



**COMPETITION TRIBUNAL
REPUBLIC OF SOUTH AFRICA**

Case No.: IR007Apr25

In the matter between:

LIFE HEALTHCARE GROUP (PTY) LTD	First Applicant
LIFE RENAL CARE (PTY) LTD	Second Applicant

And

MEDICLINIC SOUTHERN AFRICA (PTY) LTD	First Respondent
MEDICLINIC RENAL SERVICES SOUTH AFRICA (PTY) LTD	Second Respondent

Panel:	A Wessels (Presiding Member) A Ndoni (Tribunal Member) I Valodia (Tribunal Member)
Heard on:	29 August 2025
Last submission on:	09 September 2025
Order issued on:	23 February 2026
Reasons issued on:	23 February 2026

REASONS FOR DECISION

INTRODUCTION

[1] In this matter, Life Healthcare Group (Pty) Ltd (“Life Healthcare Group”) and Life Renal Care (Pty) Ltd (“Life Renal”) (collectively “Life”) seek interim relief in terms of section 49C of the Competition Act, No. 89 of 1998 (as amended) (the “Act”) against Mediclinic Southern Africa (Pty) Ltd (“Mediclinic SA”) and Mediclinic Renal Services South Africa (“Mediclinic Renal”) (collectively “Mediclinic”).

[2] On 06 February 2025, Life filed a complaint with the Competition Commission (“Commission”) (the “Complaint”)¹ alleging that Mediclinic seeks to prevent the provision of in-hospital dialysis services by third-party dialysis service providers, including Life Renal and mobile dialysis service providers, at Mediclinic’s multidisciplinary hospitals.² Life submitted that this conduct has the effect of substantially preventing or lessening competition within the relevant markets, and does not result in any technological, efficiency or pro-competitive gains which outweigh that effect, in contravention of the Act. The substantive relief sought by Life in their Notice of Motion was the following:

“1. For a period of six months from the date of the Tribunal's order, or the conclusion of a hearing in respect of the prohibited practices alleged by the Applicants, whichever is the earlier:

1.1 the First and Second Respondents (collectively, the "Respondents") are directed to reinstate the Second Applicant's ("Life Renal Dialysis") access permissions and on-site storage, and to ensure that it is permitted to administer renal dialysis treatment and/or extracorporeal blood related treatment to patients at Mediclinic Vergelegen, Mediclinic Morningside, Mediclinic Panorama and Mediclinic Potchefstroom (i.e., should Life Renal Dialysis' access permissions and on-site storage permissions be revoked at Mediclinic Potchefstroom prior to the date on which this Tribunal hands down its order in this matter), where Life Renal Dialysis has been requested to administer such treatment by a referring clinician and subject to Life Renal Dialysis' continued substantial adherence to the Respondents' reasonable infection control, security and other protocols;

1.2 the Respondents are directed to permit Life Renal Dialysis to administer any form of inpatient renal dialysis treatment and/or extracorporeal blood-related treatment to patients at all Mediclinic hospitals in South

¹ Competition Commission Case No. 2025FEB0007.

² Life’s founding affidavit, paragraph 6.

Africa, and to refrain from in any way preventing or impeding Life Renal Dialysis from doing so, where Life Renal Dialysis has been requested to administer such treatment by a referring clinician and subject to Life Renal Dialysis' continued substantial adherence to the Respondents' reasonable infection control, security and other protocols;

1.3 the First Respondent is directed to circulate a communication to all clinicians, including but not limited to nephrologists, physicians, nurses and renal technologists, and to hospital executive and clinical management, at all Mediclinic hospitals in South Africa explaining the nature and meaning of the obligations set out in paragraphs 1.1 and 1.2 above, and expressly indicating that all clinicians are free to call for the services of Life Renal Dialysis to treat patients at Mediclinic hospitals, and that they will not suffer any repercussions as a result of exercising their clinical discretion in this regard; and

1.4 the First Respondent is directed to circulate a communication to all employees of the Second Respondent explaining the obligations set out in paragraphs 1.1 and 1.2 above, and indicating that Life Renal Dialysis is permitted to treat patients at all Mediclinic hospitals in South Africa and should not be prevented or impeded from carrying out such services, in any way whatsoever.

2. The costs of this interim relief application (including the costs of two counsel) shall be paid by such Respondents as oppose this application, jointly and severally, the one paying the other to be absolved.

3. Further and/or alternative relief as the Tribunal deems appropriate.”

[3] Following the hearing, we received submissions from the parties relating to the relief sought in the matter.³ Having considered all of the submissions and

³ Email correspondence from Life dated 01 September 2025 and email correspondence from Mediclinic dated 05 September 2025.

evidence before us, we decided to dismiss the interim relief application. The reasons for our decision are set out below.

PROCEDURAL BACKGROUND

- [4] The matter also concerned one procedural aspect, namely Mediclinic's application for leave to file a supplementary affidavit.
- [5] Prior to the hearing on 12 August 2025, Mediclinic applied for leave to file a supplementary affidavit to place evidence before the Tribunal regarding the list of hospitals provided by Life in annexure RA2 (annexed to Life's replying affidavit), where third party service providers administer dialysis treatment at Life hospitals. Mediclinic submitted that the evidence was first adduced in Life's replying affidavit and that it did not have an opportunity to deal with the veracity of the submissions. In short, Mediclinic challenged the accuracy of the list of hospitals where third party service providers administer dialysis treatment concluding that Life provides exclusive dialysis services in the majority of its own hospitals.
- [6] Thereafter, on 27 August 2025, Life filed an affidavit in opposition of Mediclinic's application to file a supplementary affidavit, citing that Mediclinic has mischaracterised the information relating to the list of hospitals and third-party services providers.
- [7] During the hearing, both Life and Mediclinic were given an opportunity to make submissions on the factual position of the Life hospitals listed in annexure RA2 and whether a third-party dialysis service provider operated at these hospitals. In the main, Mr Wesley, on behalf of Life, was satisfied that because Mediclinic did not object to Life filing an answer to its supplementary affidavit that the prejudice falls away.⁴

⁴ Hearing transcripts, pages 60-61.

[8] In the circumstances we granted Mediclinic leave to file the supplementary affidavit and for Life to file a response thereto.

RELEVANT FACTUAL BACKGROUND

The parties and their business activities

Life Healthcare Group and Life Renal

[9] Life Healthcare Group is a provider of acute hospital care in South Africa through its network of private multidisciplinary hospitals in which it provides a comprehensive suite of services, including emergency units, maternity wards, paediatric care, cardiac services, obstetrics and gynaecology, fertility wards, ophthalmology, orthopaedic specialists, neurology, plastic surgery, neurosurgery and general surgery.⁵ In addition to the main services, Life Healthcare Group also offers complementary services through dedicated divisions and/or subsidiaries.

[10] Of particular relevance to the Complaint and to this application is Life Renal, which offers dialysis services through (i) in-hospital dialysis units resident in 31 of Life Healthcare Group's 48 multidisciplinary hospitals, (ii) mobile units which travel to administer dialysis both at Life Healthcare Group's multidisciplinary hospitals which do not have resident dialysis units, as well as other third-party, multidisciplinary hospitals, and (iii) standalone clinics which operate separately from, and outside of, multidisciplinary hospitals.⁶

[11] In 2024, Life Healthcare Group acquired the dialysis services business from Fresenius Medical Care South Africa (Pty) Ltd ("Fresenius") ("*Life-Fresenius Merger*").⁷ Fresenius entered the market in 2001 and provided renal dialysis services in Southern Africa independent of any hospital group, until it was acquired by Life Healthcare Group in 2024.⁸

⁵ Life's founding affidavit, para 28.

⁶ Life's founding affidavit, para 29.

⁷ Under Tribunal case no. LM035Jun23.

⁸ Mediclinic's answering affidavit, para 2.

[12] The *Life-Fresenius Merger* was approved subject to an open access condition in terms of which, Life Healthcare Group undertook by agreement with the Commission, to continue to permit third-party dialysis service providers reasonable access to its multidisciplinary hospitals to administer dialysis on a mobile basis for a fixed period of five years (“Open Access Condition”).⁹ The Open Access Condition is subject to third party providers (i) having been requested to administer treatment by a referring nephrologist or physician and (ii) adhering to Life’s infection control, security and other reasonable protocols as set from time to time.¹⁰

Mediclinic SA and Mediclinic Renal

[13] Mediclinic SA is a provider of acute hospital care in South Africa through its network of private multidisciplinary hospitals. Mediclinic owns and operates 50 hospitals and 14 Day Case Clinics in Southern Africa.¹¹ According to Mediclinic, it is the 3rd largest private hospital business in South Africa behind Netcare Group Limited (“Netcare”) and Life.

[14] Mediclinic Renal was established in 2021 through its merger with dialysis service provider, BGM Renal Care (Pty) Ltd (“BGM”), and has established its own renal dialysis treatment facilities at 12 of its hospitals (some being acute and others being acute and chronic).¹²

[15] Prior to Mediclinic’s acquisition of BGM in 2021, it did not have its own dialysis service provider, and all in-hospital dialysis services in Mediclinic hospitals were attended to by third-party dialysis service providers.¹³ At Mediclinic

⁹ Life’s founding affidavit, para 12. Also see the Tribunal’s reasons in the merger between *Life Healthcare Group (Pty) Ltd and Fresenius Medical Care South Africa (Pty) Ltd in respect of the dialysis services business* CT Case No. LM035Jun23, para 30 (“*Life and Fresenius Merger*”).

¹⁰ Annexure A to the order in the *Life-Fresenius Merger* under Tribunal case no. LM035Jun23.

¹¹ Mediclinic’s answering affidavit, para 8.

¹² Mediclinic’s answering affidavit, para 9.

¹³ Life’s founding affidavit, para 88.3.

hospitals where Mediclinic Renal does not provide renal dialysis services, these services are provided by third parties.¹⁴

[16] Mediclinic Renal focuses on the provision of acute renal dialysis services within Mediclinic hospitals. Mediclinic also operates a limited number of co-located and stand-alone renal dialysis clinics. Mediclinic does not have mobile dialysis units.¹⁵

[17] Our observation, in light of the above, is that the market (as it relates to renal dialysis services) is undergoing structural changes. This is evident from the fact that both Life and Mediclinic have acquired dialysis services providers and have (to some extent) insourced these services. The other large hospital group in South Africa, Netcare which has more hospital beds than the parties to this matter, has jointly owned National Renal Care since 1995.

Life's complaint and Mediclinic's response

[18] According to Life, following Mediclinic's acquisition of BGM in 2021, third parties including Life Renal were still permitted to administer dialysis at Mediclinic hospitals. This changed in 2024.

[19] During January 2024, immediately prior to the *Life-Fresenius Merger*, Mediclinic commenced giving notice that it would no longer permit Fresenius (now Life Renal) to provide services at various Mediclinic hospitals.¹⁶ Life Renal was given notice that it was no longer able to provide dialysis services at the following five Mediclinic hospitals ("Affected Hospitals"):

19.1 Mediclinic Vergelegen (Somerset West, Cape Town) with effect from 01 November 2024;

19.2 Mediclinic Morningside (Sandton, Johannesburg) with effect from 15 December 2024;

¹⁴ Mediclinic's answering affidavit, para 13.

¹⁵ Mediclinic's answering affidavit, paras 11-12.

¹⁶ Life's heads of argument para 28.

- 19.3 Mediclinic Panorama (Panorama, Cape Town) with effect from 03 March 2025;
- 19.4 Mediclinic Potchefstroom with effect from 15 June 2025;¹⁷ and
- 19.5 Mediclinic Newcastle, with effect from 31 August 2025.¹⁸

[20] Life submitted that the practical implication of its exclusion from the Effected Hospitals is that Mediclinic has denied Life Renal access permissions and on-site storage and has prevented Life Renal from administering treatment to inpatients at these hospitals. Further that nephrologists¹⁹ and specialist physicians operating at the Effected Hospitals are prevented from using the services of Life Renal to administer in-hospital dialysis treatment to their patients, in instances where patients require acute or chronic dialysis treatment.²⁰

[21] Life contends that Mediclinic acts as a monopoly provider in the upstream market for the provision of express access permissions and reasonable on-site storage to third-party mobile dialysis service providers within particular Mediclinic hospitals and is able to leverage its market power in this regard to withhold access to such necessary inputs from service providers.

[22] Life argued that this effectively enables Mediclinic to foreclose rival dialysis service providers from operating in the relevant downstream market for the provision of in-hospital dialysis services at a particular hospital distorting competition in favour of its own dialysis service provider, Mediclinic Renal (“foreclosure theory of harm”).

[23] Life submitted that Mediclinic, by virtue of its upstream market power, is able to exclude Mediclinic Renal’s rivals from competing with it by denying access

¹⁷ Life’s founding affidavit para 17.

¹⁸ Life’s replying affidavit, para 302.

¹⁹ A nephrologist is a medical doctor who specializes in kidney health, diagnosing and treating diseases and conditions affecting the kidneys, such as chronic kidney disease, kidney stones, kidney infections, and kidney failure, managing treatments like dialysis and transplantation, and addressing related issues like high blood pressure and electrolyte imbalances.

²⁰ Life’s founding affidavit para 18.

permissions to the hospital and reasonable on-site storage within Mediclinic hospitals.²¹

[24] To this end, Life argued that Mediclinic is engaging in the following exclusionary acts:

24.1 preventing dialysis patients (customers) as well as their referring nephrologists or specialist physicians (suppliers) from dealing with a competitor of Mediclinic Renal, being Life Renal in contravention of section 8(1)(d)(i);

24.2 requiring that dialysis patients admitted to a Mediclinic hospital in terms of a contract, pursuant to which the patient is provided with hospital services, are also required, should they need dialysis, to obtain dialysis services from Mediclinic Renal only in contravention of section 8(1)(d)(iii) of the Act; and/or

24.3 otherwise engaging in an exclusionary act where the anti-competitive effect is not outweighed by any alleged efficiency benefits in contravention of section 8(1)(c) of the Act.²²

[25] Mediclinic however contends that its decision to revoke Life Renal's access from the Effected Hospitals is as a result of a roll-out strategy in terms of which Mediclinic intends to insource its renal dialysis services at its hospitals nationally ("insourcing decision").²³ Mediclinic submitted that it has legitimately decided to insource its renal dialysis services which were previously provided by Life Renal particularly because Mediclinic has no oversight or authority over the practices, hygiene, infection control, security and other reasonable protocols of third party service providers.²⁴

²¹ Life's founding affidavit para 19, page 16.

²² Life's founding affidavit, para 21.

²³ Mediclinic's heads of argument para 2, page 2.

²⁴ Mediclinic's answering affidavit, para 30.

[26] Before we turn to our assessment of the merits, we note that the application was brought by Life and the relief sought, if granted, would solely affect and be relevant to Life. No other third parties are before us, and our determination and assessment are confined to the conduct and circumstances of Life and does not contemplate the potential industry wide effect of Mediclinic's decision to insource.

[27] We proceed to assess these respective claims under section 49C and the relevant prohibited practice sections of the Act.

LEGAL FRAMEWORK

[28] Section 49C(2)(b) of the Act sets out the Tribunal's approach to adjudicating interim relief application, it reads as follows:

"Interim Relief

...

The Competition Tribunal ... may grant an interim order if it is reasonable and just to do so, having regard to the following factors:

- (i) the evidence relating to the alleged prohibited practice;*
- (ii) the need to prevent serious or irreparable damage to the applicant; and*
- (iii) the balance of convenience."*

[29] Section 49C(3) explains that:

"In any proceedings in terms of this section, the standard of proof is the same as the standard of proof in the High Court on a common law application for an interim interdict."

[30] An applicant is only required to make out a *prima facie* case, not to establish its case on a balance of probabilities as was stated in *eMedia*, where the Competition Appeal Court ("CAC") explained that "[t]his really means that the

Tribunal must make a summary assessment before granting the interim relief. This assessment is only at a prima face level."²⁵

[31] In *Sekunjalo*, the CAC further confirmed that the requirement of evidence relating to the alleged prohibited practice means *prima facie* evidence.²⁶ In this way interim relief applications under section 49C are analogous to interim interdict applications in the High Court, where applicants seek relief pending the determination of some other dispute.

[32] Therefore, it is not the function of the Tribunal to arrive at a definitive finding of a contravention.²⁷ To this end, a successful applicant in an interim relief application is only required to make out a *prima facie* case of prohibited conduct and is not required to prove its case on a balance of probabilities.

[33] In matter between *Depansum (Pty) Ltd t/a dLocal and VISA Inc. and Others*,²⁸ the Tribunal relied on the matter between *Simon NO v Air Operations of Europe AB and others*²⁹ regarding the approach with respect to disputes of fact.

In this regard, we bear in mind that this is an application for an interim interdict. To the extent that there are disputes of fact, we ought to follow the approach articulated in the Gool case:

"The accepted test for a prima facie right in the context of an interim interdict is to take the facts averred by the applicant, together with such facts set out by the respondent that are not or cannot be disputed and to consider whether, having regard to the inherent probabilities, the applicant should on those facts obtain final relief at the trial. The facts set up in contradiction by

²⁵ *eMedia Investments (Pty) Ltd v Multichoice (Pty) Ltd and another* (201/CAC/JUN22) (1 August 2022) at para 93.

²⁶ *Mercantile Bank, A Division of Capitec Bank Ltd and others v Surve` and others* [2023] 3 CPLR 33 (CAC), at para 25.

²⁷ *GovChat (Pty) Ltd and another v Facebook Inc. and Others* Case No: IR165Nov20, at para 20.

²⁸ Competition Tribunal Case No. IR020Aug23.

²⁹ 1999 (1) SA 217 (SCA) at 228.

the respondent should then be considered and, if serious doubt is thrown upon the case of the applicant, he cannot succeed.”

[34] In *Nedschroef*, the Tribunal explained that the three factors must be understood holistically to determine whether a case for interim relief has been established

*“...an application may meet the three factors, but there may be reasons why granting the application is not reasonable and just. Conversely, an applicant may not make out a strong case on all three of the factors, but the Tribunal may nevertheless consider that an order for interim relief is nevertheless reasonable and just ...”*³⁰

[35] In *eMedia*, the CAC held that when examining the three factors, consideration must be given to whether there are “*clear, non-speculative and uncontroversial facts*” that support the grant of interim relief, and that “*whilst there will inevitably be disputes of fact*”, that should not prevent the Tribunal from taking a “*robust approach*” on the evidence and submissions before it, given that a full examination and determination of the merits will be undertaken at the hearing in which final relief is sought.³¹

Section 8 of the Act

[36] Section 8 of the Act prohibits conduct of a firm that amounts to an abuse of its dominant position. There are two types of abuse of dominance. The first being exploitative as it is aimed at consumers and the second type is exclusionary as it impedes or prevents rivals from expanding in the market. For our purposes it is important to only focus on the sections Life alleges Mediclinic to have contravened, which are sections 8(1)(c), 8(1)(d)(i), and 8(1)(d)(iii).

³⁰ *Nedschroef Johannesburg (Pty) Ltd v Teamcor Limited and Others* (95/IR/Oct05) [2006] ZACT 7; [2006] 1 CPLR 98 (CT) (1 February 2006) at paras 23-25.

³¹ *eMedia Investments (Pty) Ltd v Multichoice (Pty) Ltd and another* (201/CAC/JUN22) (1 August 2022) at paras 80-81.

[37] Section 8(1) states that it is prohibited for a “*dominant*”³² firm to:

- “(c) engage in an exclusionary act, other than an act listed in paragraph (d), if the anti-competitive effect of that act outweighs its technological, efficiency or other pro-competitive gain; or
- (d) engage in any of the following exclusionary acts, unless the firm concerned can show technological, efficiency or other pro-competitive gains which outweigh the anti-competitive effect of its act—
 - (i) requiring or inducing a supplier or customer to not deal with a competitor; and
 - (iii) selling goods or services on condition that the buyer purchases separate goods or services unrelated to the object of a contract, or forcing a buyer to accept a condition unrelated to the object of a contract”

[38] Section 1 defines an “*exclusionary act*” as “*an act that impedes or prevents a firm from entering into, participating in or expanding within a market.*” The term “*participate*” is in turn defined as “*the ability of or opportunity for firms to sustain themselves in the market.*”

[39] Both sections 8(1)(c) and 8(1)(d) distinguish between an “*exclusionary act*” (as defined above) and an “*anti-competitive effect*”. In *Uniplate*, the CAC explained that an exclusionary act may give rise to an anti-competitive effect, however, to establish a contravention of the sections that effect must be proven.³³

[40] Section 8(1)(c) contains a general prohibition of anti-competitive exclusionary conduct. Where a contravention of section 8(1)(c) is alleged, the onus is on the applicant to prove elements of an exclusionary act and the anti-competitive effects. This can be demonstrated through evidence of harm to consumer

³² In terms of section 7, “A firm is dominant in a market if (a) it has at least 45% of that market; (b) it has at least 35%, but less than 45%, of that market, unless it can show that it does not have market power; or (c) it has less than 35% of that market but has market power”. “Market power” is defined in section 1(1) as “the power of a firm to control prices, to exclude competition or to behave to an appreciable extent independently of its competitors, customers or suppliers”.

³³ *Uniplate Group (Pty) Ltd v The Competition Commission of South Africa* (176/CAC/Jul19) [2020] ZACAC 10 at para 23.

welfare or foreclosure in the market, which can be based on reasonable inferences from proven facts.³⁴

[41] Under section 8(1)(d), the existence of an exclusionary act is assumed if the conduct referred to in the section is established. Under this section, the requirement of a substantial anti-competitive effect is met either (i) if there is “*evidence of actual harm to consumer welfare*” or (ii) “*if the exclusionary act is substantial or significant in terms of its effect in foreclosing the market to rivals*”.³⁵

[42] In terms of section 8(1)(c), the onus is on the complainant to show that the anticompetitive effect of the conduct outweighs the technological, efficiency and pro-competitive gains.³⁶

[43] Once the elements of section 8(1)(d) are proven, the onus shifts to the respondent to prove that the anti-competitive effects of the conduct are outweighed by pro-competitive gains.

[44] In *Computicket*, the CAC emphasised that, in order to establish an “*anti-competitive effect*” for purposes of section 8(1)(d), it must be shown that the harm in question, “*whether in the form of actual or potential harm, strengthens the dominant firm’s position to the extent that competitive rivalry is significantly impeded or is likely to be so impeded by the impugned conduct of the dominant firm.*”

[45] In the light of these general principles, we now turn to our analysis of each of the elements required to establish a contravention of section 8(1)(d) and section 8(1)(c) with reference to the particular facts in this case.

ANALYSIS

³⁴ *Competition Commission and South African Airways (Pty) Ltd* (18/CR/Mar01) [2005] ZACT 50, at para 132

³⁵ *GovChat (Pty) Ltd and another v Facebook Inc. and Others* (Case No. IR165Nov20), 11 March 2021 at para 142.

³⁶ *Competition Commission v Senwes Limited* (110/CR/Dec06) para 170.

Relevant markets and dominance

[46] To succeed under section 8(1)(d) or 8(1)(c) of the Act, Life must first establish that Mediclinic is dominant in a relevant market, as defined in section 7 of the Act. Section 7 of the Act states that:

A firm is dominant in a market if-

(a) it has at least 45% of that market;

(b) it has at least 35%, but less than 45%, of that market, unless it can show that it does not have market power; or

(c) it has less than 35% of that market, but has market power

[47] The first enquiry therefore concerns the relevant market definition, thereafter whether Mediclinic is in fact dominant in the identified market(s).

[48] One complicated issue in this application concerns the parties' divergent positions on the appropriate market definition(s).

48.1 Life argued that there are two relevant market definitions: (i) the upstream market should be defined as the market for the provision of reasonable on-site storage facilities and express access permissions to mobile dialysis service providers at a given acute multidisciplinary private hospital;³⁷ and (ii) the downstream market defined as the market for the provision of in-hospital dialysis services at particular hospitals.³⁸

48.2 Mediclinic contrastingly argued that the appropriate market definition is a single holistic market for the provision of acute multidisciplinary

³⁷ Life's founding affidavit, para 69.

³⁸ In the alternative Life argued that the relevant markets are the (i) upstream market for the provision of acute multidisciplinary private hospital services and the (ii) downstream market for inpatient dialysis services. Life defined these markets to advance its leveraging theory of harm. See Life's founding affidavit, paras 72-73.

inpatient private hospital services.³⁹ In the alternative, Mediclinic adopted the market definitions assessed in the *Life-Fresenius Merger* being the (i) upstream market for the provision of in-hospital acute multidisciplinary inpatient private hospital services and (ii) downstream market for the provision of dialysis services.

Essential features of the dialysis market

[49] Dialysis entails the removal of excess water, solutes and toxins from the blood in patients whose kidneys are not capable of performing this function. Dialysis is prescribed by specialist physicians or nephrologists who refer patients to dialysis services providers.⁴⁰

[50] There are three distinct categories of patients who receive dialysis treatment (i) acute inpatients, (ii) chronic inpatients and (iii) chronic outpatients. These categories are briefly described below.

50.1 **Acute inpatients** can be defined as patients who have no history of kidney failure and have not previously been treated with dialysis, but who are admitted to hospital on an inpatient basis as a result of an acute episode and who require dialysis during their admission. Acute inpatients can be sub-divided into (i) those owing to catastrophic events which causes their kidneys to shut down but these patients are anticipated to regain normal kidney function over time, and (ii) so-called 'crash landers' who experience a sudden deterioration in their health and are diagnosed with kidney disease. These patients, while initially acute patients become chronic patients who require ongoing dialysis treatment on an outpatient⁴¹ basis.

³⁹ Mediclinic's answering affidavit, para 43.

⁴⁰ Life's founding affidavit, para 36.

⁴¹ Outpatients refer to a class of patients who have been diagnosed with kidney disease and require ongoing dialysis treatment. The application before us does not concern chronic outpatients.

50.2 **Chronic inpatients** have already been diagnosed with kidney disease and receive treatment on an outpatient basis but are in poor health and are admitted into hospitals for medical conditions and are subsequently admitted for acute episodes.⁴²

50.3 **Chronic outpatients** are patients who have been diagnosed with kidney disease and obtain ongoing chronic dialysis treatment on an outpatient basis.⁴³

[51] Inpatients (both chronic and acute) are admitted to multidisciplinary hospitals and receive dialysis treatment on an inpatient basis. The dialysis treatment in this instance is administered by (i) in-hospital units which are located in and operate from hospital premises (“in-hospital units”) and (ii) mobile dialysis units which travel to the hospital premises to administer treatment (“mobile units”).⁴⁴

[52] With respect to in-hospital dialysis units, the equipment used to administer the treatment is fixed to the hospital premises at an intensive care unit (“ICU”) or high care ward. The inpatients receive bed-side dialysis treatment. The mobile units however need to transport their equipment to the relevant hospital premises where the dialysis treatment will be administered. The mobile unit service providers are given access and storage space for their equipment at relevant hospital premises.⁴⁵

[53] Chronic outpatients who receive treatment on an outpatient basis can receive treatment from an in-hospital unit or from a standalone clinic. With respect to the standalone clinics, these are facilities which operate outside of, and separately to a multidisciplinary hospital and only treat outpatients. Chronic outpatients require regular dialysis treatment and are not limited to receiving

⁴² Life’s founding affidavit, para 38.

⁴³ Life’s founding affidavit, para 38.2.

⁴⁴ Life’s founding affidavit, para 41.1.

⁴⁵ Life’s founding affidavit, para 41.1.

treatment from in-hospital units or mobile units.⁴⁶ Outpatient dialysis treatment administered in-hospital mimics that of a standalone clinic.

[54] Standalone clinics only offer services to chronic outpatients, whereas acute and chronic inpatients are limited to only receive treatment from in-hospital units or mobile units able to administer treatment at a hospital premises.⁴⁷

[55] Considering the above, for both acute and chronic patients, but especially chronic outpatients who require ongoing dialysis treatment dialysis, dialysis is non-substitutable. Therefore, demand is perfectly inelastic, meaning that demand for dialysis will remain constant even in the event of changes in price.

Medical aid schemes and the effect on price and network arrangements

[56] A feature of the market relating to hospital services is the role of medical aid schemes in determining the price of hospital services, as well as network arrangements between hospitals and medical aid schemes.

[57] The parties did not adduce evidence related to network arrangements between services providers and medical aid schemes.

[58] We understand however from the Commission's Health Market Inquiry ("HMI") that factors such as networks initiated by providers and funders, and whether the medical practitioner concerned is contracted to a medical scheme influence the choice of general practitioners ("GPs"), specialists and hospitals which patients choose.⁴⁸

[59] Mediclinic submitted that the price of hospital services is determined in negotiation with medical schemes. Notwithstanding this, Mediclinic submitted that the volume of patients could reduce or increase bargaining power *viz-a-viz*

⁴⁶ Life's founding affidavit, para 41.3.

⁴⁷ Life's founding affidavit, para 41.5.

⁴⁸ Competition Commission's final findings and recommendations report in the Health Market Inquiry, September 2019, page 46.

medical aid schemes.⁴⁹ In its oral submissions, Mediclinic further submitted that hospitals are constrained by market conditions and by the sensitivity of medical aids and doctors to the overall cost composition of services, which is transparent and itemised in detailed billing.⁵⁰

[60] Life concedes that there are hospital specific tariffs set nationally by medical aid schemes. Life however contends that there is scope for potential price competition because the countervailing powers of medical aid schemes is not absolute. First, because the tariffs may not be the same for Life and Mediclinic and that price competition may take place in this regard where there is more than one service provider. Secondly, private hospitals do not need to charge the tariff they may charge above it and require co-payments.⁵¹

[61] The parties did not deal with the effect of medical aid schemes on the prices of in-hospital services (or in particular dialysis treatment) or the limitations on patient choice with respect to network arrangements between hospitals and medical aid schemes. We remain cognisant however that medical aid schemes do influence the choices of patients.

The role and purpose of market definition

[62] It is well established in both jurisprudence and in the relevant economics literature that the purpose of market definition is to delineate the boundaries within which competitive constraints operate, in order to assess the presence or absence of market power.

[63] Market definition therefore serves as an analytical tool of classification, identifying the scope of the relevant market, and constitutes a preliminary step in the assessment of market power.⁵²

⁴⁹ Mediclinic's answering affidavit, para 62.

⁵⁰ Hearing transcripts pages 168-169.

⁵¹ Hearing transcripts, page 174.

⁵² M Motta *Competition Policy: Theory and Practice* 2004 (Cambridge University Press: New York), page 101.

[64] Further, the European Commission in its Notice on Market Definitions states that:

*“Market definition is a tool that the Commission uses to identify and define the boundaries of competition between undertakings. The main purpose of market definition is to identify in a systematic way the effective and immediate competitive constraints faced by the undertakings involved when they offer particular products in a particular area.”*⁵³

[65] In the *eMedia*⁵⁴ the CAC stated that *“when applying the provisions of the Act dealing with the abuse of dominant position it is necessary to define the market as this illuminates the primary competitive drivers that operate in a given case and the first step in the process entails the consideration of the stage of supply relevant to the inquiry sometimes referred to as the functional dimension of the market. From there on one defines the product dimension and lastly, the geographic dimension with the objective of identifying the competitors of the firm concerned that are capable of constraining the firm's behaviour and preventing it from behaving independently of competitive pressure.”*

[66] With the above in mind, we now turn to consider the assessment of the relevant market(s).

Our assessment

Product market

[67] In our view, the conclusion in this application hinges primarily on whether Life has made out a *prima facie* case that Mediclinic is dominant in the narrow market for the provision of reasonable on-site storage facilities and express

⁵³ Commission Notice on the definition of the Relevant Market for the Purposes of Community Competition Law, Official Journal, OJ [2024] C 1645, para 6 available at https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:C_202401645 last accessed on 03 January 2026.

⁵⁴ *eMedia Investments (Pty) Ltd v Multichoice (Pty) Ltd and another* (201/CAC/JUN22) (1 August 2022) at para 58.

access permissions to mobile dialysis service providers at a given acute multidisciplinary private hospital. This is so because, if a case of dominance has not been made out, that is where the matter ends.

[68] At the nub of Life's case is the fact that it considers Mediclinic's decision to revoke Life's access to the Effected Hospitals as a strategy aimed at 'locking in' patients, which prevents patients from using alternative dialysis service providers once admitted to Mediclinic hospitals.

[69] A distinguishing feature in this case, in our view, is the fact that Life's narrow market definition considers competition which takes place at the point of care (once a patient has been admitted), whereas Mediclinic's broad market definition considers competition which takes place before patients are admitted in the form of referrals from specialists.

[70] Both Life and Mediclinic acknowledge that the market for the provision of acute multidisciplinary inpatient private hospital services in South Africa is a well-defined market in competition jurisprudence.⁵⁵

[71] We agree with Mediclinic that the broad market for the provision of acute multidisciplinary inpatient private hospital services in South Africa is a well-established market. Albeit in merger transactions, the Tribunal has previously conducted its assessments in the market for the provision of acute multidisciplinary private inpatient hospital services.⁵⁶ We briefly discuss some relevant South African and international case law in hospital and hospital services markets.

[72] In *Mediclinic Southern Africa (Pty) Ltd and Matlosana Medical Health Services (Pty) Ltd* ("*Mediclinic-Matlosana Merger*")⁵⁷ the Tribunal assessed the market for the provision of private multidisciplinary acute inpatient hospital services

⁵⁵ Life's founding affidavit, para 72. Mediclinic's heads of argument, para 79.

⁵⁶ *Life and Fresenius Merger* CT Case No. LM035Jun23 para 28. *Mediclinic Southern Africa (Pty) Ltd and Matlosana Medical Health Services (Pty) Ltd* CT Case No. LM124Oct16, para 81. See also *Netcare Hospitals (Pty) Ltd and Lakeview Hospital* CT Case No. LM193Oct17, para 17.

⁵⁷ Competition Tribunal Case No. Lm124Oct16, para 103.

(excluding day case services of these hospitals). This merger involved Mediclinic's acquisition of Matlosana Medical Health Services, a private company which owned and managed two multidisciplinary private hospitals.

[73] Similarly in the merger between *Netcare Hospitals (Pty) Ltd and Lakeview Hospital*⁵⁸ the Tribunal assessed the market for multidisciplinary private hospital services which was agreed to by the parties. In terms of this merger, Netcare acquired Lakeview Hospital, which operated as a licenced private hospital.

[74] Additionally, in the merger between *Phodclinics (Pty) Lid & Others and Protector Group Medical Services (Pty) Ltd (in liquidation) & Others*⁵⁹ the Tribunal assessed the market for the provision of private hospital services, which was not contested by the parties in this matter. Likewise in the merger between *Life Healthcare Group (Pty) Ltd and Joint Medical Holdings Limited*⁶⁰ the market definition for the provision of private hospital services was not contested by the parties and assessed by the Tribunal.

[75] We additionally considered the *Life-Fresenius Merger* as well as international case law relating to dialysis.

[76] In the *Life-Fresenius Merger*, the Tribunal, without concluding on the relevant markets, assessed the market for the provision of dialysis services. We understand that there is no other South African jurisprudence which defines a market for dialysis services.

[77] In the European Commission ("EU") merger between *Galencia & Fresenius Medical Care and Vifor Fresenius Medical Care Renal Pharma JV*.⁶¹ Galencia operates as an international group active in the provision of healthcare and develops, manufactures and sells pharmaceutical products. Fresenius is active

⁵⁸ Competition Tribunal Case No. LM193Oct17, para 17.

⁵⁹ Competition Tribunal Case No. Case Number 122/LM/Dec05.

⁶⁰ Competition Tribunal Case No. Case No. 74/LM/Sep11.

⁶¹ Case No. COMP/M.6091.

in renal dialysis including, research and development, the sale of dialysis products and the provision of dialysis services. Vifor mainly operated in research and development as well as marketing and distribution of renal dialysis equipment. The EC in this merger left the product market definition for dialysis services open and did not further segment the dialysis market into separate markets for the two types of dialysis treatments hemodialysis (“HD”) and peritoneal dialysis (“PD”).

[78] In considering international jurisprudence, we considered the matter between *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984) (“*Jefferson Case*”). Whilst we do not rely on the principles in this matter, the matter interestingly considered whether a hospital’s exclusive contract requiring patients to use a particular anaesthesiology group was an illegal tying arrangement in violation of the Sherman Act. The U.S Supreme Court held that the contract was not illegal because the hospital lacked sufficient market power to coerce patients and restrain competition. We briefly set out the U.S Supreme Court’s findings in the *Jefferson Case*.

78.1 In this matter, the East Jefferson Hospital entered into an exclusive contract with Roux Associates, a firm of anaesthesiologists, which stipulated that only Roux could provide anaesthesiologic services at the hospital. As a result, Dr. Edwin G. Hyde (“Hyde”), an anaesthesiologist, was denied staff privileges at the hospital. Hyde claimed that this exclusive contract was a violation of section 1 of the Sherman Act, arguing that it constituted an illegal “tying arrangement” that restrained competition.

78.2 The Federal District Court ruled in favour of the hospital, finding the contract’s anticompetitive effects to be minimal and outweighed by improvements in patient care. However, the U.S. Court of Appeals for the Fifth Circuit reversed the decision by labelling the contract as illegal “*per se*” under the Sherman Act. The U.S. Supreme Court ultimately reversed the Appeals Court’s decision.

- 78.3 The U.S Supreme Court had to consider whether the exclusive contract between the hospital and firm of anaesthesiologists was in violation of the Sherman Act because every patient undergoing surgery at the hospital had to use the services of one firm of anaesthesiologists, and, if not, whether the contracts were nevertheless illegal because it unreasonably restrained competition among anaesthesiologists.
- 78.4 There were at least 20 hospitals in the New Orleans metropolitan area, and approximately 70% of the patients living in the Jefferson Parish area went to hospitals other than East Jefferson. The entire New Orleans metropolitan area was regarded as the appropriate relevant geographic market in which hospitals compete, this evidence convinced the District Court that East Jefferson does not possess any significant “market power”; and concluded that petitioners could not use the Roux contract to anticompetitive ends.
- 78.5 The same evidence led the Court of Appeals to draw a different conclusion. Noting that 30% of the residents of the Parish go to East Jefferson Hospital, and that in fact *“patients tend to choose hospitals by location rather than price or quality,”* the Court of Appeals concluded that the relevant geographic market was the East Bank of Jefferson Parish. The conclusion that East Jefferson Hospital possessed market power in that area was buttressed by the facts that the prevalence of health insurance eliminates a patient's incentive to compare costs, that the patient is not sufficiently informed to compare quality, and that convenience tends to magnify the importance of location.
- 78.6 The Court of Appeals held that the case involves a “tying arrangement” because the *“users of the hospital's operating rooms (the tying product) are also compelled to purchase the hospital's chosen anaesthesia service (the tied product).”* Having defined the relevant geographic market for the tying product as the East Bank of

Jefferson Parish, the court held that the hospital possessed “*sufficient market power in the tying market to coerce purchasers of the tied product.*”

- 78.7 The U.S Supreme’s Court’s analysis focused on the hospital’s sale of services to its patients, rather than its contractual arrangements with the providers of anaesthesiologic services. It further considered whether petitioners were selling two separate products that may be tied together, and, if so, whether they have used their market power to force their patients to accept the tying arrangement.
- 78.8 It was held that there was nothing inherently anticompetitive regarding the packaged sales. Only in instances where patients were forced to purchase Roux’s services as a result of the hospital’s market power would the arrangement have anticompetitive consequences. The U.S Supreme Court held that if no forcing was present, patients are free to enter a competing hospital and to use another anaesthesiologist instead of Roux.
- 78.9 The U.S Supreme Court found that the evidence adduced was insufficient to provide a basis for a finding that the contract unreasonably restrained competition. The record established that the choice of anaesthesiologists at the hospital was limited to one of the four doctor who are associated with the contracting firm. It was further found that if the respondent were admitted to the hospital’s staff, the range of choice would be enlarged, but the most significant restraints on the patient’s freedom to select a specific anaesthesiologist would nevertheless remain. There was further no evidence that the price, quality, or supply or demand for either the “tying product” or the “tied product” has been adversely affected by the exclusive contract, and no showing that the market as a whole has been affected at all by the contract.

- [79] These established markets were tested through a series of economic and factual evidence adduced during hearing proceedings.
- [80] We also considered the Commission's final findings and recommendations report in the HMI. It was found that the healthcare facilities sector consists mainly of general acute care hospitals which offer a wide range of specialities though there are significant similarities in the range of specialties offered by all general acute hospitals.⁶²
- [81] The Commission's report held that *"though we find that acute private hospitals compete on the basis of specialties and sub-specialties, it is nonetheless not necessary to breakdown the analysis to the speciality level, as private acute facilities compete on the same broad set of specialties and services. We have concluded that it is sufficient to analyse "in-hospital healthcare services as generally provided by general acute hospitals".*⁶³
- [82] In our view, Mediclinic's reliance on this established market is not controversial. In the circumstances, it is not necessary to belabour these reasons with evidence and arguments in support of Mediclinic's purported market definition.
- [83] Life's purported market definition is, however, both novel and contentious. It assumes that a single hospital premises may, in and of itself, constitute a contestable market.
- [84] In Life's view, Mediclinic's conduct is tantamount to foreclosure in respect of inpatients admitted to Mediclinic hospitals who receive dialysis. Life contended that because Mediclinic has a monopoly on its premises, this allows it to control, and effectively deny, access permissions and on-site storage facilities to third party dialysis service providers and favour its own in-hospital dialysis services.

⁶² Competition Commission's final findings and recommendations report in the Health Market Inquiry, September 2019, page 64.

⁶³ Competition Commission's final findings and recommendations report in the Health Market Inquiry, September 2019, page 64.

[85] Life has thus adopted an exceptionally narrow market definition which confines the relevant market to a particular multidisciplinary hospital's premises.

[86] We have not found any jurisprudence, and neither has Life provided any, which supports this novel approach. In light of this, we have sought to assess the plausibility of these market definitions in the present proceedings to determine whether Life has made out a *prima facie* case of dominance.

Life's purported vertical relationship between the upstream and downstream markets

[87] Not only are Life's purported market definitions novel, but they also present an alternate vertical relationship. Life defined the upstream market as one for provision of reasonable on-site storage facilities, and express access permissions to mobile dialysis service providers at a given acute multidisciplinary private hospital and the downstream market for the provision of in-hospital dialysis services at a particular hospital.

[88] Life submitted that "*Mediclinic acts as an operator of acute multidisciplinary hospitals, in terms of which it provides inputs into the provision of a range of in-hospital healthcare services within its hospitals. In respect of in-hospital dialysis services, those inputs are access to, and reasonable on-site storage within, the relevant multidisciplinary hospital to dialysis services providers.*"⁶⁴

[89] According to Life, the provision of access permissions and reasonable on-site storage facilities to mobile dialysis providers constitutes an essential input into the market for the provision of in-hospital dialysis services, the two markets are vertically related.⁶⁵

[90] In the *Life-Fresenius Merger* the Tribunal considered the vertical relationship between the parties and found that the transaction raised vertical overlaps. This

⁶⁴ Life's founding affidavit, para 64.

⁶⁵ Life's heads of argument, para 52.

was so because Life provides acute multidisciplinary private hospital services and Fresenius was a dialysis service provider which administers dialysis treatment to patients admitted to acute hospitals.⁶⁶ In its input foreclosure assessment, the Tribunal considered Life's upstream market for the provision of multidisciplinary acute private hospital services and foreclosure related to access to hospitals which offered these services.

[91] In the present case Life considered the relevant input in the upstream market as storage space at a specific hospital and the downstream market correspondingly in respect of dialysis within that specific hospital.⁶⁷ In both instances the upstream and downstream are narrowly defined with respect to a particular hospital.

Demand and supply-side substitution

[92] A key element in the determination of the relevant market is the concept of substitutability. Below, we briefly set out principles related to demand and supply side substitutability as well as an assessment thereof.

[93] In defining the relevant market(s), it is necessary to consider both demand-side and supply-side substitution.

[94] Demand-side substitution occurs where consumers would switch to alternative products or services in response to a small but significant increase in price; such alternatives are therefore part of the same market. Supply-side substitution arises where suppliers can readily shift production or entry to provide the product or service in question, thereby exerting a competitive constraint. Both forms of substitution assist in delineating the boundaries of the market and in assessing the extent of market power.

⁶⁶ *Life and Fresenius Merger* CT Case No. LM035Jun23, para 26.

⁶⁷ Life's replying affidavit, para 32.

Demand side substitutability

[95] Life submitted that “a patient that is admitted to a multidisciplinary hospital as a result of an acute episode (i.e., either an acute or chronic inpatient) is typically confined to a hospital bed for the duration of their treatment, often within an ICU, and this is a very significant restriction on their ability to procure dialysis services outside of the hospital (e.g., at a Standalone Clinic, or at another multidisciplinary hospital) for the duration of their treatment. That is, the relevant market is limited to the provision of in-hospital dialysis services within a particular multidisciplinary hospital.” [own emphasis]⁶⁸

[96] In our assessment of demand side substitution factors, we first considered the hypothetical monopolist test set out below.

Hypothetical monopolist test

[97] The hypothetical monopolist test is an established economic test relied on to determine the extent of a product market. This test starts by looking at the narrowest possible putative markets and asks whether a hypothetical monopolist over that putative market could increase its profits by implementing a small but significant non-transitory increase in price (“SSNIP”) above the competitive level.

[98] Constrained by the evidence before us, we are unable to conduct the SSNIPP test to determine the extent of the relevant market(s).

[99] During the proceedings, we however enquired from Mediclinic how one would apply the SNNIP test in circumstances where Mediclinic has enforced a barrier to entry for third party dialysis service providers at its hospitals.⁶⁹

⁶⁸ Life’s founding affidavit, para 59.1.

⁶⁹ Hearing transcript, page 166.

- [100] Mr Blou on behalf of Mediclinic explained that the present matter concerns foreclosure whereas the SNNIPP test will seek to determine whether or not Mediclinic has market power such that it is able to price its services independently of competitors.⁷⁰
- [101] Mr Blou submitted that if one were to apply the SNNIP test, total costs to the patient would increase agnostic of the particular in-hospital service provided. This would ultimately influence Mediclinic's ability to compete effectively in the multidisciplinary private hospitals market. Mr Blou further submitted that the ability to set prices is also affected by medical aid schemes.⁷¹
- [102] No evidence adduced by Life or Mediclinic apart from the abovementioned offered further assistance in conducting a SNNIP test to determine the appropriate market definition(s).
- [103] Whilst the SNNIP test primarily concerns consumer behaviour in the event of a price increase, the European Commission has also recognised that a decrease in quality may affect consumer behaviour. The European Commission's *Notice on the definition of the relevant market for the purposes of Union competition law* recognised alternatives to the SSNIP test, such as assessing the switching behaviour of customers of a zero-price product in response to a small but significant non-transitory decrease of quality ("SSNDQ").⁷²
- [104] In the present instance, whilst the parties did not directly make submissions or adduce empirical evidence relating to the SSNDQ, they did in their written and oral submissions explain the effect of a decrease in quality on patients' choices in both the broadly and narrowly defined markets.

⁷⁰ Hearing transcript, page 167.

⁷¹ Hearing transcripts, pages 167-168.

⁷² In general, an SSNDQ is applied as a conceptual framework for a qualitative assessment of demand substitution. The Commission does not usually assess whether such an SSNDQ would be profitable for a hypothetical monopolist. Moreover, a quantitative application of the SSNDQ test is subject to several difficulties, including in relation to the quantification of quality. See The European Commission's *Notice on the definition of the relevant market for the purposes of Union competition law* footnote 54.

[105] Mediclinic submitted that in the event that Mediclinic does not provide a high-quality service to patients, failure to do so would result in reputation harm and patients would “switch” to other vertically integrated multidisciplinary hospitals immediately or when they are admitted next.⁷³

[106] Life denies this owing to its narrow market definition which presumes that patients confined to hospital beds cannot readily switch dialysis services providers by relocating to another hospital.⁷⁴

[107] Considering the inconclusiveness of the SNNIP and SSNDQ tests we now turn to consider demand and supply side substitutability to determine the plausibility of Life’s purported market definitions.

Demand side substitution factors

[108] In Life’s view, patients’ confinement to a hospital and the inability to exercise choice suggests that there is no demand-side substitution. Life submitted that the lack of demand-side substitution as above described is the key to delineating the relevant market.⁷⁵

[109] In light of the above, we consider (i) classes of patients, (ii) the role of nephrologists and (iii) bundling of hospital services as demand side substitution factors.

(a) Classes of patients

[110] As above described, dialysis patients can broadly be classified as acute inpatients, chronic inpatients and chronic outpatients. Acute inpatients are admitted and receive treatment as a result of catastrophic events or unexplained deterioration in health (so-called crash landers). In the first

⁷³ Mediclinic’s answering affidavit, paras 40, and 58.2.

⁷⁴ Life’s founding affidavit, para 80.

⁷⁵ Life’s heads of argument, para 46.

instance we consider the classes of patients namely acute and chronic inpatients who receive in-hospital dialysis services.

- [111] With respect to catastrophic events, it stands to reason that patients (especially in life threatening situations) would, out of necessity, choose the nearest hospital to receive treatment and at least be stabilised. Patient's choice is driven by urgency and proximity rather than considerations such as price, reputation or prior preference. In such circumstances, patients will, out of necessity, seek treatment at the nearest hospital capable of providing immediate stabilisation, because timely treatment as opposed to mode of service delivery determines the patient's ultimate choice.⁷⁶
- [112] From a demand-side substitution perspective, this shows that hospitals within a reasonable geographic radius exert competitive constraint on one another in respect of catastrophic events (and by implication in respect of dialysis services), as patients regard these facilities as interchangeable in the face of urgency. In this instance, the relevant competitive constraint therefore arises from the availability of alternative hospitals.
- [113] The Commission's final findings and recommendations report in the HMI stated that acute private hospitals compete on the basis of specialties and sub-specialties.⁷⁷ Further that "*there is competition for patients at the local level*".⁷⁸ We also understand from the HMI that the HMI focused on multidisciplinary acute facilities and day facilities which provide primarily in-hospital care, since both private acute facilities and day facilities provide a range of in-hospital healthcare services within certain geographic areas and, therefore, compete with one another.⁷⁹

⁷⁶ Hearing transcripts, page 76.

⁷⁷ Competition Commission's final findings and recommendations report in the Health Market Inquiry, September 2019, page 64.

⁷⁸ Competition Commission's final findings and recommendations report in the Health Market Inquiry, September 2019, page 67.

⁷⁹ Competition Commission's final findings and recommendations report in the Health Market Inquiry, September 2019, page 247.

[114] Life described crash landers as patients who experience “a sudden unexplained deterioration in their health and are for the first time diagnosed with kidney disease”.⁸⁰ Further that a crash lander is a “patient who has not historically received chronic dialysis treatment is admitted, for example, to Mediclinic Vergelegen owing to an acute episode⁸¹ when it is discovered for the first time that the patient has a condition which will necessitate them obtaining dialysis treatment for the duration of their admission but also ongoing, chronic dialysis treatment post-discharge.”⁸²

[115] To our understanding, when patients of this nature seek medical attention, they do not at that stage know that they have kidney disease. This was explained by Mr Blou on behalf of Mediclinic during the proceedings.

“MR BLOU: ... *But he was not even admitted for that, he was admitted for a cardiac problem because the cardiologist of his choice or the choice of his GP which happens to be at that hospital, that is what dictated his choice to go to Mediclinic or Life in the first place. He now happens to need - because there is a relationship between cardiac problems and kidney problems, he now happens to need dialysis which he was not admitted for, an acute dialysis.*”

[116] From the oral evidence it would appear as though crash lander patients (who after being discharged become chronic outpatients) make a decision on which hospital or general practitioner before they know the extent of their medical condition. Mr Blou on behalf of Mediclinic made this point during the hearing stating that:

⁸⁰ Life’s founding affidavit, para 38.1.2.

⁸¹ In medical terms, an acute episode describes a health issue with a sudden onset, rapid progression, and usually a short duration, requiring prompt attention but often resolving fully with treatment, unlike chronic conditions which develop slowly and last long-term.

⁸² Life’s founding affidavit, para 95.6.

“MR BLOU: ... *there might be a situation where in-hospital I have to get radiology done urgently. That is not a market. That is a customer need that arises after he has already made his choice.*”⁸³

[117] Life argued that acute and chronic inpatients become ‘captive’ to Mediclinic Renal for in-hospital dialysis treatment.⁸⁴

[118] We agree that once a patient is admitted to a particular hospital the patient is effectively confined to a hospital bed for the duration of their admission and will be curtailed from exercising choice in respect of which service provider administers dialysis services. However, Life’s purported market definitions ignore the pre-admission decisions made by patients in the broad market for the provision of acute multidisciplinary private hospital services (particularly as explained in relation to acute inpatients owing to catastrophic events and crash landers).

(b) Role of nephrologists and specialist physicians

[119] It is common cause that the decision as to which dialysis service provider to use is dictated by the referring nephrologist.⁸⁵ Life submitted that *“the decision as to which dialysis services provider a patient is referred to typically rests with the relevant patient’s nephrologist or specialist physician, and that referral decision is primarily informed by the nephrologist or specialist physician’s perception of the quality of care provided by particular dialysis services providers.”*⁸⁶

[120] It is also common cause that once a patient is discharged from a Mediclinic hospital it will be referred by their nephrologist to standalone facilities (which administer dialysis to chronic outpatients) or other in-hospital chronic facilities. During the hearing proceedings, Mr Wesley, on behalf of Life, stated that:

⁸³ Hearing transcript, page 135.

⁸⁴ Life’s founding affidavit, paras 78, 81 and 112.

⁸⁵ Hearing transcripts page 150.

⁸⁶ Life’s founding affidavit, para 44.

“MR WESLEY: ... *Ms Ndoni, what we said and I think what Mediclinic agrees is that those patients who are out-patients, they get their first treatment in the hospital and that is done by the referring doctor. But obviously, it can only be to a provider in the hospital, because they cannot leave.*”⁸⁷

[121] According to Life, prior to Mediclinic’s decision to revoke its access to Mediclinic’s premises, nephrologists or specialist physicians could freely refer inpatients at Mediclinic hospitals for dialysis by third-party providers, who would administer the dialysis treatment on a mobile basis at the Mediclinic hospital in question.⁸⁸

[122] It appears as though nephrologists and specialist physicians are the main channel through which demand side substitutability operates, given that the decision regarding which hospital a patient is admitted at is largely based on the nephrologist or specialist physician’s discretion.⁸⁹

[123] Other factors which may affect nephrologist / specialist physician’s choice of services providers when referring patients are briefly set out below.

123.1 *Perverse incentives:* Mediclinic alleged that Fresenius (prior to the *Life-Fresenius Merger*) adopted a practise where nephrologists are incentivised for referring patients to certain service providers.⁹⁰ Mediclinic submitted that such perverse incentives are prohibited in terms of the Ethical and Professional Rules of the Health Professions Council of South Africa (“HPCSA”) as these incentives may threaten the independence of the practitioner. Mediclinic alleges that these perverse incentives would inhibit independent service providers ability to compete with Life in Mediclinic hospitals.⁹¹ Life denies these

⁸⁷ Hearing transcripts, page 25.

⁸⁸ Life’s founding affidavit, para 11.

⁸⁹ Life’s replying affidavit, para 9.3.4.

⁹⁰ Mediclinic alleges that it does not believe that this practice has stopped since Fresenius was acquired by Life. Mediclinic’s answering affidavit, para 88.

⁹¹ Mediclinic answering affidavit, para 88.

claims and state that payment to nephrologists are remuneration for legitimate work undertaken.⁹²

123.2 *Admission rights:* Life also submitted that “*in circumstances where a nephrologist or physician operating from a Mediclinic hospital wishes to refer an acutely ill patient to receive in-hospital dialysis from a Life Renal Dialysis Mobile Unit but as a result of the Respondents’ foreclosure strategy is unable to do so, that nephrologist or physician cannot simply have the relevant patient admitted at another multidisciplinary hospital for treatment. This is because doctors require admission rights to have patients admitted at particular hospitals, and doctors very seldom have admission rights at numerous hospitals.*”⁹³ This is not disputed by Mediclinic.⁹⁴

[124] We do not pronounce on the impact of the alleged perverse incentives on nephrologists’ ability to influence demand side substitution as this falls outside the ambit of our scope. We further note that the submissions regarding admission rights were not pursued during oral argument and no further submissions on the effect of admission rights on the nephrologists’ choice of service providers was put before us.

[125] Based on the evidence before us, we are unable to determine whether the discretion exercised by nephrologists or specialist physicians in referring patients to dialysis service providers enhances or constrains demand-side substitution.

(c) Bundling of hospital services

[126] Mediclinic primarily argued that patients choose hospitals based on an integrated bundle of services (including dialysis) and that competition occurs

⁹² Life’s replying affidavit, para 9.3.15.

⁹³ Life’s founding affidavit, para 96.8.

⁹⁴ Mediclinic’s answering affidavit, paras 164-166.

between these bundles.⁹⁵ Life however argued that there is a separate, hospital-specific, relevant market for in-hospital dialysis services.

[127] According to Life, patients do not typically consider quality, choice and/or cost of dialysis services when choosing a hospital (and as such, the upfront competitive constraints at the hospital-level do not translate into constraints at the dialysis services-level), and second that, once they have been admitted to a given hospital, patients are 'locked in' to the services available at that hospital.⁹⁶

[128] In our view, although patients may be locked into a hospital once admitted and do not typically select hospitals based on dialysis services alone, it is plausible that inpatient dialysis is an inseparable component of a broader suite of acute hospital services. This is especially true in respect of acute inpatients who do not know that they have kidney disease upon admission. These patients seek medical treatment for illness and injury often not even knowing the type of hospital service they will eventually need.

[129] It stands to reason that the patient's choice is based on the overall general suite of services offered by an acute multidisciplinary hospital. Once a patient is discharged and requires dialysis as a chronic outpatient, the patient will then be able to exercise choice with respect to a dialysis service provider as this can be done at standalone clinics or in-hospital units.⁹⁷

[130] Life also does not adduce evidence on patients' choice in circumstances where multiple hospital services are required simultaneously. We can safely assume that there may be instances where acute inpatients receive a range of services which could include for example, amongst others, dialysis, orthopaedic care, and oncology services as part of a single instance of being treated upon

⁹⁵ Described as a "system market" which is a unified market for the primary product and the secondary product (i.e., a market for razor heads and replacement heads). OFT Guidance on Market Definition (2004), p. 21, para 6.1. Also see Mediclinic's answering affidavit, para 40.

⁹⁶ Life's replying affidavit, para 18.

⁹⁷ Hearing transcripts, page 26.

admission. Would the implication be that the patient is locked in with respect to each of these distinct hospital services?

[131] In our view, it is more plausible that competitive constraints operate at the level of the hospital bundle rather than at the level of distinct individual hospital services. Mr Blou on behalf of Mediclinic captures this stating that:

“MR BLOU: ... But the choice that is made here is not tested by the patient on his bed as to which he would like a range of nephrology services from which to choose and which X-ray definition. He has gone to a hospital that if an eventuality arises, that hospital will be able to treat all of his ills.”⁹⁸

[132] Accepting a hospital-specific market for in-hospital services on the basis of a patient being locked in would assume the existence of separate hospital-specific monopolies for each inpatient service.

Conclusion on demand-side substitutability

[133] Based on the above, we are of the view that acute inpatients are able to exercise choice and choose between alternative acute multidisciplinary hospitals in response to changes in factors such as price and quality before their admission to a hospital.

[134] We find Mediclinic’s purported broader market definition more plausible as patients are able to exercise choice before admission based on a general suite of hospital services offered in instances where they are not certain of the extent of their medical condition. The above supports defining the relevant market more broadly.

⁹⁸ Hearing transcript, page 86.

Supply side substitutability

- [135] Supply side substitution in the present instance is uncontentious. It is common cause that dialysis can be administered to patients admitted to a multidisciplinary hospital by an in-hospital unit that is located within the relevant hospital, or by a mobile unit that is capable of providing renal services at the relevant hospital in a short period of time.⁹⁹ There are further no technical barriers preventing mobile units from providing dialysis services within their operating areas because there is no material differences in processes, staff and equipment used to administer in-hospital dialysis to acute and chronic inpatients, or to administer in-hospital dialysis treatments in different multidisciplinary hospitals.¹⁰⁰
- [136] Even in instances where a mobile unit does not presently operate within a given multidisciplinary hospital, they can quickly, and without incurring significant cost, begin administering treatment to inpatients within that particular multidisciplinary hospital.
- [137] Lastly, an external dialysis services provider that administers treatment in a standalone clinic (to chronic outpatients) can also readily reallocate existing capacity to provide in-hospital, mobile dialysis services via Mobile Unit without incurring significant additional costs; any such additional costs would be primarily limited to the purchase of a portable reverse-osmosis water purification machine, and the purchase or lease of a vehicle to transport staff and equipment.¹⁰¹
- [138] We also understand from the oral submissions by Life that outpatient facilities could be located close to acute multidisciplinary hospitals. Mr Wesley on behalf of Life submitted that Mediclinic has an outpatient facility, Rochester Place, which is located 350 m away from the Mediclinic Morningside hospital.¹⁰²

⁹⁹ Life's founding affidavit, para 59.2

¹⁰⁰ Life's founding affidavit, para 59.2.

¹⁰¹ Life's founding affidavit, para 59.4.

¹⁰² Hearing transcripts, page 24.

- [139] According to Life, however supply-side substitution can only take place if third party service providers have access to the hospital and on-site storage facilities which is considers the two key inputs for dialysis service providers to render in-hospital services.¹⁰³
- [140] Mediclinic did not make any explicit submissions in relation to supply-side substitution.
- [141] The conclusion with respect to supply side substitution is thus affected by the conclusion reached with respect to the relevant market definition(s).

Geographic market

- [142] With respect to the geographic markets, Life submitted that because patients admitted on an inpatient basis (including both acute and chronic inpatients) are confined to hospital beds (and cannot travel to receive dialysis treatment), the choice of dialysis services provider is limited to in-hospital units and mobile units capable of travelling to, and operating effectively at, the relevant hospital at which the patient is admitted.¹⁰⁴
- [143] In relation to mobile units, Life submitted that while the precise distances a particular mobile unit is willing and able to travel to administer dialysis treatment may depend on its specific capabilities and certain characteristics of the relevant area, mobile units typically operate within a 50 km, or shorter, radius from their “base”.¹⁰⁵ Life concluded that the relevant geographic market is within at most a 50 km radius from the relevant multidisciplinary hospital in question.¹⁰⁶

¹⁰³ Life’s heads of argument, para 48.

¹⁰⁴ Life’s founding affidavit, para 60.

¹⁰⁵ Life’s founding affidavit, para 61.

¹⁰⁶ Life’s founding affidavit, para 62.

[144] In response, Mediclinic submitted that they do not dispute that renal dialysis services providers compete for space and patients within a particular catchment area. Mediclinic further accepted that mobile services providers will not travel excessive distances to deliver their treatment. The precise boundaries of the market will vary around the country.¹⁰⁷ Mediclinic further submitted that the provision of renal dialysis services must be considered in its proper context at both a regional and national level; and the market percentage held by the relevant parties in these geographic areas determined.¹⁰⁸

[145] Whilst Life contends that the geographic market is confined to individual hospital premises and that mobile units operating within those hospitals serve areas within a 50 km radius of their base, the evidence before us does not permit a definitive determination of the appropriate geographic market. This is particularly so in instances where we have not been persuaded that the market is as narrowly defined as Life suggests.

Artificial monopolies

[146] Adopting the narrowest approach with respect to market definition risks collapsing market definition into automatic dominance and ignores *ex ante* competition.

[147] In our view, Life's purported market definition focuses on substitution after admission. This is evidenced by the fact that Life viewed Mediclinic's market definition as one which "*fails to assess competition at the point where it matters most for patients - the point of care for bed-bound patients requiring dialysis within specific hospitals.*"¹⁰⁹ Whereas Mediclinic's purported market definition considers substitution before admission adopting a single holistic market for the provision of multidisciplinary hospital services where hospitals are chosen by patients based on an integrated bundle of services.¹¹⁰

¹⁰⁷ Mediclinic's answering affidavit, para 143.

¹⁰⁸ Mediclinic's answering affidavit, para 144.

¹⁰⁹ Life's replying affidavit, para 13.

¹¹⁰ Hearing transcripts, page 120.

[148] The effect of endorsing Life's approach, in our view, is that it creates an artificial or false monopoly. In effect, the market definition in and of itself confers dominance, we will discuss this in the section to come.

[149] Defining the market at the level of a single hospital risks treating external constraints faced by Life as evidence of market power, thereby artificially constructing a monopoly that does not stem from exclusionary conduct or a lack of potential competition. A market defined in such a narrow sense risks over-stating market power and understating competitive pressure from neighbouring hospitals, specialist facilities, or potential entrants.

[150] Competition in hospital markets often takes place through non-price factors, i.e., hospital/treatment quality, reputation, clinical specialisation, and medical aid negotiations, across a network of facilities rather than at the level of an individual hospital. If each hospital were defined as its own market, all hospitals, would be monopolists, thus rendering market shares uninformative and undermining the purpose of market definition as a tool to assess competitive constraints. This approach, in our view, would be inconsistent with competition-law principles, which seek to distinguish between monopoly power arising from market structure and that arising from artificial segmentation of demand.

Conclusion on the relevant market

[151] Life's novel approach to the market definition required us to undertake foundational inquiries the proper determination of the relevant market. In doing so, we were bound to determine this on the evidence properly before us. We are therefore not at liberty speculatively to advance or rely on theories in circumstances where the case presented is not substantiated by evidence presented by the Applicant.

[152] Based on the above, we find that the *prima facie* relevant market is the market for the provision of acute multidisciplinary private hospital services. In light of this, we turn to whether Mediclinic is dominant in this market.

Dominance and market power

- [153] It is trite that a firm is presumed to be dominant if it has market share between 35% and 45%, unless it can show that it does not have market power.¹¹¹ Conversely, where a firm's market share is below 35%, the onus rests on the applicant to show that the respondent firm has market power.
- [154] The Act defines market power as "*the power of a firm to control prices or to exclude competition or to behave to an appreciable extent independently of its competitors, customers or suppliers.*"¹¹²
- [155] In the present circumstances, we consider whether Life has made out a *prima facie* case that Mediclinic is dominant in the market for the provision of acute multidisciplinary private hospital services.
- [156] Notwithstanding Life's narrow market definition for the provision of reasonable on-site storage facilities and express access permissions to mobile dialysis service providers at a given acute multidisciplinary private hospital, it also advanced an alternative market definition.¹¹³ Life argued that the market for the provision of acute multidisciplinary private hospital services (primary market) functions as a related, complementary market to the market for inpatient dialysis services (secondary market) ("leveraging theory of harm").¹¹⁴ Accordingly to Life, Mediclinic is able to leverage its market power in the primary market (hospital services) once patients are 'locked in' into the secondary market (in-hospital dialysis services at a particular hospital).¹¹⁵
- [157] According to Life, when a patient is admitted to a Mediclinic hospital for acute multidisciplinary hospital services (which are distinct from specialist disciplines, like dialysis services) (primary market), that inpatient is captive to Mediclinic for

¹¹¹ *Nationwide Airlines and Others v South African Airways (Pty) Ltd and Others* (92/IROct00), p 9.

¹¹² Section 1 of the Act.

¹¹³ Life's founding affidavit, para 72.

¹¹⁴ Life's founding affidavit, para 73.

¹¹⁵ Life's replying affidavit, paras 16-17.

those hospital services and Mediclinic accordingly has market power in respect of the inpatient healthcare services provided to that patient (secondary market).¹¹⁶

[158] Mediclinic concedes that controlling access to its own hospitals can prevent downstream competitors from providing services in its hospitals, but that this does not confer market power.¹¹⁷ Mediclinic also contended that the market does not consist of two tied markets (the primary hospital services market and the secondary inpatient healthcare services market) but rather that the market is a single holistic market for multidisciplinary services.

[159] Life did not adduce evidence that Mediclinic has a market share of above 35% in the broadly defined market for the provision of acute multidisciplinary private hospital services. In this regard, Mediclinic submits that it is not dominant in this market given that it is *“smaller than Life and Netcare and has a market share well below 35%.”*¹¹⁸

[160] In its heads of argument, Mediclinic further submitted that Life operates more hospitals than Mediclinic and Life Renal generates substantially more revenue than Mediclinic Renal.¹¹⁹

[161] With respect to market power, Life contends that through its conduct, Mediclinic is able to leverage its market power from the hospital care market (primary market) to the inpatient dialysis services market (secondary market).¹²⁰

[162] According to Life, when considering Mediclinic Renal’s ability to exercise market power within the market for the provision of in-hospital dialysis services at a given Mediclinic hospital, Mediclinic Renal’s market position in this regard is inherently intertwined with Mediclinic’s position within the related market for

¹¹⁶ Life’s founding affidavit, para 80.

¹¹⁷ Mediclinic’s answering affidavit, para 149.

¹¹⁸ Mediclinic’s answering affidavit, para 49.

¹¹⁹ Mediclinic’s heads of argument, para 6.

¹²⁰ Life’s heads of argument, para 53.

acute multidisciplinary private hospital services.¹²¹ This argument advanced by Life assumes that Mediclinic has market power in respect of inpatient healthcare services provided to patients admitted to its hospitals. Effectively, that Mediclinic is able to act independently of its competitors in the provision of inpatient healthcare services for the duration of that patient's admission.¹²²

[163] Life contends that the implication of Mediclinic's market power as above described, is that Mediclinic is able to influence the number of patients available for treatment by Medical Renal and its competitors in the market for the provision of dialysis services.¹²³

[164] At the heart of this enquiry into market power is whether one is dealing with two tied markets (primary hospital services market and secondary in-hospital dialysis treatment market) or a single holistic market being the market for hospital services.

[165] In our view, Life's leveraging theory of harm concluded that there is a distinct narrow downstream market for inpatient dialysis services. Life's leveraging theory of harm rests on the fact that once patients are admitted they are effectively locked in. Life however does not adduce evidence that Mediclinic has market power in the primary market to leverage into the secondary market.

[166] On the evidence before us we are of the view that Life has not adduced sufficient evidence to make out a *prima facie* case that Mediclinic has market power (in neither of the purported primary or secondary markets).

[167] Life has additionally not provided a regional assessment of competing hospitals in at least each of the Effected Hospitals where it has to date been excluded. This type of assessment may have been helpful in determining whether or not in isolated cases (i.e., where Mediclinic hospitals exist with no rivals within a reasonable proximity) Mediclinic would be able to exercise market power.

¹²¹ Life's founding affidavit, para 77.

¹²² Life's founding affidavit, para 78.

¹²³ Life's founding affidavit, para 79.

[168] During the hearing, regarding market power, we noted that as in COVID cases, market power may be inferred from conduct. While those cases concerned independent pricing, we noted that the total foreclosure of competitors could similarly be indicative of market power.¹²⁴ We asked the parties for their views on this.

[169] In response to this, Mr Wesley, on behalf of Life, submitted that “... *as a matter of practicality, Mediclinic has an ability to act independently of what like Renal Care wants but even on its own referring doctors and its hospitals want.*”¹²⁵

[170] Mr Blou, on behalf of Mediclinic, however submitted that COVID cases have to be considered in the context of supply and demand which were created in peculiar circumstances as a result of the pandemic. Further that the analysis under the COVID cases is not appropriate in the present circumstances.¹²⁶

[171] We agree with Mediclinic that the assessment of market power during the COVID-19 pandemic is not the appropriate analysis in the present case. The assessment of market power in COVID related matters was premised on the exceptional circumstances which existed.

[172] For the reasons above, we are of the view that Life has not made out a *prima facie* case that Mediclinic is dominant in any of the markets defined.

Conclusion

[173] We reiterate the guidance in *eMedia*, where the CAC emphasised that in interim relief cases “*whilst there will inevitably be disputes of fact*”, these should not prevent the Tribunal from taking a “robust approach” on the evidence before it.

¹²⁴ Hearing transcripts, page 61.

¹²⁵ Hearing transcripts, page 61.

¹²⁶ Hearing transcripts, pages 138-139.

- [174] Further that the purpose of the Competition Act serves as a guideline which should be followed when applying the Act. Victor J (Manoim J concurring) stated that *“the approach calls for a transformative constitutional approach and must be consistent with the scheme of the Competition and apply a context-sensitive approach.”*¹²⁷
- [175] In the spirit of applying a context-sensitive approach in our determination, we emphasise that this matter concerns two of the three largest private hospital groups in South Africa, each with financial resources and institutional sophistication competing at the apex of the market.
- [176] It is also worth emphasizing that the hospital services at the centre of this matter are provided within the private sector, which mainly provide health services to high-income consumers and those with medical insurance. The matter does not strictly speaking concern access to healthcare services, especially for low-income individuals, and it does not relate to healthcare provided in the public sector. Instead, this matter is about competitive conduct of private hospital groups operating within the private healthcare market where prices are determined largely as an outcome of negotiations between suppliers (private hospitals) and funders (medical aid schemes).
- [177] Given the nature of the alleged contravention, our key consideration in this matter related to whether or not Mediclinic is dominant in the relevant market(s). Whilst being mindful of the above-described context, our determination of Mediclinic’s is grounded in, and confined to the evidence before us.
- [178] In the absence of a finding that Mediclinic holds a dominant position, its decision to insource renal dialysis services is unlikely to contravene the Act, which is concerned with conduct that has the potential to substantially prevent or lessen competition. Mediclinic’s decision to insource is not, in our view, in and of itself, indicative of a prohibited practice.

¹²⁷ *eMedia Investments (Pty) Ltd v Multichoice (Pty) Ltd and another* (201/CAC/JUN22) (1 August 2022) at para 84.

- [179] Although a robust approach involves context-sensitive considerations and transformative constitutional imperatives, in the present matter, we have concluded that there are not clear, non-speculative and uncontroversial facts supporting the granting of the interim relief sought by Life.
- [180] Based on the evidence before us, the market defined by Mediclinic for the provision of acute multidisciplinary inpatient private hospital services in South Africa appears to us *prima facie* to be the plausible relevant market in the present matter.
- [181] On the conspectus of evidence before us, Life has not adduced sufficient evidence to support its purported narrower market definitions. Life's novel approach to the market definitions in our view has the unintended consequences of creating an artificial monopoly where Mediclinic's hospital premises constitutes a market in and of itself. Whilst there may be credence to this, the evidence before us did not support a *prima facie* finding that this market definition is plausible.
- [182] Undoubtedly, the Complaint will be referred to this Tribunal where the relevant facts relating to the market definition will be fully and properly ventilated.
- [183] With respect to dominance and market power, we conclude on the basis of the evidence before us, that, Life has not made out a *prima facie* case that Mediclinic is dominant in any of the aforementioned considered markets.
- [184] Considering the above, we do not assess the remaining factors.
- [185] We make the following order:

ORDER

[186] Mediclinic's supplementary affidavit and Life's response there to is admitted.

[187] For the reasons above, we dismiss Life's application for interim relief.

[188] There is no order as to costs.

Signed by: Imraan Valodia
Signed at: 2026-02-23 10:52:28 +02:00
Reason: Witnessing Imraan Valodia

Imraan Valodia

23 February 2026

Date

Prof. Imraan Valodia

Ms Andiswa Ndoni (Concurring)

A Wessels (dissenting)

- [189] I have had the privilege of reading the reasons and order of my brother Prof Imraan Valodia, which my sister Ms Andiswa Ndoni concurs with. It is with regret that I record my disagreement with the conclusions on *prima facie* market delineation and *prima facie* dominance and therefore with the order given on that basis.
- [190] The conduct in issue is the Respondents' refusal to permit the Applicants (Life Healthcare Group (Pty) Ltd ("Life Healthcare Group") and Life Renal Care (Pty) Ltd ("Life Renal Care")), trading as Life Renal Dialysis¹²⁸, access to, and reasonable storage space in, five hospitals that Mediclinic operates in order for Life Renal Care to provide renal dialysis services at these hospitals. These hospitals are Mediclinic Vergelegen (in Somerset West, Cape Town); Mediclinic Morningside (in Sandton, Johannesburg); Mediclinic Panorama (in Panorama, Cape Town); Mediclinic Potchefstroom; and Mediclinic Newcastle.
- [191] The Respondents are Mediclinic Southern Africa (Pty) Ltd ("Mediclinic") and Mediclinic Renal Services (Pty) Ltd ("Mediclinic Renal Services"). Mediclinic owns and operates 50 hospitals and 14 Day Case Clinics in Southern Africa. Mediclinic Renal Services, established in 2021, has to date established its own renal dialysis treatment facilities (some being acute and others acute and chronic) at twelve of its hospitals.
- [192] Life Renal Care offered dialysis services at the abovementioned hospitals until Mediclinic Renal Services entered the market(s).¹²⁹ It is not in dispute that the Respondents' conduct prevents Life Renal Care from offering any renal dialysis services (described below) at each of the abovementioned five Mediclinic hospitals. As Mediclinic puts it: "*For so long as they [patients] are admitted at Mediclinic, Life cannot treat them*".¹³⁰

¹²⁸ Life Renal Care and Life Renal Dialysis are used interchangeably in these reasons.

¹²⁹ FA, para 14.

¹³⁰ Mr Prinsloo AA, para 146.

[193] In my view the Applicants have made out a case for a *prima facie* separate relevant product market for the provision of in-hospital renal dialysis services (explained below) and Mediclinic Renal Services *prima facie* is dominant in terms of section 7 of the Competition Act 89 of 1998 as amended (“the Act”) in the provision of in-hospital renal dialysis services at each of the five hospitals in question.

[194] My approach and my reasoning are elucidated here.

Approach to interim relief

[195] It is trite that in interim relief in terms of section 49C of the Act the applicant only needs to establish its case on a *prima facie* basis.¹³¹ The Tribunal is enjoined to “*make a summary assessment ... This assessment is only at a prima facie level*”¹³² and with reference to “*prima face evidence*”.¹³³ This also applies to the issues of market delineation, as well as dominance as defined in section 7 of the Act (that is a prerequisite for a section 8 ‘abuse of dominance’ contravention).

[196] I take guidance from the Competition Appeal Court (“CAC”) in *eMedia* where it states that the Tribunal and CAC must when applying the provisions of the Act take a transformative constitutional approach and must apply a context-sensitive approach.¹³⁴ The CAC guides that the jurisprudential and transformative principles apply both at interim relief stage and at final relief stage.¹³⁵

[197] In *eMedia*, the CAC has further enunciated the approach to disputes of fact in interim relief proceedings. The CAC has found that while “*there will inevitably*

¹³¹ *eMedia Investments Proprietary Limited South Africa v Multichoice Proprietary Limited and Another* [2022] CPLR 23 (CAC) (“*eMedia*”), *inter alia* paras 67 and 95.

¹³² *eMedia*, para 93.

¹³³ *Mercantile Bank, A Division of Capitec Bank Ltd and others v Surve and others* [2023] 3 CPLR 33 (CAC), para 25.

¹³⁴ *eMedia*, para 84.

¹³⁵ *eMedia*, para 95.

be disputes of fact” in interim relief matters, that should not prevent the Tribunal from taking a “*robust approach*” on the evidence before it.¹³⁶

[198] Since context matters, the assessment of market delineation and dominance on a *prima facie* basis must be done in its proper context on a case-by-case basis taking into account any relevant conduct of the respondent(s) in the matter. The conduct at issue may affect market conditions, for example, the assessment on the supply side of barriers to entry into the market(s) in question, and may raise barriers to entry, as is the case here, as explained below.

Contextual, constitutional approach

[199] It is common cause that the Respondents are preventing the provision of in-hospital dialysis services (explained below) by a third-party, Life Renal Care, at five of its hospitals.

[200] The matter, in essence, concerns access by affected customers (i.e., dialysis patients) to healthcare services. Renal dialysis services are provided to patients with acute kidney failure, end stage kidney failure and chronic kidney disease. It filters waste products, toxins, and excess fluid from the blood when the kidneys fail, artificially performing their vital function of maintaining fluid/electrolyte balance.

[201] Renal dialysis therefore is a life-enhancing and life-saving treatment, which is required by many thousands of patients in South Africa. The South African Renal Registry collects, analyses and publishes information on kidney replacement therapy (“KRT”) for patients with kidney failure in South Africa. The South African Renal Registry Annual Report states that the total number of patients on KRT on 31 December 2022 was 9 342¹³⁷ (including patients in the

¹³⁶ *eMedia*, paras 80 – 81.

¹³⁷ This is higher than the 8 866 reported for December 2021, and the 8 734 reported for December 2020.

private and public sectors).¹³⁸ In the private sector, the number of patients increased from 6 576 in 2021 to 6 967 in 2022.¹³⁹ A 2021 estimate regarding low-middle income countries, indicate that only 20% of dialysis patients received the care they require.¹⁴⁰ The Applicants submit that this 20% figure is likely true of South Africa, if one considers that approximately only 16% of the South African population has access to private healthcare and that government provides some, but very little, access to dialysis in the public sphere.

[202] It is evident from the above that patients that need dialysis are severely compromised from a health perspective.¹⁴¹ They are a vulnerable group of patients in that a patient that requires renal dialysis may face a life-or-death situation should treatment not be administered. Therefore, particularly the quality of service they receive is important to these patients, in addition to the price of the service provided, elucidated on below.

[203] Dialysis is prescribed by specialist physicians or nephrologists who refer patients to dialysis service providers. Such service providers employ specialist medical technologists and nephrology nurses i.e., renal technologists and renal nurses to administer dialysis to the patients.

[204] The decision as to which dialysis services provider a patient is referred to typically rests with the relevant patient's nephrologist or specialist physician. That referral decision is primarily informed by the nephrologist or specialist physician's perception of the quality of care provided by particular dialysis services providers. Significantly, the referral of patients by nephrologists and specialist physicians to particular dialysis services providers is a function of their ability to exercise clinical independence in determining an appropriate protocol of care for their patients.

¹³⁸ South African Renal Registry Annual Report 2022 published in October 2024 in *African Journal of Nephrology*, Vol 27, No 1, 2022, pages 58 - 69.

¹³⁹ Page 62 of the Report.

¹⁴⁰ www.kidney.org/kidneydisease/global-facts-about-kidney-disease.

¹⁴¹ Mr Streak AA, para 16.

- [205] Given the above context, the matter clearly invokes dialysis patients' constitutional right to have access to healthcare and the Respondents' conduct must be assessed in that light.
- [206] The Constitutional Court has recognised the importance of promoting a competitive environment in which healthcare services are provided in alignment with the constitutional right of access to healthcare services provided in section 27 of Constitution of the Republic of South Africa, 1996 ("the Constitution"). In the words of the Constitutional Court in *Mediclinic*:¹⁴² "*The Constitution provides for a fundamental human right 'to have access to health care services'*".¹⁴³ In terms of section 27 the constitution "*Everyone has the right to have access to health care services, ... The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights*".
- [207] The Constitutional Court in *Mediclinic* goes on to say "*Besides, both the Tribunal and the Competition Appeal Court are institutions of the State that bear the obligation to facilitate rather than impede, albeit inadvertently, the right of access to health care services.*"¹⁴⁴
- [208] The Constitutional Court has enjoined the competition authorities to promote the spirit, purport and objects of the right of access to healthcare services and, in doing so, to consider "*[t]he vulnerability of uninsured patients, the fundamental right to access health care services, the objectives laid out in the Preamble and purpose of the Act and the need for consumers to have a free and wider choice of high quality goods and services ...*"¹⁴⁵. (emphasis added)
- [209] The Constitutional Court in *Mediclinic* further notes the ever-rising tariffs consumers of medical services already have to contend with in the private sector and the impact thereof on the interests of the public.

¹⁴² *Competition Commission of South Africa v Mediclinic Southern Africa (Pty) Ltd and Another* 2022 (4) SA 323 (CC) ("*Mediclinic*").

¹⁴³ *Mediclinic*, para 71.

¹⁴⁴ *Mediclinic*, para 71.

¹⁴⁵ *Mediclinic*, paras 72 and 74.

- [210] As also indicated by the Constitutional Court, regard must be had to the preamble and purpose of the Act. The Court reminds us that sight must never be lost of the central purpose for the enactment of that Act and for the investigative and adjudicatory structures that it gave birth to.¹⁴⁶ It says that the institutions created to breathe life into the critical provisions of the Act must never allow what the Act exists to undo and to do, to somehow elude them in their decision-making process.¹⁴⁷
- [211] The purpose of the Act is to promote and maintain competition in the Republic in order *inter alia* - to provide consumers with competitive prices and product choices. The Respondents' conduct affects South African hospitalised dialysis patients' access to a choice of dialysis service providers. In fact, the Respondents' conduct to deny a competitor access to its hospitals in question leaves inpatients (patients who receive dialysis services in a hospital, described further below) in those hospitals with just a single choice of service provider. Mr Prinsloo of Mediclinic Renal Services submits that once patients have chosen to be admitted at a Mediclinic hospital and, having made that choice, will receive the services that Mediclinic chooses to provide to them.¹⁴⁸ In his words, once "*Patients have chosen Mediclinic as their hospital provider. For so long as they are admitted at Mediclinic, Life cannot treat them.*"¹⁴⁹
- [212] Mediclinic has essentially acquired for Mediclinic Renal Services the right to service a 'captured' set of dialysis patients, as explained below.¹⁵⁰
- [213] As background, I note that the outcome of the current application may have wide implications. Although the current application relates to the abovementioned five hospitals, Mr Prinsloo, a director of Mediclinic Renal Services and a director of BGM Renal Care (Pty) Ltd ("BGM"), concedes that "*It is correct that, over time, Mediclinic will seek to insource its renal dialysis*

¹⁴⁶ *Mediclinic*, para 5.

¹⁴⁷ *Mediclinic*, para 7.

¹⁴⁸ Mr Prinsloo AA, para 40.

¹⁴⁹ Mr Prinsloo AA, para 146.

¹⁵⁰ FA, para 96.2.

*services (at least the acute services) at most of its hospitals.*¹⁵¹ (emphasis added).

[214] Furthermore, Mr Prinsloo indicates that this decision of Mediclinic to insource Mediclinic's offering of renal dialysis services is part of a national strategy.¹⁵²

[215] Given Mediclinic's explanations for why it is denying the Applicants access to provide services at the hospitals in question, one can reasonably draw the inference that (all) third-party mobile dialysis services providers could potentially be excluded from the five hospitals in question (and potentially all other Mediclinic hospitals).

Types of patients and patient groups

[216] There are two groups of renal dialysis patients: (i) patients who receive dialysis services in a hospital because they have been admitted to the hospital - referred to as 'inpatients'; and (ii) chronic 'outpatients' that have not been admitted to a hospital.

[217] It is common cause that dialysis services can be provided to patients in hospitals by two types of services providers:

(i) a service provider that is resident in the relevant hospital ("in-hospital or resident units"); and

(ii) a service provider that provides mobile dialysis services and are able to come to a particular hospital to administer treatment ("mobile units").¹⁵³
The latter depends on access rights to the relevant hospital, as explained below.

[218] Regarding inpatients, there are two categories of inpatients:

¹⁵¹ Mr Prinsloo AA, paras 120 and 155.

¹⁵² Mr Prinsloo AA, para 120.

¹⁵³ FA, paras 37.1 and 41.1.

- (i) patients who have no history of kidney failure and have not previously been treated with dialysis, but who are admitted to hospital on an inpatient basis as a result of an acute episode and who require dialysis during their admission - referred to as 'acute' inpatients; and
- (ii) patients that have already been diagnosed with kidney disease who have been admitted to hospital - referred to as 'chronic' inpatients.

[219] Both acute and chronic inpatients receive treatment while confined to a hospital, often in a hospital's intensive care unit, and so are limited to receiving dialysis services from in-hospital units and mobile units that have access to the relevant hospital.¹⁵⁴

[220] Outpatients, on the other hand, can receive dialysis treatment at (i) a standalone dialysis clinic i.e. a clinic that operates outside of a multidisciplinary hospital; or (ii) at an in-hospital dialysis unit that treats chronic outpatients in addition to treating inpatients.¹⁵⁵

Timing of the foreclosure and overlap

[221] It is important to note that the Applicants were the incumbent service provider at each of the five Mediclinic hospitals where they have now been denied access.

[222] Mediclinic in 2021 decided to invest in the establishment of renal dialysis services capability. It created a new legal entity, called Mediclinic Renal Services with BGM as a minority shareholder, in 2021.¹⁵⁶ Mediclinic in 2024 and 2025 decided to remove Life's access rights at the five Mediclinic hospitals

¹⁵⁴ FA, para 41.1.

¹⁵⁵ FA, para 37.2.

¹⁵⁶ Mr Streak AA, para 10.

when it itself entered the dialysis services market(s) at the five hospitals in question.¹⁵⁷

[223] Mediclinic in my view does not need to exclude Life from the hospitals in question in order for Mediclinic Renal Services to provide its own rival service at these hospitals. The factual evidence shows that Mediclinic commenced implementing its strategy of exclusion at the precise time of its own entry. For a period of time however there were two rivals competing for the provision of dialysis services to inpatients at the five hospitals in question.

[224] Following Life Renal Care's receipt of the first notice from the Respondents on 1 August 2024 in which it was informed that it would no longer be permitted to administer dialysis services at Mediclinic Vergelegen, Mediclinic then iteratively excluded Life Renal Care from:

224.1. Mediclinic Vergelegen, with effect from 1 November 2024. As to the overlap between Life and Mediclinic providing dialysis services at Mediclinic Vergelegen "*there was a period of overlap (as Mediclinic Renal Services established itself) when both parties provided [dialysis] services*"¹⁵⁸;

224.2. Mediclinic Morningside, with effect from 15 December 2024. At Morningside, there was a period of several months where both parties operated¹⁵⁹;

224.3. Mediclinic Panorama, with effect from 3 March 2025. At Panorama, "*a phased approach was adopted in relation to this specific hospital*"¹⁶⁰;

¹⁵⁷ Mr Prinsloo AA, para 27.

¹⁵⁸ Mr Prinsloo AA, para 122.

¹⁵⁹ FA, para 48.3; AA, para 125.

¹⁶⁰ FA, para 51; AA, para 131; see Mediclinic's own email of 10 March 2025 (annexure FA7, 118), confirming both will operate.

224.4. Mediclinic Potchefstroom, with effect from 15 June 2025. At Potchefstroom, there was “a period of overlap as Mediclinic Renal Services established itself”¹⁶¹; and

224.5. Mediclinic Newcastle, with effect from 31 August 2025.

[225] From the above it is evident that for a period of time at Mediclinic Vergelegen, Mediclinic Panorama and Mediclinic Potchefstroom both Mediclinic and Life administered dialysis treatment to (acute and chronic) inpatients. Following the exclusion of Life at Mediclinic Vergelegen, Mediclinic alone now administers dialysis treatment to all inpatients and no third-party dialysis providers are present at the hospital to impose a competitive constraint on Mediclinic. This is similarly the case in relation to Mediclinic Panorama, and similarly the case in relation to Mediclinic Potchefstroom from 15 June 2025.

[226] For a period at Mediclinic Morningside, Mediclinic, Life and National Renal Care administered dialysis treatment, with National Renal Care only being permitted to treat paediatric cases¹⁶². It appears reasonable to infer from Mediclinic’s reasons given for denying Life access to Mediclinic Morningside, that National Renal Care could likewise be denied access and, if it is provided with access, then only to treat a small subset of (paediatric) inpatients. Mediclinic does not disclose to the Tribunal its exact intentions regarding access to National Renal Care at Mediclinic Morningside. If it is allowed access, it raises the question why Life Renal Dialysis has been targeted as the party being denied access.

[227] Competition assessment involves a consideration of both actual and potential competition. The Respondents’ suggestion that its conduct has no effect on competition because it is simply replacing one provider, Life Renal Care, with another, Mediclinic Renal Services, is a mischaracterisation of the counterfactual and an incorrect assessment of potential competition. Furthermore, Mediclinic’s characterisation of one monopolist being replaced by

¹⁶¹ Mr Prinsloo AA, para 136.

¹⁶² Mr Prinsloo AA, para 148.

another only makes sense if in-hospital dialysis services constitute a separate relevant product market in which monopolisation is indeed possible.

[228] I have dealt with the fact that Mediclinic's entry into providing dialysis services at the hospitals means that there were two service providers at the hospitals for a period of time. Moreover, Life Renal Care (the incumbent before access was denied) in theory could have been constrained by the threat of new entry by mobile units. That potential threat has now been eliminated through the Respondents' gatekeeping role to access (described below).

[229] I conclude that the true counterfactual is a world in which dialysis services providers coexist at a given Mediclinic hospital and are able to compete with one another, promoting *inter alia* service quality. This would allow nephrologists or specialist physicians and patients to choose among them. The below analysis of market characteristics shows this to be the case at a number of hospitals, and the Respondents in my view do not put up convincing facts, even *prima facie*, to contradict that the true counterfactual is more than one service provider at a given hospital.

[230] The effect of Mediclinic's conduct to exclude Life from access to and storage at the hospitals in question means that Life has been completely foreclosed from operating in Mediclinic Vergelegen, Mediclinic Morningside, Mediclinic Panorama and Mediclinic Potchefstroom (with effect from 15 June 2025); and at the time of hearing it would shortly have been excluded from Mediclinic Newcastle.¹⁶³ This is Mediclinic's express intention.¹⁶⁴ For dialysis patients at the hospitals the inevitable consequence is that they may only make use of Mediclinic as service provider.

Quality as a factor of competition

[231] It is common cause that quality is an important feature of dialysis services.

¹⁶³ FA, para 90; RA, para 302.

¹⁶⁴ Mr Prinsloo AA, paras 27 – 31; Mr Streak AA, para 26.

- [232] Mr De Ruyter, the Clinical Development Manager at Mediclinic Renal Services, explains that the quality of care that is provided and patient well-being is important, as is an improvement in clinical quality, as well as innovation and being in line with international standards.¹⁶⁵
- [233] Mr Streak, the Operations Executive of Related Business at Mediclinic Southern Africa, explains that the quality of dialysis equipment that service providers use is important.¹⁶⁶
- [234] Mr Prinsloo of Mediclinic Renal Services submits that the services offered by Mediclinic Renal Services are of a very high professional standard and at least equivalent (but probably superior) to the services provided by any third-party renal dialysis services provider.¹⁶⁷
- [235] The quality of dialysis services provided may be reduced, for example, by using lower quality consumables and/or equipment, reducing the number of attending staff members, not maintaining the equipment required to provide dialysis and/or not investing in newer technologies.¹⁶⁸
- [236] As noted above, the quality-of-service assessment is typically made on behalf of the patient by his/her nephrologist or specialist physician. When a nephrologist or specialist physician refers a patient to a dialysis services provider, they exercise their clinical independence to refer that patient to whichever dialysis services provider they deem most appropriate. An important consideration in this regard will be the nephrologist or specialist physician's perception of the quality of a particular services provider's care which might relate to, for example, the professionalism of their renal technologists and renal nurses and their use of high-quality equipment and consumables when administering treatment.

¹⁶⁵ Mr De Ruyter AA, paras 18, 20, 27, 28.2, 29 and 66.

¹⁶⁶ Mr Streak AA, para 14.

¹⁶⁷ Mr Prinsloo AA, para10.

¹⁶⁸ FA, para 96.3.

- [237] *Prima facie* patients will as a result of the Respondents' conduct be deprived of the benefits that competition between two rival operators in the hospitals in question will bring in terms of choice and quality.
- [238] I note that the Respondents' claim that its service is superior to Life's and indeed all other dialysis services providers have been identified *ex post facto*. These concerns relate to alleged historic incidents involving the dialysis services business of Fresenius Medical Care South Africa Proprietary Limited ("*Fresenius*") prior to its acquisition by Life Healthcare Group. Life Renal Dialysis prior to the implementation of the abovementioned transaction never provided dialysis services at any Mediclinic hospital.
- [239] In conclusion, competition is a key driver of service levels in renal dialysis. Indeed, if the Respondents were correct in their assertion that Mediclinic Renal Services' service offering is superior to that of Life Renal Dialysis (and others), and that nephrologists prefer Mediclinic for that reason, these alleged advantages would lead to a natural, market-based shift in referrals from Life Renal Dialysis to Mediclinic Renal Services over time. That would reflect effective competition (if allowed to take place) on the merits.

Price as an element of competition

- [240] On the evidence before the Tribunal, I do not, even at a *prima facie* level, accept the Respondents' allegation that renal dialysis services providers are constrained by the countervailing power of medical schemes and that potential price increases are not a function of competition between renal dialysis services providers.¹⁶⁹ Despite the Respondents being in the position to put up evidence in support of these allegations and revealing how they negotiate with medical aids, they put up no evidence in support of this bold allegation. No examples are given of how medical aids would or have in the past effectively constrained the prices charged by dialysis service providers in South Africa in general or in relation to specific hospitals.¹⁷⁰

¹⁶⁹ Mr Prinsloo AA, para 58.1.

¹⁷⁰ Transcript p 104 lines 14 to 20; p 107 lines 3 to 5; and p 146 lines 12 – 15.

- [241] The competitive dynamics regarding the pricing of dialysis services are far more complex with various factors to consider. As noted above, the Constitutional Court in *Mediclinic* correctly notes the ever-rising tariffs consumers of medical services already have to contend with in the private sector and the impact thereof on the interests of the public. One can hardly say that price is not an issue to South African dialysis patients, both insured and uninsured.
- [242] Even where dialysis patients are insured, there may still be differences between tariffs for dialysis services i.e., Life's tariff and Mediclinic's tariff negotiated with each of the medical aids may differ. The parties have not provided the Tribunal with this information. Importantly, however, is that competitive rivalry may force one or both of these service providers to charge lower tariffs.¹⁷¹
- [243] Furthermore, private hospitals are not limited to charging the medical aid tariff and may charge above it and require co-payments even for those who are on medical aid.¹⁷²
- [244] Even where patients do have medical aid cover, they may not have sufficient cover. Many patients are restricted by their medical schemes in their coverage and choices, specifically those patients on more affordable medical plans.
- [245] Uninsured patients also need to be considered. These patients are not covered by medical aid at all.¹⁷³ As indicated above, many South Africans that need dialysis treatment are estimated not to receive it in South Africa despite that seriously impacting their health and that not receiving treatment may lead to their death.

¹⁷¹ Transcript p 174 lines 16 to 18.

¹⁷² Transcript p 174 lines 19 to 21.

¹⁷³ Transcript p 174 lines 7 to 9.

Barriers to entry

- [246] In order to understand and contextualise the Respondents' conduct, I next consider barriers to entry into the provision of dialysis services which include certain skills, capital outlay and licencing in certain provinces.
- [247] In relation to skills, entry requirements include technical skills as dialysis services can only be administered by clinical technologists which require four years of completion.¹⁷⁴ Mr De Ruyter from Mediclinic Renal Services indicates that while it prefers to recruit staff with dialysis experience, this is not always possible.¹⁷⁵
- [248] In relation to capital requirements, the Tribunal in the *Life/Fresenius merger* refers to the merger parties' submission that a medium-sized dialysis centre (accommodating 18 dialysis sessions per day) could cost between R2 and R5 million, whereas a mobile unit could cost R180,000 (the cost of one dialysis machine and a vehicle).¹⁷⁶ Mr Prinsloo of Mediclinic Renal Services submits that a new standalone dialysis unit outside of a hospital requires an investment of not less than R5 million per new unit.¹⁷⁷ He indicates that mobile renal dialysis equipment can be acquired at much less at less than R1 million per unit.¹⁷⁸
- [249] In relation to regulatory barriers, the Tribunal in the *Life/Fresenius merger* notes that the Commission submitted that at a national level, a license is not required for the establishment of a facility. At a provincial level, the Western Cape and Eastern Cape require regulatory licensing.¹⁷⁹

¹⁷⁴ See para 42 of the Commission's Report in *Life Healthcare Group (Pty) Ltd v Fresenius Medical Care South Africa (Pty) Ltd in Respect of the Dialysis Services Business* (LM035Jun23) [2024] ZACT 38 (18 March 2024) ("*Life/Fresenius merger*").

¹⁷⁵ Mr De Ruyter AA, para 32.

¹⁷⁶ Para 17 of the Tribunal's decision. The Commission in that matter further indicates that B Braun, a corporate dialysis service provider, estimated that it could cost approximately R3,5 million to establish a dialysis facility (see para 43 of the Commission's Report).

¹⁷⁷ Mr Prinsloo AA, para 18.

¹⁷⁸ Mr Prinsloo AA, para 18.

¹⁷⁹ Para 18 of the Tribunal's decision.

- [250] Considering the above, specifically the relatively low capital barriers for mobile units, *prima facie*, absent the conduct of the Respondents to deny access to its hospitals in question, the barriers to entry for mobile units into providing dialysis services in hospitals are surmountable.
- [251] Importantly, however, the Respondents' conduct raises these entry barriers to the point where the barriers for mobile units to enter the hospitals are no longer surmountable, i.e., Mediclinic puts up an absolute barrier to Life Renal Care (and potentially other third-party service providers, as indicated above) providing any dialysis services at the five hospitals in question. Thus, what are contestable markets in economic terms become incontestable because entry barriers for mobile units into the hospitals are no longer surmountable.
- [252] With the above background regarding the types of dialysis customers and customer groups, the timing of the targeted foreclosure in terms of access, quality of service and price as elements of competition, and barriers to entry and how that is affected by the Respondents' conduct, I turn to the market delineation assessment.

Market delineation

Applicants' submissions

- [253] The Applicants submit that there is a separate relevant product market for the provision of in-hospital dialysis services within a particular acute multidisciplinary hospital. This includes services by resident units and mobile units, if the latter are afforded express access permissions and reasonable on-site storage facilities within the relevant hospital.

Respondents' submissions

- [254] The Respondents submit that the patient makes his/her choice of a renal dialysis services provider prior to hospitalization.¹⁸⁰ The contention rests on the notion that there is a "systems market", that patients choose hospitals based

¹⁸⁰ Mr Prinsloo AA, para 153.

on an integrated bundle of services (including renal dialysis), and that competition occurs between providers of these bundles.

[255] The Applicants disagree with the above and submit that it is not the case that patients, prior to their admission to a particular multidisciplinary hospital, assess the cost and quality of the full complement of integrated healthcare services offered by that hospital, including, in particular, the acute dialysis services offered by the hospital; and choose the hospital to which they wish to be admitted on that basis.

Assessment

[256] The question that arises is if in-hospital dialysis services *prima facie* can be regarded as a separate relevant product market.

[257] It is common cause that in general patients that have been admitted into a hospital have no option but to receive dialysis treatment in that hospital. In terms of the market characteristics described above this however does not mean that there may not be more than one service provider in the hospital, if feasible. Specifically mobile units face relatively low entry barriers if permitted access to the relevant hospital.

[258] As context, I note that other than dialysis services, there are other examples of services where third parties independent of the hospital owner(s) provide services within hospitals. One can think of a number of healthcare professionals and allied professionals that provide medical services in hospitals such as doctors, physiotherapists, dieticians, biokineticists, as well as pathologists where hospitals make use of players such as Lancet, Pathcare, Ampath and others to provide pathology services to patients in hospitals.

Market characteristics

- [259] Regarding dialysis, it is common cause that at a number of hospitals in South Africa, third-party service providers (that are independent from the hospital in question) offer dialysis services in the hospital, typically through operating mobile units. There are even examples of hospitals where several different dialysis providers operate in the same hospital.¹⁸¹ That multiple dialysis service providers can operate in the same hospital is borne out by the evidence in relation to, for example, Life Healthcare's Wilgers hospital, where there are a number of different dialysis providers.¹⁸² The same applies to Netcare's Unitas hospital, where there are at least 10 such providers.¹⁸³
- [260] Thus, the two other large hospital groups, Life and Netcare, which both have their own dialysis services provider¹⁸⁴ each allow third-party dialysis service providers to administer dialysis to patients at certain of their hospitals.
- [261] Mediclinic itself, up until relatively recently, did not have its own dialysis services provider capable of administering dialysis to patients at its hospitals. Access by (mobile and other) dialysis service providers to Mediclinic hospitals was not an issue prior to Mediclinic's acquisition of BGM in 2021. Since Mediclinic did not have its own dialysis services provider, accordingly, at all Mediclinic hospitals, third-party dialysis services providers administered dialysis. Furthermore, at all the Mediclinic hospitals where Mediclinic Renal Services does not provide renal dialysis services, access is provided to third parties to provide these services.¹⁸⁵
- [262] Turning to Life, Life Renal Dialysis offers dialysis services through in-hospital dialysis units resident in 31 of Life Healthcare Group's 48 multidisciplinary hospitals. In the remaining hospitals these services are provided by mobile units. On the evidence before the Tribunal access to third-party dialysis service providers is certainly the case in the hospitals operated by Life. This is in fact

¹⁸¹ RA, paras 124 and 126.

¹⁸² RA, para 126.

¹⁸³ RA, para 124.

¹⁸⁴ Life Healthcare Group, which has Life Renal Dialysis, and Netcare, which has National Renal Care.

¹⁸⁵ Mr Prinsloo AA, para 13.

required in terms of the Tribunal's order in the *Life/Fresenius merger* where it imposed a merger condition on Life to provide open access to its hospitals by permitting third-party dialysis services providers reasonable access to its hospitals ("the open access condition").¹⁸⁶ What led to that merger condition being imposed were concerns raised by third-party dialysis service providers in the industry in regard to access to Life's hospitals.¹⁸⁷

[263] Fresenius, prior to the abovementioned acquisition, was given access to hospitals as an independent dialysis service provider.¹⁸⁸ It entered the market in 2001, providing renal dialysis services independently of any hospital group, until it was acquired by, and became vertically integrated with, Life Healthcare Group Holdings Limited in 2024.

[264] Third parties have provided dialysis services in 17 of 40¹⁸⁹ identified Life hospitals in recent years.¹⁹⁰ The Applicants confirm that should any third-party dialysis services provider wish to provide the full suite of in-hospital dialysis services at these or any other Life hospitals, they will be permitted to do so.¹⁹¹ Therefore potential entry by third-party dialysis services providers and competition is possible at all Life hospitals where Life Renal Dialysis currently is the sole provider if called to do so in the clinical discretion exercised by a relevant referring nephrologist or specialist physician (and subject to compliance with the protocols of the hospital in question).¹⁹²

¹⁸⁶ See clause 7 of the Tribunal's imposed conditions. In terms of the open-access condition the merger parties shall continue to permit third-party dialysis services providers reasonable access to the Acquiring Firm's (i.e., Life Healthcare Group) hospitals on a mobile basis for a period of at least five years for the purposes of administering acute renal, mobile chronic or any other form of inpatient renal dialysis treatment and/or extracorporeal blood related treatment, per the referral or request of a doctor, subject to such providers (i) having been requested to administer such treatment by a referring nephrologist or physician, and (ii) adhering to the acquiring firm's infection control, security and other reasonable protocols as set from time to time.

¹⁸⁷ Implemented on 1 April 2024.

¹⁸⁸ Mr Prinsloo AA, para 2.

¹⁸⁹ The other 8 of Life's 48 hospitals in total are specialised hospitals that do not offer the full range of acute care services (such as mental health hospitals). See Supplementary Affidavit of Ms Michelle Dennis, the Renal Operations Manager at Mediclinic Renal Services, para 7.

¹⁹⁰ In two of those hospitals the third party (National Renal Care) provides only plasmapheresis and plasma exchange dialysis services.

¹⁹¹ Applicants' Opposing Affidavit to the Respondents' Application for leave to file a Supplementary Affidavit, para 42.

¹⁹² Applicants' Opposing Affidavit to the Respondents' Application for leave to file a Supplementary Affidavit, paras 7 and 8.

[265] Ms Noeleen Phillipson (“Ms. Phillipson”) indicates that based on her time as the Chief Executive Officer of National Renal Care, she was unaware of any incident where it was thought to have created an infection event at a hospital.¹⁹³

[266] The above factual evidence *prima facie* dispenses with the notion that it is not possible to have more than one dialysis service provider in the same hospital and with the Respondents’ argument that allowing Life a presence in the hospitals in question would materially impair Mediclinic’s ability to control infection rates within its hospitals.¹⁹⁴

[267] I pause to mention that a relatively small amount of storage space is required by a rival supplier of dialysis services in a hospital. Ms Phillipson indicates that a storage facility of perhaps 10 or 15 square metres is required at any hospital, where hospitals measure hundreds, if not thousands, of square metres in floor area per hospital.¹⁹⁵ Furthermore, Mediclinic (and any other hospital owner) would be within its rights to charge a reasonable rental for that relatively small storage facility.

Potential access gatekeeping by hospital owner(s)

[268] It is common cause that for any dialysis services provider to provide its services inside a hospital, the hospital owner has to provide access to the specific hospital. In this way hospital owners have a potential ‘gatekeeping’ role in terms of access. This applies to Mediclinic in this matter.

[269] The Commission in its Report in the *Life/Fresenius merger* notes the submissions made by independent dialysis providers that access to acute hospital and referrals from acute hospitals (i.e., by nephrologists operating at acute hospitals) is important for independents to be able to operate profitably.¹⁹⁶ The South African Clinical Technologist Association submitted

¹⁹³ RA, para 58.

¹⁹⁴ Mr Streak AA, paras 15 and 16.

¹⁹⁵ AA, para 63.

¹⁹⁶ Para 44 of the Commission’s Report.

that corporate dialysis providers create barriers to entry for independent practitioners with prohibitive rules denying independent practitioners access to their hospital facilities.¹⁹⁷ EGFR Dialysis also raised concerns regarding the proposed merger raising barriers to entry as independent service providers are denied the opportunity to administer dialysis services at the Acquiring Group's hospitals.¹⁹⁸ This led to the imposition by the Tribunal of the open access condition in the *Life/Fresenius merger*.

[270] The particular hospital owner therefore has a potential gatekeeper role in relation to express access permissions and reasonable on-site storage facilities within a particular hospital. In relation to Mediclinic, it is common cause that Mediclinic has absolute control over access to its hospitals and storage space in its hospitals. It submits that “for so long as [patients] are admitted at Mediclinic, Life cannot treat them”¹⁹⁹ and that it “controls access to its own hospitals and can therefore prevent a downstream competitor from providing services at its own hospitals”.²⁰⁰ Mr Prinsloo of Mediclinic Renal Services confirms that it is self-evident that a dialysis services provider cannot provide services from a hospital at which it has no access rights.²⁰¹

[271] The Applicants submit that the provision of access permissions and reasonable on-site storage facilities to mobile dialysis providers constitute an essential input into the market for the provision of in-hospital dialysis services. This in my view is correct - access is a prerequisite for any entry and the conduct of the Respondents to deny access to the hospitals in question underscores this. This gives rise to a classic input foreclosure theory of harm, whereby Mediclinic's withholding of access to those essential inputs results in the foreclosure of a mobile dialysis services provider at each of the hospitals in question.

Approach to market delineation

¹⁹⁷ Para 35.3 of the Commission's Report.

¹⁹⁸ Para 34 of the Commission's Report.

¹⁹⁹ AA, para 146.

²⁰⁰ AA, para 149.

²⁰¹ Mr Prinsloo AA, para 140.1.

[272] Competition authorities recognise that market realities and consumer behaviour are relevant considerations in defining markets. The appropriate market definition depends on the facts of each case; the relevant market concerned must be identified according to the particular facts of the case in hand.²⁰²

[273] For example, the United Kingdom's Competition and Markets Authority confirms that the scope of the relevant market may differ according to the focal point under consideration. It states: "*The steps in applying this approach are as follows. We start by considering a hypothetical monopolist of the focal product (i.e. the product under investigation).*"²⁰³ (emphasis added) Likewise, the EC's 2024 Market Definition Notice affirms that different market definitions may be appropriate depending on the concerns and the theory of harm under consideration.²⁰⁴

[274] That market definition may be affected by conduct is also recognised in the EU Notice, which states:

"as market definition seeks to identify the effective and immediate competitive constraints that are relevant for the competitive assessment of specific conduct or concentration, the outcome of market definition can differ depending on:

...

*the competitive concerns under consideration. The relevant effective and immediate competitive constraints in a specific case may depend on the competitive concerns under consideration. ..."*²⁰⁵ (own emphasis)

[275] One must be cautious of automatically and uncritically adopting market delineation in cases such as mergers to prohibited practice cases (section 8 in this case) since there may be differences in both the focus and in the approach

²⁰² See Office of Fair Trading (UK), Market Definition Guidelines (OFT403, 2004), para 5.7.

²⁰³ See Office of Fair Trading (UK), Market Definition Guidelines (OFT403, 2004), para 2.9.

²⁰⁴ European Commission, Market Definition Notice (2024), para 18(c).

²⁰⁵ European Commission Notice on the definition of the relevant market for the purposes of Union competition law (2024) at para 18(c).

to the assessment. Whilst in the assessment of mergers it may not make a significant difference whether one includes (potential) competitive constraints at the market definition stage or in the later stages of analysis, in section 8 cases, in contrast, where dominance is a prerequisite, an inappropriately broad market delineation may mean that the anti-competitive effects are never assessed because the dominance threshold was assumed not to have been met. The OECD correctly notes that in cases of monopolisation or abuse of dominance, market definition is more complicated on a conceptual level as in merger cases as it has – at least in some jurisdictions (such as ours) – a dual function, i.e. to determine whether a firm has a dominant position and to support the assessment of possible anti-competitive effects.²⁰⁶

[276] Furthermore, market definition is often primarily used as a screening tool to identify potential anti-competitive effects and this rings especially true for uncontested merger cases where the precise market delineation often is left open.

[277] This case is not one of assessing competition between hospitals in the context of a hospital merger where one wants to assess constraints on the hospital(s) overall. The definition of the relevant market in mergers generally turns on the transaction at hand and the competitive overlap between the merger parties' activities and what constraints are in place, whereas the relevant market in a prohibited practice case is defined by reference to the impugned conduct and its effects.

[278] This case in fact illustrates the danger of not engaging with conduct since conduct may alter the way in which one may theoretically consider both demand and supply. As indicated above, the Respondents' conduct to deny access to the hospitals in question alters the market structure by raising barriers to entry into in-hospital dialysis services on the supply side to an absolute level. Put differently, a market segment (in-hospital dialysis services) that is potentially contestable becomes incontestable through the Respondents'

²⁰⁶ Organisation for Economic Cooperation and Development ("OECD"), *Market Definition*, Policy Roundtable, Background Note (2012), para 3.4.

conduct. This alters the way in which one would consider the matter relative to a merger where such (potential) conduct may not be present or not be obvious.

[279] The Applicants' submission that the Tribunal must follow the same market definition as it did in the *Life/Fresenius merger* ignores the nature, context and facts of this case.²⁰⁷ That case involved a merger transaction which *inter alia* had a vertical overlap between a multidisciplinary services hospital and a renal dialysis services provider. Given *inter alia* the imposed open access condition that addressed third-party concerns about access to Life's hospitals, the Tribunal did not need to make any definitive finding regarding market delineation and left it open.

[280] In *Federal-Mogul Aftermarket Southern Africa*, the CAC held that: "*Great care should be taken before applying principles borrowed from the United States or indeed other competition law regimes....*".²⁰⁸ I do not place any reliance on the USA matter of *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984) in the assessment of this case. It is based on different enabling legislation, deals with a different relevant market (i.e., anaesthesiology), and deals only with tying in terms of a *per se* USA rule.²⁰⁹ Importantly however it does not take into account the context of South African competition law, specifically the objectives of our Act including the socio-economic objectives, different market structures, and the constitutional approach that is required in a South African competition law context. One should in general be cautious when considering USA case law because markets in the USA tend to be far less concentrated than our markets in South Africa and therefore their approach differs to ours.

[281] With the appropriate focal product in mind, i.e., dialysis patients and how they are affected, I turn to demand- and supply-side considerations.

Demand- and supply-side perspective

²⁰⁷ Mr Prinsloo AA, paras 33 and 34.

²⁰⁸ *Federal-Mogul Aftermarket Southern Africa (Pty) Limited v The Competition Commission [2005] 1 CPLR 50 (CAC)*, at para 53.

²⁰⁹ 'Tying', as dealt with in this USA matter, is a (modified) *per se* rule in the USA.

[282] Market delineation is foremost assessed from a customer (in this case patient) perspective, i.e., from the demand-side. This is in line with the objectives of the Act to promote and maintain competition in the Republic in order *inter alia* “to provide consumers with competitive prices and product choices” and the imperative to consider competition matters through a constitutional lens in South Africa - consumers’ fundamental human right to have access to health care services. One must in the analysis therefore not lose sight of the point where competition actually matters for patients.

[283] The European Union Commission Notice on the definition of the relevant market for the purposes of Union Competition law (“EU Notice”) states:

“Demand substitution constitutes the most effective and immediate disciplinary force on the suppliers of a given product. An undertaking’s influence over prevailing conditions of sale – such as prices, the level of innovation or the quality offered – depends on the extent to which its customers can easily switch to available products that the customers consider as substitutes. Demand substitution is therefore the main consideration when defining the relevant product market.”²¹⁰ (emphasis added)

[284] Regarding the various services offered within a multidisciplinary hospital, from a demand-side perspective, a patient that requires dialysis services cannot switch to any other type of service that is provided in or outside of a hospital. Thus, from a functional, demand-side perspective there are separate relevant markets for each of the multidisciplinary services that hospitals provide such as physiotherapists, dieticians, biokineticists, pathologists, and dialysis services. The Respondents concede in relation to questions from the panel that, from a demand-side perspective, individual multi-disciplinary services offered by hospitals are not interchangeable or substitutable.²¹¹

²¹⁰ European Union Notice at para 23(a).

²¹¹ Transcript p 164 lines 8 to 15.

- [285] To determine the parameters of the relevant market, competition authorities typically apply the principles of the hypothetical monopolist test, an antitrust analytical tool used to define the relevant product and geographic markets by determining the smallest group of products over which a sole profit-maximizing seller could profitably impose a “*small but significant and non-transitory increase in price*” (the so-called SSNIP test), typically 5% to 10% (depending on the products/services under consideration and other market characteristics). It tests hypothetically if consumers would switch to substitutes in the case of a SSNIP, forcing a price increase to be unprofitable or preventing a small but significant non-transitory quality deterioration²¹².
- [286] The OECD notes that from an economic point of view the hypothetical monopolist test is the correct conceptual framework to define a relevant market as a first step in competition analysis. If sufficient data about the substitution behaviour of consumers and also on profit margins is available, the hypothetical monopolist test can be implemented by a critical loss analysis.²¹³
- [287] The SSNIP test requires starting with the narrowest plausible market and expanding only where a SSNIP would not be possible.²¹⁴ I note that starting with a broad market for all renal dialysis services, as advanced by the Respondents, avoids the SSNIP test and avoids assessing the conduct of the Respondents and its effects.
- [288] Starting with the narrowest plausible market as the test requires, i.e., patients that have been admitted to hospital or inpatients, it is common cause that these patients cannot switch to a provider of dialysis services outside of the hospital. Thus, from a SSNIP perspective, if the price of in-hospital dialysis services

²¹² A small but significant non-transitory decrease of quality (“SSNDQ”).

²¹³ Organisation for Economic Cooperation and Development (“OECD”), *Market Definition*, Policy Roundtable, Background Note (2012), para 3.4.

²¹⁴ Sutherland & Kemp in *Competition Law in South Africa* (chapter 10.5, page 13) explain the correct application of the SSNIP test as follows: “*All products that consumers regard as substitutes and the territory, within which they are regarded as substitutes, must be established. Most competition law sources state that this will generally be determined with reference to the SSNIP test... The market must be defined as narrowly as possible.*”

increases by a small but significant amount, or if the quality of service deteriorates by a small but significant amount, the patient cannot switch to a service provided outside of the hospital. This is because a patient that is admitted to a multidisciplinary hospital as a result of an acute episode (i.e., either an acute or chronic inpatient) is typically confined to a hospital bed for the duration of their treatment, often within an ICU, and this places a very significant restriction on their ability to procure dialysis services outside of the hospital (e.g., at a standalone clinic, or at another multidisciplinary hospital) for the duration of their treatment.

[289] Since in-hospital dialysis patients have no realistic outside options, they are effectively 'locked in'. Since none of the patients can realistically switch in response to a SSNIP or a SSNDQ, no critical loss analysis is required (i.e., critical loss assessment is only applicable where some customers may shift and some not). It follows from this that the scope of the relevant market *prima facie* is hospital-specific: once acute patients are admitted to a given multidisciplinary acute care hospital, they then have to receive dialysis treatment at the same hospital since they are locked in.

[290] The above however does not mean that inpatients have no potential choice. They potentially have more than one in-hospital alternative if one or more mobile units are permitted access to the hospital in question.

[291] Inpatients and outpatients are distinguishable. Chronic outpatients may be able to switch between facilities if they are in close proximity to other outpatient facilities. This is however not the case with inpatients.

[292] Importantly, the available (undisputed) pricing evidence shows *prima facie* that (acute and chronic) inpatients and (chronic) outpatients are not in the same relevant product market since healthcare funders (i.e., medical aid schemes) ordinarily have different compensation tariffs applicable to acute as opposed to

chronic dialysis - with tariffs for acute dialysis being higher than those for chronic dialysis.²¹⁵ This is not disputed in the Respondents' answer.²¹⁶

[293] The reason for the abovementioned price differences between dialysis services administered to inpatients and outpatients is that inpatients requiring treatment (i) will often need dialysis almost continuously for a period of time (i.e., for the duration for which they remain acutely ill) and that essentially necessitates a greater number of hours of dialysis within a day; and (ii) the treatments must be administered by a dedicated renal technologist or renal nurse.

[294] The above is in contrast to chronic outpatients who have regular, scheduled appointments on particular days of the week at a standalone clinic or in-hospital unit and where they are attended to by renal technologists or renal nurses who are able to administer dialysis to several patients at the same time.²¹⁷ This is not disputed in the Respondents' answer.²¹⁸

[295] These price differences mean that dialysis services provided to outpatients do not constrain the pricing of acute dialysis treatment to inpatients or the quality of service, meaning that they *prima facie* constitute different relevant product markets.

[296] As indicated above under market dynamics, third-party mobile units are provided with access to certain hospitals to provide renal dialysis services within the hospitals including at Mediclinic's hospitals where Mediclinic Renal Services does not provide renal dialysis services.²¹⁹ Mobile providers do in fact compete in relation to certain hospitals — but only if granted express access and storage space. Therefore, they *prima facie* can compete effectively and constrain an in-hospital dialysis unit. Recall that the Tribunal has in the *Life/Fresenius merger* imposed a condition on Life to provide open access to third party dialysis service providers.

²¹⁵ FA, para 42.

²¹⁶ Mr Prinsloo AA, para 117.

²¹⁷ FA, para 43.

²¹⁸ Mr Prinsloo AA, para 117.

²¹⁹ Mr Prinsloo AA, para 13.

- [297] Furthermore, the assessment of barriers to entry shows that with respect to mobile units, there *prima facie* are no significant technical or capital barriers preventing a mobile unit from providing dialysis services in a hospital. This means that even where a mobile unit does not presently operate within a given hospital, they *prima facie* can quickly, and without incurring significant cost, begin administering treatment to inpatients within that particular hospital – unless they are denied access as an essential element of entry.
- [298] In economic terms from a demand-side perspective in my view there *prima facie* is a separate relevant product market for in-hospital dialysis services, which may from a supply-side perspective be provided in two ways. First, there may be supply through an in-hospital dialysis unit located within the particular hospital. Second, a dialysis service provider may have a mobile unit that can readily be moved into the hospital in a short period of time. The caveat is that in order for mobile service providers to provide dialysis services in a hospital they must be able to have access to the hospital, as explained in the access gatekeeping section above. Access is an essential input for entry to occur.
- [299] With respect to the appropriate geographic scope of this market, I note that, because patients admitted on an inpatient basis (including both acute and chronic inpatients) are confined to hospital beds (and cannot travel to receive dialysis treatment), the choice of dialysis services provider, from an in-patient perspective, is limited to in-hospital units and mobile units capable of travelling to the relevant hospital at which the patient is admitted.
- [300] As indicated above, market delineation is foremost about demand-side substitution - it focusses on the customer/patient. Inpatients are a particularly vulnerable group of patients in that most patients who are admitted to multidisciplinary hospitals will be completely unaware that they will require dialysis services during their admission. Indeed, patients typically do not know in advance of admission that they will require dialysis during a hospital stay - particularly in the context of acute dialysis treatment. Dialysis may only become necessary later on, when the patient experiences an unanticipated

deterioration in kidney function or complications related to other medical conditions identified during the hospital stay.²²⁰

[301] As also indicated above, the decision as to which dialysis service provider to use is taken on behalf of the patient by his/her nephrologist or specialist physician that must make a quality assessment. This decision - exercising clinical independence - is made at the time that the service is needed (and not upfront prior to admission). This means in my view that patients *prima facie* do not typically consider quality, choice and/or cost of dialysis services when choosing a hospital as contended by the Respondents. Thus, *prima facie* an upfront decision by patients does not translate into constraints at the dialysis services-level.

[302] I conclude that the *prima facie* relevant market for purposes of evaluating the Respondents' conduct is one in which in-hospital dialysis services are considered separately to multidisciplinary hospital services, and within a particular hospital.

***Prima Facie* Dominance**

[303] Having defined the *prima facie* relevant market as above, the question is if the Respondents in relation to the five hospitals in question have a dominant position in terms of the Act (as a requirement for a section 8 contravention).

[304] In terms of section 7 of the Act a firm is dominant in a market if-

- (a) it has at least 45% of that market;
- (b) it has at least 35%, but less than 45%, of that market, unless it can show that it does not have market power; or
- (c) it has less than 35% of that market, but has market power.

[305] It is trite that dominance can be established by demonstrating that a firm has the market positions as per the abovementioned thresholds in section 7 or has

²²⁰ RA, para 9.3.2.

market power. The CAC explains that even if there is no evidence that the firm's market share exceeds one of the threshold requirements in sub-sections 7(a) or (b), it still might be considered dominant under 7(c) if it can be shown to have market power.²²¹ Sutherland & Kemp say the following about market power in an abuse of dominance context: "*The conduct of firms with market power is the central concern of the abuse provisions*".²²² The position is put equally emphatically in Economics for Competition Lawyers: "*Indeed, at the core of competition law is the control of market power*".²²³ Whish remarks that "*[i]t is the issue of market power that lies at the heart of competition law and policy*".²²⁴

[306] Furthermore, in *Babelegi Workwear* the Tribunal found that market delineation is merely a means to an end and that market power is the ultimate consideration for dominance and section 7(c) has market power at its core.²²⁵ The Tribunal's decision in *Babelegi Workwear* was upheld before the CAC. The Tribunal further notes that recent developments in the literature and competition economics practice offer means for measuring market power directly, dispensing with the need for market delineation.²²⁶

[307] As the Tribunal further explained in *Dis-Chem*: "... *competition law enforcement is not concerned with the actual size of the firm but instead with the ability of that firm to exercise market power. In other words, we are concerned with the extent of that firm's ability to influence a market or as defined in section 1 of the Act "the power of the firm to control prices, to exclude competition or to behave to an appreciable extent independently of its competitors, customers or suppliers."* Thus, the notion of dominance is inextricably bound to the notion of

²²¹ *Mercantile Bank, A division of Capitec Bank Ltd and Others v Sekunjalo Investment Holdings (Pty) Ltd and Others* (CAC144/Oct2022) [2023] ZACAC 2 (17 July 2023), para 47.

²²² Sutherland & Kemp, *Competition Law of South Africa* 7.7.6.1.

²²³ *Economics for Competition Lawyers*, Niels et al, Oxford University Press, 1st ed, page 116.

²²⁴ *Competition Law*, Whish & Bailey, Oxford University Press, 9th ed, page 25.

²²⁵ *Competition Commission of South Africa v Babelegi Workwear and Industrial Supplies CC* ("*Babelegi Workwear*"), para 83.

²²⁶ For example, in the UK, in *Arriva The Shires Ltd vs London Luton Airport Operations Ltd*, Case No. HC13d01784, abuse was found without a specific market definition being provided, as competitive concerns existed irrespective of the specific market definition. See *Babelegi Workwear*, para 85.

market power.²²⁷ The CAC has subsequently reaffirmed the correctness of the Tribunal's approach in *Tsutsumani*.²²⁸

[308] “*Market power*” is defined in the Act as the power of a firm to control prices, to exclude competition or to behave to an appreciable extent independently of its competitors, customers or suppliers.

[309] As indicated above, the CAC in *eMedia* has found that the Tribunal must when applying the provisions of the Act take a transformative constitutional approach and must apply a context-sensitive approach.²²⁹ A transformative constitutional and a context-sensitive approach means that one should have regard to how patients, that have a constitutional right of access to healthcare,²³⁰ are affected by the conduct. Furthermore, as indicated above, one must not lose sight of the point where competition actually matters for patients (as assessed by their specialist physicians and/or nephrologists). Recall that the Constitutional Court reminds us that the institutions created to breathe life into the critical provisions of the Act must never allow what the Act exists to undo and to do, to somehow elude them in their decision-making process.²³¹

[310] Competition between dialysis services providers at a hospital level *prima facie* is in the public interest from a customer/patient perspective and aligned to the spirit of the objectives of the Act “*to provide consumers with competitive prices and product choices*”. Mediclinic's strategy to deny access to the hospitals by denying an essential input for entry *prima facie* materially diminishes any incentive to have competitive service offerings including in regard to quality and price.

[311] Allowing third-party (mobile) dialysis service providers reasonable access to administer dialysis in hospitals would be pro-competitive since it will allow

²²⁷ Competition Commission of South Africa vs Dis-Chem Pharmacies Limited (CR008Apr20) (“*Dis-Chem*”) para 100.

²²⁸ *Tsutsumani Business Enterprises CC v Competition Commission of South Africa*, (2023) ZACAC 6 (13 October 2023) (“*Tsutsumani*”), paras 19 and 20.

²²⁹ *eMedia*, para 84.

²³⁰ Section 27 of the Constitution.

²³¹ *Mediclinic*, para 7.

nephrologists and/or specialist physicians operating from Mediclinic hospitals (at which the foreclosure strategy has been rolled out) to refer their patients to whichever dialysis services provider they regard to be most appropriate in the circumstances. This referral decision should be exercised with clinical independence, primarily informed by the quality of care provided by a particular dialysis services provider.²³²

[312] From a competition perspective, the effect of having a choice of dialysis service providers is that the service providers would have to compete for custom through, most significantly, ensuring the sustained provision of high-quality care. Not being able to exercise any choice impedes the nephrologists' and/or specialist physicians' ability to exercise their clinical discretion by determining an appropriate course of treatment to be administered by a services provider that they regard as best suited for the treatment of their patient.

[313] Furthermore, competition between service providers in the hospitals in question would *prima facie* promote responsiveness, improve quality, and protect against complacency by ensuring that a single dialysis services provider would not operate within a hospital without competitive challenge or constraint.

[314] Excluding a rival has the opposite effect from the above: Mediclinic *prima facie* eliminates all competitive pressure on Mediclinic Renal Services altogether in relation to inpatients at the hospitals. This will *prima facie* diminish or remove the incentives Mediclinic Renal Services would otherwise have (i) to maintain and improve upon service offering and quality; (ii) not to increase prices, or to decrease prices in response to rivalry; and (iii) to innovate in terms of its service offering.²³³ This is not in the interest of patients, inconsistent with the values in the Bill of Rights and undermines access to healthcare contrary to the constitutional imperative of greater access to high-quality healthcare services in South Africa.

²³² FA, para 44.

²³³ FA, para 112.

- [315] I note as regards the Respondents' suggestion that a reduction in Life's revenue is pro-competitive, that this argument erroneously conflates harm to an incumbent competitor with benefit to competition in the relevant markets. This is misinformed. That the Applicants could lose revenue as a result of the Respondents' foreclosure strategy is not itself evidence of improved outcomes.
- [316] It is common cause that prior to excluding Life Renal Care, the incumbent dialysis service provider at the five hospitals in question, there were two service providers at these hospitals, Life Renal Care and Mediclinic Renal Services, at least for a period of time.
- [317] Mediclinic's conduct of excluding Life as a dialysis provider from administering renal dialysis services at Mediclinic hospitals in competition with Mediclinic clearly prevents Life Renal Care (and potentially any other third-party dialysis service provider), from participating in the relevant markets for the provision of in-hospital dialysis services at the particular hospitals.²³⁴ There is no dispute on this. Following the foreclosure there will be no possibility of competition between dialysis service providers at the affected hospitals. This constitutes complete foreclosure in the provision of in-hospital dialysis services.
- [318] The above analysis of barriers to entry have found that *prima facie* absent the conduct of Mediclinic to deny access - an essential input for entry - the barriers to entry specifically for third-party mobile units into providing dialysis services in the hospitals are surmountable. In this case, from a supply side, there therefore is a competitor that can provide mobile in-hospital services (as noted, the actual incumbent provider prior to being denied access).
- [319] Mediclinic's conduct fundamentally alters the market dynamics and structure and prevents potential competition, since its conduct renders the market for in-hospital dialysis services incontestable.²³⁵ In terms of economic theory, even where there is no actual entry, potential entry may still affect the elements of competition including quality of service and pricing decisions. Thus, Mediclinic's

²³⁴ FA, para 89.

²³⁵ Not to be confused with markets that may be uncontested.

conduct and decision to remove access has rendered the in-hospital market, as a matter of structure, incontestable.

[320] Mediclinic forecloses Life Renal Care by putting up an absolute barrier for it to provide dialysis services to inpatients at each of the hospitals, making Mediclinic the monopolist provider. The Respondents in this sense act to an appreciable extent independently from this competitor (and other potential competitors) by preventing supply-side competition from mobile units occurring in the hospitals.

[321] Mediclinic is candid about shielding Mediclinic Renal Services from competition: “*For so long as they [patients] are admitted at Mediclinic, Life cannot treat them*”.²³⁶ It has complete market power in relation to access. There is no opportunity for substitution or for bypassing Mediclinic’s control of access through any other means. It exercises this market power, allowing Mediclinic Renal Services to become the monopolist provider in the five hospitals. Mediclinic, in effect, successfully executes its access gatekeeping function to prevent any dialysis competition within the hospitals by denying an essential input for entry.

[322] The effect of the above is that Mediclinic’s conduct prevents renal dialysis patients (customers) through their referring nephrologists or specialist physicians from engaging with dialysis services providers other than Mediclinic, particularly Life Renal Care, when seeking acute renal dialysis treatment at the Mediclinic hospitals in question.²³⁷ Importantly, the Respondents have the ability to unilaterally exclude Life Renal Care from providing any mobile dialysis services at the hospitals in question - despite this *prima facie* being in the public interest, a factor that must be considered in terms of the objectives of the Act, specifically giving customers access to choice, thus affecting patients’ fundamental human right to have access to health care services.²³⁸

²³⁶ Mr Prinsloo AA, para 146.

²³⁷ FA, para 88.2.

²³⁸ *Mediclinic*, para 71.

[323] The above in my view illustrates that Mediclinic *prima facie* is able to implement its strategy not to give Life Renal Care access to the five hospitals in question without regard to nephrologists/specialist who practice in these hospitals and ultimately their dialysis patients in the hospitals, i.e. customers. This enables Mediclinic Renal Services to become the monopolist provider of dialysis services in the hospitals. Each of Mediclinic and Mediclinic Renal Services, and acting collectively, *prima facie* behaves to an appreciable extent independently of their dialysis patients in these hospitals terms of section 7(c) of the Act. This is done by Mediclinic putting up an absolute barrier to access - an essential element for entry to occur - preventing mobile units from entering the hospitals. This then allows Mediclinic Renal Services to operate as monopolist in the provision of in-hospital renal dialysis services for inpatients at the relevant Mediclinic hospitals.

[324] On the analysis above, I conclude that the dominance threshold has *prima facie* been met for interim relief to be granted to the Applicants. The primary foreclosure in this matter occurs *prima facie* in relation to competition for in-hospital renal dialysis services for (acute and chronic) inpatients at the relevant Mediclinic hospitals where Life Renal Care has been completely excluded from operating as rival.



Mr Andreas Wessels

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