COMPETITION TRIBUNAL
REPUBLIC OF SOUTH AFRICA

Case no.: 11/LM/Mar05

In the large merger between:

Medicross Healthcare Group (Pty) Ltd

and

Prime Cure Holdings (Pty) Ltd

Non-Confidential Reasons for Decision

Order

The Tribunal issued an order on 15 September 2005 prohibiting this merger.

Our reasons for the order follow.

The Transaction

The transaction on which the Tribunal has ruled envisages that Medicross, a company discussed below, will acquire the entire share capital of, and loan claims against, Prime Cure, also a company discussed below. firms are managed healthcare companies providing primary care healthcare services to medical aid schemes through a network of doctors or "service providers". Post-merger, Prime Cure will become a wholly-owned subsidiary of Medicross.

The Parties

The ***primary acquiring firm*** is Medicross Healthcare Group (Pty) Ltd ("Medicross"). Medicross is owned as to 80% by Network Healthcare Holdings Limited ("Netcare"), which is listed on the JSE in the health sector, with the remaining 20% being held by Netpartner Investments Limited ("Netpartner"). Netpartner is owned by doctors and other healthcare service providers and holds a strategic shareholding in Netcare as well as having other functions. One of them is the

ownership of 100% of the share capital of Netcare Direct Managed Care (Pty) Limited ("Netdirect"), a company which undertakes risk-transfer managed care - a concept explained at some length below.

Each of these entities is described more fully in the section below dealing with the structure of the Netcare group,

5. The ***primary target firm*** is Prime Cure Holdings (Pty) Ltd ("Prime Cure"). Its shareholders are:

Brait Private Equity	34.2%
Praxis Private Equity	29.30%
CDC Financial Services Mauritius Ltd	11.3%
Total Support Management (Pty) Ltd	8.22%
Other minority shareholders	16.95%

Prime Cure's subsidiaries include Prime Cure Health (Pty) Ltd, Prime Cure Management Services (Pty) Ltd and Prime Cure Occupational Wellness (Pty) Ltd. Prime Cure operates chiefly in that part of the healthcare industry serving low-income patients.

Prime Cure manages and administers 45 primary healthcare centres or clinics. They are located in residential townships or industrial areas conveniently accessible to the homes or work-places of low-income earners. Prime Cure centres accommodate 47 general practitioners (GPs), and nurses play a large role in providing primary healthcare services at these centres.

The healthcare professionals at Prime Cure's centres are grouped into "incorporated practices" and are charged rental by Prime Cure and fees for equipment use and staff and administration costs. These practices treat patients who are members of the medical schemes with which Prime Cure has managed care contracts, and also other patients who have no connection with Prime Cure and who may or may not be members of medical schemes.

The Prime Cure healthcare centres receive about 800,000 patient visits annually.

Prime Cure also manages and administers four independent GP practices which operate outside its healthcare centres.

In addition to these operations, Prime Cure has a contractual network of some 2,000 GPs and 800 associated healthcare professionals, such as dentists, optometrists, and specialists, who provide medical services to members of the medical schemes which have managed healthcare contracts with Prime Cure.

Prime Cure's managed healthcare contracts cover primary, primary plus secondary, or full-risk (i.e. primary plus secondary plus tertiary) capitation. Capitation is a

concept explained below.

Prime Cure has managed care contracts with 24 medical schemes, covering approximately 115,000 "lives" (principal members plus dependants). We emphasise that, in contrast to Medicross, these contracts are chiefly designed for health insurance options having low-income earners as members, although there is evidence that Prime Cure has made an entry into the "buy-down" market, serving higher or middle-income earners.

Prime Cure is also involved to some extent in providing occupational health services under contract to employer organisations. These services comprise undertaking medical examinations and on-going health screening, issuing health certificates, and operating employee-assistance programmes, on-site clinics and related services. Prime Cure's turnover from this business is not large.

The Netcare Group Structure

Disentangling the complex web of cross-holdings and management contracts in the Netcare group is not a simple matter – in fact, Mr. Pieter Dorfling, an executive director of Medicross and CEO of Netdirect, and one of the witnesses at these hearings, often had to explain which hat he was wearing. It is nevertheless clear that the acquiring firm, Medicross, is a member of a group of companies that has the Netcare private hospital network at its centre.

The Netcare group comprises a number of companies supplying a large range of healthcare services. Among these are private hospitals and specialised clinics, pharmacies located within the hospitals, emergency ambulance services, pathology and dialysis units, and the compilation and dissemination of healthcare management information. For the purposes of evaluating this transaction – as will become apparent later on - the Netcare activities that are of particular pertinence are, firstly, the network of 64 **private hospitals** which is the largest in the country and which we shall refer to as Netcare. Secondly, Medicross, the **clinic network** which provides a range of primary care services and is the primary acquiring party in this transaction. Thirdly, Netdirect, a **managed care company** which has been in existence since June 2003, and which targets low-cost medical scheme options. All these entities are discussed more fully below.

Netpartner

Netpartner is owned as to 48% by Netcare and as to 52% by healthcare professionals who numbered 9,000 at the time of the Commission's recommendation. Netpartner, with a holding of 16.2% in Netcare (at the time of the merger notification – it had risen to 17,5% at the time of the hearings) is the largest single shareholder of Netcare. Netpartner is controlled on the operational level by Medicross in terms of a management agreement.

It has several functions, one being to serve as the entity through which doctors and other medical service providers associated with Netcare hold shares in the group, and it also acts as an assembly point for these professionals in their relationships with Netcare.

Netpartner owns all the issued shares of NetDirect.

Netdirect

In the sphere of managed healthcare Netpartner operates through its subsidiary, Netdirect, which is the Netcare group's "entry vehicle" into the low-cost end of this arena. Netdirect is controlled by Medicross in terms of a management contract.

The merging parties supplied remarkably meagre information on Netdirect when filing their merger notification. No information whatsoever was proffered on the existence and extent of Netdirect's operations and Netdirect's focus on low-cost medical scheme options, at least in the version of these documents which reached the Tribunal. The only evidence available is that Netdirect has a network of more than 800 doctors. The significance of Netdirect, as the Netcare group's existing contracting entity for low-cost medical scheme options, emerged only during the course of the merger hearings.

We deal more with Netdirect below when describing the activities of Medicross.

Medicross

Medicross is a primary healthcare entity engaged in four areas of activity:

providing primary healthcare through the operation and administration of medical centres;

Medicross has 53 centres (clinics) around the country, specifically targeted at higher income patients. GPs, dentists, optometrists, pharmacists and other healthcare professionals work at these centres. Most of these centres have day theatres for minor surgical procedures, and other services ancillary to primary healthcare, such as radiology and pathology, are available.

The GPs and other medical professionals working at these centres are not employed by Medicross and not obliged to work exclusively at Medicross centres. They are however required to comply with clinical guidelines specified by Medicross. Medicross centres accommodate 413 GPs and 153 dentists.

practice administration services

Medicross provides administration services to 21 independent medical practices in

return for fixed monthly management fees.

<u>development of clinical guidelines and disease management programs</u>

These are services aimed at maintaining consistent clinical standards at Medicross centres.

<u>Managed care services</u>

From Medicross' merger documentation as filed with the Commission, it emerges that Medicross has managed care contracts with 15 medical schemes, covering some 35,000 lives, and extending to a multi-part formula arrangement for the remuneration of service providers. Apparently these activities fall considerably short of capitated primary care.

Both Mr Strauss, the witness from Discovery who negotiates directly with the Netcare group with respect to managed care contracts, as well as counsel for the Commisson, referred to the confusion which exists regarding the identities of Medicross and Netdirect in relation to their respective product offerings. The record shows the difficulties experienced by all concerned in establishing the boundaries between Medicross' activities and those of Netdirect.

As indicated above, Medicross manages the operations of Netdirect under a management contract, and Medicross and Netdirect contract with medical aid schemes to provide various forms of managed care. Netdirect appears to be at least the nominal contracting party in relation to low-cost medical scheme options. Medicross handles the administration of all the arrangements and the management of relationships with healthcare service providers with whom the scheme members consult.

According to Mr Dorfling, there is little overlap between the roles of Medicross and Netdirect. NetDirect utilises the Medicross managed care infrastructure for its operational capability. He describes Netdirect as a "facilitator of risk transfer, network arrangement, network management" whilst Medicross is a practice management administrator, deriving the bulk of its income from practice management. He distinguishes Netdirect and Medicross thus:

> *"Medicross fulfils the administration function, 100% correct. But again, Medicross never entered into the kind of total risk taking environment where that is the core objective of NetDirect. But the management capabilities and functionalities performed by Medicross in terms of an administrative agreement, correct."*

Unfortunately the Tribunal does not have information about the scale of Netdirect's activities in conjunction with Medicross in terms of number of lives or turnover.

The Rationale

Medicross believes that there is likely to be significant growth in demand for managed care services for those medical scheme options servicing low-income earners. This predicted growth in demand will derive from government's efforts to extend medical insurance to its lower income employees and from its stated commitment to a system of 'social health insurance' which is intended to extend health insurance coverage to uninsured South Africans in the lower paid part of the labour market.

In this context, then, Medicross advances two primary reasons for the transaction. First, Prime Cure brings to the merged entity an established base of low-income lives covered. This would enable the merged entity to, in the words of Mr. Dorfling, 'hit the ground running'. As we shall demonstrate, a new entrant's ability to weather the initial period where it builds a base of lives sufficient to incentivise its doctors to assume risk or, even to offer discounted fees, is a critical determinant of sustainable entry. Secondly, the merged entity will be able to take advantage of Prime Cure's established relationships with the medical schemes and with institutions, notably trade unions, which are an important source of access to the medical schemes. In short, as we shall elaborate below, Medicross believes that the transaction will enable it to overcome two critical barriers to entry, viz, 'lives' and what we will refer to as 'social capital' being a web of relationships, notably with trade unions, but also, as we shall elaborate, with doctor networks. Note that the acquiring party makes it absolutely clear that its entry is not dependent upon the merger. That is, it can, through Netdirect, enter the market anyway.

We were informed that the institutional investors who own the significant majority of Prime Cure's shares wished to exit from their investment. It appears that Prime Cure's shareholders have, over the past three years, been involved in a number of discussions regarding the possible sale of the company. These included far-reaching discussions with the large hospital group, Afrox Healthcare (since renamed Life Healthcare). There have also been several detailed discussions with Care Cross, Prime Cure's largest competitor. There were also discussions in September 2004 with empowerment parties who had expressed an interest in taking control of Prime Cure.

However, as we show below, the stated rationale neglected to outline the unitary interests between the three chief protagonists in the Netcare Group.

The unitary interests of Medicross, Netpartner and Netdirect

The merger notification and competition analysis documents filed by Medicross, again in the form in which they reached the Tribunal, convey the impression that Medicross will have to make an entirely fresh entry into the low-cost area of managed care operations, relying entirely on Prime Cure to achieve this entry, and

that Medicross alone will benefit from the merger. Yet it is clear to the Tribunal that for the purposes of competition analysis in this merger there is no distinction between Medicross, Netdirect and Netpartner. They all operate in unison to enhance the commercial interests of the Netcare group. Further, Netdirect is already a competitor in the low-cost part of managed healthcare.

The true picture emerges only from such documents as the Netpartner prospectus, dated August 2003, in which the overall strategy of entry into low-cost managed care by group entities is announced, and from the annual report of Netcare for the year to September 2004, where Netpartner's "substantial progress in developing its business model" is described in the operational review of the group. This progress is said to have included the formation of Netdirect, a company which *"has facilitated the assembly of a national network promoting and providing managed care products*". Netdirect is recorded as having concluded contracts with Discovery, Liberty, Momentum, and Eclipse medical schemes, all of which were to become operational in January 2005.

In response to a letter from the Commission, Medicross' attorneys produced the standard agreement which apparently prevails between Netdirect and the healthcare service provider groups with which Netdirect contracts. This is a comprehensive document clearly indicating a bias towards the interests of Netpartner. The names of what appear to be Netdirect's customers or putative customers, and certain details of transactions or impending transactions with them, are also revealed in this document. These entities include Day 1, Ingwe, Momentum-Pulz, Transmed, Nimas, Pathfinder, Spectramed, Protea, Siswe, Xpresmed, Bestmed, Discovery, Medicross itself, Liberty, and Eclipse (various options). It is not clear to us that agreements with all these entities were concluded, but clearly an ambitious programme of action was under way, growing from the initial contractual base described in the annual report for the year to September 2004.

In the light of this information the statements of Medicross in its merger notification documents about the rationale for the merger and of the motives and competitive position of Medicross, described below, must be treated with extreme caution.

As an example of the contrast which pertains between the merger notification and less guarded expressions of the role players, we have taken note of a due diligence report on Prime Cure prepared by a committee on which various Netcare group entities including Medicross, Netpartner and Netdirect were represented. Mr Dorfling, the CEO of Netdirect and an executive director of Medicross, was one of the committee members, and he was cross-examined about some of the information in this report. One of the pages of this report is headed "1. Purpose", and under its first bullet point it contains the statement that:

> "*the purpose of the limited due diligence performed by [Medicross] was to gain an understanding of the business processes of [Prime Cure] and to determine to*

which extent Primecure [sic] could add value to the current Medicross service offering with a specific view to enhance the Managed Care capabilities of [Netdirect] as envisaged in the Netpartner venture". (our emphasis)

It is also significant that the original sale agreement for the merger was entered into between NetPartner and the shareholders of Prime Cure. That agreement enabled NetPartner to nominate another party to undertake the transaction and that party subsequently came to be Medicross. Medicross was apparently chosen at the last moment, for no other reason than that it had the available cash. Again, the importance of the identity of the acquiring party is revealed to the Netcare group.

The triangular symbiosis between these companies in regard to the merger is thus clearly revealed.

In the parties' market and competitive analysis report, forming part of the merger notification, the rationale for the merger is stated in paragraph 2. After mentioning possible back-office savings, this document states that the principal reason for Medicross' interest in acquiring Prime Cure is Medicross' belief, shared by Prime Cure, that "*administration of managed care is an important growth area*" and Medicross' belief that "*its expansion in this area will be more cost-effective if it can build on the relationships that Prime Cure has already established with medical schemes (as opposed to having to build these relationships from the ground up)*". Some other or related purposes are also given, in anodyne terms, none revealing that Medicross is already extensively immersed in risk-transfer managed care in the low-income end of the market through its triangular relationship with Netdirect and Netpartner.

On the merging parties' own evidence, Netdirect is already providing risk-transfer managed care to low-cost options. It has stated its intention to offer both primary and secondary managed healthcare for low-income earners in a tender to the Government Employees' Medical Scheme (GEMS). Dorfling states that Netdirect's product offering is more comprehensive than that of Medicross in that it involves a primary through to a tertiary product offering, whilst Medicross has only a primary care offering. Whatever these differences, the purpose of the merger is clearly not as described in the parties' merger notification documents but rather to extend the combined strength of Medicross and Netdirect (and hence also Netpartner) in generating business in low-cost managed care. The contradiction extends beyond the stated purpose of the merger to the assertions made on behalf of the merging parties at the hearing that Medicross operated in a different relevant market from Prime Cure in that Medicross was not active in the low-cost end of the managed care market.

The Hearing

The Commission recommended that this merger be prohibited. The Commission's recommendation was filed with the Tribunal on 30 June 2005. A pre-hearing

meeting was held on the 13 July 2005. We note, for the record, that at this pre-hearing meeting the merging parties asked that we order the Commission to hand over all the notes of the Commission pertaining to its interaction with third parties. The parties were told at the pre-hearing that this request – which embodied potentially far-reaching consequences for the exercise by the Commission of its investigatory powers – could only be determined on proper application before a duly constituted panel of the Tribunal. An application to this effect was then filed and was heard by the Tribunal on 29 July 2005. In the course of the hearing, the applicants withdrew their application.

The hearing took place on 11, 12, 15, 16, 17, 19, 31 August and 1 September 2005.

The following witnesses were called by the Commission:

Dr Reinder Nauta, of Carecross
Mr David Strauss, of Discovery
Mr Brian Davidson, of Life Healthcare Group
Mr James Hodge, of Genesis Analytics, the Commission's expert

The following witnesses were called by the merging parties:

Dr Laubscher Walters, of Medscheme
Dr Robert Stillman, of Charles River Associates (CRA), the parties' expert
Mr Sean Patterson, of Brait Private Equity and a director of Prime Cure
Mr Bisnard , Managing Director of Sizwe
Mr Pieter Dorfling, Executive Director of Medicross and CEO of Netdirect

The Tribunal called the Council for Medical Schemes which was represented by Mr. Stephen Harrison and Mr. Alex van den Heever.

Competition Analysis

The Healthcare Environment

Section 12A(2)(e) of the Act provides that when determining whether or not a merger is likely to substantially prevent or lessen competition we should take account of 'the dynamic characteristics of the market, including growth, innovation and product differentiation.' We will indeed do this when we turn to a detailed examination of the impact on competition of the transaction before us. However, because there are several broader 'dynamic characteristics' that impinge significantly on the markets implicated in this decision, we thought it appropriate to outline aspects relevant to the general environment in which healthcare is provided before proceeding to a detailed consideration of the transaction itself. Pertinent to our consideration are the general state of healthcare provisioning in South Africa, the policy objectives of the South African government in the realm of healthcare provision, the mechanisms whereby government intends achieving

those objectives, and the place and role of the private sector, including the merging parties and many others who participated in these hearings, in this wider context.

The provision of adequate health care to all the citizens of the country is clearly an important plank in 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's 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 system, and 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 system, to, in other words, move a strata of those presently reliant on public healthcare over to the private healthcare system.

The constraint in effecting this movement of people from public to private healthcare is finance. Put simply, the vast majority of those who are presently reliant upon the public healthcare system cannot afford to fund private healthcare. They cannot, in other words, afford the monthly premiums charged by any of the variety of healthcare insurance schemes available on the market. From a public policy perspective the upshot of this funding constraint is that the public sector is increasingly incapable of delivering quality healthcare to those who rely upon it while the private sector remains, as it were, structurally over-capacitated. From the perspective of the private sector, it is unable, despite its excess capacity, to service a potential market of millions of South African whose healthcare needs are not adequately catered for by the public sector. Hence medicals schemes and the array of services that cluster around them, have reached the limits of their market (the number of principal members of medical schemes has remained stagnant at approximately 7 000 000 for some nine years) and some important elements of the private system – notably the hospitals – are characterised by significant excess capacity.

The challenge then is to devise funding arrangements affordable to a large part of that portion of the population that presently utilises the public healthcare system.

These would be those thousands employed in the lower reaches of the public and private sectors as well as the self-employed in both the formal and informal sectors – that is to say, the target group for private healthcare provisioning is not the indigent, but it is certainly the poor, euphemistically dubbed the 'low-income' sector of the population.

The firms involved in this merger are at the centre of this challenge precisely because they are in the business of designing and implementing affordable models of adequate healthcare provision, models that will enable the medical schemes to charge affordable monthly premiums and guarantee a level of service that the consumer is willing to purchase, that the providers are willing to supply, and that the relevant regulatory authorities are willing to sanction.

Despite millions of potential customers, the existing market in low-income healthcare provision is extremely small. Certainly, low income earners rely almost entirely on the public hospitals for secondary and tertiary care and although much of the primary care received by this part of the population is from private sector providers this is, in the vast majority of instances, directly funded by the consumer. For the most part, low income earners are not members of medical schemes and hence they are not insured for medical events.

A relatively insignificant proportion of the low-income population have bought into the few funds whose design attempts to accommodate them. The simple reason for this is that they are, by and large, still not priced at levels that low-income earners can afford. Enter then, private companies dedicated to providing a service that is aimed at decreasing the cost of healthcare insurance. This they do through attempting to address the two drivers that underpin high health insurance costs, namely the cost of healthcare products and services, and, secondly, the cost of risk.

Enter too government, driven by public policy imperatives and capacitated, first, by its huge purchasing power in the shape of many hundreds of thousands of uninsured public sector employees, second, by its ability to subsidise the provision of affordable healthcare both to those within its own employment net and to other low-income consumers of healthcare services, and thirdly by its ability to regulate healthcare costs and medical insurance.

The state's principal initial instrument is the Government Employees Medical Scheme ("GEMS") a medical scheme comprising a bouquet of high and low-income options which has recently been registered and which government intends rolling out from the beginning of 2006. GEMS is intended to cover those of its employees who are currently insured with other schemes – it is estimated that there are upwards of 60 medical schemes that provide coverage for government employees - as well as those, predominantly low-income, government employees who are presently uninsured and, as such, are dependent on the public healthcare system. There are currently about 1.1 million lives in the public sector. It is

estimated that some 400 000 government employees are not covered by any medical scheme. It appears that the intention is to phase in GEMS, focusing first on migrating already insured government employees from their current schemes to GEMS. The second phase will focus on persuading those government employees who are presently uninsured to take up one of GEMS' low-cost options. We were informed that government intends membership of GEMS to be voluntary – however a subsidy will not be made available to employees who choose to belong to a scheme other than GEMS.

Government has recently published the GEMS tender document. It calls for bids for the administration of five options, two of which are directed at low-income employees. These latter specify that the bidder is required to provide *capitated* care. The significance of this will become apparent later but, suffice for the present to note, that this is a scheme where risk is transferred from the scheme to the managed care provider or, ultimately, the providers of medical care, namely the primary care providers, the specialists and the hospitals. The GEMS tender calls for businesses to bid for eight different types of contracts - an administrator; a clearing house; two providers of primary healthcare services (for the "Sapphire" and "Topaz" options , which are described later on); an HIV/AIDS management company; a hospital service provider; managed care services and information technology services.

This complex background impacts powerfully upon the competition analysis of this merger. All merger regulation is, by its very nature, speculative, or, in the well-known description of Judge Richard Posner, 'predictive'. Anti-trust decision makers have attempted to lend as much science and certainty as possible to the process of merger regulation by utilising evidence of past and current market behaviour in tandem with economic theories and tools, which, in combination, permit of intelligent and relatively reliable prediction.

However this merger is characterised by particularly severe analytical problems. We are, in essence, dealing with a new market. As already outlined, the poor have been effectively excluded from the market for private healthcare services by the inability of the health insurance sector to devise affordable funding options and by the inability of the healthcare service providers to reduce costs to the sort of levels that enable the supply of a marketable package of healthcare services.

This is not to say that cost has not been a consideration in the supply and funding of private healthcare in the upper and middle-income markets. Of course it has been and cost considerations confronted in these markets underpin many of the debates – as well as the institutions and instruments – that are pertinent to the current efforts to extend these products to the poor. These are all instruments of 'managed care'. Hence efforts to discourage the ultimate consumers of healthcare products from 'over-utilisation' have been led by the introduction by Discovery Health – South Africa's largest medical schemes administrator – of the 'savings account' concept. A variety of managed care concepts aimed at disincentivising 'over-

provision' by the service providers – these ranging from pre-authorisation for hospital services through to the identification of designated (and, therefore, often discounted) service providers that rely on the utilisation of networks of GPs, specialists and hospitals – have, in relatively recent years, become ubiquitous features of current healthcare provision.

However, none of these interventions have brought private healthcare within the range of low-income consumers. Indeed the record shows that they have not been particularly successful in holding down the costs of private healthcare although it is, of course, extremely difficult to construct the counterfactual. What is reasonably clear, however, is that in order to extend private healthcare to the poor, new approaches and products are going to have to be devised. The parties to this merger – and particularly Prime Cure, the target firm - are at the forefront of this thinking and this is why they are counted amongst the small number of firms that have made inroads, slight though they may be, into the untapped market for the provision of private healthcare to the poor.

The analytical complexities of this merger are massively compounded by the important role played by regulation in the private healthcare market, not to mention by the state's role as a critically important direct provider of healthcare services. As already noted, the very notion of extending private healthcare to the poor is catalysed by the state's decision to adopt this model in its efforts to meet its mandate to provide affordable healthcare to all of its citizens.

The poor, of course, have always been with us although this, on its own, has not inspired entry into this market. It is the advent of a state dedicated to providing healthcare to the poor that has created this market. The merging parties have claimed that the expressed desire of key private players – notably the large medical scheme administrators – to enter this market is inspired by the downward pressure on their prices and margins. The Commission has cast some doubt on whether prices and margins in this part of the broader healthcare market have been subject to downward pressure, but even if this is so, then it is fair to say that this has, in significant part, resulted precisely from state intervention - particularly from the imposition of a prescribed set of minimum benefits as well as a range of other regulatory interventions. Nor has the state been content to focus its attention on the healthcare funders. The producers and retailers of pharmaceutical products – another important driver of healthcare costs – have also come in for considerable and controversial attention from the state. These interventions have, in turn, impacted on other providers of healthcare services who are more directly implicated in this transaction, notably doctors and private hospitals, the latter a particularly important component of healthcare costs, who have derived large margins from the sale of medicines.

Nor is the regulatory framework settled. Far from it. The state's intervention in the area of pharmaceutical pricing and provision has been subject to swirling public controversy and wide-ranging litigation that is, as yet, not yet fully resolved. In

the area of healthcare funding and management, the state has, predictably, moved most decisively in the provision of healthcare insurance to its own employees. As already elaborated, it has done this by registering a new medical insurance fund – GEMS – and within this framework it has, it appears, prioritised the movement of those of its employees already covered by medical insurance into GEMS and, then, the extension of coverage to those of its lowest paid employees who are, as yet, uninsured. It has indicated that once this has been achieved – itself, as we shall indicate, no mean task – it will seek to extend this coverage beyond the public sector, thus constructing what is generally referred to as a system of 'social health insurance'.

However, while the state's overall objectives are reasonably clear, the precise tools that will be deployed to achieve these objectives are by no means finally resolved. While it appears, as will be elaborated at length, that GEMS has opted for capitation as the preferred mode of providing cost-effective options for its low-income employees, many commentators, including some who have actually entered bids for the tender, still insist that alternative modes of healthcare management may produce preferable outcomes. There is a strong body of opinion, eloquently articulated by witnesses in these hearings, that insists that the provision of affordable healthcare to the poor is an oxymoron in the context of the present system of prescribed minimum benefits. However the state has not, as far as we are aware, indicated that it is even reconsidering the imposition of prescribed minimum benefits which are generally identified as a cornerstone of a regulatory system that is directed at producing adequate healthcare to all of its citizens. We should also add that past experience, compounded by the huge stakes involved in the GEMS tender, suggests that the award of the tenders will be the subject of intense contestation including time-consuming litigation.

How does all of this uncertainty and fluidity impact on our consideration of the transaction that is presently before us? It means, in short, that the past is a particularly unreliable guide to the future. As we shall demonstrate, extreme uncertainty bedevils an analysis of the impact of this transaction even at the most fundamental and elementary level of merger regulation. Hence, as we shall elaborate, we are not able, with any confidence, to predict the response of consumers to price movements in the products offered by the merging parties.

It is our view, then, that this extremely fluid context, the absence of an established and stable regulatory framework for this embryonic market as well as for some related and long-standing markets (for example, pharmaceuticals), demands that we adopt a particularly cautious and circumspect approach to private interventions, such as this merger, that will inevitably impact on the development of the market under consideration. Public interest considerations impinging on the outcome of interventions in this area – be they interventions by the state, by regulators or by private market participants – are, for unimpeachably good reason, unusually intense and this also predisposes us to particular circumspection.

We are, to state the obvious, dealing with a transaction in a market that is central to the interests of the state, to the private sector and to ordinary consumers. It may well be that in a year's time, or, more likely, in five years' time, the regulatory framework and the parameters of the markets implicated in this transaction will be more certain and that the consideration of an identical or similar transaction will produce a different outcome. However, it is in the nature of merger analysis that changing eras and contexts produce different outcomes. There is no single answer that stands for all time.

The Relevant Markets

The papers filed in this merger display an unusual degree of consensus between the merging parties and the Commission over the definition of the relevant market. This is particularly unusual in the context of a merger that the Commission recommends be prohibited. One would have expected a deep-seated divergence on the boundaries of the relevant market. However, despite their initial closeness to the Commission's view, the parties have ultimately argued for a relevant market significantly broader than that contended for in their formal merger filings.

It is common cause that the merging parties' activities overlap in respect of:

primary healthcare (through the operation and administration of primary healthcare centres) and
the administration of capitated **managed care** options.

There is thus agreement on the fact that there are two relevant markets. The first can be dealt with relatively easily. This is the market for the provision of primary healthcare services. This consists of the operation of **medical centres** through which doctors, dentists and other healthcare professionals provide primary healthcare services.

The commission examined the geographical locations of the Medicross and Prime Cure medical centres and concluded that the merging parties had overlapping facilities in five centres, namely, Bloemfontein, Bluff (Durban), East London, Kimberley and Port Elizabeth.

However, it appears that the Medicross and Prime Cure facilities are directed at markedly different income groups. Prime Cure centres are located in close proximity to low-income communities, such as mass-housing townships and industrial areas, generally within walking distance for potential patients. By contrast, Medicross centres are located so as to target middle-income market earners, within easy driving distance of their residential suburbs.

It is clear that the clinics managed by the merging parties represent but a small portion of available primary care in the areas in which they are located – generally urban and metropolitan. Although this availability varies widely as between different

geographical locales there is no evidence to suggest that the clinics of the merged entity will acquire market power for the provision of primary healthcare in any single locale.

It is common cause between the parties and the Commission that this market presents no competition problems, and we concur with this assessment. This market will not be discussed further.

The second relevant market for which the parties, in their initial filings at least, contended is that for the provision of capitated managed care options. Although the Commission's market definition is not particularly lucid, it too holds most consistently that the market is that for capitated managed care options. However, on several occasions it does refer to 'the market for the provision of managed care services with a national network of service providers'.

This is the problematic market in this merger and it is precisely here that the merging parties have sought, at the stage of the proceedings before the Tribunal, to widen the boundaries of the relevant market for which they originally contended. Their stance at the hearings and in their closing argument was that the relevant market was the market for primary managed care services for low-cost medical scheme options. On this view the provision of any form of managed care at the primary level, and not necessarily capitation, makes the provider a competitor in the market. Throughout the hearings the Commission consistently took the position that the market is that for capitated managed care, provided on a national basis.

It is clear that the Commission derived its list of competitors in the relevant market from information provided by the parties in their original filings, where capitation was specified as a feature of this market.

As we shall elaborate below, in their initial filings both merging parties informed the Commission that the participants in the capitated managed care market are Care Cross, Prime Cure, Medicross, Faranani, Metropolitan (through, it later transpired, an entity called Qualsa), and 'other IPAs', that is, Independent Practitioners' Associations. As we shall see, the data supplied by the parties indicate that Faranani, Metropolitan and the IPAs are fringe players, with Care Cross, Prime Cure and Medicross accounting for the lion's share of the market. The Commission's investigators certainly accepted that the only players in the capitated managed care market were those identified by the parties. Moreover, we note – and elaborate below - that the views of the parties as contained in their initial findings were confirmed in the Commission's interaction with other parties in the broader health care market.

It is clear that whenever, in their initial filings, the parties specifically applied themselves to identifying the relevant market they explicitly and unanimously opted for the provision of *capitated* managed care as that market. Moreover, they explicitly and repeatedly identified Carecross, Primecure and Medicross as the

only significant participants in that market with very much smaller players, including Faranani, Metropolitan and selected regional Independent Practitioners Associations (IPAs), competing on the fringes of that market. In Item 16.4 of its 'Statement of Merger Information' (Commission Form CC4(2)) Medicross states quite unequivocally that

> 'the merging parties, are *in the broadest sense (our emphasis), competitors for the administration of capitated managed care options (emphasis in the original).*

In the same paragraph Medicross identifies itself, together with Prime Cure, Carecross, Faranani, Metropolitan and 'other IPAs' as the competitors in the market. Medicross further estimates that it, Prime Cure and Carecross account for 87,7% of the 'market share (lives covered by managed care'), with Faranani, Metropolitan and the 'other IPAs' accounting for the remainder of 'lives covered by managed care', that is, for 12.3% of those lives covered by capitated managed care. These views are then precisely echoed in Paragraph 16.4 of Prime Cure's equivalent submission.

Even though on its face this appeared, on this market definition, to be a potentially problematic transaction from a competition perspective, the merging parties clearly took comfort in their view that they were *not* competitors because of the different market niches that they targeted, with Medicross targeting middle and high-income consumers, and Prime Cure the low-income consumers. On this basis they held that the merger presented no horizontal problems. Again in Paragraph 16.4 of their respective form CC4 (2) submissions, both parties, having, as indicated above, identified themselves as, 'in the broadest sense, competitors for the administration of capitated managed care options', continue:

> "However, at the narrower level as discussed in the Analysis, they are not viewed as competitors *due to the fact that the parties target different income groups. (*our emphasis*).*"

This conclusion was cogently countered by the argument advanced in the Commission's recommendation. This acknowledged the distinct market niches which had existed in the past, but nevertheless, concluded that the transaction would give rise to a substantial lessening of competition, relying on the doctrine of 'potential competition'. Effectively, the Commission argued that Medicross, through or in combination with Netdirect, was poised to enter the low-income segment of the market and that its competitor in the low-income segment, notably Care Cross, through its associated company, One Care, had already entered the upper-income segment.

Clearly the parties recognised in the course of preparing for these hearings that their defence of the transaction rested on thin ice and so have sought to amend their case by expanding the contours of the relevant market.

Counsel for the merging parties argued that his clients should not be held to their original definition of the relevant market. He insisted that because these are not adversarial proceedings but rather proceedings in a truth-seeking enquiry, the parties' filings cannot be given the status of pleadings but are rather their initial contentions in an unfolding enquiry in which their ideas and opinions will evolve as evidence and argument are submitted to the Tribunal. He has sought to characterise the Commission's defence of its view of the relevant market as unduly dogged and inflexible.

While, in general, there may be some broad validity in these contentions, they are ultimately not persuasive. It is one thing to argue that the Commission should be prepared to confront, with a relatively flexible mind, evidence and argument submitted to the Tribunal to the effect that the Commission had opted for too narrow a market definition. However, it is quite another matter to insist that the parties should be at liberty to broaden or abandon the boundaries of the relevant market for which they initially contended. The view of the relevant market that is contained in their initial filings reflects the merging parties' understanding of the world in which they conduct their business and this view from the coalface appropriately guides the Commission's investigation. The parties' effective definition of the relevant market is in fact derived from their identification of their competitors. We can understand why business people may misinterpret a request to identify a 'relevant market' – this is a term of art in competition law and economics that may well not be easily understood by one not versed in anti-trust theory. However they are not asked to do this. They are rather asked to list their competitors, and this is the first, and most important, building block in the Commission's definition of the relevant market. There can surely be few business people worthy of the name who would not understand a request to identify their own competitors.

It is wholly conceivable – even likely - that a merging party which is familiar, or is familiarised, with the nature of a competition enquiry may take an unduly expansive view of its competitors and the reason why the Commission then interrogates these submissions further is to establish whether the views they contain are sustainable or not. However the Commission cannot reasonably be expected to believe that the merging parties have inadvertently omitted to mention a host of significant competitors. In the hearings, the witnesses for the merging parties identified companies or divisions of companies such as Solutio, Qualsa and Yarona as competitors in the market, and yet we are asked to believe that they somehow neglected to refer to them as competitors in their initial filings. For example, the legal representatives of the merging parties castigated the Commission at the hearings for failing to enquire of Medscheme, a large medical schemes administrator, whether its managed care division, Solutio, considered itself to be a competitor of the merging parties. Contrary to the merging parties' initial submissions, in which Solutio warrants not a single mention, they now contend that it is a particularly significant presence in the market. The merging

parties having not seen fit to identify Solutio as a competitor, what reason would the Commission have had to pursue this line of enquiry?

The Commission in fact approached Medscheme and many of the other medical scheme administrators whom the merging parties now insist are their competitors, because they were identified by the merging parties as their most important *customers*. The Commission's interrogation of these identified customers is entirely appropriate to that relationship. It approached each of the significant competitors identified by the merging parties – these being Faranani and Carecross – who confirmed the parties' view that they were indeed competitors and who were then interrogated on that basis. It is noteworthy that in the course of the Commission's investigations Faranani and Carecross both *confirmed* the parties' initial submissions regarding the identity of participants in the relevant market. Dr. Nauta was cross-examined at length on the identity of his competitors. While he acknowledged that entities like Qualsa (Metropolitan), Solutio (Medscheme), Sizwe and the IPAs accounted for a smattering of lives on capitated options, he did not view any of them as a significant competitive presence.

As indicated above, the parties' initial view of the participants in the market was generally borne out in the Commission's interviews with other participants in the broader health care market. Hence Transmed, one of the smaller medical schemes, identified Prime Cure and Medicross as providers of capitated options. Although it had an agreement with Qualsa (Metropolitan), it did not consider Qualsa to be a competitor of the merging parties. Spectramed, another small scheme, also listed Prime Cure, Medicross, Carecross and Faranani as well as a firm called Healthcare Alliances. A third small scheme, Ingwe, also identified Prime Cure, Medicross, Faranani and Carecross as national providers of national primary care solutions. Ingwe was of the view that the IPAs' regional character placed them outside the market.

In this regard we view the evidence of Mr. Strauss of Discovery as particularly revealing. Here was a witness from South Africa's largest medical scheme administrator with responsibility for exploring and concluding agreements with service providers. His is surely a particularly privileged vantage-point from which to identify participants in the market for the provision of capitated managed care options. Schemes administered by his company are, of course, significant users of these services.

Strauss' view is that Medicross, Prime Cure and Carecross compete in this low-income market, with Carecross being "the major player". He acknowledged that Discovery had been approached by many entities claiming to be primary care providers, but added that none of them had proved to be cost-effective or "of substance enough for Discovery to contract with them." Regarding Solutio, Strauss' view was that it was effectively a data management entity. Discovery's view of Qualsa was that it managed in-hospital expenses rather than primary care.

Furthermore, having a national footprint is imperative to Discovery's selection of a primary care provider and Qualsa did not, in Discovery's view, have such a national footprint nor did it attract enough lives to make it robust. Strauss remarked that Discovery would not use it.

As for Yarona, Strauss testified that this entity had initially spun off as a division of a medical scheme and had previously made an offer to Discovery, but Discovery did not consider it to be a player. Specifically on Yarona Strauss stated:

> "Yarona's proposal relied on a network of contracted providers, but they had to bring in a third party by the name of Calabash to manage the network and to take risk within their proposal. So when we are talking specifically about Yarona, Yarona themselves, as I understand it, have a list of contracts at a particular rate per consultation, but they as an organisation do not take risks and they as an organisation, as I understand it, do not manage the doctor's utilisation patterns".

Because the merging parties have made so much of Solutio's alleged presence in this market, it is as well to spell out the precise extent of its involvement.

Dr Walters testified as to Solutio's involvement with low-cost insurance options. He referred firstly to the Bonitas medical scheme, an open scheme administered by Medscheme which has a low-cost capitated option ("Boncap"). This is managed by Prime Cure and Faranani. This option consists of 400 lives, with 4 000 being added in January 2006, making a total of 5 400 lives. [.......CONFIDENTIAL......]

Secondly, in respect of the Liberty medical scheme, also an open scheme administered by Medscheme, there is presently a capitated low-cost option, with Faranani as the primary service provider. Similarly, Liberty has a medium-cost option, which is a 'virtual' capitated model, with Medicross as the service provider. [.......CONFIDENTIAL......]. Walters testified that the number of lives with Faranani was of the order of a few hundred, while Medicross administered some 600 lives.

Thirdly, Walters referred to Protecta, a closed-scheme also administered by Medscheme, with the low-cost capitated option currently managed by Prime Cure. [.......CONFIDENTIAL......] He could not specify how many lives were entailed.

Walters also made mention of Sasolmed, a closed-scheme which also has a low-cost option for which Solutio is presently bidding. It is not a capitated product but a managed fee-for-service option, that is, for the most part, confined to Secunda, Sasolburg and Pretoria. It has about 5000 lives in the low-income option. He also made mention of the AECI scheme where it appears that manages the low-cost option. It appears that Solutio's role is limited to oversight of the Carecross

contract on behalf of the scheme in order to ensure that service delivery is adequate.

Ultimately, it seems that the only primary care capitated current business that Solutio itself provides is in respect of the Daimler Chrysler scheme. This is a closed regional scheme where, acknowledges Walters, the capitation fee is exceptionally generous.

We concur with the Commission that Solutio's share of the capitated managed care market, when measured by number of lives, is so small that it cannot be considered a competitive constraint on the major participants in the market. It is limited to schemes administered by Medscheme where, for the most part, it continues to rely on one of the major providers of capitated options. We should also note that most of the low-cost schemes in which it plays a role are small, closed and regionally-based.

It is, of course, eminently possible that the exercise of market power on the part of the participants in a relevant market may induce new entry into the market. This will be an important part of our enquiry, particularly when the question of entry barriers is examined. It is also possible that the conduct of existing players in the market may be constrained by potential rivals who are easily able to utilise existing assets and know-how deployed in a related market to enter the market in question - so-called supply-side substitution. This too will be examined when we consider entry barriers. However we are, on the basis of their own contentions, satisfied to conclude that the parties confidently identified the relevant market as that for the administration of *capitated* managed care and, more revealing of their view as to the boundaries of their market, they identified the participants in that market - their competitors in other words - as Care Cross, Prime Cure, Medicross, Faranani, Metropolitan and certain of the IPAs. It would be difficult to deny that the data in the parties' own filing reveal that Faranani, Metropolitan and the IPAs are nothing more than fringe players. We will show that the evidence demonstrates that they are destined to remain on the fringes of the market.

We find that the relevant product market is that for the provision of capitated primary managed healthcare products.

There are various forms of capitated products. There is the form of capitation where the managed care organisation effectively assumes the risk from the scheme. The most advanced form of capitation is where the managed care organisation then transfers the risk to the service provider. Ultimately this is the desired end-point of capitation because it effectively incentivises the service provider to tailor his treatment regime to the limits imposed by the capitation fee. And there are variations on this theme. In his evidence Dr. Walters of Medscheme/Solutio spoke of 'gain sharing' options which combined capitation – where the managed care organisation or service provider assumed all the 'downside' risk - with an arrangement that enabled the scheme to share some of the 'upside' with the

managed care organisation or the provider.

Although the merging parties argued that there are managed care mechanisms that are substitutable for capitation, we will show that it is widely recognised that the product that is most effective for the provision of low-cost insurance options is indeed capitation. Variants of this approach are steps along what Dr. Walters described as a 'journey' toward the attainment of the provision of a fully capitated product, one in which the service providers assume the risk. Although the precise boundaries of the market for which the Commission contends are sometimes blurred our definition is certainly close to the Commission's view and to the view for which the merging parties initially contended. It is certainly narrower than the parties' revised view of the market which effectively argues that ***all*** managed care products are substitutable, and are adequate to the task of securing health care options for the poor.

Almost as many definitions of 'managed care' and 'capitated managed care' have been proposed in these proceedings as there were witnesses. Dr Walters' definition seems to capture the essence of the concept of managed care:

> "there are three things about managed care and I am sounding like a professor, but it is quite simple. You set standards, you set financial standards, you set clinical standards. That's the first thing. The second one is you must have systems, processes and systems to actually administer those standards and the third thing is that you must analyse the outcomes. That's managed care."

As for *capitated* managed primary care the most succinct definition is contained in the witness notes handed up by Mr. Dorfling at the hearing. There 'capitation' is defined as,

> "a method of payment for health services in which a provider is paid a fixed, per capita, amount in advance for each enrolee without regards to the actual number of nature of services provided to each member in advance. This involves a great deal of risk sharing."

The Medicross website also offers a succinct insight into the content of managed healthcare and the role of risk-sharing under capitation:

> "As well as providing healthcare services at industry negotiated fee-for-service tariff rates for the medical aid and private patient, Medicross offer a range of unique, comprehensive managed healthcare plans on a capitated basis (a fixed monthly fee) to look after the patient's individual healthcare requirements. Managed Healthcare is a means of providing healthcare services within a ***defined network of service providers****, who in turn assume the responsibility and therefore the* ***risk*** *of providing quality, cost-effective care, while ensuring that only* **appropriate services** *are delivered. Under this model,*

emphasis is placed on keeping the patient well, rather than treatingepisodes of illness. In this environment the primary healthcare practitioner is responsible for ***managing downstream utilisation*** *of services and effectively becomes the custodian of the patient's healthcare funds."*(Our emphasis added)

Mr. Strauss' outline of the workings of Discovery's capitated primary care option, the Key Care plan, also pinpoints the essential features of capitation:

'Adv Berger*: What was then the arrangement between the scheme and Carecross?*

Mr . *Strauss*: *The arrangement was that Carecross would provide all the primary care benefits though a network that they would put together. There would be a capitated payment, a fixed payment per member per month from the scheme to Carecross in return for which they would provide a list of services according to specific medical codes and according to specific medial ferneries (should read 'formularies') and pathology tests and radiology tests.'*

In concept capitated managed care is a species of managed care that is characterised by a '*fixed payment per member per month from the scheme'* – with the inevitable consequence that there is a transfer of risk from the medical scheme to the managed care organisation**.** In its implementation, capitated primary care and other forms of risk-transferring managed care require that the managed care entity which contracts with the medical scheme undertakes the supervision or management of a network of primary healthcare providers who generally assume a part of the risk. If they in turn receive their remuneration by way of a capitation payment, there is risk transfer to their level or tier in the healthcare matrix. In other cases, the managed care entity may retain the whole or a part of the risk at its level by paying the service providers on a fee-for-service basis. The Commission's expert, Mr Hodge, elaborated further on the concept of capitation and the concept of the passing of risk:

"So in terms of the third model, which is what we are talking about, the providers today with ***primary capitated managed care****, that company takes on risk. So it offers a scheme for a* ***fixed fee per member per month*** *to manage and typically this involves unlimited day-to-day benefits. And they then established a doctor network or in some cases clinics and they will pay the doctors either on a capitation basis themselves and pass down the risk or on a discounted fee-for-service.*

As I've documented there, they perform certain functions. So they ***overlap in terms of the administrator*** *in terms of doing claims processing. But the key aspects, which Dr Nauta brought out is the ability to* ***monitor, analyse and specifically manage utilisation****. If you're on risk, you need to manage the utilisation and especially if you're paying your doctors on a fee-for-service basis to ensure that essentially the income you get in is not exceeded by the benefits you pay out. You've clearly got to implement trained doctors. We've heard more, let's say intangible aspects such as getting their buy-in to manage the concept, and just manage the doctor relationship in*

*general to ensure that the doctors provide cost-effective and quality health care." (*our emphasis added.)

Although some witnesses argued averred that there are primary managed care products for low-cost insurance options that do not rely on full capitation, in truth much of the evidence before us regards capitation as an essential element of a managed care product directed at providing health insurance for low-income consumers. This is not to deny Dr. Walter's contention that full capitation lies at the end of a long journey that may begin with varying mechanisms for managing a fee-for-service arrangement and that ultimately ends with full risk transfer. But it is to insist that a high degree of risk transfer, (in the form of capitation) is required if healthcare provision is to be extended on a significant scale to low-income earners. Dr. Nauta contends that the transfer of risk"

> *"…is really critical to the success in this market. You've got to ultimately transfer risk from you as entity in the middle, that buys this from various options and various schemes, to the doctor."*

And for all Mr. Dorfling's insistence on a range of alternative managed care products for the low-income market, it does not seem that the merging parties disagree with Nauta's assessment of the non-substitutability of anything except risk transfer – in other words, capitation - in respect of the low-income market. Dr. Stillman, reports that:

> *"Medicross shares the common view that to offer a medical scheme option that covers prescribed minimum benefits at these price points, i.e. low price points, the managed care model, as opposed to the fee-for-service model, is the only practical alternative. Medicross believes moreover that to provide a private healthcare product at these price points, it will be necessary for managed care to be on a full risk basis, i.e. to offer a managed care plan that covers specialists, medicines, hospitals as well as primary care."*

Stillman sums up the merging parties' view:

> *"In sum the parties believe that the only effective way to deliver low-cost medical scheme options at prices affordable to low-income consumers, is through a full-risk managed care product offering".*

Thus, by the merging parties own reckoning, full risk transfer is necessary if health care insurance is to be made available to low-income consumers. And it is this model that requires highly organised primary care provider networks and a sufficient number of lives to incentivise the doctors and other medical service providers to accept full risk transfer.

Mr. Dorfling contended that the extension of private healthcare to low-income

consumers could be achieved by a range of managed care products. He lists what he believes are a number alternative managed care products adequate to the task of ensuring low-income health insurance option, although**,** as elucidated earlier**,** even he concedes that full-risk transfer is the 'most effective' mechanism.

Indeed it is clear that the demand-side of the market also recognises the non-substitutability of full-risk capitation. The GEMS tender for its Topaz and Sapphire options, from where the bulk of the predicted surge in demand for low-cost insurance cover is expected to emanate, clearly specifies that GEMS is calling for tenders for full-risk capitation.

We should, for the sake of completeness, comment on a distinction much relied upon in the parties' initial filings and dealt with by the Commission in its report, but which now seems to have been abandoned by both. This is the distinction between the provision of capitated managed care products for low-income earners (where Prime Cure is focused), and capitated products for the middle and higher income markets. This latter is the segment where Medicross is focused and is often referred to as the 'buy-down' market. It is not clear to us that either the parties or the Commission ultimately attached much significance to this distinction. It is clear that capitation is a mechanism for offering low-cost medical insurance and it is the low-income segment of the population at whom it will be aimed. There is a prospect of part of the higher-income part of the market 'buying-down' and this is already occurring to some limited extent. But it will be limited because these options embody limitations imposed on the scheme member that higher income options do not, and, for that reason, these options are unlikely to attract significant support from higher income purchasers of medical insurance. Moreover these 'buy-down' options will not be actively marketed or facilitated. At all levels, the healthcare providers clearly attempt to maintain a separation between the high-income and low-income purchasers of medical insurance, precisely because of the prospect of high-income purchasers availing themselves of options that cost less than they are able to afford, thereby eroding revenues and profits. In the face of ever-rising healthcare costs, we conclude that while buy-down is a phenomenon that is unstoppable, on present evidence it is unlikely to proceed so far that it blurs or eliminates the boundaries set by capitation.

Geographic Market

The **geographic** market is in our view national. There is a limited market for regional primary managed care products and this market may be penetrated by regional providers utilising regional networks. However, it is our view that these will service a shrinking portion of the overall health insurance market, including the low-income market. We will, in our discussion of entry barriers, outline why we view the regional IPAs to be inadequate substitutes for well-organised national networks – indeed, although the evidence is not unanimous, credible evidence pointed to important weaknesses of the regional IPAs, weaknesses that militate against them providing the extent and character of network management that

primary managed care for low-cost health insurance demands. Many of the medical aid schemes, large and small, submitted that a national footprint was one of the key criteria they would look for in selecting a managed care provider. Mr Strauss, of Discovery, was particularly emphatic in this regard:

> "MR STRAUSS*: From our perspective we're always ... one of the first criteria will be for a national footprint, Faranani, as they've produced their membership lists, have always dominated Gauteng rather than anyone else. We've been into their organisation and looked at their systems and their processes, many of which they outsource, and they just haven't seemed to attract the lives to make them into a robust organisation."*

In short, there will be niche opportunities for regional providers of capitated primary managed care. But these are unlikely to constrain the competitive behaviour of the national providers. Accordingly, we conclude that the geographical market is national.

Activities in this market engage closely with related markets. In particular, interaction with the market for the provision of private hospital services and the market for the provision of medical scheme administration services will be selectively considered.

The Impact of the Merger on Competition

The relevant product market – the market for the provision of capitated primary managed healthcare products – is highly concentrated. The merging parties estimate that there are 342 000 lives covered by capitated managed care options. Of these, 10,2% are covered by Medicross, 33,6% by Prime Cure and 43,9% by Carecross. That is, 87,7% of the number of lives covered by capitated managed care options are accounted for by the three largest players. Faranani is estimated to enjoy a market share of 5%, with Metropolitan's share standing at 1,5% while 'other IPAs' collectively account for 5,8%.

This is, by any reckoning, a highly concentrated market. However a merger cannot be judged on this fact alone. We proceed then to examine the impact of the merger on competition.

The Commission has argued that this transaction has both a horizontal and vertical dimension. The horizontal dimension arises from the merger of two firms involved in the same product and geographical market. The vertical dimension refers principally to the place of the acquiring firm in the Netcare hospital group. We will analyse each of these dimensions in turn.

Section 12A(2) provides a non-exhaustive list of factors that are to be considered in the assessment of the impact of a merger on competition. Those factors that are pertinent in the consideration of the impact of the horizontal dimensions of the

merger are 'the ease of entry into the market, including tariff and regulatory barriers' (12A(2)(b)), 'the level and trends of concentration, and history of collusion, in the market' (2(c)), 'the degree of countervailing power in the market' (2(d)), 'the dynamic characteristics of the market, including growth, innovation and product differentiation' (2(e)), 'the nature and extent of vertical integration in the market' (2(f)) and 'whether the merger will result in the removal of an effective competitor' (2(h)).

The Horizontal Dimensions of the Merger

Price sensitivity

Before turning to a detailed consideration of the factors listed in Section 12(A)2, we examine a proposition that has, to a greater or lesser extent, received the endorsement of several of the witnesses who participated in these hearings. This concerns the question of price responsiveness. In essence the merging parties assert that this is an unusually price-sensitive product, and consequently that there is limited capacity for the exercise of market power.

Firstly, it is clear that the product which is assumed to be inordinately price sensitive is not the managed care product (in this case, capitated managed care) at all, but rather refers to the insurance product itself. It is then implicit in the assumption that because an increase in the price of the capitated managed care product will be passed through to the consumers of the insurance products their conjectured sensitivity to price increases will restrain an exercise of market power on the part of the managed care providers.

We should be clear that there is insufficient evidence to sustain the assumption – and that is all that it is – that low-income consumers will be particularly sensitive to movements in the price of health insurance. Dr. Stillman, the merging parties' expert witness, concedes that because these low-income insurance products are 'new development(s)' there is insufficient empirical evidence to undertake the standard statistical and econometric tests that would be normally employed to resolve this disagreement.

It appears to us that many of the ready assumptions that are made regarding the price sensitivity of the insurance product confuse the entry-level price – what several witnesses refer to as the 'price point' - with responsiveness to changes in price. It is common cause that a large class of consumers, so-called 'low-income consumers', has effectively been locked out of private health insurance because even the lowest price options remain out of their reach. Low-income consumers do not partake of health insurance for the same reason that they do not partake of first-class air travel: they cannot afford it. They are not at all sensitive to movements in the price of these products because they simply do not feature in the consumption baskets of low-income consumers.

Prodded by a combination of government interventions and their own commercial interest in tapping a potentially large new market, a range of players in the healthcare industry are only now actively exploring mechanisms for lowering the cost of private healthcare insurance to the point where it enters the consumption baskets of these low-income consumers. None – in the private sector at any rate - are more actively involved in this quest than the parties to this merger and their fellow participants in the relevant market. However once affordable products have been developed – and managed care products directed at the provision of low-income healthcare insurance will be key to achieving this – there is no *a priori* reason for assuming that those who purchase these options will be particularly sensitive to price increases.

Indeed because this is an insurance product – albeit a short-term insurance product – one could reasonably conjecture that a consumer who has already sunk a material part of her income into purchasing this product would be reluctant to forgo the possibility of recouping this in the shape of future payouts when these are required. We acknowledge that regulation has attempted to lower the costs of switching from one health insurance plan to another. But these efforts notwithstanding, there are cogent reasons why switching costs will remain particularly high. Not the least of these reasons is that this is a notoriously complex product making comparison between alternative options difficult. Moreover, many consumers will purchase their health insurance plan from agents who may not always have an interest in enhancing the consumer's ability to make the necessary comparisons between the products on offer.

In any event there remains an unresolved disagreement between the parties and the Commission regarding the intensity of competition between medical schemes themselves. The Commission has taken the view that competition between medical schemes is muted and, therefore, that competition in this market will act as a poor indirect restraint on the primary managed care market. The merging parties assert a contrary view. There is not sufficient evidence for us to decide the intensity of competition in the medical schemes market here. However we do note Mr. Hodge's observation that primary managed care is but one component of the contributions to the cost of a scheme option. Therefore a substantial increase in the primary care component may then not reflect as a significant increase in the end price of the overall option and this may enhance the ability of the provider of capitated managed primary care products to exercise market power.

We note too that Prime Cure has recently increased its premiums by some 25% and that Medicross' predictions for the merger reflect significantly increased prices by Prime Cure and a simultaneous growth in membership. Again this is not definitive. But it is not consistent with the notion of a highly price-sensitive market unable to absorb even modest price increases.

We turn now to an examination of those factors listed in Section 12(A)(2) of the Act that are pertinent to our consideration of the impact of this transaction on

competition.

Barriers to Entry

The Commission has concluded from its investigations that entry barriers into the market for capitated managed care options are significant. The record evidences considerable support for this conclusion. The most important entry barriers that are identified include the need for significant financial backing, administrative capacity, the existence of significant economies of scale represented by the number of insured lives, and then finally, and in our view, decisively, to a range of elusive factors that we collectively refer to as 'social capital'. These latter include the capacity to build relationships with those institutions – notably the trade unions - that hold considerable sway over the decisions of those most likely to opt for low-cost health insurance options, as well as relationships with doctors and other primary care providers, reflected in the ability to assemble and maintain well-organised networks of primary care providers.

The parties themselves have identified high entry barriers. Prime Cure, the target firm, is quite explicit in this regard. The 'Limited Confidential Information Memorandum' or 'LCIM', a report prepared by a firm of consultants, Sevillano, Houseman, which was commissioned by Prime Cure and whose conclusions appear to be based entirely on interviews with Prime Cure management and shareholders, makes several direct references to the high entry barriers. It identifies the necessity to build relationships with the trade unions as a particularly significant barrier. It also argues that new entrants will have to rapidly secure a significant number of insured lives. The consultants clearly believe that Prime Cure has overcome these barriers and thus represents an attractive acquisition opportunity. Mr. Patterson, a witness representing the Prime Cure shareholders, attempted to represent this as a 'selling document' and thus predictably hyperbolic, but this does not strike us as credible. It was, after all, a document presented to a potential purchaser extremely well versed in the healthcare sector generally and one that had experience of attempting to develop and market capitated options. It seems unlikely that Medicross, or its controlling shareholder, Netcare, would have been persuaded by mere puffery. Indeed, Medicross, presents these factors – Prime Cure's established relationships and its insured lives – as the principal reasons for undertaking the transaction. We are assured that Medicross/Netdirect will enter the market if the transaction does not take place but that it will, by its own admission, take it from 18-36 months to do so and this from the firm that is, as we shall elaborate, probably best placed for rapid entry.

Dr. Nauta, the managing director of Carecross, the largest provider of capitated managed care services, testified to the high entry barriers surrounding this market. He believes that there are two particularly significant barriers to entry, these being the construction and management of a primary care providers network, and the accumulation of the number of capitated lives necessary to cohere the network.

Nauta began his testimony with an overview of earlier – although still relatively recent – attempts to provide managed care for the low-income market. It is an account littered with the corpses of some very significant national and international companies that tried and failed to enter this market. The merging parties appeared unable to dispute Nauta's account of unsustainable entry as evidenced by the very high failure rate of entrants. However they argued that this was either irrelevant in that it effectively required us to stand in judgement of what are essentially commercial strategies. Alternatively they insisted that it represented the workings of a robust market characterised by easy entry and exit. Both of the arguments advanced by the merging parties are, on the facts of this case, unpersuasive. The inability of new entrants – some very powerful and otherwise successful parties in the insurance and healthcare sectors – to sustain a presence in this sector, despite the appearance of strong latent demand and the consequent incentive to stay the course, strongly suggests that they did not succeed in overcoming the entry barriers identified by Nauta and others and thus they failed.

Nauta's conceptualisation of the sort of network that is required and the difficulty of organising and maintaining such a network, differs significantly from that proffered by many of the parties' witnesses. However, it is conceptually persuasive and his approach has succeeded where most others have failed. He effectively outlines two network models. The first – which is the Prime Cure and Medicross model – is centred on a network of primary care clinics. In Nauta's view, this is a very costly mode of entry. The alternative model is that pursued by Nauta's company, Carecross. This model does not rely on bricks and mortar investments in a network of clinics but rather on the tight organisation of independent general practitioners and other primary care providers.

Several witnesses insisted that the formation of a network of doctors was a simple task. None of the networks – including the Carecross network – is able to insist on the exclusive loyalty of its members. It costs individual practitioners nothing to belong to a network and so many doctors retain membership of several networks. It seems that a mere circular letter is sufficient to recruit nominal network members and we were presented with many examples of networks organised precisely in this manner. Indeed it would be fair to say that this is the mode of organisation that characterises most networks. However this is decidedly not the mode of organisation favoured by Nauta, nor does he believe that this mode of organisation will bear the weight of providing capitated managed care products.

It appears that the Carecross primary cure providers' network is not an open-ended affair assembled by means of a mere circular letter. Indeed Nauta testifies to the long process of building trust amongst doctors who were going to have to accept Carecross' invasive management of decisions and practices hitherto under the exclusive control of the doctors and, as they moved onto capitation, a reduction in

the fee that they earned from each individual patient in exchange for the relative certainty that capitation offers. These factors require a relatively concentrated network that permits of constant contact between the network organisers and the service providers who are members of the network. An open-ended and diffuse network does not lend itself to micro-management nor does it enable the service provider to build an insured low-income patient base sufficient to make the capitated fee an attractive alternative to the normal individual fee. It is for this reason, testifies Nauta, that after a long period of intensive one-on-one recruitment of service providers, Carecross now has more of them applying for membership of its network than it is willing to accept:

> "…it has to be a closed network to be sustainable and so as I've pointed out earlier, although we now have a lot of takers for Carecross, we don't allow doctors in easily, because it would just dilute our potential…the margins and our ability to manage doctors."

Note that Nauta specifically distinguishes the requirements of a network providing managed care to lower-income groups – this is the Carecross network – from that required for providing these services on a capitated basis to a higher income group. Hence, the One Care network, which is also part of the Carecross stable but is directed at a higher income market similar to that targeted by Medicross, is an open network where the patient essentially elects her primary care provider who, on acceptance of certain conditions, signs up for membership of the One Care network.

We find Nauta's analysis of the requirements of an effective primary care network persuasive. Certainly we are persuaded that the degree of network organisation required for the provision of capitated managed care at the lower end of the market significantly exceeds the open-ended approach to networks favoured by those who insist on low entry barriers to entry in this market. Nauta's analysis also provides a particularly clear explanation of the importance of a base of insured lives. It is not merely a case of spreading these lives over the fixed costs of organising the network - a traditional economies of scale argument – but rather of spreading as *many lives* as possible over as *few doctors* as possible in order to incentivise the members of the network to move to a capitated model of managed care. This is why successful managed care for low-income consumers requires a network that is both carefully selected or 'closed' and is highly organised and closely monitored. This is precisely why the organisation of the network constitutes a substantial entry barrier and one that is not overcome by the easy and rapid recruitment of a nominal network.

Nauta testified that on a practitioner basis, once each doctor is treating between 200 and 400 lives, a capitation proposal is put. According to him, the model would not work for fewer than 100 000 lives, but this depended upon the extent of the network:

"DR NAUTA*: Possibly not as much as I ... you know, I think if you have 10 doctors, then you can capitate with 20 000 lives. You know what I mean? But nationally to make sure that your footprints stay nationally and that you don't lose your peripheral doctors, because nobody ever goes there and you always need them, it's very critical to get a big contract, if you can't cope with the pensioners or the wives.*
In the South African world a lot of wives live in rural areas and their husbands work. Then you can't get the contract, because you've got to have someone in Umgoma (should read 'Nongoma') that's also a Carecross doctor to fulfil the promises that you've done and if you then are that big – in our case roughly 700 sites – then you need a 100 000 lives, I would guess. I mean, you know it's not a scientific thing, but that gives you enough interest by all the parties to be the glue that sticks it together and as it grows, clearly things got easier on our side and the whole model maintains itself."

According to Mr. Patterson, a critical mass of 90 000- 100 000 lives was required before Prime Cure was able to turn a profit. Similarly, in Prime Cure's Limited Confidential Information Memorandum, there is reference to this critical mass of approximately 100 000 lives having been reached. The Medicross due diligence of Prime Cure also emphasises the importance of volumes in overcoming entry barriers. It identifies specifically that Prime Cure has researched critical mass and that any further lives add to the bottom line. A number of the submissions to the Commission from small schemes or administrators state that this is typically a 'numbers game'.

The merging parties insist that the established medical schemes administrators are particularly well placed to overcome any barriers to participating in the relevant market.

The views of Discovery Health, the country's largest medical schemes administrator, were represented at the hearings by the head of its health department agreements division, Mr. Strauss, who presented a particularly coherent analysis of barriers to entry. He categorised entry barriers under three headings. The first is capacity in administration. This comprises the ability to receive, adjudicate and process claims, and to pay them over to the appropriate party. It also encompasses call centre query resolution.

Secondly, financial resources are required. This entails the ability to finance an organisation that is taking risk and to provide for claims volatility. Furthermore, infrastructure is required for an organisation that is starting up and assuming risk, and it is necessary to finance that infrastructure while, in the first phase of entry, income is limited because of the small number of insured lives.

Finally, network management skills – that is, the ability to manage networks of

primary care providers - are fundamental. Strauss believes that Discovery does not possess these last-mentioned skills. Indeed it is precisely for want of these skills that Discovery had not, at the time of Strauss' written submission, decided to enter the market. The network managers have to possess both an intimate knowledge of the workings of the primary care market and an ability to micro-manage the doctors participating in the network. He summarises the primary care network skills required as:

> "… being able to predict the utilisation patterns, being able to price, having sufficient data to enable one to price particular procedures or particular consultation rates, to determine how much one should be paying on the one hand to the providers of service, and how much based on utilisation then one could charge the members. The other part on (should read 'of') network management is being on the ground and meeting with doctors and being sure that they are managing in terms of the expected unitisation (should read 'utilisation') and entering into any risk sharing agreements that you can with them."

Strauss contended that Discovery possessed neither of these latter skills. Discovery's established schemes tended to attract middle and upper-income individuals and hence it was not familiar with the low-income market. And the 'medical savings account' concept pioneered by Discovery was deemed provider-unfriendly because it provided an effective break on utilisation.

> 'The results of us not being au fait with the low-income market and not having very good relationships with primary care providers for the reasons around the savings accounts, made us believe that we should not be ….if there were other organisations who had better relationships in that market and a better understanding of that market, we should leverage off that expertise.'

Strauss also argued that Discovery would, in attempting itself to manage a primary care providers network, encounter particular difficulties in ring-fencing its low-income options, in other words in persuading the primary care providers to accept a fee structure that distinguished to a significant extent between members of different Discovery schemes.

What then do we make of Discovery's decision to enter the market, a decision which was announced on the eve of our hearings? In essence Discovery has announced that it has terminated its existing contracts with Carecross and Prime Cure and that it will, as of the 1st January 2006, manage its low-income option, the Key Care plan, itself.

We note firstly, that Discovery is best placed of all the medical scheme administrators for relatively rapid entry into the relevant market. Discovery entered the low-income market – through its Key Care option – some **two years** ago and, so, amongst the large medical schemes administrators, it is certainly a first mover in

this area. In so doing it has not only been able to acquire some knowledge of the low-income market but, more important, it has a ready 90 000 low-income insured lives with which to springboard itself into the low-income market. These refer to the lives insured through the Key Care plan, Discovery's low-income option. These favourable entry conditions are not mirrored in any of the other medical schemes administrators. It is, in effect, reward for Discovery's entrepreneurial approach to health care insurance, for its willingness to test the risky low-income market at a time when its major rivals were, as Dr. Walters of Medscheme testified, content to remain in their comfort zone of high- and middle-income earners with a limited exposure to certain low-income closed schemes with limited membership. Accordingly we do not believe that Discovery's entry portends an easy entry path for other medical schemes administrators. It is the product of factors particular to Discovery's relatively early entry into this market.

Secondly, Discovery's success in this market is far from assured. It appears that Discovery will opt for an open network, one in which the Key Care member will select a primary care provider who, subject to agreeing to the plan's terms, will become a member of the network. We have already noted Dr. Nauta's critique of this approach to network construction – although he acknowledges that Discovery may be somewhat aided by its brand and the sheer size of its operation and by the fact that the Key Care plan is certainly pitched at the upper end of the low-income market, the jury is still out on whether or not Discovery will overcome the difficulties in network management to which Dr. Nauta refers. Certainly, the Discovery network is nowhere near ready to operate:

[…quote confidential…..*"*]

And there is also the vexed question of assembling an open network to service a Discovery scheme where many, possibly all, of the members of the network will be serving other Discovery members on significantly different terms and conditions:

"Adv Unterhalter*: Yes, so its not as if you have to assemble this afresh. You have already existing relationships with these doctors, or some anyway.*

Mr Strauss*: There is a big difference. The existing relationships we talk of is a relationship where those same doctors service our broader population. What we are asking them to do for this product is to ring-fence differentiated pricing."*

Discovery itself is clearly circumspect in its own assessment of its prospects for the establishment of a successful network. We share that caution and, accordingly, conclude that Discovery's entry and, certainly, the sustainability of that entry, is by no means a *fait accompli.*

This brings us to our third comment on Discovery's entry. It is clear that Discovery has been intent upon removing the *administration* component from its contracts

with Carecross and Prime Cure. [.......CONFIDENTIAL......] It is also speculated that Discovery may have been concerned that its core function – administration – was being contracted out to a third party and, at that, to a potential competitor in administration in a growing segment of the medical schemes administration market. Strauss makes it clear that first prize for Discovery was that it reclaimed and internalised the administration component of the contract while Carecross continued to manage the network. Carecross refused to accept this and so, it seems after intense negotiation, the entire contract was cancelled. Given these uncontroverted facts, it does not seem unduly speculative to suggest that when Discovery confronts the difficulties in organising a network and Carecross contemplates whether or not the proverbial half-loaf is better than none, that it may well transpire that the managed care function crucial to sustainable low-cost healthcare options, namely the management of the network, will revert to Carecross and Prime Cure, companies with a successful track record in this area.

It is interesting that an important witness for the parties, Dr. Walters, the managing director of Solutio Healthcare Management, the managed care division of the large medical schemes administrator, Medscheme, provided some of the most cogent testimony in support of the view that entry barriers are indeed high.

We have already noted that, despite the omission of any reference to Solutio in their initial filings, the parties now attempt to present this entity as a particularly significant competitor, or, at least, potential competitor in the market for the provision of managed care services to low income health insurance options. We have shown that this represents, at best, a heroic view of Solutio's current position in the market and an exaggerated and highly speculative view of its future prospects.

Walters' testimony establishes that Solutio has assembled an impressive capacity for undertaking managed care. This bears out a point made earlier to the effect that managed care concepts and instruments have played an important role in efforts to control costs – though largely in the areas of secondary and tertiary care provision – even in schemes directed at middle- and high-income categories. However, this formidable array of managed care skills does not seem to have assisted Solutio in significantly penetrating the low-income sector thus bolstering our view that we are here dealing with what is essentially a new market. Solutio has been assembling a network of primary cure providers since 2002. Walters testified that they have in this time signed up 4000 practices on the Solutio network. However the level of organisation of the network has clearly proceeded little beyond the signing up stage – it is not, in other words, a well organised network. When asked how many doctors were members of his firm's network, Walters simply replied: 'your guess is as good as mine'. Walters clearly acknowledges that Solutio will only gradually evolve from a company focused on 'benefit management' – the form that managed care takes in relation to the middle and high income insurance options – to one focused on 'relationship management', the form that managed

care will take in relation to capitated insurance options. This suggests that he expects a slow and gradual growth in the number of low income lives signing up for GEMS.

In summary, Solutio appears to be providing a capitated managed care option to one of the medical schemes administered by Medscheme, this being DCMED, the closed medical scheme for Daimler-Chrysler employees. By Walters own admission this is an a-typical low-income option. Certainly the capitation fee paid to the doctors on the network is unusually generous. As indicated above, it appears that the primary managed care component of Medscheme's low income options is contracted out to Prime Cure and Carecross, [.......CONFIDENTIAL......].

At best for the parties, Solutio's experience suggests that relatively small, closed schemes, and preferably those that are administered by Medscheme, that are regional in nature, and that are complemented by an active human resource management function in the firm whose employees are members of the scheme, represent its most likely potential customers. We note that the schemes which Walters claims are about to desert Prime Cure and Carecross in favour of Solutio, appear to fit this profile. If one accepts that much of the growth in the low-income market is going to be in large, national open schemes, this does not, on its own, suggest a significant future role in the relevant market for Solutio.

And nor, when one considers Dr. Walters' views of entry barriers into this market, should his modest view of Solutio's future role be surprising. It is worth quoting Dr. Walters' eloquent testimony at some length.

He describes, in some considerable detail, the steps involved in organising a network of primary care providers. The network to which he refers is clearly an 'open' network, similar to that which Discovery now intends assembling. What emerges from the following quotation is that while it is easy to sign up large numbers of doctors to an open network, it is clearly extremely difficult to utilise this essentially unorganised network as an effective instrument of managed care:

> *"The first step in a network, in a proper network, is to link every single beneficiary in a medical scheme to a certain General Practitioner. The beneficiary must make a decision that this is then the General Practitioner that I am going to consult. The second step is for that General Practitioner to contractually accept all the clinical responsibilities surrounding that patient, that beneficiary. That contract is usually between the doctor and ourselves as a managed care company, as a network company, a managed care company with network capabilities.*
>
> *So the first step, beneficiary links to a doctor. The second step, doctor assumes responsibility. The third step, profiling that doctor to ensure that that doctor meets those contractual obligations. The next step, if the doctor meets*

the contractual obligations which are both financial and clinical, you will reward that doctor. That doctor will get certain benefits from that. Whether it be financial or whether it be that you don't tamper with his practice at all, but there will be rewards in it for the doctor. But if the doctor does not meet his contractual obligations, the doctor is warned. He gets a time period to actually do some self improvement, change his behaviour patterns and if he still does not change his behaviour patters, he is referred to his peers, to his fellow doctors that contractually his (should read 'he's') already selected to be his peers that will review his case if he is errand (should read 'errant').

So, in that case his case is then referred to a group of his peers, who meets like this and they look at all the data and information and they try and help him, but if then he is not…he doesn't prove that he wants to be helped, there are then penalties. He could be kicked off the network. He could ….there are several penalties. Now that peer review mechanism you will understand is critical if you want to have cost effective quality care within a network of doctors. Now, usually we employ the IPA, the local doctor independent practitioners association to perform that function.
[…….CONFIDENTIAL……].*"*

When asked, under cross-examination, why Solutio, despite its formidable managed care capacity, continued to contract with Medicross and Faranani, Walters replied:

"Because we cannot do peer review. It should be the peers that should be reviewing the peers. We cannot unilaterally sit in an ivory tower and structure standards of good practice. We can do that, but it's unfair and it's not good practice to do that, to sit in an ivory tower and say, this is what you shall do. *<u>We've got to collaborate with these people.</u> That works. They're part of the business. They're part of the future. We've got…and if we move towards real risk sharing, then they must be enabled to be part of the risk sharing and this is just building up to that moment in time."(*our emphasis*)*

In the course of explaining why Solutio had found it necessary to hire a third party, […….CONFIDENTIAL……], to oversee the networks with which Solutio was contracted, Walters emphasised […….CONFIDENTIAL……]:

"Pure (this should read 'peer) management being where we identify a certain doctor not meeting clinical or cost effectiveness criteria, we need to refer that doctor to peer group to make a decision about that doctor status. […….CONFIDENTIAL……].*"*

Walter's scepticism of the regional IPAs is reinforced by the store that he sets by *national* networks:

"We need networks with national footprint. Currently we have too few. We

think we've got a network with a national footprint. I'm pretty sure Discovery will have a network with a national footprint. We need networks with a national footprint that can actually compete with one another, and currently we're playing around with small numbers of doctors within networks and uncompetitively priced products. That's the challenge…"

His prognosis for other of the fringe players in the market is equally pessimistic. Of Faranani, he says:

" […….CONFIDENTIAL……]:*"*

Again, on the difficulties of practicing managed care in the low income market generally and, particularly in organising and maintaining networks:

"ADV BERGER*: So you took a decision in 2002 that you had to move into this market, this capitated managed care market…*
DR WALTERS: And into the total networking market, which capitation … I think you are focussing totally on capitation and that might be not the right focus in my opinion. In my opinion the question is have you got an effective network of providers with proper contracts where the members are educated and understand what it is all about. That's the biggest problem why healthcare is failing in South Africa, is members aren't well educated and do not understand what these low-cost options actually mean.
ADV BERGER: Now I assume that takes time to set up such a network.
DR WALTERS: That's the issue. You need to educate the members. You need to have a provincial infrastructure. You need to have client liaison offices that can actually go and talk to the members, let alone the brokers don't tell them the truth or tell them the hard truth. Sorry, I strike that. You need proper brochures, which they never read, which you've got to interpret to them. You need to link them with doctors. You need to educate the doctors. You need to contract the doctors. The contracts need to be quality contracts. They need to have all the obligations written in. You need to then monitor those. You need to profile those. You need to have the ability to interpret the results from the profiling. You need to then develop the contributions and the benefit tables. You need to ensure that the model is viable. You need to go on like this forever. It's a huge amount of building, which we've decided to embark on in 2002 and which is evolving as we speak to meet the needs of the marketplace.
ADV BERGER: So you've been building this for the last 3 years.
DR WALTERS: Yes."

And then, further, Walters provides a graphic description of the difficulty of managing networks in one of the schemes of which he has direct experience:

"DR WALTERS*: You see that's not, it's such a difficult question because there's so much work to be done. You need to go on national road shows, you know with the Sasolmed doctors I have monthly meeting with them on business issues. I have monthly meetings with them on clinical issues, it's a lot of time, it's so time consuming. Now for the IECA network we're doing the same. For*

the DCMED we're doing the same. I'm constantly in the air of going somewhere to meet with them. You need an infrastructure to actually just to organise all these meetings."

And on the importance of financial capacity and the role of the quantum of lives in the entry process, Dr. Walters testifies:

"…ADV BERGER*: Yes. And you also need to have deep pockets, at least in the initial stages.*

DR WALTERS: That's the risk-based capital that you need to set aside, and there is an actuarial formula based on the number of lives and the chronicity, people with chronic diseases and gender and all those kinds of things. There is a formula that you calculate your risk-based capital that you need to set aside."

And further:

"*But as an interim measure you can't capitate all the doctors on the ground. You can only capitate those that have the necessary volume of patients and that have the necessary expertise. So it's a process that you go through in order to have a fully capitated environment. And that's the model that we are … there are also other refinement that you can get pools of doctors and pay them on a budget, which is also a type of risk sharing, although not capitation."*

So, I'm not trying to give you a long story about this. I'm just saying that the capitation that you are talking about is a journey. It's not a snap and there you've got a capitated network. It's a journey."

And clearly it is a journey, the successful conclusion of which requires a well-organised network and a rapid growth in membership.

Despite this apparent state of 'un-readiness' Mr. Walters testified that Medscheme/ Solutio would be tendering for the Sapphire and Topaz low-cost options in the GEMS. Clearly, by Walters own analysis of the requirements for providing capitation – an express requirement of these two options – Solutio is not yet ready. This seems to evidence the widely held belief that the low-cost options on GEMS will grow very slowly.

We have then examined the entry prospects of South Africa's two largest medical schemes administrators. In our view, Discovery's entry is the product of circumstances peculiar to Discovery, in particular its first-mover advantage that has enabled it to begin with a membership base which, though significantly smaller than its targeted projections, will act as an important springboard. However, we are not yet persuaded that even Discovery will sustain this entry.

Medscheme through Solutio is, in our estimation, some considerable distance from a

competitive, sustainable presence in this market. It is, by Dr. Walters' own admission, a late and somewhat reluctant entrant into the low-income market. Solutio has, to be sure, assembled an impressive managed care capacity but this seems to consist largely in a data gathering and analysis capacity directed at reducing costs in Medscheme's traditional middle-to upper-income market. Solutio has a limited track record in the successful utilisation of primary care networks and where this occurred – with the Daimler Chrysler scheme representing its only sustained success – it has been assisted by unusual circumstances.

The merging parties contended that were other fringe players, in addition, that is, to Discovery and Medscheme, that were poised to enter the relevant market. Medical scheme administrators Old Mutual, Sizwe and Metropolitan were mentioned as were the IPAs, regional networks of primary care providers.

The basis for the contention that Old Mutual was contemplating entering the market appears to be its written submission to the Commission in which it indicated a desire to enter this market and a recent letter addressed to doctors in which it appears to be soliciting membership of a primary care providers network. In fact Old Mutual is clearly some way from possessing the attributes necessary to overcome the identified barriers to entry. We have already indicated our scepticism of networks organised in the manner that Old Mutual has chosen. The submission referred to makes vague mention of possible synergies that Old Mutual's property division may provide in the establishment of a network of primary care clinics. Several witnesses – notably Dorfling and Nauta – have called this mode of entry into question. Even if the establishment of a bricks and mortar clinic network is a viable mode of entry it will clearly take some considerable time to set this up. It is clear to us that Old Mutual has not given much thought to entering this market.

Old Mutual does not even seem to have entered the market for the administration of low-income health insurance options. The strongest indication of its intention to do so is its recent acquisition of Sizwe, a small medical scheme administrator that does have exposure to the low-income market. However Sizwe clearly does not have the capacity to provide capitated managed care products for this market. Sizwe's witness in the hearings – Mr. B. Singh – insisted that the regional IPAs constituted a ready supply of primary care networks. He argued that the regional limitations of these networks could be overcome by the expedient of entering into contracts with expanding numbers of these in order to achieve national coverage. Other witnesses have, as noted above, already indicated their scepticism of the IPAs' ability to provide risk-transfer managed care products. We share this. Sizwe's experience of providing risk transfer managed care products to low-cost options appears, not unlike Medscheme, to have been confined to small, regionally confined medical schemes and there is no evidence to suggest that this will translate into a ready ability to serve large, open, national schemes.

We should note that even if the large medical schemes administrators are easily able to overcome the barriers to entry – and we do not accept that this is the case – their presence will provide cold comfort to the smaller administrators and to schemes not administered by the large administrators. The merging parties insisted that the large administrators would be willing to sell their managed care services to those schemes and administrators who do not possess these capabilities. In fact both Mr. Strauss, on behalf of Discovery, and Dr. Walters on behalf of Medscheme, indicated that while they would, in principle, be willing to provide these services to schemes that they did not administer, neither expected this to occur on a significant scale. They reasoned that the administrators of these schemes would fear losing their administration business to the large administrators. Dr. Walters also identified technical difficulties in Solutio providing managed care products to plans not administered by Medscheme:

> *"Now when you ask me about other schemes, the problem is usually the systems. How do you interact and interface with schemes not administered by Medscheme. How do you get the processes to align and the systems to talk to one another. Now, that is a problem. But we've had extensive experience over the years...We've provided services to Prosana, to Open Plan, to Transmed, to Bestmed, to Lamaf (should read 'Camaf'), to Munimed, to Selfmed and to Topmed. Over time we've made a corporate decision. A corporate Medscheme decision was made to focus more on the schemes that are administered by Medscheme.*

It makes it easier. It makes for more efficiency and therefore our costs come down. Our prices come down. So, we have to a large extent got rid of these schemes."

In summary we do not believe that the barriers to entry will be overcome easily or rapidly by either the administrators or by other primary care networks such as the IPAs. We do, however, believe that the most likely source of competition for the two largest players in the relevant market that we have identified, namely Carecross and Prime Cure, is likely to emanate from Medicross/Netdirect. Medicross is already in this market albeit at the higher end. It also has an established clinic network which Mr. Dorfling indicated would constitute the 'hub' of a larger primary provider network. The Netcare group has, for long, attached importance to the assembly of a network of primary care providers and Netdirect is living proof of this. Although the network is not tightly organised, the networks of clinics that belong to the merging parties alone will facilitate the development and tighter co-ordination of the more extensive doctors' network. Also Netcare has attempted to cement the ties between the Netcare group and the doctors' network through enabling the doctors to participate in Netcare equity. In short, conditions favour an early Medicross/Netdirect entry, a process which, in fact, appears to be well under way.

We conclude then that the entry barriers surrounding this market are indeed formidable. Nor, despite Discovery's recent decision to enter the market, are the

large players like Medscheme well positioned to enter this market in the near term. Discovery's ability to do so is strongly conditioned upon its early entry into the low-income health insurance market.

The level and trends of concentration, and history of collusion, in the market

This is, as we have earlier observed, a new market. It is also a market in which sustainable entry has proved manifestly difficult. The evidence is that several large and reputable firms have entered the market only to exit, having failed to develop a sustainable presence. The market is, accordingly, highly concentrated. This merger would serve to increase that concentration. Only three firms (Carecross, Prime Cure and Medicross) have managed to sustain a presence in the market with a small number of others operating on the fringes of the national market (Faranani) or in regional niches (several IPAs). Not only does this transaction merge the second (Prime Cure) and third (Medicross) largest of the three firms that have proved capable of sustaining a presence in the national market, thus accounting for the Commission's description of this as a 'three to two' merger, but it will result in the co-ordination of the merged entity with the only would-be entrant, Netdirect, that is well positioned for entry in the relatively short term. Hence the level of concentration is high and this merger exacerbates this. To the extent that the embryonic nature of this market permits of any trend analysis, the high failure rate of would-be participants may be said to point towards a trend towards greater concentration.

There is no evidence that suggests collusion between the existing participants in the relevant market. We note, however, that should one of the non-Netcare hospital groups, namely Mediclinic and Life Healthcare, wish to participate in a full risk capitation scheme (that is, a scheme that offers capitation at the primary, secondary and tertiary care levels) it will be obliged to offer its services to a managed care provider capable of delivering primary care services to low income options. To the extent that Netcare's rival hospital groups are reluctant to enter into a full-risk capitation arrangement where the primary care component is in the hands of a member of the Netcare group, it will be forced to turn to the only remaining provider of these services, namely Carecross, which will thus enjoy considerable market power in relation to the those who will find it necessary to partner with it in order to participate in the provision of full-risk capitation. Mr. Brian Davidson, the Life Healthcare group representative who testified at these hearings, clearly indicated his discomfort at Life Healthcare assuming risk in respect of tertiary provision where the primary component was in the hands of an 'unfriendly' party:

> *"Now there is a, I am using this by way of example to answer your question, there is a provision made for a primary care network service the same as Gems option and we're saying to ourselves, hang on, if say we have a non-friendly, to use that word, primary care network or a primary care network that belong to one of the competitors, is that additional risk to us? Is it*

possible that they could pass on or cost shift the risk to the hospital's little cost centre. I don't know who is going to be the managed care organisation who is going to be managing the risk between all of the parties who will be contracting with this particular option, because that again is also out for tender as is the Medical Scheme Administration itself.
I would like to, we would like to think that a neutral efficient and effective managed care organisation should be able to correctly manage and prevent any cost sifting between the various institutes. I am not an expert at that process, therefore I don't know how it is going to work. So, to answer your question a long way, we would be worried about contracting with one of our competitors' subsidiaries for that reason".

However, even more disturbing from a competition point of view is the prospect that Netdirect's entry into this market will facilitate collusion in the all-important private hospital market. Three possibilities arise from the participation of Netcare group interests in primary care provision for low income consumers. Either this will effectively preclude – or, at least severely discourage - the other hospital groups from participating in the tertiary component of full risk capitation (thus giving Netcare- associated companies market power in relation to the purchasers of full-risk capitation) or, as outlined above, it will effectively oblige those of Netcare's rival hospital groups who wish to participate in the provision of full-risk capitation to purchase the primary care component from Carecross (thus giving it considerable market power). But possibly the most disturbing prospect is precisely that Netcare's rivals will find their way clear to negotiating their participation in the tertiary component of a full-risk product with a managed care company that is part of their rival group. This will mean that Netdirect, part of the Netcare group, will be negotiating capitation fees with Mediclinic and Life, Netcare's rivals in the private hospital market, thus further facilitating the flow of information between the hospital groups and this explicitly in the areas of costs and prices and covering the core competitive strategies of the three groups. This is of particular concern in a market that well-placed commentators have already described as a cartel. A previous decision of this Tribunal noted the following assessment by an investment banker of the private hospital market:

"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 ("HASA") – have managed to standardize industry pricing by agreeing set tariffs with the Medical Aids represented by the Board of Healthcare Funders ("BHF")…

The key issue will be the extent to which the dissolution of the formal, collective price setting arrangement in favour of one-to-one negotiations will increase the likelihood of price competition amongst the primary service providers. On the face of it, the encroachment of the Government on the

private sector (via the establishment of private wards) and the diminishing growth opportunities in the top end of the local market could provide an incentive for one of the primary service providers to break ranks and initiate a price war in order to increase market share and sustain the growth performances that shareholders have grown accustomed to. This is, in our view, unlikely. The primary service providers have operated as a cartel over the past 3 years and have established exceptionally healthy profit margins".

The Tribunal went on to note that, Mr. Richard Hogben, a previous CEO and Chairman of Afrox Healthcare and currently a non-executive director of Life Healthcare, in commenting on this assessment, conceded that the private hospitals did not compete on price. He described the competitive dynamics of the market in the following terms:

> "…The basis of competition between private hospitals is about several elements, of which price is not really one…The basis of competition between a hospital is distinct units. It's about its location. It's about the quality of the doctors that it has that work there and the quality of the doctors that work in those hospitals is really driven in many ways by the quality of the hospital facility and the quality of care that is given in that hospital…The question of price as a competing factor between the hospitals is of lesser significance, unless it becomes extreme."

We recognise that this may not be a merger-specific effect. Netdirect will enter the market regardless of this transaction and so the opportunity for information sharing that it provides will be there whether or not the merger takes place. However, the removal of a rival – Prime Cure – to Netdirect and Medicross, increases the likelihood of a relationship between Netcare, on the one hand, and Mediclinic and Life Healthcare on the other and certainly aggravates our concerns regarding the future state of competition in a vital related healthcare market.

The dynamic characteristics of the market, including growth, innovation and product differentiation

We have already commented at some length on certain of the dynamic characteristics of this market. In summary, this is a market whose environment is unusually fluid and uncertain. Direct government provisioning – most notably in the supply of hospital services – is a ubiquitous feature of the market and will remain so. This impacts on the supply of all healthcare services and products, including pharmaceuticals. Private provisioning of healthcare services is, if anything, more pervasive but it takes place in the context of wide-ranging regulation including of medical insurance and private hospital services as well as regulation of the production, patenting, licensing, dispensing and distribution, both wholesale and retail, of pharmaceutical products.

The complexity that characterises the surrounding environment is immeasurably compounded by the state of flux that seems to have become, both in South Africa

and elsewhere, a constant feature of the regulatory framework as governments everywhere struggle to ensure the supply of basic healthcare services to all of their citizens without massively compromising fiscal stability and sustainability. South Africa has certainly not escaped this experimentation in healthcare provisioning, its own efforts severely complicated by the AIDS pandemic. The courts, including the Constitutional Court, have played and will continue to play a central role in determining the character of the healthcare system with some crucial judgments pending and further litigation undoubtedly in the pipeline.

Moreover, government intervention in healthcare provisioning has direct reference to the market implicated in this transaction. We have outlined, at some length, government efforts to relieve the overstretched public healthcare system by moving a large proportion of those who utilise it to a private healthcare system that, particularly in the supply of private hospital services, is characterised by significant excess capacity. In order to realise this objective, private healthcare funders are under considerable pressure to design insurance options that are affordable to the large low- income segment of the population and that, in turn, can only be achieved through the development of mechanisms that lower the cost of primary, secondary and tertiary healthcare, including the cost of pharmaceutical products.

To this end government has registered a medical scheme – GEMS – that includes options directed at low-income consumers. It has called on private sector firms to tender for providing the array of services necessary for the effective functioning of the planned new insurance scheme. Evidence submitted to these hearings has revealed the significant lack of certainty amongst key players in the healthcare sector regarding the future character and size of this scheme. And if other experiences of government intervention in the healthcare system are anything to go by, litigation will inevitably accompany the process of getting this ambitious intervention off the ground and, in particular, the process of awarding the tenders.

As already elaborated, the parties to the transaction before us are amongst those very few entities in the healthcare market that have successfully delivered private healthcare to low-income consumers. This has involved considerable risk, the surmounting of significant entry barriers and constant innovation and experimentation. But the market is still in the early stages of its development. In this unusually dynamic context it is our view that competition authorities should approach private interventions that will impact on the structure of the market with considerable circumspection.

We know that the Netcare group will, through the medium of Netdirect/Medicross, intensify its participation in this market irrespective of whether or not this merger goes ahead. This is to be welcomed and encouraged. Mr. Dorfling has clearly indicated that he believes that there are sustainable low-income options that do not rely on capitation. The clinic networks of Medicross and Primecure feature prominently in his conception of the low-income product that is to be offered as

does Netdirect's primary care providers network. The vertically integrated Netcare group may permit of modes of provision that are denied others who do not enjoy these links with secondary and tertiary providers. There is undoubtedly significant room and an urgent requirement for experimentation and innovation. We have little doubt that a significant merger in this embryonic market will slow the pace of innovation, it will reduce the number of alternative modes of provision on offer, and it will likely slow the pace at which new forms and concepts of low-income healthcare insurance are introduced.

The parties insist that GEMS and other government initiatives guarantee rapid growth in the demand for managed care products for the low-income market and that this will assure entry by players that have shown little appetite for serving low-income consumers. The record clearly shows that up until now the development of this market has been slow and has not lived up to the expectations of experienced healthcare providers. For example note that even the aggressive and innovative Discovery has fallen significantly short of its predictions for growth in Key Care, its low-income option. In 2003 Discovery had projected that within 2-3 years (that is, by 2005), the number of lives on Key Care would be [confidential] when, in fact, Key Care only currently covers approximately [confidential] lives.

Nor was the view that GEMS would account for massive, rapid growth in the market shared by all of the witnesses in these proceedings, Dr. Nauta, for example, said:

> *"…there's a promise of many lives, up to millions. I'm very sceptical about the ability to have a scheme of that size go so quickly. I just look at Discovery's own growth, which took them 10 years to get them to where they are and this scheme says, I'm going to do twice as much in, you know, one year, its going to be very difficult and keep in mind, those lives are all essentially forced onto this.*
>
> *So when you force a life into a scenario, you really need to be ready to deliver and the doctors must be there and it must go smooth, otherwise people just won't go. It's different when you voluntarily buy with all sorts of other promises the way, you know, good, open schemes have done. So you're asking me what I think about them? I suppose it's coming. It's been postponed by a year already in the past. To really have a big thing up and running in 4 months from now, I think is totally impossible, but if it's a voluntary scheme and it says, guys you want to join, join, then it will slowly grow and whether that growth rate is going to get them to 4 million or 2 million, whatever."*

Indeed, Nauta argued persuasively that the interest taken by most of the established medical schemes and medical schemes administrators in the GEMS tender – and which the parties have cited as evidence of significant new entry into this market - was centred around the prospect of losing existing insured lives in the public sector, rather than at the prospect of gaining thousands of new, hitherto uninsured lives. In other words, those interested in the GEMS tender are, argues Nauta, not

necessarily bidding for low-income lives. They are bidding for the lives of those members of the public service who are *currently* insured, those able to afford insurance at present levels and so who have joined existing schemes aimed at high- and middle-income earners:

> *"They have them right now. They will lose them. Forget about the new 500 000 that are going to come into the kitty still.*

My personal conviction right now is that nobody really is there yet. We just need to not lose suddenly 50 or 100 000 lives. There are at least 20 schemes that could go out of business because they're small. They'll never get in here. But they have 10 000 lives. Small schemes like Conmed, run very successfully. Suddenly we know their stats, it happens, and 80% of their lives will disappear. So everyone gets in there to keep what they have, is my real view right now. And it's logical that you'll do it. It's easier to keep to what you have then to get the new stuff. And that's where particularly Discovery, who has just got Lamaf, which is a big scheme, in the semi-state, state world, they'll lose them if they don't get into this fold. So I think that is the motivation right now.

> *And clearly if one day the State has enough money to subsidise the rest and get them all in, that'll come proportionally to those same players."*

Mr. Davidson, the witness from Life Healthcare, is also relatively modest in his predictions of the conversion of currently insured public sector employees to GEMS. The success or otherwise of the conversion – which Davidson refers to as the 'first phase' – will determine how government enters the second phase in which those who currently fall out of the net of insured lives will be offered low income options. But that will still pre-suppose a significant subsidy from government.

The Commission's expert witness, Mr. Hodge, underlined the significant uncertainties surrounding the growth of GEMS and in particular the inability to predict which of those converting out of their existing schemes would opt for the capitated options within the GEMS boutique.

Dr. Walters expressed the view that it would take 'years' for GEMS to grow significantly. He conceded that he had 'no idea when the market will grow and how large the market will grow'. However he clearly acknowledges that Solutio will only gradually evolve from a company focused on 'benefit management' – the form that managed care takes in relation to the middle and high income insurance options – to one focused on 'relationship management', the form that managed care will take in relation to low income insurance options. This suggests that he expects a slow and gradual growth in the number of low income lives signing up for GEMS.

Mr. Singh of Sizwe, called by the merging parties who identified Sizwe as an active

participant in the low income market, clearly articulated the extreme uncertainty surrounding GEMS and the growth that it was expected to generate:

"*Mr. Singh: Chairperson, I could also say that there is a potential of 400 000 members. Like I said earlier, there is no science or any survey to say that the models or the products offered by GEMS is going to be affordable.*
Chairperson: Yes
Mr. Singh: So one of the scenarios then I could paint to you is that no one of those 400 000 members will join GEMS again because of affordability."

The evidence then suggests not so much the certainty of rapid growth – as claimed by the merging parties - but rather the significant uncertainty surrounding the scale and character of that growth. In particular, all the witnesses concurred that, in the initial years of the GEMS product, the focus would be on the migration of those currently insured from their existing schemes to GEMS. The low-income options in which, to use Dr. Walter's characterisation, 'relationship management' rather than 'benefit management' was key, are some years off. For the first years of the GEMS era, the schemes will be intent on maintaining their existing membership in the public sector.

We conclude then that the dynamic features of this market and its surrounding environment serve to reinforce the likelihood that the merger will substantially lessen competition. It is a new market surrounded by considerable regulatory uncertainty. The further development of the product in question – capitated primary managed care - demands high levels of risk-taking and investment in innovation and experimentation. It is a market in which those concerned to promote competition would wish to emphasise the importance of new competitive entry and innovation of the sort promised by the acquiring party if its attempts at entry through merger do not succeed. We find that the further dynamic feature said to characterise this market – the rapid and significant levels of demand growth that the parties have predicted and which they rely upon for their argument that new entry will be significant – is less certain both as to scale and direction than that predicted by the parties.

The nature and extent of vertical integration in the market

There are only three firms of significance in the market. Of these, one – Medicross - is part of a larger healthcare group, the Netcare group of companies. Our impression is that, with the significant exception of the Netcare group, the healthcare sector has not been characterised by significant vertical integration. This merger represents an extension of the degree of vertical integration in the market. Discovery Health's announced intention to enter the market represents another instance of vertical integration. It was suggested that as regulatory interventions limit returns in parts of the health value chain – for example in schemes administration, in private hospitals and in pharmaceutical distribution – the large players in these markets will look to profit from participation in other

parts of the health value chain.

The vertical issues at stake in this transaction were extensively canvassed in the hearings and are examined below.

Whether the merger will result in the removal of an effective competitor

As already extensively elaborated this is a merger of two of only three significant players in this market. There can be little doubt that, from this perspective, the merger results in the removal of a significant competitor. Prime Cure's successful participation in this market rests on its network of primary care clinics and the larger primary care providers' network that it has established. Several witnesses – including Mr. Dorfling insisted that the establishment of a new clinic network no longer offered a cost effective basis for entry into the market. However, it is also clear that the existing clinic networks owned by Medicross and Prime Cure would constitute the 'hub' of the merged entity's strategic approach, with the extensive Prime Cure and Netdirect primary care provider networks comprising the 'spokes'. The obstacles in the way of the formation of a new clinic network, combined with the support for an approach to managed care in the low-income market that relies on the combination of a clinic network and a primary care providers' network, serve to reinforce our view that the merging of the only two entities that command access to both clinic and provider networks removes an effective competitor in circumstances where the competitive advantage enjoyed by the target company will not be easily replicated.

Although it was suggested that the target firm, Prime Cure, has, in the recent past, experienced financial difficulties, the failing firm defence was not invoked by the merging parties. It appears that earlier efforts to sell Prime Cure had foundered because of the difficulties it was experiencing at the time. It then appeared that the Prime Cure shareholders became actively engaged with the management of the company in an effort to place the company on a sounder footing precisely on order to enable the shareholders to exit their investment. Medicross' desire to absorb Prime Cure suggests that these efforts to turn around the target have borne fruit.

The successful turnaround of Prime Cure notwithstanding, its shareholders still intend to exit the investment. This was confirmed by Mr. Patterson, a witness representing Prime Cure's largest shareholder, Brait. Patterson noted, however, that a rejection of this transaction on competition grounds would significantly hamper efforts to sell Prime Cure which, he averred, would only attract a suitor from within the industry. However, if other institutional investors are persuaded that Prime Cure has a foothold in a market which is poised to grow significantly and in which entry barriers limit the prospect of new entry – views that, as we have elaborated, appear to be held by the both of the merging parties – then there is no obvious reason why new buyers should not be found.

Nor does our finding that the merger currently proposed is likely to lead to a

substantial lessening of competition preclude other firms in the healthcare sector from acquiring Prime Cure. This decision is predicated on the fact that the buyer is already active in this market and that the group of which the acquiring firm is part is well placed to intensify its involvement in the market even in the absence of the proposed merger. There are many powerful entities in the healthcare sector that are not in the same position as Medicross/Netdirect and to whom the same strictures are, accordingly, unlikely to apply. The Prime Cure shareholders may, to be sure, have to forgo part of the 'strategic' premium that Medicross is willing to pay. However, in our estimation, the 'strategic value' amounts to little more than the market power that will accrue to the acquiring firm from the elimination of one of its few competitors and the heightening of entry barriers that will confront new entrants, even those would-be new entrants already active in the broader healthcare sector.

The acquiring company has also attempted to justify the merger on the basis that the merged entity will, as a result of the combination of the assets of the two companies and the financial strength of the Netcare group, be better placed to develop cost-effective products for health insurance options aimed at low-income consumers. This argument may have some salience in circumstances where the market is increasingly dominated by a firm that is not party to the merger and where the merger is then effectively a defensive response to the growth of that rival. However, this is clearly not the case here and there is no *a priori* reason why the effect of the lessening of competition in consequence of the merger should be countervailed by the superior resources of the merged entity. This is, in effect, an efficiency argument and, as such, is dealt with below. We have, in a previous decision, indicated our scepticism of this argument for a more 'effective' competitor and then in a situation where the need for a defensive strategy against an increasingly powerful competitor was more clearly established than in the case of the transaction presently before us. In the circumstances of the present market we have two firms – Carecross and Prime Cure - of broadly similar strength, and a third – Medicross/Netdirect – that is well placed to compete effectively with the two market leaders. Each of the firms has distinct competitive strength and strategies. They should be afforded every opportunity to develop these.

We find, then, that the horizontal dimensions of this merger are likely to lead to a substantial lessening of competition in the relevant market.

The Vertical Dimensions of the Merger

The Commission, as well as a number of witnesses who testified at the hearings – notably Mr. Strauss of Discovery Health, Mr. Davidson of Life Healthcare and the Council for Medical Schemes – have made much of the vertical dimensions of this transaction. However, while the Commission is clearly concerned at the impact on competition of the transaction's vertical aspects, it is not certain how much weight these considerations were given in its decision to recommend that the merger be prohibited. It is our finding that the merger falls to be prohibited on its horizontal

dimensions alone. While the Commission's careful scrutiny of the vertical dimensions of this merger is well-advised and the anxieties of the witnesses regarding the progressive vertical integration of the Netcare group is appreciated, the evidence does not lead us to conclude that the vertical dimensions of this transaction will give rise to a substantial lessening of competition in the relevant market.

Simply stated, the vertical dimensions arise from the expansion, through the merger, of the Netcare group's association with primary care providers, that is, with general practitioners, who are the key conduit through which patients are referred to specialists. The overwhelming proportion of South African specialists are associated with one or other of the three large national private hospital groupings –indeed it appears that the private consulting rooms of a large number of South African specialists are typically located in a private hospital belonging to one of the three groups. The concerns of the Commission and the witnesses are rooted in the allegation that the referral practices of the practitioners associated with the Netcare group will reflect the interest of the group's core investment – that is, its network of hospitals – rather than the interests of consumers or of those who fund the consumption of hospital services. By the same token, it is alleged that the resulting distortion in referral patterns will favour the Netcare hospital group at the expense of its rivals.

There can be little doubt that vertical integration lies at the heart of the Netcare group's competitive strategy. Equally there can be little doubt that the core objective of this strategy of vertical integration lies in its putative ability to influence referral patterns in Netcare's favour. Thus, it is plain to see that the hospital group has literally surrounded itself with the key platforms of hospital referral – an ambulance service, a pathology service, a dialysis unit and primary care services. With respect to primary care services – the area that we are called upon to examine in this transaction – it is important to recall that it is not only through Netcare's control of the Medicross clinic network that its relationship with primary care providers is effected. It is also cemented through Netpartner and Netdirect. Note, as already elaborated, that Netpartner is controlled as to 48% by Netcare and as to 52% by some 9000 healthcare practitioners, the majority of whom are primary care providers. Netpartner is, at 17.5% (at the time of the merger hearings), the largest single shareholder of the listed entity, Netcare. Netpartner wholly controls Netdirect, which offers full risk capitation products including a network of primary care providers who service the primary care component of the full risk product. It is to be expected that many of the 800 members of the Netdirect network of primary care providers are to be counted amongst the 9000 medical practitioners who hold equity in Netpartner and, through Netpartner, in Netcare itself.

The attempt by Mr. Dorfling to cast these arrangements with medical practitioners as nothing more than a goodwill-building strategy is thoroughly unpersuasive. There are constant references throughout the relevant parts of the record to the

'gatekeeper' role played by medical practitioners. Netcare itself, and specifically in relation to this transaction, reckons its potential gains by reference to the positive impact that it will have on referrals. There is little doubt then that Netcare is not merely concerned to befriend the gatekeeper; it is concerned to align the interests of the gatekeeper with those of the Netcare hospital group. We have to satisfy ourselves, firstly that the gatekeeper is an effective gatekeeper – that is, can the gatekeeper determine the identity of those who pass through the gate. And, secondly, even if the gatekeeper is effective, we must ask ourselves whether this is likely to substantially lessen competition.

The interests and concerns of the industry players – Davidson and Strauss – who professed concern at the vertical dimensions of this transaction are reasonably clear. Mr. Davidson, who represents a competing hospital group, is concerned that the Netcare-aligned practitioners will favour the Netcare hospitals and this in one of three ways. First he fears that these practitioners will 'under-refer' patients to Netcare's competitors or, conversely, that they will 'over-refer' to Netcare hospitals. In a context where all the private hospitals experience significant excess capacity this is, of course, a serious concern for Netcare's competitors. Secondly, he fears that, in certain circumstances, the Netcare-aligned practitioners will *over*-refer to Netcare's competitors or, conversely, *under*-refer to Netcare hospitals. Thirdly, and a variant of the second concern, he is concerned that the Netcare-aligned practitioners may *selectively* refer as between the three competing hospital groups so as to favour the commercial interests of Netcare.

These concerns which, on the face of it, appear mutually exclusive, do indeed arise under different incentive regimes. Firstly, where a patient is on a full fee-for-service option, that is, where each engagement with a primary, secondary and tertiary provider is covered by medical insurance (albeit subject to managed care interventions such as hospital pre-authorisation), then, while the incentive of each provider is to retain the patient as long as is feasible (that is to 'over-treat' at each stage), once a referral is medically indicated, then the incentive of the referring primary care practitioner is to refer the patient to an allied secondary and tertiary provider. In this incentive regime, the secondary and tertiary provider will be happy to accept this referral because the medical insurance cover of the patient fully covers both of these treatment stages.

Secondly, however, where a patient is on a capitated primary care option but has fee-for-service cover at the secondary and tertiary stages, the incentives shift significantly at the primary stage of treatment but remain the same at the secondary and tertiary stages. The primary care provider is incentivised to refer the patient as soon as possible – to 'under-treat' - but the incentives of the secondary and tertiary providers remain as outlined in the previous paragraph. That is to say, the secondary and tertiary providers are pleased to accept the patient because her treatment at this stage is fully insured by her fee-for-service cover at these stages.

In the two incentive regimes described above, a primary practitioner aligned to a secondary and tertiary provider will be incentivised to support his ally. That is, he will refer his patient to his allied secondary and tertiary provider. The second of the regimes described – that capitated primary care and fee-for-service secondary and tertiary care – is particularly attractive to the allied secondary and tertiary providers because the primary care provider is incentivised to 'under-treat' or, what is the same thing, 'over-refer'.

The third incentive regime is where the patient is on 'full-risk capitation', that is where each provider – primary, secondary and tertiary – is capitated. In this regime, each provider is incentivised to under-treat, that is, over-refer. Accordingly here, a primary care provider allied to a secondary and tertiary provider is incentivised both to under-treat and to (over) refer to the *competitors* of his allies at the secondary and tertiary stages. As already indicated, Mr. Davidson expressed concern that under this regime – as he put it, a regime where the primary care provider is in 'unfriendly' hands – the primary care provider may well fine-tune his referrals and refer treatment that would not exceed the capitation fee to his allies with the costly treatments that exceed the capitation fees going to the competitors. As caricatured in the hearing, a Netcare-aligned primary care practitioner may refer the appendectomies to his allies and the liver transplants and hip replacements to his allies' competitors.

Mr. Davidson was unable to produce evidence that suggested that this sort – or, for that matter, any sort - of distortion in referral patterns actually occurred. Where the regimes that involve capitation are concerned, this may be because capitation is in its infancy and the evidence has not started to come through. And of course it may be because primary care providers are neither willing nor able to distort referral patterns in this way.

Mr. Strauss of Discovery did testify that Discovery's data suggests that referrals from Netcare-related platforms exceeded the hospital group's market share. While the merging parties did not put up alternative evidence they argued that a range of ethical, practical and contractual considerations severely limit the ability to influence GP referral patterns.

The parties made much of the argument that ethical considerations would limit the extent to which primary care providers responded to incentives designed to influence their referral patterns. These considerations militate against under-treatment in general as well as against a referral pattern that privileged, for commercial gain, referral in favour of a particular secondary or tertiary provider. Mr Dorfling testified that in terms of practice protocol laid down by the Health Professions Council of South Africa, ("HPCSA") – he referred to a policy document on undesirable business practices and to a policy statement pertaining to perverse incentives and related matters - if a practitioner is found guilty of any form of channelling, he would lose his licence to practice medicine. Dorfling also testified that a Netcare committee, chaired by the Chairman of Netcare, closely

monitored inappropriate referral patterns that may arise through the operation, in the Netcare group, of these incentives.

The material incentive for a primary care provider to favour Netcare hospitals appears to reside in the indirect shareholding that a large number of primary care providers hold, through Netpartner, in Netcare. The merging parties demonstrated that the size of the effective incentive to the doctors was insignificant.

Nor, argued the parties, were the material gains to Netcare hospitals of much consequence. The parties tracked referrals from Prime Cure clinics to hospitals and showed that any impact on referral rates arising from the absorption of Prime Cure into the Netcare stable would be insignificant. They argued that referrals from Medicross did not reveal a pattern that favoured Netcare. Under Discovery's Foundation plan, where there was an open network of hospitals, the referral to Netcare hospitals approximately equated to the hospital group's overall market share.

There are, of course, contractual arrangements that directly require referral to pre-selected tertiary providers. These are the so-called preferred provider options in terms of which referrals to the designated tertiary providers are mandated by the scheme. However Mr. Dorling argued that the preferred provider arrangement would have to be registered with the Registrar of Medical Schemes. If the Registrar held that patients were prejudiced by the preferred provider arrangement, he could refuse to register it.

The parties also insisted that it is very difficult change the referral patterns of general practitioners. They pointed out that most referrals to tertiary care facilities were made by specialists and that the pattern of GP to specialist referral is governed by a number of highly idiosyncratic factors, mostly of a personal nature – university and other social ties featured strongly amongst these factors. Accordingly, insisted Mr. Dorfling, the only effective way to alter an entrenched referral pattern was through an enforceable scheme rule.

The parties claimed that a number of prosaic but important issues overwhelmingly determined referral patterns, for example proximity, the more so in a income community where patients and their families are sensitive to transport costs and distances. Therefore, if patients are in close proximity to a Life or Mediclinic hospital, they will be referred there, regardless of whether the primary care provider belongs to a network owned by the Netcare group.

Finally, the merging parties argued that skewed referral patterns would be detected and disciplined by medical schemes, the more so if Netcare hospitals were – as the disputed evidence submitted by Mr. Strauss purported to demonstrate – more expensive than the other hospital groups.

In short, the Commission did not present evidence that established that the vertical

integration that characterises Netcare distorted referral patterns, although Mr. Strauss did present disputed evidence to this effect. Ironically there can be little doubt that Netcare's intent in building its vertically integrated structure is precisely to influence referral patterns. However, there is little evidence that this has succeeded. We concede that it is possible that even influencing referral patterns at the margins may, in a business where risk and return are so finely balanced, wreak considerable harm on competitors, and it is clearly these calculations that underpinned Mr. Davidson's concerns that are outlined above.

However, the evidence does not justify this conclusion and, even if it did, it is not clear that this would amount to a substantial lessening of competition. The Commission conceded that there was no evidence or even likelihood of foreclosure. While foreclosure may not be the only mechanism whereby a vertical merger threatens competition, it is the most common and, in the absence of an alternative theory and supporting evidence, we conclude that there is no evidence that the vertical dimensions of this merger will give rise to a substantial lessening of competition.

Efficiencies

Having found that the merger is likely to substantially lessen competition in the relevant market, we are required, in terms of Section 12A(1)(a)(i) to assess whether it will result in any technological, or other pro-competitive gains of a magnitude sufficient to offset the lessening of competition. Note that the Act specifies that we should only have regard to those efficiencies that, but for the merger, would not have occurred.

In their competitiveness report and through their expert's testimony, the merging parties claim various efficiencies. In their closing arguments however, they did not appear to rely very heavily on the efficiencies claimed. The parties' heads of argument make scant reference to efficiencies. We are not sure whether they have abandoned these claims but deal with them here anyway.

Dr. Stillman, the expert for the merging parties gave evidence of the perceived efficiency gains that would accrue from the merger. The efficiency arguments are, as noted above, predicated on the claim that the combined assets of the merging parties will better support the development of low-cost options in a market that will soon witness a significant boost to demand. The merger with Prime Cure will give Medicross access to Prime Cure's experience in providing primary care to the low-income market, and ensure that Prime Cure is assisted by the financial resources of Medicross. The merging parties claim that Netcare's financial resources will strengthen Prime Cure's balance sheet. Stillman averred that even when the medical scheme passed risk from

itself to a capitated managed care provider, it was still obliged to concern itself with the question of the financial strength of the provider, because if the capitated provider proves unable to meet its obligations, residual liability remains with the scheme. Therefore, schemes are generally more interested in a provider in a capitation arrangement if the provider has a strong balance sheet. However, Stillman himself questions whether this is a merger-specific efficiency – as we have already observed Prime Cure has access to alternative sources of capital and other equity investors, particularly if the capital market shares the merging parties predictions regarding the growth of this market. This merger does not exhaust potential sources of capital investment.

Stillman identified Prime Cure's business processes for implementation of managed care protocols as a further source of efficiency. This includes working information technology systems and processes for micro-management of doctors that Medicross could apply to roll out its Netdirect offering. Again Stillman acknowledges that these are facilities that Medicross itself could purchase and implement but claims that it would take between 18 and 36 months to have these fully operational. Contrary to Stillman's stated view we do not view these efficiencies as merger specific.

The third category of efficiency Stillman lists is savings in infrastructure cost. Stillman indicates that the merger would allow the merging parties to save some R6-R8 million per year through the elimination of duplicate activities in respect of human resource staff, call centre and finance staff, as well as other infrastructure. However, Stillman conceded that these figures were not independently analysed by him but were derived from savings estimates given to him by the merging parties. Note however that a particularly comprehensive due diligence prepared by the acquiring company concluded that are no "back-office" savings to be gleaned from this merger. The LCIM, prepared on behalf of the target company and which has been described as a 'selling document', supports this conclusion. A series of retrenchments effected in recent months led to the conclusion that excess labour costs had already been squeezed out of the target company and that there is very limited room for further cost reduction. The due diligence report and LCIM memorandum from Prime Cure both say that there are very limited back office savings.

> "*We are of the opinion that very little additional overhead synergies can be extracted as a massive restructuring involving 125 employees have taken place in the last 18 months.*"

The commission observed that the alleged infrastructure savings of R6 to R8 million are unsubstantiated and also drew our attention to the conclusions in Prime Cure's limited confidential information memorandum regarding efficiencies.

Dr. Stillman nevertheless insists that his discussions with Medicross reveal that they will, in fact, eliminate duplicate back office functions. He acknowledges that these efficiencies are not generally given much weight by competition authorities. This is the view taken by this tribunal in an earlier decision:

> *"Areeda treats plant size and plant specialization economies as those most worthy of recognition but is more sceptical about claims for others frequently raised which he describes as "ordinary efficiencies" e.g. distribution, procurement and overhead economies"*

Stillman also mentions tax savings consequent upon the merger although he concedes that these "are absolutely never considered a merger specific efficiency and never recognised". This is also congruent with the view of tax savings and other pecuniary gains taken by us in *Trident Steel :*

> "Pecuniary efficiencies would not constitute real economies nor would those that result in a mere redistribution of income from the customers, suppliers or employees to the merged entity. Without categorically rejecting them we would be more sceptical than the Canadian courts in accepting certain efficiencies such as administrative efficiencies since these can be established in most mergers."

Finally, Stillman also argued that the Prime Cure clinics would benefit from the application of the approach taken by Medicross' medical centre model (that is, the clinics) if it could be applied to Prime Cure centres. It appears that Medicross clinic facilities assemble a larger and more diverse grouping of healthcare professionals than does Prime Cure and that this generates certain scope and scale economies which are not generated through Prime Cure's more restricted utilisation of its clinics. However we are not able to evaluate this claim on the basis of the evidence presented. He also argued that converting Prime Cure clinics to a fuller service model would create additional opportunities for members of the South African Medical and Dental Practitioners, ("SAMDP") a group of black doctors and dentists indirectly affiliated with Medicross. However, he could not adduce any more precise evidence in support of this claim or ascribe it any economic value.

Dr. Stillman also argued that vertical integration would improve pricing incentives. He suggested that Netcare's participation in Netdirect's full-risk offering enabled the hospital group to segment its market and to price at the margins appropriate to each segment. Again it is difficult to see how this is a merger specific effect – it should be equally attainable to any hospital group that participates in any full-risk offering. It is not immediately apparent why the tertiary provider and the managed care provider have to be part of the same corporate structure to achieve this efficiency.

We are not persuaded that the efficiency gains claimed outweigh the anti-competitive effects of this merger. The parties' own expert acknowledged that many of the efficiency claims were not merger-specific. Certain of the claims were contradicted in several important documents, for example in the detailed due diligence report.

We therefore conclude that the efficiencies claimed do not countervail the lessening of competition to which the transaction will give rise.

Public Interest Issues

244. These were not argued and we agree with Commission that there are no public interest factors which would justify approval of this merger.

Order

We find that the horizontal dimensions of this merger are likely to lead to a substantial lessening of competition in the relevant market. We also find that there are no countervailing efficiencies or public interest considerations. We have accordingly ordered that this merger be prohibited.

_____________ 13 October 2005

D Lewis **Date**

Concurring: Y Carrim, L Reyburn

For the merging parties: Adv. D. Unterhalter, instructed by Webber Wentzel Bowens Attorneys

For the Commission: Adv. D. Berger, instructed by Attorneys