

Agenda

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Partial acquisition: lessons from hospital merger assessment in South Africa

Life Healthcare Group, a national private hospital provider in South Africa, has increased its stake in Joint Medical Holdings, a private hospital group in Durban, from 49% to 70%. Despite the concern of the South African Competition Commission that the merger would result in a combined market share of over 45% in the Durban area, it was unconditionally cleared by the Competition Tribunal in 2012. What arguments did the parties put forward?

Life Healthcare Group (LHG) is one of three major national providers of hospital services in South Africa,¹ owning more than 50 hospitals in seven of South Africa's nine provinces. Joint Medical Holdings (JMH) is a smaller private hospital provider that owns five hospitals, all of which are in the Durban area.

LHG first acquired a 25% stake in JMH in 1997,² and increased this to 49.4% in 2003. The remaining 50.6% of equity in JMH was owned by doctors who work, or have worked, in JMH's hospitals. In 2011, LHG increased its stake to 70%, making it the majority owner. Prior to this, the companies had been separate entities, with JMH having a separate board that did not report to LHG (although LHG had representation on JMH's board to reflect its shareholding); they also had separate management structures and different IT systems. The South African Competition Commission (SACC) therefore treated the 2011 acquisition as a merger of the two firms.

The merging parties, however, argued that, despite having only a minority stake in JMH, LHG made decisions on behalf of JMH (ie, it had de facto control). This included LHG negotiating tariffs with insurers on behalf of JMH since 2003, which meant that the two had the same tariffs. As a result, the merging parties argued that the merger would have no impact on patients. A key question in this case was therefore how to choose the appropriate counterfactual for assessing this increase in stake in JMH (ie, determining how much competition there would have been between the merging parties if the 2011 share acquisition had not gone ahead), and whether the acquisition would lead to any anti-competitive effects compared with the counterfactual.

The counterfactual

The Competition Tribunal had to determine the correct counterfactual for assessing the merger, and whether LHG's conduct—ie, the fact that it made decisions (including setting tariffs) on JMH's behalf prior to 2011—was an appropriate counterfactual.

Typically, such decisions are subject to approval by the majority stakeholders. However, in some situations where active shareholders have less than a 51% stake, the minority stakeholder may be able to influence these decisions—ie, to have de facto control.

Following its review of the evidence, the Tribunal decided that LHG's de facto control, with its 49% stake in JMH, was the correct counterfactual against which to assess the merger, but emphasised that this did not amount to sole control, as it was subject to challenges from JMH's doctor shareholders. It therefore decided that, prior to the 2011 acquisition, the firms did not constitute part of a single economic entity, and LHG did not have the right to negotiate tariffs on behalf of JMH. It therefore determined that the correct counterfactual was that, pre-merger, LHG and JMH would have priced their services independently of each other.

Theories of harm

The approach taken by the SACC in this case followed the standard approach employed in assessing the competitive effects of mergers. First, the SACC defined the relevant market and assessed whether the merger was likely to lead to a creation or strengthening of market power for the merging firms. It then assessed the theories of harm that could reasonably result from the merger. These theories of harm are split into two broad categories: price-related, and non-price-related.

Oxera provided an expert report and expert testimony on behalf of the SACC in this case.

The SACC's theories of harm are based on the premise that LHG and JMH acted as separate entities pre-merger, which is consistent with the counterfactual put forward by the Tribunal.

Market definition and market power

The SACC and the merging parties agreed that the appropriate product market definition was 'private hospital services', and that the relevant geographic market would be 'smaller than national'. The analysis presented by the SACC and the merging parties suggests that the relevant geographic market would be no larger than the Greater Durban area. This was based on the available information about where patients lived relative to the merging parties' hospitals.

The merging parties argued that the correct approach for calculating market share was to allocate 49% of JMH's market share to LHG pre-merger, and 70% post-merger. The SACC disagreed with this approach, arguing that it did not take into account the fact that LHG was moving from joint to full control in its ownership of JMH. At the same time, calculating the market share for the merging parties as separate entities pre-merger and a single entity post-merger might not capture the fact that LHG already had a 49% stake in JMH pre-merger. The SACC therefore considered that the correct approach had to lie somewhere between these two approaches.

On the basis of a range of market definitions (which included a 10km radius around the merging parties' hospitals; and the Greater Durban area), the SACC's calculations showed that the combined post-merger market share for the merging parties would be over 45% (which is the legal threshold for dominance under the South African Competition Act 89 of 1998).³

Furthermore, the post-merger Hirschman–Herfindahl index (HHI)⁴ was in excess of 2,500 (which, according to the US Department of Justice's Horizontal Merger Guidelines, is the threshold for 'highly concentrated markets').⁵ The SACC therefore concluded that the merger yielded market shares, and increases in market shares, that were consistent with the creation or enhancement of market power. This meant that there was prima facie evidence to support market power being enhanced by this merger.

Both sides also agreed that the barriers to entry into the market were substantial, and included the sunk costs of fixed investment and staff acquisition, and regulatory barriers to entry. Furthermore, the SACC argued that the bargaining power of insurers would not be sufficient to offset the increase in market power created by the merger.

Pricing theories of harm

National tariffs

Private healthcare treatment in South Africa is largely funded by insurers known as 'medical aid schemes'. Hospital prices are set through bilateral negotiation between an insurer (which could be managed through a scheme administrator) and hospital groups. A single range of tariffs is set during the negotiations between a hospital group and an insurer, which means that there is no regional variation in tariffs across a national hospital group.

The SACC's view was that, given the relatively small presence of JMH nationally, the merger was unlikely to change national tariff-setting owing to JMH's increased market power in the Greater Durban area. It therefore concluded that there would be no impact of the merger on national tariffs.

The Tribunal looked into this question in detail, asking what JMH's tariffs would have been if it had priced its services independently of LHG, and decided that JMH would have joined the National Hospital Network (NHN), which acts as a single entity for smaller independent hospital groups for the purposes of tariff negotiations with medical schemes.⁶ The question before the Tribunal was whether tariffs negotiated by NHN were lower than those negotiated by LHG.

The Tribunal appointed an independent expert to assess whether the comparison of tariffs was possible. The expert concluded that, although such an exercise was possible, it would be complex and would require a large amount of additional data. Owing to time constraints, and uncertainty about the outcome of the exercise, the Tribunal decided not to undertake it, but instead to rely on an incident in which LHG had threatened to exclude JMH from its tariff negotiation, and the experience of some factual witnesses, to conclude that NHN tariffs were likely to be lower to funders than the LHG tariff. This does not, however, resolve the question of whether they are less expensive to funders in terms of the total cost of hospital services. Tariffs are only part of the cost to funders—the other component being the cost of consumables. The Tribunal decided that these are likely to be lower for LHG than for NHN, as LHG has greater bargaining power in negotiations with suppliers of consumables. The Tribunal therefore concluded that:

the fact that the differential in tariffs would be offset by a decrease in the cost to funders of consumables, the move to alternative funding models such as designated service providers ('DSP's'), suggest that the effect of a possible increase in tariffs at JMH would, post merger, as compared to our pre-merger hypothetical, be slight.⁷

Private patients

A small percentage (less than 5%) of patients are not members of medical aid schemes and pay for their treatment privately, negotiating tariffs individually when they seek treatment. Hospitals have different discount policies, with managers permitted to approve discounts of up to ZAR50,000 (around £3,500, or €4,275). The SACC considered that, following the merger, LHG would have the ability to reduce discounts for private patients on a targeted basis, by instructing its managers to use new (lower) maximum levels of discounts—even though LHG continues to have a national pricing policy. It therefore considered that the merger would be detrimental to such consumers, since it would become more difficult for competitors remaining in the market to constrain the merging parties' pricing post-merger.

The Tribunal's opinion was that there was no empirical evidence that this change would take place post-merger. In particular, there was no evidence that JMH currently offers better terms to private patients than LHG, and, even if it did, that LHG had an incentive to alter these terms at JMH's hospitals post-merger. The Tribunal seemed to suggest that the extent of local competition did not affect the degree of discounting—rather, it noted that:

uninsured patients appear to be offered rates that depend on hospital-based considerations rather than group-based considerations, local capacity at hospitals appears to drive or at least influence the extent of discounting.⁸

Regional schemes' pricing

Some medical aid schemes specialise in particular areas of South Africa—for example, because they have a connection with an employer that has a regional focus (its medical scheme will also effectively be regional in nature, as staff tend to live near their workplace). Where a scheme is regional rather than national in scope, LHG may have the ability to reflect its degree of local market power in its pricing through bilateral negotiations with regional insurers. This would not affect its national pricing policy.

The Tribunal did not accept this argument, however. First, there were no truly regional schemes in the region of KwaZulu-Natal (KZN). Second, negotiations would typically be undertaken by national medical scheme administrators, which would negotiate tariffs on behalf of several insurance schemes. The administrators' outlook and objectives would therefore be national rather than regional.

Non-pricing factors

Reduction in quality of services, and 'tunnelling'

Quality is highly important in the provision of healthcare services. One of the theories of harm put forward by the SACC was that, following the merger, LHG might have an incentive to undertake fewer costly investments in the quality of services. The quality would be lower than in the counterfactual situation in which the merger between LHG and JMH did not take place.

A subset of this theory of harm is 'tunnelling', in which one company holding a majority stake in another firm attempts to enrich itself at the expense of the minority shareholders. The SACC considered that, when deciding whether to invest in LHG hospitals or JMH hospitals, the merged entity would have an incentive to invest in LHG hospitals, since it owned 100% of the shares and therefore obtained 100% of profits from LHG hospitals, but only 70% from JMH hospitals. There would therefore be an incentive to divert ('tunnel') patients from JMH to LHG hospitals, for example by giving preference to investment in LHG hospitals.

The Tribunal argued that LHG already had the ability to divert patients pre-merger, given its de facto control. Since LHG's economic interest would increase from 49% to 70%, such behaviour would be less likely to take place post-merger. In light of this argument, the Tribunal dismissed this theory of harm. It could be argued that the Tribunal decision in relation to this was contradictory, as, according to the counterfactual accepted by the Tribunal, LHG would not have been able to control JMH's investment decision, given its minority stake.

Conclusion

The SACC has opposed a number of private hospital mergers in South Africa over the past ten years, all of which have ultimately been approved by the Tribunal. This indicates that the two bodies assess private hospital mergers differently. In this case, the differences appear to relate to two aspects, which might warrant consideration in future merger assessments.

- The first is the choice of counterfactual. In its assessment, the SACC assumed that the fact that LHG negotiated tariffs on behalf of JMH made for a viable counterfactual, and hence it did not carry out an in-depth assessment of the counterfactual tariff. The Tribunal was not able to carry out this assessment within the short timescale available,

and thus ruled that it was unlikely to have been different from the post-merger tariffs. The SACC therefore appears to have missed an opportunity to provide relevant evidence on this particular matter.

- Second, although the SACC put forward several theories of harm, the Tribunal dismissed a number

of them (despite admitting that some might have been plausible), since they were considered too theoretical and lacking in analysis and evidence. This shows the importance of conducting an empirical assessment of theories of harm and determining their likelihood in practice, as well as the importance of basing the analysis on solid theoretical foundations.

¹ The others are Netcare and Mediclinic.

² The acquisition was made by Presidential Medical Investment Limited (Presmed), which later merged with the company that would become LHG.

³ Competition Act no. 89 of 1998, Chapter 2, Part B, Section 7 (a).

⁴ The HHI is a measure of concentration. It is calculated as the sum of the market squares of all the firms in the market, and so ranges between 0 (where there are many firms with small market shares) and 10,000 (where one firm has a monopoly—ie, 100 squared).

⁵ US Department of Justice and the Federal Trade Commission (2010), 'Horizontal Merger Guidelines'.

⁶ The NHN was founded in 1996 to represent small independent hospitals. The SACC granted an exemption to the NHN that allowed it to negotiate tariffs, on behalf of its members, with the medical schemes or their administrators. The members are bound by the agreed tariffs once they are set.

⁷ Competition Tribunal of South Africa (2012), *Life Healthcare Group (Pty) Ltd v Joint Medical Holdings Ltd (74/LM/Sep11) [2012] ZACT 88*, October 24th, para 87.

⁸ *Ibid.*, para 88.

If you have any questions regarding the issues raised in this article, please contact the editor, Dr Leonardo Mautino: tel +44 (0) 1865 253 000 or email l_mautino@oxera.com

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