) Estimates of out of pocket healthcare expenditure in South Africa vary, the general consensus appears to be that such costs are just below 20% of total healthcare expenditure. Ataguba and McIntyre (2009) estimate that 14% of total healthcare expenditure is out of pocket whilst McLeod (2009) estimates this to be approximately 18%.
\(^{(54)}\) A number of NHRPL circulars were published in 2004 anticipation of the implementation of the price list in 2005. See <http://www.medicalschemes.com/files/Circulars/Circular_54_2004.pdf>
\(^{(55)}\) Supra n39.
\(^{(56)}\) Supra n31, supra n39.
\(^{(57)}\) Ibid.
the insurers and healthcare providers led to a court battle that culminated in the price list being set aside by order of the High Court.\textsuperscript{59 60}

The current situation in the South African healthcare market raises significant concerns given that the state of the public healthcare system, which services approximately 80% of the population\textsuperscript{61}, is beset by a number of problems that result in it not being able to provide adequate healthcare services. The cost of private healthcare is considered one of the contributing factors that limit access to the private healthcare system, access which could greatly assist in increasing the number of people receiving adequate healthcare services in South Africa. Given the concerns relating to the cost of private healthcare, the role of competition policy in ensuring high quality private healthcare at lower prices with a wide choice for consumers has been brought to the spotlight.

3. \textbf{What can competition policy do?}

To date the cost of private healthcare in South Africa still remains a concern and the view that intervention by the competition authorities can contribute to the attainment of the desired pricing outcomes still prevails in certain circles. As such, there have been growing calls for diagnostic purposes, policy formulation and direct intervention for the competition authorities to institute a market inquiry aimed at determining the cost drivers that have led to what are perceived to be unacceptably high costs.\textsuperscript{62} This brings to question the ability of competition policy to achieve universal access to healthcare services (including to private hospital services) at acceptable prices and quality levels.

The question of competition policy intervention in healthcare markets has been the subject of debate that has revealed divergent views with one side adopting a “hands-off” approach arguing that the uniqueness of the healthcare market renders it unsuited to competition policy intervention\textsuperscript{63}. On the other hand, there is a view that healthcare markets are not any more unique than other markets and therefore should be subject to the same level of competition scrutiny as other markets in the economy\textsuperscript{64}.

To elucidate, the argument advocating for no competition intervention in healthcare markets finds its origin in Arrow (1963)\textsuperscript{65} who argued that healthcare markets are significantly different from highly stylized, perfectly competitive markets. Arrow (1963)\textsuperscript{66} recognised that healthcare markets are highly differentiated given the variety of treatments on offer and the geographic location of service providers (including, \textit{inter alia}, practitioners and hospitals). Further, from the demand side information is imperfect given the expert nature of the service provided. As such healthcare services are generally considered credence goods because it is

\textsuperscript{59} Case no: 37377/09
\textsuperscript{60} Supra n39.
\textsuperscript{61} Supra n13.
\textsuperscript{64} Ibid.
\textsuperscript{66} Ibid.
difficult for customers to decide *ex ante* whether the service is of high or low quality\(^{67}\). Hospital markets, in particular, are generally characterised by a small number of firms, with costly entry and exit conditions prevailing in these markets.\(^{68}\) Purchasing is often done by a third party, the medical schemes, through negotiations which can have significant transaction costs\(^{69}\). Given such features, there is a view that bespoke regulation of healthcare markets is perhaps better suited to delivering desired pricing, quality and quantity outcomes than general competition policy.

The opposing view argues that whilst product differentiation and information asymmetries can soften competition this does not imply that competition cannot work in markets such as those in the healthcare sector\(^{70}\). Similarly, while oligopoly markets with a small number of firms may present challenges to competition, it is generally accepted that such markets are better suited to organising exchanges.\(^{71}\) Gaynor (2012) argues that this can also be equally applied to other healthcare markets. Further, due to significant entry and exit costs, healthcare markets are unlikely to develop beyond typical oligopolistic markets. The transaction costs in healthcare markets, whilst significant, are not unique as each market requires some expenditure in order to obtain goods. Whilst information asymmetries may present significant challenges to the uninhibited functioning of competition in such markets, adjustments to the information asymmetry such as seller reputations, warranties, independent ratings of sellers, as is the case with other markets that require minimum standards, can address and enhance market functions in the healthcare sector\(^{72}\).

The proponents of this view use the private hospital markets as an example and suggest various conditions that must be present in order for competition to properly function. These include:

- “enough” hospitals;
- incentives for hospitals to attract patients;
- demand responsiveness to differences across hospitals; and
- “enough” information.\(^{73}\)

Abraham *et al* (2007)\(^{74}\) finds that competitive outcomes in hospital markets increase substantially as more hospitals enter a market. Similarly Bresnahan and Reiss (1991)\(^{75}\) find significant increases in competition and competitive outcomes as the number of competitors increase in the markets for doctors, dentists, and

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\(^{68}\) Some of the observations of the competition authorities pertaining to the structural nuances of the market for the provision of private hospital services are discussed in section 2 hereunder.

\(^{69}\) Supra n63.


\(^{71}\) Supra n63.

\(^{72}\) Supra n63.

\(^{73}\) Ibid


pharmacists. The authors also argue that demand responsiveness to price and quality can stimulate competition when consumers have access to information that will assist in their selection process.

The role for competition in healthcare markets, and hospital markets in particular (which is the focus of this paper) is to support better incentives for healthcare providers to work efficiently and deliver desired price and quality outcomes for patients. It is commonly accepted that the existence of competition in any market will deliver higher quality goods and services at lower prices and provides consumers with greater choice. Such pro-competitive outcomes may be the result of, *inter alia*, lower barriers to entry which lead to more competition which encourages efficiencies and innovation manifesting in lower prices and greater choice for consumers. The existence and functioning of competition in private healthcare markets can work to reduce costs, allow for more people to have access to these services and thus reduce the burden on the public health system. Maier-Rigaud (2012)\(^76\) states, however, that such beneficial outcomes are also dependent on the country’s regulatory and institutional environment, as well as the responses of consumers and healthcare providers to policy reforms. We discuss this in further detail below.

Therefore despite the peculiarities of the healthcare markets, competition can take place and deliver pro-competitive outcomes. As we demonstrate below South Africa has recognised that there is a role for competition in healthcare markets, however, the success of such competition law intervention in achieving the aforementioned benefits is subject to debate.

4. **Reflections on competition policy interventions in the South African private hospitals market**

**Introduction**

The evolution of competition law intervention in the South African healthcare industry appears to demonstrate the use by the competition authorities of (except for market inquiries) nearly every tool at its disposal. Its intervention from a merger perspective has informed its subsequent initiation of prohibited practice complaints. Continued investigations in the healthcare industry have historically revealed a prevalence of collaboration between industry stakeholders (which although leading to decreased transaction costs, simultaneously resulted in undesirable outcomes), all of which has arguably contributed to the current state of the private healthcare market in South Africa.

Over the last decade or so, competition law intervention in this market has been a fluid process, adapting to changing circumstances and new developments, all the while informed by a burgeoning understanding of the healthcare market and its unique nuances by the competition authorities. We describe hereunder, a brief historical account of some of the competition authorities’ interventions in the market for the provision of private healthcare services including hospitals. Kindly note, however, that owing to length limitations, the assessment from a merger perspective herein focuses primarily on a sample of large mergers in this relevant

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market. The interventions are demonstrative of the adaptability of competition law as a tool to eradicate the perceived ills in the market for the provision of private hospital services.

The developmental years

In 2001 (approximately two years pursuant to the Competition Act coming into force in South Africa)\(^{77}\) the proposed merger between Afrox Healthcare Limited ("Afrox") and Amalgamated Hospitals Limited (the "First Afrox Merger")\(^{78}\) was assessed by the competition authorities.

This investigation by the competition authorities into the competitive and public interest effects of the transaction brought into the open some of the competitive dynamics (or lack thereof) in the affected markets, which dynamics are discussed in more detail hereunder.

In its assessment of the proposed transaction, the Tribunal heard arguments from the merging parties that the relevant product market ought to comprise a broad market for hospital services, inclusive of both private and public hospital services.\(^{79}\) It was argued that since many state hospitals offer services in direct competition with private hospitals by, \textit{inter alia}, reserving wards for private, fee-paying patients, the provision of such hospital services ought to comprise a single relevant product market. The Commission disagreed with the arguments of the merging parties. It argued that the types of services offered by each of state and private hospitals differed considerably in respect of cost, quality of facilities and standards of services, resulting in such hospitals not competing for the same customers.\(^{80}\)

The Tribunal agreed with the assertions of the Commission and found the relevant product market to comprise that for the provision of private hospital services. It opted, however, not to sub-delineate between the various services on offer at such private hospitals\(^{81}\) – a relevant product market definition which appears to have been consistently applied.\(^{82}\)

From a relevant geographic perspective, although the Tribunal found it unnecessary to make a definitive finding in this respect, it appeared to favour that geographic market proposed by the Commission, namely that private hospitals are only likely to compete with each other within a 20-40 kilometre radius.\(^{83}^{84}\)

\(^{77}\) Supra n45.
\(^{78}\) Afrox Healthcare Limited and Amalgamated Hospitals Limited Case No. 53/LM/Sep01.
\(^{79}\) Supra n78 at page 3.
\(^{80}\) Supra n78 at page 4.
\(^{81}\) The services on offer at private hospitals potentially extend to various specialist services such as obstetrics, gynaecology, radiology, neonatal intensive care unit, paediatrics, general surgery, urology, as well as the housing of particular facilities, such as intensive care / high care units, theatre facilities and pharmacies. Supra n78.
\(^{82}\) In each of the cases considered herein, the relevant product market was found by the Tribunal to comprise the market for the provision of private hospital services. Phodiclinics (Proprietary) Limited and Others and Protector Medical Group Services (Proprietary) Limited (in liquidation) and Others, Case No. 122/LM/Dec05 (the "Phodiclinics Decision").
\(^{83}\) This view was repeated in the Second Afrox Merger (see supra n98) in which the Tribunal restated its reluctance to definitively delineate the boundaries of the relevant geographic market. In the Phodiclinics Decision, the Tribunal was further cognisant of the fact that the competitive implications of a merger in the market for the provision of private hospital services should be assessed from both a regional and a national perspective. Supra n83 at page 11 and 12.
In assessing the competitive considerations pertaining to the proposed transaction, the Tribunal took note of the unique structural characteristics of the relevant market, including the significant barriers to entry, an aspect of its analysis to which much attention has subsequently been paid. The Tribunal took cognisance of the fact that the Department of Health serves as the “gatekeeper” to the market for the provision of private hospital services, issuing licences for the construction of new private hospitals to which conditions are usually attached. As a result of various factors, including this regulatory barrier, the market for the provision of private hospital services was acknowledged to be highly concentrated, dominated by certain major participants – Netcare Hospital Group (Proprietary) Limited (“Netcare”), Medi-Clinic Corporation Limited (“Medi-Clinic”), Joint Medical Holdings and, of course, the acquirer in this instance, Afrox.

In addition to the structural peculiarities of the relevant market, the Tribunal’s analysis exposed the market to be devoid of price competition, since various tariffs to be charged for private hospital services were determined on an annual basis by the BHF, in consultation with the private hospitals. Due to the involvement of the BHF in this regard, the merging parties argued that competition between the private hospitals occurred on the basis of factors other than price, such as quality of service to attract patronage, winning favour with the referring doctor, location, the existence of a multi-disciplinary pool of healthcare providers, possession of state-of-the-art equipment and the like. To elucidate, the Tribunal explained that the tariff determined jointly by the BHF and private hospitals and known as the ‘scale of benefits’, would comprise the amount of finance each medical scheme would be prepared to cover for any specified service offered by a private hospital. Any private hospital that charged in excess of the jointly determined scale of benefits would be obliged to recoup the difference from the patient directly, which would, of course, pose an administrative burden to the hospital in question. Thus, noted the Tribunal, private hospitals were unlikely to charge prices beyond those recommended by the BHF.

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85 As indicated in section 2 above, it is argued by some that the unique characteristics of this particular market render it unsuitable to competition law intervention.
86 Supra n83.
87 Supra n78 at page 7.
88 As indicated in the Phodiclinics Decision, the Department of Health, at one stage, placed a moratorium on the issuing of new licenses for the construction of new private hospitals, resulting in the fact that new entrants were only able to enter the relevant market by means of the acquisition of existing private hospitals. Supra n83 at page 43 and 44.
89 Such conditions may include the types of services which may be offered or the number of beds which a private hospital may house. Supra n83.
90 Supra n78 at page 6.
91 Netcare (as defined herein) is a direct subsidiary of Netcare Limited, which entity changed its name from Network Healthcare Holdings (Proprietary) Limited in 2008. For ease of reference, the entire Netcare Limited group (in particular its interests in the private hospital market) will be referred to as Netcare herein. Macgregor, <http://research.mcgregorbfa.com> (accessed 11 August 2012)
92 The First Afrox Merger specifically contemplated the magnitude of Joint Medical Holdings as a participant in the Kwa-Zulu Natal market for the provision of private hospital services. It was not cited as a major participant in this relevant market in the subsequent decisions of the Tribunal considered herein.
93 Supra n78 at pages 5 and 6. Certain other industry bodies were also discovered to be involved in the determination of industry tariffs.
94 Supra n78 at page 6.
95 Post the intervention of the competition authorities from a prohibited practice perspective (described in more detail hereunder), it would appear that there is price competition in the private hospital market since and some hospitals charge prices higher than those recommended by medical schemes, with the result that the hospital is obliged to recoup the difference from the patient directly.
The Tribunal concluded that the proposed merger would unlikely substantially lessen or prevent competition in the identified market, since the involvement of the BHF would restrict the merged entity's ability to unduly inflate its prices post-merger. On the basis of the foregoing, the First Afrox Merger was unconditionally approved.\(^{97}\)

Less than 6 months later, Afrox Healthcare Limited again sought the approval of the competition authorities to merge with a Pretoria-based hospital group, Wilgers Hospital Limited (the "Second Afrox Merger").\(^{98}\)

Consistent with its review of the First Afrox Merger, the Tribunal repeated its analysis and conclusion regarding the relevant product and geographic markets. In addition, it made reference to the high levels of concentration evident in the market for the provision of private hospital services, in which it found Medi-Clinic, Afrox and Netcare to collectively account for approximately 74% of the national market.\(^{99}\)

Focusing its attention on the impact of the proposed transaction in Pretoria, the Tribunal noted that the market share attributable to the merged entity would reach almost 25% post-merger, resulting in it being a significant participant therein, second fiddle only to Netcare.\(^{100}\) Notwithstanding this, the Tribunal restated the view it had expressed in the First Afrox Merger, namely that price competition in this relevant market was significantly influenced by the involvement of participants other than the private hospitals, namely the BHF, HASA and SAMA.

One of the factors which also appeared to comfort the Tribunal in its decision to unconditionally approve this second acquisition by Afrox, was the advice it received from the merging parties that Curamed Holdings Limited ("Curamed"), the third largest participant in Pretoria (after the merged entity and Netcare), was to imminently increase its 16.3% market share due to its construction of a new private hospital in Pretoria East.\(^{101}\) On this basis, it was anticipated that upon completion of its construction, Curamed would comprise a noteworthy competitor to Netcare and Afrox in Pretoria.

In that same year, however, Medi-Clinic sought the approval of the competition authorities for its acquisition of Curamed.\(^{102}\) The Tribunal’s analysis, conducted on the basis of the Gauteng region, indicated that the merged entity was to account for approximately 16% therein.\(^{103}\) The Tribunal unconditionally approved Medi-Clinic’s acquisition of Curamed on the basis that the transaction would not substantially lessen or prevent competition.\(^{104}\) Consequently, Medi-Clinic (which did not have any presence in Pretoria pre-merger)

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\(^{97}\) In reaching this decision, the Tribunal further stated that adverse competitive effects were likely to arise only where a proposed merger affects the ability of hospitals to compete for doctor’s referrals or where the merger negates the countervailing power of the BHF.

\(^{98}\) Afrox Healthcare Limited and Wilgers Hospital Limited, Case No. 15/LM/Feb02

\(^{99}\) Supra n98 at page 3.

\(^{100}\) Supra n98 at page 3.

\(^{101}\) Ibid.

\(^{102}\) Medi-Clinic Corporation Limited and Curamed Holdings Limited Case No. 74/LM/Oct02

\(^{103}\) The remaining market share was attributable to the other two major players, Netcare and Afrox, as well as the existence of 8 independent private hospitals.

\(^{104}\) Supra n102.
acquired Curamed’s six Pretoria-based hospitals without any limitation, bringing the total number of private hospitals under its control on a country-wide basis to 42.\(^{105}\)

During the consideration of the aforementioned mergers, a common theme became evident to the Commission – the influence of certain industry bodies in this market resulted in the fact that pricing appeared to be the product of considered negotiation between relevant industry stakeholders. An analysis conducted by Rand Merchant Bank reveals\(^ {106}:\)

"The strategic behaviour of these groups has historically been characterised by a conscious avoidance of price competition. Rather than attempt to aggressively win market share through price wars and intensive advertising campaigns, the hospital groups – via their joint membership of the Hospital Association of South Africa – have managed to standardize industry pricing by agreeing set tariffs with the Medical Aids represented by the Board of Healthcare Funders."

On this basis, the Commission initiated industry-wide investigations into this conduct citing the BHF, HASA, as well as SAMA, as alleged participants in a price fixing scheme in breach of section 4(1)(b) of the Competition Act.

**A collaborative procedure**

The Commission’s subsequent investigation revealed that the historical regulation of the private healthcare sector and the level of statutory intervention therein contributed to the acceptance of a standardised tariff system, which tariff was published on an annual basis and readily available to all participants.\(^ {107}\) Although this system appeared to give rise to certain advantages (such as informing financiers of the risk of investing in new private hospitals, easing the administrative burden of collecting payments from patients or serving as an ethical touchstone for private hospitals in South Africa), the publication of such standardised tariffs also resulted in a limitation to price competition in the relevant market.\(^ {108}\) For this reason, the Commission initiated individual complaints against HASA, SAMA and the BHF for price fixing.

HASA, an industry association established in the 1940’s\(^ {109}\) and representing the interests of approximately 200 privately and independently owned hospitals in South Africa\(^{110} \quad 111\) was pre-2004 involved in the determination, recommendation and publication of annual benchmark tariffs for the rendering of certain hospital services by private hospitals.\(^ {112}\) The recommended annual tariffs were published in the “HASA Recommended Tariffs for Private Hospitals and Private Psychiatric Hospitals” to which private hospitals would have access. It is noteworthy, however, that HASA’s involvement in this conduct (at least until August

\(^{105}\) Ibid.


\(^{107}\) Competition Commission and the Board of Healthcare Funders of Southern Africa Case No. 07/CR/Feb05.

\(^{108}\) Competition Commission and the Hospital Association of South Africa / Ordinary Members of the First Respondent Case No. 24/CR/Apr04.

\(^{109}\) Supra n110.


\(^{111}\) These members are estimated to account for almost 93% of the private hospitals in South Africa. Supra n108.

2000) was excused from competition law liability owing to an exemption it had procured from the competition authorities to conduct itself in a manner that would ordinarily fall foul of the provisions of the Competition Act.\textsuperscript{113}

The Commission’s complaint against HASA culminated in the negotiation of a settlement agreement as between HASA and the Commission. In terms of this agreement, HASA admitted that its conduct comprised the fixing of a selling price in breach of section 4(1)(b)(i).\textsuperscript{114} Going forward, HASA undertook to refrain from engaging in the joint determination and / or publication of recommended tariffs, either together with its members, with SAMA or with the BHF.\textsuperscript{115} For its involvement in this contravening conduct, HASA agreed to pay an administrative penalty of R 4 500 000, which agreement was confirmed as a consent order by the Tribunal.\textsuperscript{116}

Shortly after its conclusion of the aforementioned settlement agreement, the Commission entered into similar negotiations with SAMA\textsuperscript{117} \textsuperscript{118}, an association described as a “champion” for doctors\textsuperscript{119}, that would as part of its functions, jointly determine and publish recommended benchmark tariffs for certain medical services on an annual basis. Such recommended tariffs would be published in the annual publication entitled “Benchmark Guide to Fees for Medical Services”.\textsuperscript{120}

In contrast to the activities conducted by HASA, SAMA was not at any time in the possession of an exemption from the competition authorities to engage in such conduct. Consequently, the act of jointly determining and publishing such tariffs was argued by the Commission to comprise the fixing of a selling price in breach of section 4(1)(b)(i), an allegation to which SAMA admitted.\textsuperscript{121} However, in mitigation thereof, SAMA argued that its infringement of the Competition Act was more technical than substantive in nature since (1) the published tariffs were intended to comprise only “guidelines” or recommendations as opposed to fixed prices and (2) only approximately 8 000 of its members were involved in private practice and could subsequently be said to have engaged in such conduct.\textsuperscript{122}

In the settlement agreement concluded between the Commission and SAMA, SAMA undertook to cease engaging in such prohibited conduct immediately and, as retribution for its conduct, paid an administrative penalty in the amount of R 900 000, which was confirmed by the Tribunal.\textsuperscript{123}

Finally, the BHF, whose involvement in the market for the provision of private hospital services appeared to have triggered the industry-wide investigation, was found to be a body representing approximately 85% of

\begin{itemize}
  \item \textsuperscript{113} Competition Commission and the South African Medical Association and the Members of the First Respondent Case No. 23/CR/Apr04.
  \item \textsuperscript{114} Supra n108.
  \item \textsuperscript{115} Ibid.
  \item \textsuperscript{116} Ibid.
  \item \textsuperscript{117} It has been estimated that these practitioners comprise approximately 70% of public and private sector doctors in South Africa. The South African Medical Association, < www.samedical.org > (accessed 6 August 2012).
  \item \textsuperscript{118} SAMA represents over 15 000 medical practitioners in South Africa. Supra n113.
  \item \textsuperscript{119} Supra n117.
  \item \textsuperscript{120} Supra n113.
  \item \textsuperscript{121} Ibid.
  \item \textsuperscript{122} Ibid.
  \item \textsuperscript{123} Ibid.
\end{itemize}
South African medical schemes.\(^{124}\) Its main function was recorded to be the dissemination of information to key stakeholders in the healthcare sector\(^{125}\) \(^{126}\) which (pre-2004) included the determination and annual publication of recommended benchmark tariffs in the “Board of Healthcare Funders of Southern Africa, Benchmark Tariffs.”\(^{127}\)

Similar to its findings in each of the HASA and SAMA investigations, the Commission argued that the determination and publication of recommended tariffs for certain healthcare services by the BHF fell foul of section 4(1)(b)(i) of the Competition Act. The BHF and the Commission concluded a settlement agreement (which was subsequently confirmed as a consent order by the Tribunal) in terms of which the former, inter alia, undertook to cease publishing recommended benchmark tariffs.\(^{128}\) Whilst the BHF also acquiesced to the payment of a settlement amount to the tune of R500 000, it specifically indicated that any such undertaking negotiated between it and the Commission was done absent an admission of guilt.\(^{129}\)

Having intervened to eliminate the alleged price fixing of which it was aware in this relevant market to improve price competition therein, the attention of the competition authorities was diverted, once more, to the ongoing merger transactions in the market for the provision of private hospital services. In contradiction to the relative ease with which merger transactions in this relevant market appeared to have historically passed muster during the developmental years, the competition authorities – older and wiser – thoroughly explored the mechanics of each transaction (as indicated hereunder), fully utilising the tools at its disposal, presumably with a view to safeguarding the competitive process in the market.

**Strong medicine: The post-2004 era**

During 2004, the competition authorities were approached to consider the proposed acquisition of Afrox by Business Venture Investments No 790 (Proprietary) Limited (“BVI”).\(^{130}\) By way of background, Afrox Oxygen Limited (“AOL”), the ultimate controller of Afrox, sought to realise its investment and exit the market for the provision of private hospital services, by ridding itself of Afrox.\(^{131}\)

The market for the provision of private hospital services, was at the time dominated (and had been for some time and is still today) by Afrox, Medi-Clinic and Netcare.\(^{132}\) Naturally, the acquisition of Afrox by either Medi-Clinic or Netcare would accord upon the acquirer a significant competitive advantage. Each of Netcare and Medi-Clinic thus sought to participate in the bidding process for Afrox.

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125 Such key stakeholders included medical schemes and administrators, medical scheme members and consumers, regulatory authorities, relevant government departments, businesses and labour organisations
126 Supra n124.
127 Ibid.
128 Supra n107.
129 Supra n127.
130 Supra n106.
131 Ibid.
132 Supra n78, 98, 102.
Upon submission of its bid, however, Netcare was informed by an investment bank which it approached to loan the necessary funds for the acquisition, that the bids of large hospital groups (which term could conceivably only have been made in reference to it and Medi-Clinic) would not be considered, due to the foreseeable hurdle that would be faced in the procurement of competition law approval. Medi-Clinic, in the form of its empowerment partner, BVI, submitted a persuasive offer\textsuperscript{133} which was accepted by AOL despite anxiety that the execution of the acquisition could be thwarted by the competition authorities. In an attempt to, \textit{inter alia}, counter this apprehension, it was agreed that BVI (in which Medi-Clinic held a 25% controlling stake) would acquire control of Afrox directly. Thereafter, and to guarantee the loan capital fronted by Medi-Clinic for BVI’s direct acquisition, BVI would sell 2 500 of Afrox’s private hospital beds to Medi-Clinic.\textsuperscript{134}

Displeased with this result, Netcare made application and was granted permission to intervene in the Tribunal proceedings. Simultaneously, High Court proceedings were initiated in an attempt to “settle” the disagreement between Netcare (and various other smaller stakeholders) on the one hand and Medi-Clinic, BVI and Afrox on the other. Ultimately, Netcare’s interference was somewhat successful since Medi-Clinic’s proposed acquisition of the 2 500 Afrox beds\textsuperscript{135} was, \textit{inter alia}, set aside and replaced with an “equal opportunity” provision\textsuperscript{136} which requires that any subsequent disposal of the Afrox assets is to be offered to each of Medi-Clinic and Netcare on identical terms and conditions, affording each entity an equivalent opportunity to submit offers in relation thereto.\textsuperscript{137}

Cognisant of the structural links between role players at multiple levels in the healthcare sector\textsuperscript{138}, the Tribunal approved the proposed acquisition, subject to specifically crafted conditions.\textsuperscript{139} Undoubtedly, the Tribunal sought to curb the temptation of utilising the merged entity as a vehicle for collusion and subsequently imposed conditions intended to eliminate the existence of cross-directorships. Moreover, presumably in an attempt to prevent the market from reaching saturation point without its involvement, the Tribunal also imposed certain conditions restricting subsequent purchases of equity in either BVI or Afrox by Medi-Clinic or Netcare.\textsuperscript{140}

The intent of the competition authorities to restrict the burgeoning levels of concentration in the market is also evident in its consideration of the proposed acquisition of the assets of New Protector Group Holdings (Proprietary) Limited by Phodiclinics (Proprietary) Limited and DJF Defty (Proprietary) Limited.\textsuperscript{141} In this regard, the Tribunal was cognisant\textsuperscript{142} of the fact that the significant concentration levels evident in the market

\begin{itemize}
  \item \textsuperscript{133} Supra n106, paragraph 28.
  \item \textsuperscript{134} Supra n106.
  \item \textsuperscript{135} Despite the conclusion of the settlement agreement, Medi-Clinic doggedly persevered that it was entitled to 2500 of Afrox’s private hospital beds by virtue of a separate commercial agreement to which both it and BVI were party (a demand it later adjusted to 1500 private hospital beds). BVI’s failure to comply with the terms of the agreement resulted in it offering Medi-Clinic compensation in the amount of R50 million for what was termed the “the relinquishment of rights” which had been allegedly secured through the Disposal and Cooperation Agreement.
  \item \textsuperscript{136} Supra n106.
  \item \textsuperscript{137} Ibid.
  \item \textsuperscript{138} Supra n106, paragraph 59.
  \item \textsuperscript{139} Ibid.
  \item \textsuperscript{140} Ibid.
  \item \textsuperscript{141} Supra n83.
  \item \textsuperscript{142} Supra n83, at page 7. This concern was originally raised by the Council for Medical Services.
\end{itemize}
may have been, *inter alia*, occasioned by the involvement of the three dominant players therein in a series of successive and progressive “creeping mergers”. By way of explanation, merger transactions culminating in incremental and *de minimis* increases in the market share of the acquirer are, traditionally, unlikely to attract competition law scrutiny. However, the continuous purchase of independent hospitals by the major players in this relevant market has potentially contributed to the placement of a significant portion of the relevant market in the hands of a few astute participants. It was argued that these progressive acquisitions by the large hospital groups have, over time, contributed to the high concentration levels, and in turn, the high costs of private hospital care.

In response to “creeping merger” allegations and irrespective of the origin of the concentration levels evident in this relevant market, the competition authorities appear to have addressed this concern from two ends. In the first instance, the decision of the competition authorities to grant an exemption application made by the National Hospital Network (“NHN”) ostensibly resulted in the empowerment of smaller, independent hospitals. The NHN, a network of independent private hospitals active in South Africa, sought an exemption from the competition authorities in 2005 to act in a cooperative manner presumably with a view to posing a significant competitive constraint to the activities of the three main hospital groups. The notification of this exemption (which was initially to endure until 4 November 2008) specifies that membership to the NHN (and thus the benefit of the exemption) is restricted to hospitals which are not owned or controlled by one of the three large hospitals groups, being, of course, Medi-Clinic, Netcare and Afrox.

In the second instance, the competition authorities indicated a reluctance to allow anti-competitive conduct by the three dominant players (from both a merger perspective and a prohibited practice perspective) to occur without censure.

For instance, during 2007, the competition authorities were requested to assess a proposed transaction, in terms of which Netcare sought to acquire sole control over Community Hospital Group (Proprietary) Limited (“CHG”). By virtue of an earlier transaction, Netcare had a pre-existing 43.75% stake in CHG which it now sought to increase to 100%. During the Commission’s investigation, however, it became apparent that...
Netcare’s initial acquisition conferred upon it joint control, from a competition law perspective, and was allegedly implemented sans the approval of the competition authorities.152

The multi-faceted involvement of the competition authorities in this matter is arguably rooted in the historical conduct of the three major participants in the market for the provision of private hospital services – Netcare, Afrox and Medi-Clinic. Briefly153, the Malesela Hospital Group (which later became CHG) originally controlled various hospitals throughout South Africa – Montana Park Clinic, Bougainville Hospital, the N17 Hospital and Kuils River Hospital – and was also the beneficiary of the licenses to the Fourways Hospital and the Southgate Hospital (collectively the “CHG Hospitals”). As a result of serious, and unexpected, financial upheaval, the survival of these hospitals was suddenly in jeopardy. The incorporation of a new partner and financier became the only means for the CHG Hospitals to avoid liquidation. Whilst each of Medi-Clinic, Netcare and Afrox were approached to offer aid in this respect, it was later unearthed that the parties had reached agreement as between themselves to refrain from participating in this process (which agreement Afrox later defied when it engaged with the liquidators for a piece of the CHG Hospitals, presumably in an attempt to protect certain of its own hospitals to which the CHG Hospitals posed a direct threat from a geographic perspective).154

Whilst not wholly successful, Afrox’s endeavours were rewarded when it was able to obtain control over the Fourways Hospital.155 Netcare, seeking an empowerment partner, came to the proverbial rescue of CHG156, and over time, acquired a 43.75% stake in CHG in exchange for its efforts absent the requisite approval of the competition authorities.157 With this stake CHG was immediately enveloped as part of the Netcare brethren158, even implementing identical tariffs to those which Netcare had negotiated with medical schemes.

In assessing the competitive implications of Netcare’s acquisition of control over CHG, the Tribunal confirmed its previous ascertainment of the boundaries of the relevant product market159 and assessed the various theories of harm to which the proposed merger could allegedly give rise without reference to any specific geographic boundaries. It acknowledged that a forward-looking hypothesis of the potential effects of the proposed transaction was bedevilled from the outset. Due to the evolution of both the relevant market and CHG since Netcare’s initial acquisition, such an analysis required ‘guesstimation’ and imagination on the part of the witnesses, absent any clear direction or guidance from legislation.160

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152  Ibid.
153  Supra n151.
154  Supra n151 at paragraph 22 and 23.
155  Although Afrox subsequently changed its name to Life Healthcare Group Holdings Limited, we will continue to refer to it as Afrox herein. Macgregor, <http://research.mcgregorbfa.com > (accessed 5 August 2012). Life Fourways Hospital is now operating in Fourways within the Afrox stable.
156  Supra n151.
157  Supra n151 at paragraph 24 and 25.
158  Immediately post-2000, the two entities began conducting themselves as constituent member firms of a single economic entity. Netcare’s substantial influence over CHG was evident in the rolling out of its accounting systems, IT platforms, nursing and management training programmes across all the CHG hospitals. Supra n151 at paragraph 24.
159  Although the Tribunal expressed various reasons as to the difficulty in delineating the boundaries of the relevant product market, it ultimately decided that its previous ascertainment thereof (namely the market for the provision of private hospital services) would suffice for its analysis of this transaction. Supra n151 at paragraph 31 to 39.
160  Supra n151 at paragraph 7.
Ultimately, and despite the Commission’s recommendation that the proposed merger be prohibited, the Tribunal found that Netcare’s acquisition of control over CHG did not result in a substantial lessening or prevention of competition in the relevant market. The Tribunal noted that any potentially anti-competitive undercurrent evident in this relevant market was neither caused by nor aggravated by Netcare’s acquisition of control of CHG. In closing, however, the Tribunal cautioned the Commission that any evidence of anti-competitive conduct between the three dominant players (for instance, the conclusion of agreements between players to refrain from participating in a bidding process) should not be permitted to continue with impunity.

Cognisant of the fact that Netcare and CHG had acted in contravention of the provisions of the Competition Act for some time, the Commission alleged that Netcare’s adoption of CHG as one of its own resulted in dual contraventions of the Competition Act: firstly, in gun-jumping by virtue of its initial acquisition of control over CHG and second, in so doing, the parties conducted themselves as constituent halves of a notional whole without regard to the provisions of section 4 of the Competition Act, which prohibits competitors from engaging in conduct which comprises the fixing of a selling price or terms and conditions ancillary thereto.

As retribution for its involvement in such conduct, the Commission together with Netcare and CHG initially approached the Tribunal to confirm a settlement agreement in terms of which the parties had agreed to pay a cumulative administrative penalty of R6 million. The Tribunal expressed its discontent with the terms of the settlement agreement, describing it as “inappropriately low” to pose a significant deterrent and disincentive to other firms seeking to engage in price fixing and implement mergers in contravention of the provisions of the Competition Act. For this reason, the Tribunal did not confirm the contents of the settlement agreement, a decision which was subsequently reversed by the Competition Appeal Court.

Since the Tribunal’s consideration of the aforementioned transaction, the competition authorities have been requested to assess the competitive implications of various other acquisitions, including Afrox’s acquisition of Amabubesi Hospitals (Proprietary) Limited, Bayview Private Hospital (Proprietary) Limited, as well its acquisition of an additional interest in Joint Medical Holdings Limited to consolidate its pre-existing 49% interest therein, each of which have been unconditionally approved.

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161 Supra n151.
162 Supra n151 at paragraph 113 to 115.
163 Supra n151.
164 Competition Commission and Netcare Hospital Group (Proprietary) Limited / Community Hospital Group (Proprietary) Limited In Re the large merger between Netcare Hospital Group (Proprietary) Limited and Community Hospital Group (Proprietary) Limited Case No. 27/CR/Mar07.
165 Ibid.
166 Netcare Hospitals Group (Proprietary) Limited / Community Hospital Group (Proprietary) Limited and Norman Manoim NO / Urmila Bhoola NO / Yasmin Carim NO / The Competition Tribunal / The Competition Commission Case No. 75/CAC/Apr08. The Competition Appeal Court confirmed the settlement agreement between the merging parties and the Commission as a consent order.
167 Life Healthcare Group (Proprietary) Limited and Amabubesi Hospitals (Proprietary) Limited / Bayview Private Hospital (Proprietary) Limited Case No. 11/LM/Mar10
168 Note that this transaction was unconditionally approved despite the Commission’s recommendation that it be prohibited on the grounds that it would result in a situation of regional dominance which “undermines the ability of funders to stimulate competition”. Competition Commission, Competition Commission recommends prohibited of healthcare merger published on 19 January 2012 <www.commpcom.co.za> (accessed 7 August 2012)
169 Supra n167.
Final prognosis

On the basis of the foregoing, it would appear that the Tribunal has attempted to take a firm hand to participants in the market for the provision of private hospital services in an attempt to constrain burgeoning concentration levels therein.

The history of competition law intervention in the South African market for the provision of private hospital services is demonstrable of the fact that the authorities have utilised experience gained, as well as the tools at its disposal, to conduct extensive investigations into this particular market to fulfil its mandate of safeguarding the competitive processes therein. When concerned that a merger could potentially result in anti-competitive outcomes in this relevant market, the competition authorities have utilised the instruments available to them and designed specific conditions to address such concerns. In addition to its use of merger review, its initiation and/or investigation of alleged prohibited practices and its negotiation and conclusion of settlement agreements with industry stakeholders, the competition authorities have also renewed (which renewal only lapses in 2018) its bestowal of an exemption upon a group of independent hospitals (now coined the “New National Hospital Network”) permitting continued engagement in a process of collective bargaining in this relevant sector with impunity.\textsuperscript{171}

Notwithstanding its creative use of the options available to it, the fact that the market for the provision of private hospital services is still characterised by escalating costs and significant concentration levels, is perhaps illustrative of the fact that the goal of ensuring the population’s access to quality healthcare services cannot be achieved in the South African context solely by the use of competition law and policy.

5. International perspectives

Introduction

The experiences of other jurisdictions provide insight into alternate types of tools which have been used in conjunction with competition policy to assist in achieving the desired price, quality and access objectives in healthcare. The literature reviewed collectively acknowledges that in order for competition to deliver improvements in the provision of healthcare services, certain regulatory conditions and market structures ought to be in place. Implicit in this is the recognition that the goal of equal access to hospital services may not be solely achieved by means of a competitive market outcome\textsuperscript{172}.

Given that there are no countries that have implemented successful healthcare regimes with profiles similar to that of South Africa, countries that are perceived to have successful healthcare systems (taking account of the differences in market structure and economic profiles of such countries) have been considered herein. In


\textsuperscript{171} Government Gazette, 6 February 2009, Notice 120 of 2009, Notice of an Application for an exemption in terms of section 10(1)(b) of the Competition Act: New National Hospital Network.

this section, the tools employed in the healthcare sectors of the United Kingdom, Germany and the United States are considered to firstly assess the degree to which such tools have contributed to achieving positive outcomes therein and secondly, to identify the lessons that can be learnt to potentially bolster competition law interventions in private healthcare markets in South Africa.

The United Kingdom ("UK")

Falling within the stable of the United Kingdom's Department of Health, the NHS offers residents of the United Kingdom access to a variety of quality healthcare services, from alcohol addiction support to open heart surgery. Launched with the ideal that quality healthcare services should be available to all, the NHS celebrates its 64th birthday this year.173

Cooper (2012)174, in his assessment of the impact of competition in the UK’s NHS,175 finds that its introduction during the period 1997 to 2010 has been successful, leading to reductions in death rates, improvements in hospital quality, management and productivity. The reforms implemented to foster competitive outcomes focused on linking performance with financial and non-financial incentives for healthcare providers. These included a performance management programme for secondary care providers; a pay-for-performance scheme for primary care which tied the income of general practitioners partly to achieving performance levels on a range of clinical practice, patient experience and patient outcomes; and the introduction of patient choice and fixed price hospital competition in the market for secondary care for NHS funded patients. The author avers, however, that other policies must also be in place to support competition to yield desirable outcomes.176 A brief exposition of the UK market structure and regulatory reforms gives context to the underlying success of competition in this market.

The UK healthcare market is largely underpinned by the NHS as the largest provider of healthcare services in the United Kingdom, with limited participation by the private sector.177 The NHS is considered, to a certain extent, to pose some competitive constraint to the private healthcare service providers through its interaction with private healthcare providers in various ways. The NHS, as a provider of healthcare services in general, is also a participant in the private healthcare market in that it provides the same services as these market participants through its Private Patient Units ("PPUs")178, is a significantly large procurer of private healthcare services and can place limits on NHS consultants to practice in the private healthcare markets. It is within this setting that the UK policy-makers sought to introduce policy reforms that would aid the functioning of competition to the benefit of consumers. The key element of the NHS reforms was to give patients formal choice over where they received secondary care; a reimbursement system that was tied to

173 Supra n5.
175 The NHS is the UK’s publically-funded healthcare service.
176 Ibid.
177 Supra n5.
178 PPUs are privately funded public providers of healthcare services. Report on the market Study and proposed decision to make a market investigation reference, Office of Fair Trading, 2011.
clear performance criteria including clinical practice, patient experience and patient outcome measures; and patient choice and fixed price hospital competition.\textsuperscript{179}

These reforms included the introduction of a ‘Payment by Results’ system, which paid hospitals a government determined fee, based on the patient’s diagnosis, adjustment for local economic wage rates, hospital characteristics and illness severity.\textsuperscript{180} The government also encouraged entry by new private healthcare providers and afforded hospitals additional fiscal and management autonomy, including the ability to retain surpluses. In conjunction with these reforms, the government implemented regulatory reforms designed to guarantee minimum standards of hospital performance.\textsuperscript{181} Lastly, the government introduced information portals aimed at assisting consumers and purchasers’ choices. The information provided focussed on the providers’ performance, including its facilities’ waiting times, activity rates, infection rates, mortality rates and readmission rates as well as comments and recommendations from individual patients.\textsuperscript{182}

It is important to recognise that the UK health system is largely a regulated market with fixed prices that are determined by an external body. Economic theory dictates that under such a setting, hospitals are likely to compete on non-price dimensions i.e. quality in order to attract patients.\textsuperscript{183} This, however, is dependent on the level at which the administered price is set as it may incentivise or disincentivise improvements in quality. In order for price and quality competition to properly function under such circumstances, access to cost information and quality indicators is important as this will form the basis upon which tariffs and performance standards can be set.\textsuperscript{184} Further, access to information for consumers, either directly or through referrals by general practitioners, assists such consumers in making informed quality choices, thereby encouraging competition between hospitals.

\textbf{Germany}

The structure of the German healthcare market is similar to that of the UK in that a large majority of the population is insured with a statutory health insurance fund, with only approximately 10% of the population utilising private health insurance.\textsuperscript{185} On the supplier side, public hospitals, charitable (church) hospitals and private hospitals account for roughly 49, 34 and 17% of the accommodation capacity in the healthcare market respectively.\textsuperscript{186} The German government has put in place a “Hospital Plan” which is essentially a capacity plan established annually by each federal state in cooperation with the hospitals and health insurers in that state to meet the expected demand for stationary treatment. Enrolment in this plan qualifies hospitals, both private and public, for investment subsidies from the state that assist in building, expanding and

\textsuperscript{179} \textit{Ibid.}
\textsuperscript{180} \textit{Ibid.}
\textsuperscript{181} \textit{Ibid.}
\textsuperscript{182} \textit{Ibid.}
\textsuperscript{183} As indicated above, this is consistent with arguments raised in a South African context, when merging parties sought to explain the types of non-price competition engaged in by participants in the market for the provision of private hospital services since price competition was prevented by the existence and involvement of bodies such as the BHF.
\textsuperscript{184} \textit{Ibid.}
\textsuperscript{186} \textit{Ibid.}
modifying hospitals, including equipment. Remuneration of operational costs is provided for through payments by the health insurers and to a certain extent by the patients themselves.

A reimbursement system, referred to as the Diagnosis Related Groups ("DRGs"), which describes an in-patient case and sums up all hospital resources devoted to that case from the beginning of hospitalisation until discharge, was introduced in 2003. These DRGs are allocated a specific cost weight with regard to a general per-diagnosis-value which is determined by the average costs of all cases in a particular geographic state. Negotiations between the insurance funders and regional hospital associations set a base rate to be paid to the hospitals. Such negotiations also extend to the number of services to be provided by the hospitals. Essentially this system calculates hospital remuneration and prices for treatments.

In conjunction with the DRGs system Germany has put in place a number of other regulatory provisions aimed at ensuring minimum quality standards. These include minimum training standards for staff, minimum number of standard treatments performed, guidelines on examination and treatment procedures which are devised and published collectively by the providers and the funders. Lastly, hospitals are compelled to publish reports every two years in which they report the number and form of services provided and whether minimum required standards have been fulfilled.

The price caps resulting from the DRGs exert downward pressure on costs and prevent price increases by hospitals with market power. The regulation of minimum standards ensures that consumers, government and service providers are cognisant of quality choices available and can therefore assess healthcare services on the basis of quality.

**The United States of America ("USA")**

The structure of the USA hospital market differs to that described above in that non-profit and for-profit hospitals account for approximately 80% of the total market and public hospitals the remainder. The ownership, management and operation of these hospitals is, however, inter-linked as non-profit hospitals may sometimes own for-profit hospitals or the management of one is done by the other. In this system, government is the biggest purchaser of healthcare services and the reimbursement system used is the DRG, similar to that used in Germany. As the largest purchaser of healthcare, the government has significant influence in the market and providers are responsive to the incentives devised to improve price and non-price competition. This reimbursement system has also been adopted by private healthcare funders. The USA has also introduced a managed care programme which provides beneficiaries with a range of managed care options including health maintenance organisations and preferred provider organizations.

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187 Ibid.
188 Ibid.
189 Ibid.
190 Ibid.
192 Ibid.
193 Ibid.
194 Ibid.
It is worth noting however, that there is a lack of consumer information about the costs of hospital services, as well as incentives for the consumer to choose the most cost-effective hospitals\textsuperscript{195}. In addition, new entry to the market is difficult since the procurement of a (somewhat elusive) ‘certificate of need’ program is a prerequisite to entry.\textsuperscript{196}

The OECD Roundtable on Competition in Hospital Services

During the drafting of this paper the OECD published the outcomes of its Policy Roundtable on Competition in Hospital Services\textsuperscript{197} in which it articulated key issues emanating from this gathering. One of the key outcomes of this Roundtable was the recognition that increasing expenditure in healthcare has been a motivating factor that has lead most countries to consider introducing competition in their hospital services market. In this regard it was noted that while competition on quality can lead to better outcomes, the outcomes associated with competition on price can be ambiguous. Further, it was acknowledged that the peculiarities of the healthcare market, particularly information asymmetries, may necessitate that the scope for competition in hospital markets be clearly defined in order to ensure the delivery of socially beneficial outcomes. In defining the key indicators of competitive outcomes deriving from meaningful competition the OECD noted that there must be a wide range of accessible options for consumers; there must be interest on the part of the consumers in making choices regarding places of treatment; there must be readily available information that would assist consumers in making well-informed choices; and there must be incentives in place for hospitals to attract patients.

It was also recognised that government has a key role to play in ensuring the provision of quality healthcare services as well as cost containment. In this regard, the interplay between competition authorities, sector regulators and policy-makers was identified as critical to the achievement of this goal. It was further reiterated that competition authorities must ensure that there are competitive market structures in place in order for competition to work in such markets. This, it was argued, required that competition authorities must avoid concentration in instances where prices are not administered and also keep a keen eye on vertical and horizontal integration in hospital markets.

Lessons learnt

We now discuss the lessons drawn from the experiences of the jurisdictions noted above and identify instruments that are not currently utilised in the healthcare system in South Africa, which may require further exploration. The success of competition, public policy including regulation in the aforementioned jurisdictions has largely been underpinned by the existence of a large, influential government buyer of healthcare services, the activities of which poses a concomitant competitive constraint on the private sector. This

\textsuperscript{195} ibid.
\textsuperscript{196} ibid.
competitive constraint is not only reliant on government’s purchasing power but most importantly on the public healthcare system improving the quality of its healthcare offering.

From a South African perspective, the ability of the public healthcare system to offer healthcare services of the same quality and standard as those of the private sector, would make public healthcare a viable alternative for consumers and thereby alter the competitive dynamics in the healthcare market. There is a critical need for significant improvements in efficiencies, quality, capacity and management within the public healthcare system in order for it to exert competitive pressure on the private healthcare system, which may go a long way in ensuring efficient and equitable delivery of healthcare services in South Africa.

Combined with this is a need for a complementary regulatory policy regime designed to foster entry and improve access to consumer information as well as to guarantee a minimum set of quality standards to ensure quality competition by the service providers. Finally, policy reforms are required to encourage “patient cross-over” through programmes such as managed care and public private partnerships.

While the international healthcare sectors referred to above are largely regulated markets with significant government influence it is important to note that market determined prices can also yield desired outcomes when consumers are better informed about quality and price. In the South African context, information regarding the cost and best practice measures of the quality of healthcare services is not easily accessible to consumers.

Dranove and Satterthwaite (1992) find that if consumers have better information about price than about quality, it leads to equilibrium with sub-optimal quality. This emphasizes the role of access to information and consumer behaviour in stimulating competition in the market.

Perhaps South Africa’s response to the experience of international jurisdictions is its proposal to introduce National Health Insurance (“NHI”) in which it is anticipated that government will utilise its purchasing power to exert downward pressure on the prices of the private participants. Intended to comprise a financing policy that will cover the cost of certain healthcare services for South African residents, the NHI may go some way in redressing access to healthcare services in South Africa. However, since there are still other factors constraining access to healthcare services such as hospital costs and prices, it is important to note that administered pricing alone, as it is likely to be the case under the proposed interim Pricing Commission is unlikely to be sufficient to achieve optimal outcomes in the healthcare market, especially given that the implementation of NHI may act as a disincentive for firms as regards quality. The concomitant implementation of regulatory reforms that will ensure guaranteed minimum quality and performance standards, as well as improved access to customer information are also required for competition to

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199 Supra n11.

200 Interestingly, it would appear that healthcare services that will be for the sole account of the patient if the NHI is implemented in its current form, are similar to those excluded from the ambit of the NHS’s cover.

201 Edward West, “Price commission planned to cut private hospital fees”, Business Day, August 02 2012. Available at http://www.bdlive.co.za/articles/2012/08/02/price-commission-planned-to-cut-private-hospital-fees
effectively function in such markets. It is also important that government does not overly rely on its bargaining power as a competitive constraint but that active steps are taken to improve the quality and standards of the public healthcare system such that it is a viable alternative for consumers of healthcare services.

6. **Concluding remarks**

It would appear that the competition authorities have attempted to be creative in their use of competition law as a tool to constrain burgeoning concentration levels in the relevant market, which is potentially one of the causes of escalating hospital costs.

On the basis of the analysis set out herein, the intervention of the competition authorities appears to have given rise to some success over time. For instance, intervention from a prohibited practice perspective has curbed the culture of collaboration in the market for the provision of private hospital markets, fostering independent competition from a pricing perspective. Moreover, the competition authorities have kept a keen eye on merger activity in the relevant market and have implemented measures to address potentially anti-competitive outcomes where necessary.

Notwithstanding the foregoing, the private hospitals market is still dominated by three participants – Afrox, Netcare and Medi-Clinic. As such, it is perhaps necessary to consider the strategies utilised by other jurisdictions with a view to identifying alternate instruments that can be used in conjunction with competition law, to contribute to the attainment of the constitutional ideal of access to quality healthcare services to all.

As is the case in international jurisdictions, perhaps the best means by which access to quality healthcare services can be attained given the South African context, would be to rear a public healthcare sector that is able to exert an effective competitive constraint to the activities of the private hospitals. Perhaps a government-nurtured public healthcare sector, afforded apposite resources (in terms of both funding and human capacity) coupled with the implementation of appropriate policy reforms and improved access to price and quality information by consumers, can offer quality services at lower prices in competition with those on offer by private hospitals. Given that the public sector has an existing customer base approximately 4 times as large as that of the private sector, it is arguable that an improved public healthcare sector (potentially in the form of the NHI) could pose a noteworthy competitor to private hospitals.

Subject to the continued supervision of the competition authorities, it remains to be seen whether an approach such as this could be the medicine to cure the ills of the healthcare sector and attain equitable access to quality healthcare services to further the progress that has been made to date therein. The recently published findings of the OECD Roundtable on Competition in Hospital Services affirms the need for competition in hospital markets in ensuring competitive outcomes as regards the delivery of quality healthcare services. It further emphasises the importance of ensuring that there is a complementary regulatory and policy regime in place to ensure the achievement of desired outcomes in hospital market.
We look forward to a healthcare market inquiry that will allow for a better understanding of the competitive forces at play and thus permitting for better informed policy development, including competition policy. Our expectation is that not all ills will be cured with competition policy alone but that with an understanding of the dynamics at play, competition policy and law will have an important role to play.
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