ANNEXURE B

FACTUAL AND OTHER INACCURACIES AND RELIANCE ON ANECDOTAL EVIDENCE

1 There are a number of statements and allegations in the Provisional Report that are based on subjective and anecdotal submissions. The HMI appears to have relied on these statements without considering whether they are reliable or furnishing parties affected by them an opportunity to respond to them prior to the publication of the Provisional Report. Unfounded allegations which are of particular concern to Mediclinic are addressed below.

2 **Common ownership and cross directorships**

2.1 In the Provisional Report, the HMI expresses concern about the ownership structure of Remgro which indicates a complex inter relationship between different companies:

2.1.1 "Common shareholding and cross-directorships may distort or prevent vigorous competition as firms seek not to disadvantage returns to companies with multiple shareholding. The HMI is concerned about the chilling effect that cross-directorships may have on competition."[1]

2.1.2 "*The HMI did not find any concrete anticompetitive conduct stemming from the ownership structures. However the structure of cross holdings carries some risks for the long-term development of a healthy competitive environment. This is particularly a concern where MMI Health and Discovery Health may lack incentives to pursue innovative long-term strategies in their purchasing of healthcare due to the existence of Mediclinic in the broader group*."[2]

2.2 The HMI concedes that it found no evidence of anticompetitive conduct. Yet the allegations are serious and would require unethical conduct on the part of directors of the implicated firms.

2.3 For the following reasons the concern is more apparent than real as statutory provisions and the common law regulate the position of company directors extensively:

2.3.1 The Companies Act, 2008 addresses the standards of directors' conduct in section 76. Sub-section (2) inter alia provides:

"*(2) A director of a company must -*

(a) not use the position of director, or any information obtained while acting in the capacity of a director -

(i) to gain an advantage for the director, or <u>for another person other than the company</u> or a wholly owned subsidiary of the company; or

(ii) …,"

(emphasis added)

2.3.2 In addition, a director must exercise the powers and perform the functions of a director in good faith and for a proper purpose, in the best interests of the company, and with a degree of care, skill and diligence that may reasonably be expected of a person carrying out the same functions in relation to the company as those carried out by the director, and having the general knowledge, skill and experience of that director.[3] These fiduciary duties are owed by each individual director, regardless of whether he or she is an

[1] Provisional Report, para 84, p49
[2] Provisional Report, para 407, p147
[3] Section 76(3)

executive, non-executive or managing director. Nominee directors may not bind themselves to act in accordance with the instructions of the party who nominates them. They may not subordinate the interests of the company to the interest of the nominator. Put differently, the nominee may not further the nominator's interests at the expense of the company.

"*A director is in that capacity not the servant or agent of the shareholder who votes for or otherwise procures his appointment to the board (the position of "nominee", though referred to in the plea, would not seem to have the legal consequences alleged by the defendants). The director's duty is to observe the utmost good faith towards the company, and in discharging that duty he is required to exercise an independent judgment and to take decisions according to the best interests of the company as his principal. He may in fact be representing the interests of the person who nominated him, and he may even be the servant or agent of that person, but, in carrying out his duties and functions as a director, he is in law obliged to serve the interests of the company to the exclusion of the interests of any nominator, employer or principal. He cannot therefore fetter his vote as a director, save insofar as there may be a contract for the board to vote in that way in the interests of the company, and, as a director, he cannot be subject to the control of any employer principal other than the company.*"[4]

(emphasis added)

2.3.3 Good faith must not only be done but must manifestly be seen to be done; the law will not allow a fiduciary like a director to place him or herself in a position in which his or her judgment is likely to be biased and then to escape liability by denying that in fact it was biased. At common law, the no-conflict rule is the most important of the directors' fiduciary duties.[5]

2.3.4 A director owes no fiduciary duty to a subsidiary if he is a director only of the holding company. Where a person is a director of a holding company of its subsidiary, a fiduciary duty is owed to each company, subject obviously to the no-conflict rule referred to earlier. At common law therefore, a director owes a duty to the particular company of which he is a director, and he owes no duty to the group as such. Directors do not, merely by virtue of their office, owe a fiduciary duty to the company's creditors or prospective creditors.[6]

2.4 The competition law theory of harm regarding cross-directorship and common owners requires the relevant firms to be competitors. See, for example, the Primedia/Capricorn merger.[7] The HMI however does not propose a horizontal / collusion theory of harm (Mediclinic is the only hospital mentioned under the HMI's analysis of Remgro's interests in the healthcare sector). Instead, the HMI alleges that "MMI Health and Discovery Health may lack incentives to pursue innovative long-term strategies in their purchasing of healthcare due to the existence of Mediclinic in the broader group." What this means in practice is not clear.

2.5 In addition to the fiduciary obligations and assuming the scope for unethical behaviour exists, the economic test asks whether the relevant director has a) the ability and b) the incentive to act in such a manner.

2.5.1 In terms of ability, one can assume that a Remgro director on the Discovery board is likely to be outnumbered by directors who presumably have the profitability of Discovery as their main goal. It is unclear how a single director will convince his fellow board members to constrain Discovery in order to benefit Mediclinic (a firm they have no direct

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[4] Per Margo GOJ in *Fisheries Development Corporation of SA Ltd v Jorgensen* 1980 (4) SA 156 (W), 163; the position in English law is the same - *Boulting v ACTT* [1963] 2 QB 606, 626 per Lord Denning M.R.

[5] Gower: Principles of Modern Company Law, 7th ed, 392-393

[6] Commentary on the Companies Act of 2008, Yeats et al (2018), 2-1280

[7] *Primedia Ltd and others / The Competition Commission* [2007] 1 CPLR 113 (CT) and *African Media Entertainment Ltd v Lewis NO and others* [2009] 1 CPLR 1 (CAC)

interest in). This also assumes that the board even discusses issues of such an operational nature.

2.5.2 In terms of incentives, one needs to weigh the benefits to Remgro of reduced profit at Discovery versus some increased profit at Mediclinic. Here, shareholding percentages of the holding company should give some indication of these incentives and yet the HMI makes no attempt to analyse these. For example, Figure 3.4 in the Provisional Report records First Rand Group as only owning a 1% share in MMI and Mediclinic having no shareholding links to any of the firms in the Remgro group, other than Remgro's non-controlling shareholding of it. But most fundamentally, this theory shows no understanding of the functioning of healthcare markets.

3 **Advanced Health Case Study**

3.1 The Provisional Report makes extensive reference to Advanced Health's submissions regarding entry of day hospitals into the facilities market. This includes a statement that "Large hospital groups prevent specialists from suggesting alternative treatment facilities to patients. Advanced Health cites a speech made by the CEO of Mediclinic on 6 December 2016 in which he stated that surgeons who are using theatre lists at Mediclinic facilities are not allowed to offer alternative treatment options in alternative facilities to patients."[8]

3.2 Mediclinic does not prescribe to admitting doctors where they may or may not admit patients or which kinds of alternative treatment options may be offered to patients. As a matter of principle, Mediclinic does not place restrictions on doctors regarding treatment in alternative facilities. The relationship between Mediclinic and doctors with admission privileges has been described in detail in previous submissions to the HMI.[9]

3.3 Mediclinic's CEO, Mr Koert Pretorius, has never made a statement in the terms reported by Advanced Health, and the statement by Advanced Health is factually incorrect, and should be retracted from the Final Report.

3.4 The Provisional Report also refers to an allegation by Advanced Health that the large hospital groups adopt strategies including cross-subsidisation to "*block the entry and growth of day facilities*". The following statements are found in paragraphs 528 and 530 of the Provisional Report:

> "ADVANCED HEALTH
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> *528. Advanced Health currently has ten facilities operating in South Africa, and aims to double this by 2020. In its submission to the inquiry, Advanced Health raised concerns about the larger hospital groups' response to its business model. Specifically, it claims that its independent day hospital model threatens the market position of the three large hospital groups. The three main challenges to its business model are:*
> *528.1 a "cost shifting" strategy employed by the larger hospital groups,*
> *528.2 intense contestation for facility licences, and*
> *528.3 pressure exerted by larger facilities on practitioners."*
>
> *"530. … that care must be taken in interpreting these trends, which may simply be consistent with greater price competition in some segments of the market, and may thus be procompetitive on balance. However, it would be problematic if procedures in the more competitive segment of the market were not assigned a fair proportion of the fixed cost of the facility. In that case, this could be an example of anti-competitive cross subsidisation with the intent of blocking the entry and growth of day facilities."*

[8] Provisional Report, p 267, para 535.1

[9] For example, Mediclinic's submissions dated 31 October 2014 (paragraph 4.19); 22 August 2016; 13 September 2016 and the recorded meeting of 2 September 2016

3.5 Mediclinic can only respond with reference to its own strategy and tariffs in respect of the day hospital market. In summary, Mediclinic has not adopted any of the 'strategies' alleged by Advanced Health: it is correct, as the HMI suggests, that there is greater price competition in this segment of the market.

3.6 Mediclinic's day hospital (77 practice type) tariffs are lower than its acute hospital (58 practice type) day tariffs.

3.7 Mediclinic's strategy is to invest in building co-located 77 facilities. Mediclinic currently has two day clinic facilities in Durbanville and Limpopo and has investment in additional four day clinics (located in Centurion, Pretoria, Sandton and Tyger Valley) as part of the recently approved merger between Mediclinic and Intercare. The expansion plan includes building and purchasing co-located or nearby day hospitals. Mediclinic's day hospital tariffs are calculated based on the cost of running a day hospital which, for obvious reasons (including: no afterhours staffing, no specialised units, and low pharmacy stock requirements), is lower than that of an acute hospital facility. If it were true that Mediclinic was under-costing its day case tariffs, it would make better business sense to offer those rates at acute hospitals and avoid the investment and cost in separate facilities.

3.8 Mediclinic's tariffs applicable to day procedure patients have been calculated for various scenarios, as explained below, in keeping with the associated underlying costs of the care. The index below illustrates how Mediclinic's average medical scheme tariffs relate to each other, and explains the relevant tariffs.

Hospital	Accommodation Tariff Index
58 acute – day cases (58007)	redacted
58 acute – discounted day cases (58219)	redacted
77 day hospital (77007)	redacted

Hospital	Theatre Tariff Index
58 acute – day cases (58081)	redacted
58 acute – discounted day cases (58212)	redacted
77 day hospital (77081)	redacted

3.9 Traditionally Mediclinic billed a Dayward tariff (58007), which was set at a lower tariff than the equivalent accommodation charge for "in patients". Dayward patients and surgical "in patients" both attracted the same theatre tariff (58081).

3.10 During 2012 Mediclinic introduced a discounted Dayward tariff (58219) and Major Theatre tariff (58212) to apply to a specific, predetermined list of day procedures, recognising that it is realistic to make allowances due to the lower risk associated with these lower intensity cases. Determination of the procedures was based on research (including internationally available information from the British Association of Day Surgery), which determined appropriate clinical pathways and fitting procedures.

3.11 The aforementioned list of day procedures only attracted discounted rates if the patient was admitted and discharged on the same day. Later it became apparent that medical schemes were concerned that potentially day patients were being operated on late in the afternoon or evening, (potentially due to theatre scheduling and doctor availability) and therefore may need to stay overnight, attracting normal acute hospital rate charges. Accordingly, in 2015 Mediclinic implemented a "23 hour rule", which meant that qualifying procedures, as per the aforementioned list, would attract the discounted day tariffs if admitted and discharged within 23 hours. Patients staying overnight and being discharged within 23 hours would fall into the day case billing category. This is a pro-competitive response to funder concerns to the benefit of patients.

3.12

redacted

4 Conversion to Net Acquisition Price

4.1 It is with concern that Mediclinic notes the allegation in the Provisional Report that there was an “anticompetitive transfer of rebates on surgicals and consumables”[10] with regard to the transition towards Net Acquisition Price ("NAP"). The Provisional Report states that “it is not clear why the rebates scandal was not pursued as fraud by the CMS, the NDoH or individual schemes” and that “Discovery Health appears to have made a deal with the different hospital groups, which may explain why it did not pursue a case”.[11]

4.2 Similar incorrect statements were made in the submissions of the Board of Healthcare Funders ("BHF")[12] and the Day Hospital Association ("DHA")[13] in 2014. Mediclinic provided a detailed response to those statements in April 2015.[14] It appears as if the Provisional Report has accepted the BHF and DHA's unsubstantiated submissions and disregarded Mediclinic’s detailed written response to these allegations.

4.3 Mediclinic’s submission provided a detailed history of the tariff restructuring agreement which started during the time of the Representative Association of Medical Schemes ("RAMS"), the predecessor to the BHF.[15] Mediclinic recorded two phases that occurred in the 1990’s. Supporting documents and letters were provided in Mediclinic’s submission quoting RAMS’ desire to reduce the mark-up on the list price and wholesale discounts on pharmaceutical products and the explanation that this would be reduced by adjusting tariffs in a cost-neutral manner. The information described in Mediclinic’s submission was provided by an employee of Mediclinic who was a member of the RAMS Board at the time and had first-hand knowledge of the pharmacy rebate system.[16]

4.4 Mediclinic's April 2015 submission also provided evidence of the cost savings on pharmaceutical products achieved by Discovery Health as a result of the conversion to NAP in 2002/2003[17]. Mediclinic has previously explained[18] that no profits are earned on the pharmacy basket which accounts for, on average, approximately 27% of the total Mediclinic hospital account. Of this 27%, approximately one-third is the medicines (i.e. ethical / drug) component, which is regulated by the single exit price ("SEP") model.[19] The NAP model is applied to the rest of the pharmacy component, i.e. medical devices (surgicals, consumables,

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[10] Provisional Report, pp 233 and 234
[11] Provisional Report, p 233, para 355
[12] Submission on the Inquiry into the Private Healthcare Sector, Board of Healthcare Funders Southern Africa, 29 September 2014
[13] Submission to the Competition Commission in Regard to the Inquiry into the Private Health Care Sector, South African Day Hospital Association
[14] Market Inquiry into the Private Healthcare Sector/ Mediclinic’s Comments in Response to Stakeholder Submissions Published on 5 February 2015. Letter dated 2 April 2015
[15] Ibid, pp 39 to 42
[16] Other previous members of RAMS/BHF, who were specifically involved in running Medical Benefit Schemes, would also be able to verify the rebate model described in Mediclinic’s submissions: Mr Roly Buys; Mr Brian Cook, Mines Benefit Society; Dr Brian Brink, Anglo Mines hospitals and Goldmed; Ms Retha Ross, Transmed.
[17] Market Inquiry into the Private Healthcare Sector/ Mediclinic’s Comments in Response to Stakeholder Submissions Published on 5 February 2015. Letter dated 2 April 2015, pp 33 and 34
[18] Market Inquiry into the Private Healthcare Sector/ Mediclinic’s Comments in Response to the Call for Submissions Dated 1 August 2014. 31 October 2014. Section 4.21
[19] Mediclinic started billing at cost price for ethical products at least one year prior to the implementation of SEP by the Department of Health. The NAP model for medical devices has not yet been implemented by the Department of Health

implants and prosthesis) making up approximately 66% of the total hospital pharmacy account. The NAP model was structured to be cost-neutral in the first year of implementation, however the price increases in subsequent years were applied to the lower baseline price, resulting in cost benefits to medical schemes.

4.5 Discovery was the only funder prepared to be innovative at the time by converting to NAP in 2003. Mediclinic was the first private hospital in South Africa to introduce the NAP model for medical devices. This was motivated by Mediclinic's desire to increase the transparency of its dealings with patients on the basis that its core business is in nursing care and hospital bed facilities, rather than in intermediary services such as medicines and medical devices. Other medical schemes started adopting NAP in 2004 with most schemes moving to the NAP model between 2005 and 2006. During 2008, administrators required all hospital groups to apply the model, and the small number of schemes that had not yet recognised the value proposition also moved over to the NAP model.[20] The benefits of the model include transparency in prices with daily updates to schemes regarding price increase by suppliers. In addition, doctors are made aware of the actual cost of products which they may wish to use, and are encouraged to consider the use of more cost effective products where clinically appropriate.

4.6 It is concerning that the HMI has disregarded Mediclinic's previous submissions and based its findings in this regard on incorrect allegations. Mediclinic requests that the HMI take account of its April 2015 submission in its final report.

[20] Market Inquiry into the Private Healthcare Sector/ Mediclinic's Comments in Response to the Call for Submissions Dated 1 August 2014. 31 October 2014. Section 4.21.6