DATED 29 JANUARY 2021

DAY HOSPITAL ASSOCIATION OF SOUTH AFRICA
(ON BEHALF OF ITS MEMBERS)

EXEMPTION APPLICATION

Lawtons Africa
140 West Street, Sandton, 2196 Johannesburg

CONTENTS

1. INTRODUCTION

1.1 This is a joint application by the members of the Day Hospital Association of South Africa (the “**DHA**”) for an exemption in terms of section 10 of the Competition Act, 89 of 1998 (as amended) (the "**Competition Act**"). Section 10 provides that if a firm or a group of firms enters into or intends to enter into an agreement or a concerted practice which may contravene any of the provisions of Chapter 2 of the Competition Act, the firm or group of firms in question may apply to the Competition Commission of South Africa (the "**Commission**") for an exemption in respect of the offending conduct.

1.2 An exemption may be granted by the Commission if, notwithstanding the fact that an agreement or concerted practice constitutes a prohibited practice in terms of Chapter 2 of the Competition Act, it is found to contribute to at least one of the objectives set out in section 10(3)(b) of the Competition Act.

2. EXECUTIVE SUMMARY

2.1 The DHA, acting on behalf of its members, hereby applies to the Commission for an exemption in terms of section 10 of the Competition Act. In this application, the DHA would like to enter into a commercial agreement with the DHA members that is expected to contravene the provisions of section 4 of the Competition Act. It is anticipated that the commercial agreement will contravene section 4 of the Competition Act as it may be regarded as directly or indirectly fixing a purchase or selling price or any other trading condition. Accordingly, the commercial agreement and the conduct flowing from the said agreement may result in a contravention of section 4(1)(b)(i) of the Competition Act.

2.2 The DHA submits that the commercial agreement is expected to contribute to at least two objectives set out in section 10(3)(b) of the Competition Act. The DHA further submits that the commercial agreement meets the legal standard required for approval and respectfully submits that the Commission approve the exemption application based on the considerations set out below.

2.3 Section 10 (3) of the Competition Act provides that the Commission may only grant an exemption application if the agreement or practice concerned, or category of agreements or practices concerned contribute to any of the following objectives:

(a) maintenance or promotion of exports;

(b) promotion of the effective entry into, participation or expansion within a market by small and medium businesses, or firms controlled or owned by historically disadvantaged persons;

(c) change in productive capacity necessary to stop a decline in an industry;

(d) the economic development, growth, transformation, or stability of any industry designated by the Minister, after consulting the Minister responsible for that industry; or

(e) competitiveness and efficiency gains that promote employment or industrial expansion.

2.4 The DHA submits that this application should be approved based on the following criteria:

(a) promotion of the effective entry into, participation or expansion within a market by small and medium businesses, or firms controlled or owned by historically disadvantaged persons:

(i) the current challenges faced by the day hospital industry have resulted in the industry being unattractive for historically disadvantaged persons. In order to address these challenges, the DHA intends to develop a centralised procurement strategy that will have a strong focus on small and medium businesses as well as firms controlled and/or owned by historically disadvantaged persons, including BEE suppliers. Importantly, it is also intended to have a focused approach on the individual day hospitals' surgical / ethical baskets which are specific to day procedures and will ultimately benefit the overall cost efficiencies within the different tariff models. For further details regarding the procurement strategy, please see paragraph 11.5 below.

(b) competitiveness and efficiency gains that promote employment or industrial expansion:

(i) the DHA anticipates that the commercial agreement will enable the day hospitals to encourage patients to opt for procedures in day hospitals as opposed to either of the three largest hospital groups and/or any of the independent acute hospitals. In this regard, the DHA believes that its unique value proposition will create a volume shift in favour of day procedures. This is likely to lead to an increase in demand, and more day hospitals seeking to enter the market and/or developing / expanding their existing service offerings. For further details regarding how competitiveness and efficiency gains will promote employment or industrial expansion, please see paragraph 11.5 below.

3. THE PARTIES

The parties to the exemption application are:

3.1 The members of the DHA. The DHA is a representative body of independent, registered, and private day hospitals across South Africa with its registered address at 506 Jochemus Street, Erasmuskloof Ext 3, Pretoria, 0153.

3.2 Please see Annexure A for a list of all the members of the DHA, as at the date of filing this exemption application.

4. **THE PARTIES' ADDRESS FOR SERVICE OF DOCUMENTS**

c/o
Nkonzo Hlatshwayo / Ave Ralarala
Lawtons Africa
nkonzo.hlatshwayo@lawtonsafrica.com / ave.ralarala@lawtonsafrica.com
140 West Street
Sandton
Johannesburg
South Africa

5. **DESCRIPTION OF THE SERVICES PROVIDED BY THE MEMBERS OF THE DHA**

5.1 Day hospitals in South Africa are modern healthcare facilities which focus on the provision of short-stay surgical and diagnostic procedures which are performed in an operating theatre on a same-day basis. The patient is admitted in the morning and discharged on the same day. The day hospitals are registered with the various provincial health departments and have annual licenses to treat patients in South Africa. They are also registered with the board of healthcare funders, with a practice code prefix of 77 or 76, as most of their patients are medically insured. There are some exceptions in respect of facilities treating patients for procedures traditionally not covered by medical schemes such as cosmetic, and some fertility related procedures.

5.2 Day hospitals are generally referred to as day clinics, same-day surgical centres, day surgery units, unattached operating theatres, ambulatory surgical centres, day theatres and day procedure surgical centres. For the purposes of this exemption application, the term day hospital will assume and encapsulate the above names and references.

5.3 In South Africa, the day hospital industry developed during the 1980's. However, the DHA first came into being in 1992, ahead of its time in South Africa. This was the beginning of a complex landscape that would undergo numerous changes and be affected by various sectors and role-players over the next 20 years. The period between 2000 and 2005 in South Africa was marked by many day hospitals being closed by hospital operators who did not understand and/or did not appreciate the benefits of day hospitals and their future value in the private healthcare service delivery chain.

5.4 The hospital operators referred to are mainly the three large hospital groups that have dominated the private healthcare market, namely Life Healthcare, MediClinic and Netcare for a while. The DHA has some knowledge of actions pertaining to the closing of day hospitals by the groups but more detail and context would have to be obtained directly from the groups –

(a) Life Healthcare at one point had 10 day hospitals. They either closed day hospitals and/or relocated the beds to their acute facilities over several years and currently have only 3 day hospitals operational. Advanced Health allude to some of this history and their involvement on their website (www.advancedhealth.co.za) –

"During the early 1990's the private hospital operators functioning in South Africa demonstrated concern about the competition coming from day clinics. As a result, these groups implemented strategies in terms of which the medical scheme movement changed the tariff structure for both hospitals and day clinics in such a way that these were detrimental to day clinics.

During 2005 Life Health Care terminated the lease agreement, which applied to Medgate Day Centre. A similar event occurred in respect to the Witbank Day Clinic ("WDC") which was closed down by Life Health Care. During 2009 the original Witbank Day Clinic was refurbished and re-opened under the new name of Emalahleni Day Hospital. Advanced Health South Africa was established as the holding company for the South African operational entities and was absorbed into the Advanced group of companies."

(b) Netcare/Medicross currently has 11 day hospitals. They have either closed day hospitals moving beds into acute facilities or sold off day hospitals to other operators, recent examples include Bell Street Hospital, Optimed, Baygleston and Linkwood.

(c) MediClinic/Intercare currently also has 11 day hospitals. They previously closed day hospitals in Wierdapark and Paarl. Of the 3 large hospital groups, MediClinic/Intercare are the only group showing a renewed interest in day hospitals with active plans to expand. Their model for doing so is unique and referred to as a co-location model meaning their day hospitals are associated and linked to an acute hospital. In some instances, the hospitals are separated by merely a passage which gives opportunities to cross subsidise and allow for the movement of resources like nursing staff and medical equipment.

5.5 The DHA in its current form was revived in 2014 with its main objective being to promote day hospitals and the benefits of day surgery in South Africa as well as promoting day surgery for:

(a) the appropriate patient;

(b) with the appropriate procedure;

(c) receiving appropriate care;

(d) in an appropriate facility.

5.6 As regards the DHA's current position, it is seeing growth in the day hospital industry with more facilities opening and more day procedures being performed in day hospitals. Although the day hospitals initially experienced resistance from various industry stakeholders, more and more medical aids are following the industry trends to form day hospital networks and are leaning towards the objectives set out in paragraph 5.3 above. Day hospitals remain the appropriate setting for day surgery procedures where patients have faster same-day discharge time, on-time surgery slots and extremely low risk of infection as no long-stay medical patients are admitted.

5.7 The main objective of day hospitals is to provide quality, safe and cost-effective diagnostic, and surgical procedures on a same day basis. Day hospitals offer a safe environment for appropriate elective surgery to patients and procedures suited for day hospital environments as an alternative option to undergo surgery in acute facilities.[1] Although the report cited herein does not distinguish specifically between private acute and private day hospitals, it is noteworthy that the occurrence of hospital borne infections are virtually zero in day hospitals.

5.8 A contemporary list of procedures performed in day hospitals include the following, but important to note is that this list of procedures is by no means exhausted with continuous technological and anaesthetic advances allowing for future additions:[2]

(a) general procedures that are found across most day surgical disciplines which include: biopsies, incision, and drainage of abscess and/or cyst, the removal of foreign body, simple superficial lymphadenectomy, skin cancer and skin procedures;

(b) approved breast procedures, such as mastectomies and lumpectomies;

---

[1] The department of health's national infection prevention and control strategic framework published on 27 March 2020 provides that private hospitals showed advanced level scores in the infection prevention and control assessment framework.

[2] Day Hospital Association List of Disciplines and Procedures dated October 2020.

(c) cosmetic procedures, such as blepharoplasty, breast augmentation, face lifts, labiaplasty, liposuction, mastopexy, nose reconstruction, otoplasty and scar excision;

(d) ear, nose, and throat procedures, such as cochlear implant, middle ear procedures, tonsillectomy, repair of nasal turbinates', scopes, simple procedure for nose bleeding and sinus procedures;

(e) eye procedures, such as cataract surgery, corneal surgery, intra ocular injection, laser surgery and other eye procedures;

(f) gastrointestinal procedures, such as anorectal procedures and gastrointestinal scopes;

(g) general surgery, such as anal dilation, drainage of abscess, excision lipoma, haemorrhoidectomy, inguinal hernia repair and umbilical hernia repair; laparoscopic surgery

(h) gynaecological procedures such as cerclage of uterine cervix, dilation and curettage, endometrial ablation, hysteroscopy, laparoscopic gynaecological procedures, and sterilisation;

(i) orthopaedic procedures, such as achilleas tendon release, arthroscopy, ganglionectomy, minor joint arthroplasty, peripheral nerve neuroplasty, release of trigger finger, repair bunion or toe deformity, tendon and ligament repair and treatment of simple closed fractures; and

(j) urological procedures, such as cystoscopy, male genital procedures, removal of ureteral stones, renal calcultus and scope and pyelogram.

6. CURRENT STATUS OF THE SOUTH AFRICAN HEALTHCARE MARKET

6.1 There are more than 405 public healthcare facilities in South Africa. These facilities serve approximately 83% of the population who are largely without any type of medical cover. In contrast, there are more than 409 private healthcare facilities in South Africa, which predominantly serve those insured through medical schemes, health insurance products, and a few people who pay for their medical expenses in cash, as and when necessary. In 2018, approximately 16,4% of South Africans had medical insurance, essential for accessing private healthcare services.[3]

[3] Paragraph 2, Page 62 of the HMI Report.

6.2 There are three large hospital groups (i.e. Netcare, Mediclinic and Life Healthcare) that dominate the private healthcare market in South Africa. Within these hospital groups, there are also day hospitals which compete with the independent DHA hospital members. The closest market player to Netcare, Mediclinic and Life Healthcare is the National Hospital Network ("**NHN**"). The NHN is a co-operative grouping of independent hospitals. The NHN has been granted an exemption by the Commission to, *inter alia*, negotiate tariffs and procure surgical consumables and medical devices collectively. It bears mention that, beyond the exemption granted by the Commission, the hospitals within the NHN compete with each other.[4] Although a majority of the DHA members form part of the NHN, the DHA is not recognised as an independent body that can negotiate on its own. There are also several independent hospitals and day hospitals not affiliated to the NHN. These include Clinix Health Group Ltd and Joint Medical Holdings (JMH).[5] There is a possibility that these facilities could be interested in joining the DHA if the exemption is granted. This could improve the competitive landscape in the private healthcare market.

6.3 There are two main industry member associations in the private healthcare market, namely the Hospital Association of South Africa ("**HASA**") and the DHA. The membership of HASA predominately comprises Netcare, Mediclinic, Life Healthcare and the NHN. The DHA mainly represents the interests of independent day facilities and those that are part of the NHN.[6] In 2016, Netcare, Life Healthcare and Mediclinic collectively accounted for approximately 90% of the private healthcare market based on registered general acute beds.[7] The NHN members and other independent hospitals not affiliated to the NHN accounted for the remaining 10% of that market.[8]

6.4 The health market inquiry observed that independent hospitals' ability to compete is hampered by several factors, including limited bargaining power in tariff and network negotiations, a lack of information to implement effective performance-based reimbursement contracts, and an inability to attract specialists to their facilities.[9] They, therefore, do not provide significant competitive constraints to the relevant market. Importantly, it was reported that this is not likely to change significantly without a change in the regulatory environment designed to promote a more competitive market.[10]

6.5 It is important to note that independent hospitals received some assistance from an exemption granted by the Commission that *inter alia*, enable the NHN network to negotiate tariffs and conditions collectively. In all other respects, the NHN is not a hospital group since

[4] Paragraph 4, Page 62 of the HMI Report.
[5] Paragraph 5, Page 62 of the HMI Report.
[6] Paragraph 6, Page 63 of the HMI Report.
[7] Paragraph 10, Page 65 of the HMI Report.
[8] Paragraph 10, Page 65 of the HMI Report.
[9] Paragraph 14, Page 31 of the HMI Report.
[10] Paragraph 14, Page 31 of the HMI Report.

individual facilities remain strategically and operationally independent and compete with each other.

6.6 The private healthcare market is characterised mainly by stand-alone single practices or, in some disciplines, single-specialty group-practices but multidisciplinary teams are not a feature of the market. This absence limits up and down referral leading to an irrational use of care where specialists are performing functions that other practitioners may do without any loss of quality.[11]

7. LESSONS LEARNT FROM THE NHN EXEMPTION

7.1 The Commission granted the NHN, a co-operative venture of medical enterprises, a five-year exemption commencing from 1 November 2018 to 31 October 2023. The exemption covers collective bargaining, global fee negotiations and centralised procurement. The NHN is a non-profit company that is controlled by the board chosen by each discipline of sub-group members. Its members consist of a group of independent private hospitals who run medical establishments such as day hospitals, acute hospitals, sub-acute hospitals, psychiatric hospitals, ophthalmic hospitals, and physical rehabilitation hospitals. These members are broadly competitors in the provision of private healthcare services. For the last 14 years, the Commission has granted the NHN an exemption which allows the network to engage in collective bargaining with medical schemes and medical scheme administrators on behalf of its members. In August 2017, the NHN, in addition to the collective bargaining exemption, applied for another exemption to also engage in global fee negotiations with medical schemes, medical scheme administrators, the state and healthcare providers (professional associations) and to undertake collective or centralised procurement on behalf of its members.

7.2 After considering the exemption application and the input submitted by the relevant stakeholders, the Commission elected to grant the exemption. In this regard, the Commission considered the fact that the market dynamics in the healthcare market largely remained the same. In particular, the Commission noted that the healthcare market was characterised by high levels of concentration and high barriers to entry. Overall, the Commission found that there were pro-competitive gains that would arise from the exemption, and that these gains would enable the NHN members to compete effectively in the market.

7.3 In the HMI Report, while the Commission found that the NHN exemption had, to some extent, been successful in bringing together smaller facilities to achieve scale in negotiations,[12] it also found that the NHN exemption had only led to a marginal

[11] Paragraph 25, Page 33 of the HMI Report.
[12] Paragraph 95, Page 189 of the HMI Report.

improvement on competition and a slight decrease in overall market concentration.[13] The reasons proffered by the Commission appear to attribute this to some of the conditions placed on the NHN exemption. In this regard, the Commission described these conditions as onerous and potentially hampering their (NHN's) ability to compete with the larger groups who do not face similar conditions. In addition, the Commission found that while the NHN exemption aims to strengthen competition, creeping mergers potentially weaken the NHN and undermine the effectiveness of the exemption.[14] Importantly, the HMI Report found that caution must be exercised when comparing the NHN to the other hospital groups as they have fundamentally different business models. For example, the NHN exemption does not allow for coordinated quality initiatives or scale advantages in the form of cost efficiencies, centralised procurement, innovative risk adjustment models, or general innovation and technological improvements. Instead, the NHN exemption has imposed conditions on the NHN relating to global fee arrangements, submitting information to the Commission and stricter conditions for membership, which are not required for the other hospital groups.[15]

8. **DIFFERENCE BETWEEN THE NHN EXEMPTION AND THE DHA EXEMPTION APPLICATION**

8.1 At the outset, we must mention that 49 of the 52 members of the DHA are currently part of the NHN exemption. Of these 49 members, 46 would like to exit the NHN exemption and to apply to the Commission for a separate exemption which is intended to be more suitable for day hospitals. As it stands, the members of the DHA are not realizing the full benefits that were intended to flow from the NHN exemption. The reason why the existing exemption which permits the NHN to bargain collectively with medical schemes on behalf of its members on tariffs and other matters is not sufficient for the members of the DHA is, *inter alia*, because the day hospitals' business model requires a unique approach, which takes the following into account:

(a) [redacted] Acute hospitals are able to provide a cross-subsidization as they do same day procedures, longer stay complicated cases, cardiology, neurology, maternity and various other disciplines. The day hospital market is only limited to same-day surgery options. Day hospitals are not driven by bed occupancy, but rather, available theatre time for procedures. Their business model therefore differs from acute hospitals which also provide the same procedures. In addition, day hospitals have a high focus on their value proposition to the market, which is lost through the diverse membership disciplines within the NHN network, which predominantly comprises acute hospitals. [redacted]

[13] Paragraph 15, Page 31 of the HMI Report.
[14] Paragraph 109, Page 83 of the HMI Report.
[15] Paragraph 75, Page 186 of the HMI Report.

(b) the day hospitals are handicapped by the collective negotiations due to the limited offering of alternative reimbursement models (ARM). The exemption sought by the DHA is intended to allow for network negotiations;

(c) the introduction of a centralised procurement strategy could influence the day hospitals' input costs positively. The DHA respectfully submits that there is a reasonable opportunity for cost-efficient ARM initiatives to be introduced in the market. These ARM initiatives are specifically tailored and intended to support the cost efficiencies of day hospital procedures. This will result in patients / consumers paying lower prices for the services provided by the individual day hospitals.

(d) while the NHN exemption allows for ARM including fixed fees and global fees / bundled fees, it does not currently allow for ARM negotiations, including fixed fees and global fees / bundled fees that focus on the overall cost baskets of day hospitals. The exemption sought by the DHA is intended to create the ability for innovative ARM negotiations, including fixed fees and global fees / bundled fees that focus on the overall cost baskets of day procedures. and

(e) The exemption sought by the DHA is intended to develop a centralised procurement strategy that will have a focused approach on the day hospitals' surgical / ethical baskets that are specific to day procedures and will ultimately benefit the overall cost efficiencies within the different tariff models. The DHA respectfully submits that it will be easier for the day hospitals to develop and implement its own centralised procurement strategy. This is primarily because of the fact that day hospitals have simpler procedure categories and aligned surgical baskets.

9. **THE COMMERCIAL AGREEMENT**

9.1 The commercial agreement to be concluded between the members of the DHA consists of a memorandum of understanding. The memorandum of understanding sets out what is envisaged by the members of the DHA for a commercial agreement which will be entered into, subject to the exemption application being successful, by the members of the DHA.

9.2 Subject to the exemption application being granted by the Commission, the members of the DHA anticipate concluding a commercial agreement, which will give rise to several efficiencies and benefits to patients. We set out below the most important aspects of the proposed commercial agreement from a competition law perspective, dealing with the following:

Collective Bargaining

The DHA's members shall agree to:

(a) collectively implement the prices negotiated and agreed on their behalf by the DHA with medical schemes and medical scheme administrators;

Centralised Procurement

(b) engage in centralised procurement through a request for proposal to suppliers for the surgical cost basket (procedure related) in exchange for participation to the preferred provider list. This will ensure immediate savings to funders and administrators and will result in improved tariff negotiations. Suppliers adding value will be instrumental to the success of the DHA, ensuring the highest standards of goods, at the lowest possible prices. This will essentially support the DHA's objective to deliver the highest quality of care, at the most cost-efficient price. [redacted]

Alternative Reimbursement Models

(c) a form of payment reform that incorporates quality and total cost of care into reimbursement rather than a traditional fee-for-service structure. ARMs can apply to a specific clinical condition, a care episode, or a population.

(d) The structural and operational make-up of day hospitals enable them to offer significant ARM models and innovative tariff structures such as bundled fees. [redacted]

[redacted]

Day hospitals can offer funders and patients all types of ARM models without consequence of cross-subsidization, as their service offerings are predominantly similar in nature, which inevitably will lead to overall cost savings to funders and patients. Day hospitals will be in an optimal position to expand their ARM models, fixed fees, as well as enter into innovative bundled fee / global fee agreements, which will ensure significant savings to funders and their members on a total cost per event basis. This will lead to market competition mainly between acute hospitals where procedural networks are established.

(e) Engage in global fee / bundled fee negotiations with medical schemes, medical scheme administrators and the state.

10. **REASONS WHY THE COMMERCIAL AGREEMENT IS NECESSARY**

10.1 The commercial agreement will enable the day hospitals in South Africa to offer alternative quality and cost-efficient tariff models for day surgery procedures, with the objective to stimulate the private healthcare market, in return, providing savings to patients and funders alike. The simplicity of their operational structures, procedures and input costs creates the ability for the members of the DHA to eliminate cost inefficiencies and optimize delivery of services through progressive innovative fee structures such as ARMs. Day hospitals are slowly starting to improve their position in the private healthcare market. The day hospitals' value proposition to patients and funders is becoming more apparent. In order to enable day hospitals to progress and reap the full benefits of its unique value proposition, a collective approach is necessary. By applying to the Commission for an exemption, the members of the DHA are responding to a market which is seeking more innovative and cost-efficient alternatives in the private healthcare market.

10.2 The DHA respectfully submits that the day hospitals are perfectly poised to offer patients and funders all types of ARM models without the consequence of cross-subsidization as their services are predominantly similar in nature. This will inevitably lead to overall cost

savings to funders and patients. [redacted]

10.3 In the event that the commercial agreement is implemented, it will enable the day hospitals to achieve the following benefits which will in turn accrue to patients:

(a) appropriate care based on clinical indications, thus minimising out of pocket expenses for patients. The costs of procedures performed at day hospitals are much lower when compared to acute hospitals, due to infrastructure and staffing requirements. In addition, operating theatres in hospitals are equipped for more complex types of surgery, whereas day hospitals do not require such a wide variety of technology and equipment. The simplicity of day hospitals and their various procedures whether ambulatory or more complicated in diagnostic / surgical in nature will enable standardised negotiations which will benefit the members who are part of the DHA exemption. These benefits will ultimately be passed onto the patients / consumers;

(b) funders may reconsider co-payments due to managing risk of over-servicing in the healthcare industry. Medical schemes currently have procedural co-payments in place for certain procedures. These co-payments were introduced with the objective of addressing possible over-servicing due to patient and/or service provider behaviour. For example, insofar as acute hospitals are concerned, patients may be hospitalised for more than one day, thus allowing service providers to conduct investigative procedures during such admission, whether indicated or not. In day hospitals, this scenario is not possible. This could effectively change how procedural co-payments may be applied for day hospitals to the benefit of the member of the medical scheme;

(c) diagnostic procedures, i.e. available theatre time and rapid response to treatment options. It is important to note that no overnight stay patients are admitted. As a result, patients are operated on and discharged on the same day. This is particularly convenient where children are concerned, as they do not have to sleep in an unfamiliar environment;

(d) quicker turnaround times for patients moving in and out of hospital for procedures because of the dedicated focus and efficiencies found in day hospitals;

(e) patients will have a broader choice of service providers for day procedure services. In this regard, the inclusion of the DHA's members to network structures will result in overall cost efficiencies and positive outcomes for both the medical schemes and

the patients / consumers. This can be attributed to the available, but underutilised theatre time capacity in day hospitals;

(f) the collective negotiations will lead to standardised price structures and agreements that are more appropriate for the day hospitals. This will lead to cost and operational efficiencies that will translate to lower costs for patients / consumers;

(g) the day hospitals, as a collective, and as members with the same purpose and objectives will enable the ability to start benchmarking service delivery and to manage their costs in the network. The DHA submits that this will lead to expanded opportunities within the private healthcare market for example –

(i) such as growing the list of procedures to include more advanced and complex day procedures in line with international trends. These types of procedures are currently still being performed mostly in acute hospitals.

(ii) benchmarking will provide DHA with the ability to report on patient satisfaction, quality and cost efficiencies and addressing outliers will create value to schemes and opportunity to expand networks for procedures and ARM's.

(h) the exemption sought is intended to enable the DHA's members to interrogate the operational efficiencies and more importantly, the inefficiencies that exist in their operations. Once the DHA has identified the inefficiencies, this will enable it to address and further develop the necessary protocols that are intended to improve the day hospital's service offering to patients / consumers.

(i) the downstream cost of hospital acquired infections will be limited due to the limited exposure to these infections in day hospitals by virtue of day hospital nature in terms of smaller, more controllable, adaptable environments. Given that patients return home on the same day, the risks of cross infection are reduced, which results in a shorter recovery;

10.4 In addition to the above, the commercial agreement will result in the following efficiencies:

(a) total cost per event efficiencies. Total cost per event efficiencies relate to bundled fee / global fee agreements where all service providers participate. These agreements are based on both price as well as quality outcomes for all of the parties to the agreements. As a result, effective negotiations are likely to ensure that overall price inefficiencies and quality concerns can be identified and addressed, thus ensuring quality outcomes for all of the participating service providers; and

(b) day hospitals will exercise a better competitive constraint on general acute hospitals;

10.5 The commercial agreement seeks to achieve the following objectives:

(a) to ensure healthy competition in the private healthcare market as day hospitals. Day hospitals will be competing with other day hospitals and/or acute hospitals performing day surgery procedures.

(b) to remove or reduce the existing barriers to entry, expansion, and innovation;

(c) to enable more day hospitals to enter the private healthcare market;

(d) to create alternative solutions that will result in a more competitive environment;

(e) to create support networks and partnerships with the funders; and

(f) to support new innovative tariff structures;

10.6 Having regard to the above, it can therefore be seen that, should the Commission grant the DHA the exemption sought, this will enable the day hospitals to set the benchmark for a cost-efficient and quality service that will benefit patients/consumers, funders, doctors as well as stimulate competition in the private healthcare market, while driving down the overall cost of day procedures in the process. [redacted]

11. **STATUTORY BASIS FOR THE EXEMPTION APPLICATION**

11.1 Section 4 of the Competition Act provides that:

"*Restrictive horizontal practices prohibited*

An agreement between, or concerted practice by, firms or a decision by an association of firms, is prohibited if it is between parties in a horizontal relationship and if –

(a) *it has the effect of substantially preventing or lessening competition in a market, unless a party to the agreement, concerted practice, or decision can prove that any technological, efficiency or other pro-competitive, gain resulting from it outweighs that effect; or*

(b) *it involves any of the following restrictive horizontal practices*:

(i) *directly or indirectly fixing a purchase or selling price or any other trading condition*;

(ii) *dividing markets, by allocating customers, suppliers, territories, or specific types of goods or services;*

(iii) *or collusive tendering*."

11.2 Contravention of the Competition Act

(a) The proposed commercial agreement between the members of the DHA is likely to contravene the Competition Act as it may be regarded as directly or indirectly fixing a purchase price or selling price or any other trading condition in terms of section 4(1)(b)(i) of the Competition Act.

11.3 The Exemption

(a) Applications for exemptions are made in terms of section 10(1) of the Competition Act which provides that:

"*A firm may apply to the Competition Commission to exempt from the application of this Chapter –*

(a) an agreement or practice, if that agreement or practice meets the requirements of subsection (3); *or*

(b) a category of agreements or practices, if that category of agreements or practices meets the requirements of subsection (3)."

(b) Section 10(3) of the Competition Act sets out the requirements for an exemption. It provides that the Commission may only grant an exemption if:

"(a) any restriction imposed on the firms concerned by the agreement or practice concerned, or category of agreements or practices concerned, is required to attain an objective mentioned in paragraph (b); and

(c) the agreement or practice concerned, or category of agreements or practices concerned, contributes to any of the following objectives:

(i) *maintenance or promotion of exports*;

(ii) *promotion of the effective entry into, participation in or expansion within a market by small and medium businesses, or firms controlled or owned by historically disadvantaged persons*;

(iii) *change in productive capacity necessary to stop a decline in an industry*; *or*

(iv) *the economic development, growth, transformation, or stability of any industry designated by the Minister, after consulting the Minister responsible for that industry; or*

(v) competitiveness and efficiency gains that promote employment or industrial expansion.

11.4 There are two critical requirements that are set out in section 10(3) of the Competition Act in respect to which an application must comply:

(a) the Commission must ascertain whether the restrictive practice in question is required in order to achieve one of the objectives listed in section 10(3)(b) of the Competition Act; and

(b) the Commission must ascertain whether the proposed agreement or practice contributes to achieving any of the objectives set out in section 10(3)(b) of the Competition Act.

11.5 We respectfully submit that this application satisfies at least two of the six requirements set out in section 10(3) of the Competition Act: the promotion of the effective entry into, participation or expansion within a market by small and medium businesses, or firms controlled or owned by historically disadvantaged persons and competitiveness and efficiency gains that promote employment or industrial expansion.

(a) **promotion of the effective entry into, participation or expansion within a market by small and medium businesses, or firms controlled or owned by historically disadvantaged persons:**

(i) the current challenges faced by the day hospital industry have resulted in the industry being unattractive for historically disadvantaged persons. These challenges relate to, *inter alia*, resistance from stakeholders in the industry. Stakeholders have been reluctant to support day hospitals because investors are able to receive a more favourable return on investment when they elect to support acute hospitals as opposed to day hospitals. The resistance from stakeholders in the industry has resulted in a limited volume shift to day hospitals and has impacted the profitability and ultimately the expansion of day hospitals. In order to address these challenges, the DHA intends to develop a centralised procurement strategy that will have a strong focus on small and medium businesses as well as

firms controlled and/or owned by historically disadvantaged persons. The centralised procurement strategy is intended to have a strong focus on historically disadvantaged persons, including BEE suppliers. Importantly, it is also intended to have a focused approach on the individual day hospitals' surgical / ethical baskets which are specific to day procedures and will ultimately benefit the overall cost efficiencies within the different tariff models. For the sake of completeness, ethical baskets relate to input costs. The DHA intends to identify procurement negotiating opportunities across the DHA platform which will support the cost efficiencies which are specific to day procedures.

(b) **competitiveness and efficiency gains that promote employment or industrial expansion:**

(i) the DHA anticipates that the commercial agreement will enable the day hospitals to encourage patients to opt for procedures in day hospitals as opposed to either of the three largest hospital groups and/or any of the acute hospitals. In this regard, the DHA believes that its unique value proposition will create a volume shift in favour of day procedures. This is likely to lead to an increase in demand, and more day hospitals seeking to enter the market and/or developing / expanding their existing service offerings. The DHA respectfully submits that negotiating as a collective will improve its bargaining position. In addition, it will result in a volume shift in favour of day hospitals and will bring about stability and operational efficiencies that will make day hospitals more attractive to investors, including historically disadvantaged persons. Furthermore, this will lead to more employment opportunities in the private healthcare sector.

12. **DURATION OF THE EXEMPTION**

12.1 This application for an exemption is made for a period of 5 years from the date of commencement of the commercial agreement. We submit that the longest possible exemption period should be granted by the Commission in order to facilitate the members of the DHA the ability to fully develop and achieve the objectives set out in the commercial agreement, which objectives are consistent with the requirements that need to be fulfilled in terms of the Competition Act.

13. **MARKET DEFINITION**

13.1 Defining the relevant market requires an assessment of both the product and geographic dimensions of competition. Thus, the relevant product market considers the set of

products/services which are substitutable from the point of view of the consumer in terms of their characteristics, intended use and price. Relatedly, the geographic market delineates the area over which the incumbent is constrained from unilaterally influencing competitive outcomes. Thus, the definition of the relevant markets identifies and defines the boundaries of competition and features that may restrict, prevent, or distort competition within those boundaries. The purpose of market definition is to identify the number of competitors active in the market, assess concentration levels as well as the competitiveness or otherwise of that market.

13.2 The relevant markets are likely to be as follows:

Product Market:

(a) the private healthcare market consists mainly of general acute care hospitals which offer a wide range of specialities though there are significant similarities in the range of specialties offered by all general acute hospitals. Other players in this market include outpatient medical clinics, day hospitals for outpatient surgery and treatment, chronic disease facilities, psychiatric facilities, and post-acute facilities;[16] The Commission did not consider public healthcare facilities to be a reasonable alternative to the services of private facilities.[17]

(b) in the HMI Report, the Commission considered both demand side substitution and supply side substitution to inform the product market definition. The Commission noted that demand substitution between medical specialties is not possible. Therefore, the product markets must, in principle, be distinguished according to specialty and in some cases sub-specialty. Supply substitution between specialties at different acute care hospitals is also considered negligible. It would take a significant amount of time and investment to add a specialty to a facility meaning that entry would neither be timely nor sufficient to constrain incumbents. Accordingly, the Commission found that acute private hospitals compete on the basis of specialties and sub-specialties; it is nonetheless not necessary to breakdown the analysis to the speciality level, as private acute facilities compete on the same broad set of specialties and services. The Commission further found that it was sufficient to analyse in-hospital healthcare services as generally provided by the general acute hospitals;[18]

(c) the HMI observed that, if one has regard to the total range of treatments offered in day hospitals, general acute hospitals compete fully with, and therefore, fully

[16] Paragraph 18, Page 66 of the HMI Report.
[17] Paragraph 22, Page 66 of the HMI Report.
[18] Paragraph 20, Page 66 of the HMI Report.

constrain the competitive conduct of stand-alone day hospitals. Despite the fact that the Commission elected to describe this an asymmetric competitive constraint, for the purposes of the HMI, the Commission decided that it would be appropriate to include day hospitals in its analysis of the competitive dynamics in the broader private healthcare facilities market.

(d) accordingly, if one has regard to the approach adopted by the HMI, the relevant product market is likely to be the market for general acute healthcare services.[19]

Geographic Market:

(e) in defining the relevant geographic market for the purposes of the HMI, the Commission assessed competition and market power at the national or local level, or both. This approach took into account the fact that national contracting between funders and hospitals implies competition at the national level but also acknowledges that there is competition for patients at the local level.[20] In this regard, the Commission's approach is consistent with the Competition Tribunal's ("**Tribunal**") approach in merger reviews. In several hospital mergers, the Tribunal's position has been to assess the transactions at both a local and national level. The Tribunal also acknowledged that price competition between the major hospital groups occurs at a national level through bargaining with medical schemes, while local competition exists in terms of non-price competition to attract specialists and patients.[21]

(f) accordingly, if one has regard to the approach adopted by the HMI, the geographic market is likely to be at both a local and national level.

14. **MARKET SHARES**

14.1 As mentioned above, three hospital groups, namely Netcare, Mediclinic and Life Healthcare dominate the private healthcare market. In 2016, their market shares based on beds (and admissions) were 31% (33%), 26.8% (28.6%) and 25.3% (28.5%). A fringe of independent hospitals, mostly part of the NHN, exerts some competitive constraint in part due to an exemption from the Competition Act enabling them to negotiate with funders collectively. The market shares for the NHN and independent hospitals in 2016 based on beds (and admissions) were 13.6% (7.7%) and 2.3% (2.2%) respectively. Using the compound annual

[19] Paragraph 28, Page 67 of the HMI Report.
[20] Paragraph 29, Page 67 of the HMI Report.
[21] Paragraph 30, Page 67/68 of the HMI Report.

growth rate, the NHN registered a market share growth of 4.7% for all registered beds between 2010 and 2018 and a growth of 3.9% in acute beds.[22]

14.1 It bears mention that the three large hospital groups have a competitive advantage over day hospitals. The three large hospital groups benefit from the following:

(a) they are larger in terms of group and size. This enables their individual hospitals to have bargaining power in respect of the volumes that they are able to source from their suppliers;

(b) they have added revenue streams due to their diverse nature. The added revenue streams include emergency response (Netcare 911), primary care (Medicross), institutional hospitals and retail pharmacies etc.

(c) the three large hospital groups managing their own businesses allow for collective negotiations across diverse business units supported by centralised management structures / strategies / central procurement at executive or head office level.

(d) the three large hospitals groups with their diverse service offerings have the opportunity to cross-subsidize between departments and facilities. It is therefore reasonable to assume that losses experienced in one area due to negotiations can be recouped elsewhere within the organisation.

14.2 We set out below, a summary of the private hospitals by number of facilities:

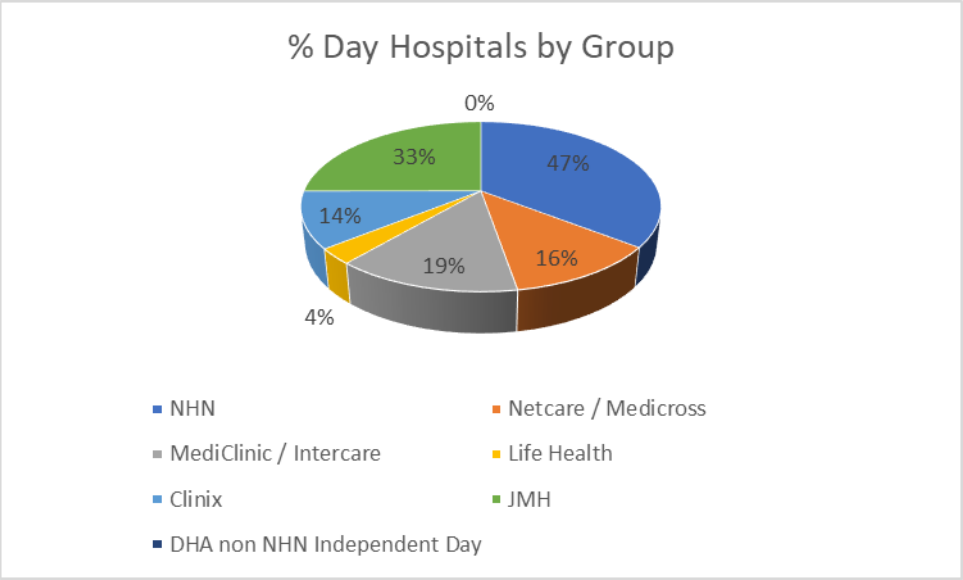
Total Number of Private Hospitals and Facility Types

Group	Total Acute	Total Day	TOTAL (Sum of Acute & Day)	Day as % of Total Acute & Day	Other
NHN	77	69	146	47%	79
Netcare / Medicross	59	11	70	16%	12
MediClinic / Intercare	48	11	59	19%	8
Life Health	49	2	51	4%	66
Clinix	6	1	7	14%	0
JMH	4	2	6	33%	1
DHA non NHN Independent Day	0	3	3	0%	0
Total	**243**	**99**	**342**	**29%**	**166**

DHA Day Hospitals	52
DHA Sharing NHN Membership	49
DHA as % of Total Day	53%

[22] Paragraph 8, Page 31 of the HMI Report.

14.3 We set out below, a chart depicting the percentage of day hospitals by group:



15. **BARRIERS TO ENTRY**

(a) The HMI Report recognises that the main regulatory barriers in the facilities market include facility licencing and Health Professional Council Regulations. The regulations are drafted in a way that makes them more prone to supporting the establishment of general acute facilities, thus limiting the establishment of other healthcare facilities such as day hospitals. In this regard, the HMI Report concludes that barriers to entry in the facilities market exist, but they are not insurmountable. What is of more concern is that the licensing process does not facilitate competition; there has also been limited entry by historically disadvantaged persons. The barriers to entry are particularly skewed against historically disadvantaged persons and innovative modes of care, such as day hospitals, which would challenge the market position of the three large incumbents.

(b) Some of the common factors that prevent or deter new day hospitals from entering the market include factors such as funder support of day procedures in day hospitals which is still limited - relative progress has been made by some funders but not across the board. Specialists are also reluctant to support day hospitals which is due to lack of insight of the level of day hospitals' offerings as well as perceptions that day hospitals are high-risk environments. This reluctance however is unfounded as the following selection criteria is used in order to determine the patients that are suited to day hospital environments:

(i) the day hospital surgeon accountable to his patient, professional societies and peers ultimately decides the appropriate surgical intervention for appropriate patients suited to day hospital environments;

(ii) patient selection further consists of a consultative process between surgeons and their anaesthetic colleagues;

(iii) patient selection addresses the suitability of the patient for day surgery. Most patients will be suitable unless an overnight stay is required based on the patient profile;

(iv) factors that may also influence selection include the risk of major complications, social conditions, and medical fitness;

(v) there should be no upper limits on age or body mass index (BMI), although each patient is judged on an individual basis;

(c) As the DHA understands it, a form of geo-mapping is used to determine the number of new healthcare beds / facilities required in line with the number of citizens that will be using those facilities. The DHA believes that the basis for determining the number of beds required should be revised and distinguish between day hospitals and acute hospitals linked to probably the biggest difference in that acute hospitals sell beds and day hospitals theatre time. This could rather allow addition of relatively smaller number of beds according to different types as in day hospitals with lower input costs and faster turnaround, caring for more patients.

(i) The Department of Health (the "**DOH**") would have to be approached to provide details of the number of day hospital licence applications received over recent years (2014 – 2021). Feedback from the department regarding rejected applications is generally vague and can often be misinterpreted. We set out two examples below:

(1) There is an existing day hospital licence or a day licence was already awarded in the same area. What is not communicated though is the probability of an existing day hospital licence with the hospital not being operational or the award of a licence but the inability of the awarded party to take action and build an operational day hospital due to a lack of investor interest. In the last instance there are examples of bona fide day hospital operators with financial means that are kept from entering the market because of this. It bears mention that the HMI Report criticised the manner in which these licences are issued. The HMI found that the issuing of licences which do not expire until a facility is constructed is problematic. The criticism was centred around the fact that such licences may continue to float in the market to the detriment of smaller and

historically disadvantaged persons who would like to enter into the market. The greatest concern is that these licences may end up being sold to the larger hospital groups thus contributing to further concentration in the private healthcare market.[23]

(2) There is no need for additional beds in a specific area based on available capacity in existing hospitals. The DHA respectfully submits that if the DOH had a better understanding of how day hospitals and acute hospitals operate, the DOH could reconsider the manner in which it conducts its analysis regarding the need for additional beds in a specific area and this could lead to more day hospitals being able to enter the market.

16. **EFFECT ON COMPETITION IN THE SOUTH AFRICAN HEALTHCARE MARKET**

(a) The members of the DHA would like to emphasise that the contemplated commercial agreement is essential for the purposes of enabling them to cooperate fully in relation to all of the commercial areas which are set out in this application. As can be seen from the above, the efficiencies and the benefits flowing from the commercial agreement are likely to have a positive impact on a market that is characterised by highly concentrated funders and facilities markets, disempowered and uninformed consumers/patients, a general absence of value-based purchasing and incumbent facilities that are not forced to innovate or to compete vigorously.

(b) Of significance is that the members of the DHA are of the view that the day hospitals will be in a position to pass-on some of those cost savings that flow from the efficiencies of the commercial agreement, to the consumers/patients. This will ultimately result in patients paying lower rates for procedures performed in day hospitals. In addition, the anticipated volume shift in favour of day procedures, is likely to lead to an increase in demand, and more day hospitals seeking to enter the market and/or developing / expanding their service offerings. This will have an overall positive impact on the market. Accordingly, the DHA respectfully submits that the pro-competitive gains resulting from the commercial agreement far outweigh the potential anti-competitive effect of the commercial agreement.

17. **PUBLIC INTEREST CONSIDERATIONS**

17.1 Once the barriers to entry that are specific to day hospitals in South Africa are removed or significantly reduced, it could lead to more day hospitals entering the healthcare market, thereby supporting small and medium businesses, and creating new job opportunities. If

[23] Paragraph 102, Page 82 of the HMI Report.

one has regard to the current economic environment, pre- and post-the Covid-19 pandemic, the exemption could also result in protecting the existing jobs in the day hospitals across the country.

17.2 The current reality is that acute hospitals are still dominating the healthcare market in terms of day procedures being performed. If this continues, day hospitals will become unsustainable and are unlikely to survive. This is neither theoretical nor an unreasonable apprehension because as intimated above, day hospitals have closed down before (between 2000 and 2005) in South Africa by hospital operators who did not understand and/or appreciate the benefits of day hospitals and their future value in the private healthcare service delivery chain. The possibility of new day hospitals entering the market is difficult to determine as DHA is not privy to this information, [redacted]

[redacted]

17.3 The commercial agreement has the potential to contribute to other public interest benefits such as employment, consumer welfare and the ability of small and medium business and/or firms owned or controlled by historically disadvantaged persons to become competitive. We briefly discuss each of these benefits below:

Job Creation:

(a) In addition to protecting the existing jobs in the day hospitals across the country, the DHA submits that the total number of employees is expected to increase if the exemption application is granted. This is expected to happen in two ways:

(i) the increased number of patients in the day hospitals will require more people to be employed by the members of the DHA; and

(ii) by leveraging on the commercial agreement, the DHA anticipates that the exemption will lead to new day hospitals being established, which will thus create new job opportunities. [redacted]

(iii) It therefore follows that should the exemption be granted, in addition to preserving the existing jobs, there is a possibility that new jobs could be created in the private healthcare market in South Africa. For a list of the staffing component for each day hospital facility, please see Annexure B.

Consumer Welfare:

(b) The DHA anticipates that, the efficiencies and the benefits flowing from the commercial agreement are likely to enhance consumer welfare. In this regard, as these efficiencies improve, the DHA is of the view that the day hospitals will be in a position to pass-on some of those cost savings to the patients/consumers. This will ultimately result in patients paying lower rates for procedures performed in day hospitals.

(c) In addition, the DHA is of the view that its value proposition will create a volume shift in favour of day procedures. Given that this is likely to lead to an increase in demand, and more day hospitals seeking to enter the market and/or developing / expanding their service offerings, patients are likely to benefit a wider variety of day hospitals to choose from. This will be more convenient for patients and will further enhance consumer welfare through a wider network of day hospitals available to consumers.

Small and Medium Businesses / Previously Disadvantaged Persons:

(d) As mentioned above, the DHA intends to develop a centralised procurement strategy that will have a strong focus on small and medium businesses as well as firms controlled or owned by historically disadvantaged persons. This strategy is intended to have a strong focus on historically disadvantaged persons, including

BEE suppliers. The DHA envisages that this will lead to a preferred provider list, where accredited suppliers will have the opportunity to participate. The approval of the suppliers will require an accreditation process which will be developed in due course. The accreditation process is going to ensure that small and medium businesses as well as firms controlled or owned by historically disadvantaged persons are considered favourably and given the opportunity to participate effectively and expand within their respective markets. The DHA supports transformation, and this will be embedded into its procurement strategy.

Transformation:

(e) The DHA supports transformation, and this will be embedded into its procurement strategy. The DHA will use a phased approach to encourage transformation of current and future members:

18. **CONCLUSION**

18.1 The DHA respectfully submits that the commercial agreement meets the legal standard required for approval. Although the commercial agreement and the conduct flowing from the said agreement may result in a contravention of section 4(1)(b)(i) of the Competition Act, the DHA submits that this application should be approved based *inter alia*, on the following criteria:

(a) promotion of the effective entry into, participation or expansion within a market by small and medium businesses, or firms controlled or owned by historically disadvantaged persons:

(i) the centralised procurement strategy that the DHA intends to develop will have a strong focus on small and medium businesses as well as firms controlled or owned by historically disadvantaged persons. The accreditation process is going to ensure, in the manner set out above, that small and medium businesses as well as firms controlled and/or owned by historically disadvantaged persons are considered more favourably and given an opportunity to participate effectively and expand within their respective markets; and

(ii) the DHA has several transformation initiatives that it intends to implement, should the Commission grant the exemption sought. These initiatives are intended to *inter alia*, improve transformation at both an ownership and a management level. These initiatives also seek to introduce strategies for staff development and training.

(b) competitiveness and efficiency gains that promote employment or industrial expansion:

(i) the DHA believes that its unique value proposition will create a volume shift in favour of day procedures. This is likely to lead to an increase in demand, and more day hospitals seeking to enter the market and/or developing / expanding their existing service offerings. The DHA respectfully submits that negotiating as a collective will result in a volume shift in favour of day hospitals and will bring about stability and operational efficiencies that will make day hospitals more attractive to investors, including historically disadvantaged persons.

(ii) in addition to protecting the existing jobs in the day hospitals across the country, the DHA submits that the total number of employees is expected to increase if the exemption application is granted. This is expected to happen in two ways:

(1) the increased number of patients in the day hospitals will require more people to be employed by the members of the DHA; and

(2) by leveraging on the commercial agreement, the DHA anticipates that the exemption will lead to new day hospitals being established, which will thus create new job opportunities.

(iii) the DHA anticipates that, the efficiencies and the benefits flowing from the commercial agreement are likely to enhance consumer welfare. As these efficiencies improve, the DHA is of the view that the day hospitals will be in a position to pass-on some of those cost savings to the patients / consumers. This will ultimately result in patients / consumers paying lower rates for procedures performed in day hospitals.

18.2 Having regard to the above, the DHA submits that the pro-competitive gains resulting from the commercial agreement far outweigh the potential anti-competitive effect of the commercial agreement. Accordingly, the DHA respectfully requests the Commission to unconditionally and expeditiously approve the exemption based on the considerations set out in this application.