Public Version
ISSN NO. 0114-2720
J4928

COMMERCE COMMISSION

Decision No. 449

Determination pursuant to the Commerce Act 1986 in the matter of an application for clearance of a business acquisition involving:

THE ASCOT HOSPITAL AND CLINICS LIMITED

and

MERCY HOSPITAL AUCKLAND LIMITED

The Commission:	PR Rebstock PJM Taylor
Summary of Application:	The acquisition by The Ascot Hospital and Clinics Limited of all of the assets (but excluding the St Joseph's Mercy Hospice and excluding Mercy's shares in Mercy Angiography Limited) or shares of Mercy Hospital Auckland Limited.
Determination:	Pursuant to section 66(3)(a) of the Commerce Act 1986, the Commission determines to give clearance for the proposed acquisition.
Date of Determination:	14 December 2001

CONFIDENTIAL MATERIAL WHICH HAS BEEN DELETED FROM THIS REPORT IS INDICATED BY SQUARE BRACKETS

CONTENTS

THE PROPOSAL

1. On 15 November 2001 The Ascot Hospital and Clinics Limited ("Ascot") registered a notice with the Commission seeking clearance under s66 (1) of the Commerce Act 1986 to acquire all of the assets (but excluding the St Joseph's Mercy Hospice) or shares of Mercy Hospital Auckland Limited ("Mercy"). This notice was amended by the applicant giving notice on 13 December 2001 that it would not acquire the shareholding of Mercy Hospital Auckland Limited in Mercy Angiography Limited.

THE PROCEDURES

2. Section 66(3) of the Act requires the Commission either to clear or to decline to clear a notice given under section 66(1) within 10 working days, unless the Commission and the person who gave notice agree to a longer period. Two extensions of time were sought by the Commission and agreed to by the applicant. Accordingly, a decision on the application is required by 14 December 2001.

3. In its application, Ascot sought confidentiality for specific aspects of the application. A confidentiality order was made in respect of the information for a period of 20 working days from the Commission's determination notice. When that order expires, the provisions of the Official Information Act 1982 will apply.

4. The Commission's determination is based on an investigation conducted by staff.

5. The Commission's approach is based on principles set out in the Commission's *Practice Note 4*.[1]

THE PARTIES

Ascot

1. Ascot is a private hospital in Auckland. It was incorporated in 1997 and started trading in 1999.

2. The shareholders and their approximate shareholdings in Ascot are: Integrated Hospitals Limited ("IHL") 82%, Calan Healthcare Properties Trust ("CHPT") 15%, and other investors 3%.

3. Ascot's business activities are the provision of facilities, staff and equipment for medical and surgical healthcare.

4. IHL also owns 50% of the shares in each of Ascot Angiography Limited ("Ascot Angiography"), Laparoscopy Auckland Limited ("Laparoscopy Auckland") and Endoscopy Auckland Limited ("Endoscopy Auckland"). In each case, the other 50% of shares in these companies is held by (different) individual doctors.

---

[1] Commerce Commission, *Practice note 4: The Commission's Approach to Adjudicating on Business Acquisitions Under the Changed Threshold in section 47 – A Test of Substantially Lessening Competition*, May 2001.

Mercy

5. Mercy is a private hospital in Auckland. It is a company incorporated in New Zealand. All of its shares are owned by Sisters of Mercy Auckland Charities Limited. All of the shares in that company are owned by Sisters of Mercy (RC Diocese of Auckland) Trust Board (the "Sisters of Mercy").

6. Mercy's business activities are the provision of facilities, staff and equipment for medical and surgical healthcare at the Mountain Road site and the provision of endoscopy services at Mercy Endoscopy Clinic at Mairangi Bay.

7. Mercy owns one third of the shares in Mercy Angiography Limited ("Mercy Angiography"). The remaining shareholding in Mercy Angiography is held equally between the Southern Cross Healthcare Trust and individual doctors.

OTHER RELEVANT PARTIES

IHL

8. IHL is a wholly owned subsidiary of Healthcare Holdings Limited ("HHL"). HHL is a private company.

CHPT

9. CHPT is a unit trust listed on the New Zealand Stock Exchange. CHPT owns the land and buildings of Ascot and is therefore its landlord. It rents other parts of the Ascot facilities to other healthcare providers. CHPT also owns other properties leased to healthcare providers in New Zealand and Australia, including Endoscopy Auckland and the Artemis Surgical and Medical Centre.

Southern Cross

10. Southern Cross Healthcare ("Southern Cross") is a "not for profit" health care organisation incorporated as a Friendly Society under the Friendly Society and Credit Unions Act 1982. For the purposes of this application there are two relevant activities of Southern Cross:

    - The provision of indemnity health insurance; and

    - Ownership of hospitals, which are operated by the Southern Cross Hospital Trust (referred to as "SCHT" within this report).

Other Private Hospitals

11. There are several other private hospitals in the Auckland region that undertake surgery. These are referred to in Table 1.

Public Hospitals

12. The public hospitals are owned by the District Health Boards (DHBs). There are three DHBs in the Auckland region. Auckland DHB has Greenlane, Auckland Hospital, National Women's and Starship Children's Hospital (and is in the process of consolidating its hospital activities at a new Grafton site). South Auckland DHB has Middlemore Hospital, the Browns Road Superclinic, the Botany Road Superclinic and Otara. Waitemata DHB runs the North Shore Hospital and Waitakere Hospital.

New Zealand Private Hospitals Association

13. The NZPHA is a voluntary association of independent hospitals in New Zealand. The majority of its members are predominantly concerned with long-term care of the elderly, though 32 are hospitals that offer a range of surgical, medical, maternity and psychiatric treatments.

Other Insurers

14. Of the approximately 30 insurance providers registered and operating in New Zealand, some offer a range of health insurance products within their insurance product suites, while some specialise in health insurance products.

INDUSTRY BACKGROUND

Healthcare Financing in New Zealand

15. In New Zealand, healthcare is financed by a mix of public and private funding, with the majority being funded from public sources (tax funded Vote Health and ACC).

16. Healthcare is delivered through hospitals and other institutions which provide medical and surgical treatments, and community based providers such as general practitioners, pharmacies and community laboratories.

17. Public hospitals are owned and run by their local District Health Board (DHB). Public hospitals undertake the majority of surgical procedures, including almost all acute procedures – those services carried out to deal with an emergency. Those private hospitals that provide surgical services focus almost exclusively on elective (arranged or non-urgent) surgery.

18. Demand for the provision of elective surgery in the public system generally outstrips supply (or funding), so provision is rationed. The private system caters for those patients who would not otherwise receive treatment in the public system, or who prefer private treatment on timeliness or other grounds.

19. Most elective surgery in private hospitals is financed by the patient, either directly or via insurance. A small amount of publicly funded elective services is provided by private hospitals on behalf of the public sector.

20. Private elective surgery is funded either by health insurance or out-of-pocket payments by patients.

The Choice of Hospitals

21. There is a relatively complex set of relationships leading to a particular patient being operated on by a particular surgeon in a particular hospital. Patients are first seen by a primary healthcare provider (usually a GP). If surgery is warranted, the patient will be referred to a surgeon. Most GPs will have particular surgeons they refer patients to. If the surgeon decides that surgery is appropriate, a decision will be made as to the hospital where the surgery will be undertaken, depending on the hospital (or hospitals) where that surgeon operates.

22. However, it is not the case that the choice of hospital lies only with the surgeon. The GP's decision to refer a patient to a particular surgeon can be influenced by either the patient's or the GP's preference for the hospital where the operation will take place, in that it is commonly known which surgeon operates at which hospital. That preference may be based on cost, but also might be based on location or anticipated quality of care. Sometimes the patient's insurer will have an influence, in that patients might be encouraged to select a particular option.

Previous Decisions

23. There are no directly parallel previous decisions by the Commission. In Decision 331, Eastbay Health Limited and Western Bay Health Limited, the Commission cleared the merger of two geographically separate public hospitals. This decision assists with aspects of market definition, but is not relevant for the competition analysis of this case.

MARKET DEFINITION

24. The Act defines a **market** as:

> *. . . a market in New Zealand for goods or services as well as other goods or services that, as a matter of fact and commercial common sense, are substitutable for them.*

25. For the purpose of competition analysis, a relevant market is the smallest space within which a hypothetical, profit-maximising, sole supplier of a good or service, not constrained by the threat of entry, could impose at least a small yet significant and non-transitory increase in price, assuming all other terms of sale remain constant (the '*ssnip* test'). For the purpose of determining relevant markets, the Commission will generally consider a *ssnip* to involve a five percent increase in price for a period of one year.

26. It is substitutability at competitive market prices which is relevant in defining markets. Where the Commission considers that prices in a given market are significantly different from competitive levels, it may be necessary for it to assess the effect of a *ssnip* imposed upon competitive price levels, rather than upon actual prices, in order to detect relevant substitutes.

27. The Commission will seek to define relevant markets in terms of four characteristics or dimensions:

    – the goods or services supplied and purchased (the product dimension);

    – the level in the production or distribution chain (the functional level);

    – the geographic area from which the goods or services are obtained, or within which the goods or services are supplied (the geographic extent); and

    – the temporal dimension of the market, if relevant (the timeframe).

28. The Commission will seek to define relevant markets in a way that best assists the analysis of the competitive impact of the acquisition under consideration. A relevant market will ultimately be determined, in the words of the Act, as a matter of fact and commercial common sense.

29. Where markets are difficult to define precisely, the Commission will initially take a conservative approach. If the proposed acquisition can be cleared on the basis of a narrow market definition, it would also be cleared using a broader one. If the Commission is unable to clear the proposed acquisition on the basis of the narrower market, it will be necessary to review the arguments and evidence in relation to broader markets.

Product Dimension

30. The delineation of relevant markets as a basis for assessing the competitive effects of a business acquisition begins with an examination of the goods or services offered by each of the parties to the acquisition. Both demand-side and supply-side factors are generally considered in defining market boundaries. Broadly speaking, a market includes products that are close substitutes in buyers' eyes on the demand-side, and suppliers who produce, or are able easily to substitute to produce, those products on the supply-side.

31. The Commission takes the view that the appropriate time period for assessing substitution possibilities is the longer term, but within the foreseeable future.[2] The Commission considers this to be a period of one year, which is the period customarily used internationally in applying the 'ssnip' test to determine market boundaries. The Commission will take into account recent, and likely future, changes in products, relative prices and production technology in the process of market definition.

Defining the Product

32. Surgeons and hospitals combine to provide surgical services to patients, but generally within private hospitals the provision of these is kept separate. This is important for market definition.

---

[2] In *Tru Tone Ltd v Festival Records Retail Marketing Ltd* [ ] 2 NZLR 351 Smellie J and the Court of Appeal on appeal approvingly quoted an earlier decision of the Commerce Commission in *Edmonds Food Ind Ltd v W F Tucker & Co Ltd* (Decision 21, June 1984) where the Commission had ruled: "A market has been defined as a field of actual or potential transactions between buyers and sellers amongst whom there can be strong substitution, at least in the long run, if given a sufficient price incentive". See also *News Limited v Australian Rugby Football League Limited &Ors* (1996) ATPR at 41,687, where Burchett J stated: "Long term prospects that can be more or less clearly foreseen are, to that extent, a present reality, from the point of view of identifying the constraints upon commercial action. This fact emphasises the importance of the principle . . . that substitution possibilities in the longer run may be very significant for market delineation." Also *Re Tooth & Co Ltd v Tooheys Ltd* (1979) 39 FLR 1 emphasises longer run substitution possibilities.

33. Generally, Ascot and Mercy are only providing the facilities and staff for operations, that is they provide the operating theatres, equipment, wards, and nursing and other staff. However, the hospital does not provide the surgeon nor the ancillary specialist skills such as the anaesthetist. The surgeon contracts with the patient separately, and will bill the patient (or insurer) separately.

34. The relationship between the surgeon and the hospital involves quality control of the surgeon by the hospital (credentialling). Only credentialled surgeons may operate at the hospital. Surgeons book time in the operating theatres of the hospital. However, there is no contract between the surgeon and hospital relating to the use of the operating theatres or throughput of patients that the surgeon will provide the hospital.

35. For that reason, any market definition – at least with respect to private elective surgery – must distinguish between the provision of surgical facilities and services and the provision of the surgery itself.

36. The applicant has suggested that the separate facilities and services that the hospital provides can be bundled together to form one aggregate market for surgical services/ facilities, rather than considering separate markets for nursing services, surgical equipment and the like. The Commission agrees with this approach.

37. The applicant has also suggested that the surgical facilities and services are fungible across medical specialities, so that general "surgical" markets can be defined rather than specific markets for each branch of medicine. With the exception of the distinction between secondary and tertiary services (see para 56), the Commission agrees.

38. It is also noted that there is an exception to the market definition concept established at para 35, which arises with surgical contracts provided by ACC or another public provider. (ACC provides the bulk of this publicly funded work.) In these circumstances, ACC selects and contracts with a "lead provider" who organises all aspects of the surgery. Generally, the lead provider is a hospital, though it is sometimes a medical practitioner. Where the hospital is the lead provider, it contracts with one or more surgeons to fulfil the surgical requirements.

39. The applicant has submitted that there are separate markets for (each of) the provision of angiography services and provision of endoscopy services. The Commission agrees with this approach.

Demand-side substitution

40. Close substitute products on the demand-side are those between which at least a significant proportion of buyers would switch when given an incentive to do so by a small change in their relative prices.

41. Initially, markets are defined for each product supplied by two or more of the parties to an acquisition. Unequivocal substitutes are combined. For each initial market so defined, the Commission will examine whether the imposition of a ssnip would be likely to be profitable for the hypothetical monopolist. If it were, then all of the relevant substitutes must be incorporated in the market. If not, then the next most likely substitute good or service will be added to the initial market definition and the test repeated. This process

continues until a combination of products is found which defines the product dimension of a relevant market, namely, the smallest combination of goods or services for which a ssnip would be profitable.

42. On the demand-side, the technical viability of one good or service as a substitute for another must be assessed. However, even where another product may technically be suitable as an alternative for the product in question, its price may be so much higher that it may be a poor substitute in an economic sense, at least for the great majority of buyers. In judging economic substitutability between products, the Commission will have regard to relative prices, quality and performance when assessing whether they are, in fact, close substitutes in the eyes of buyers.

43. The bulk of work undertaken by private hospitals such as Ascot and Mercy is privately funded. In terms of market definition, it is important to consider whether there is a distinction between public and private funding, and also whether there is a distinction between public and private providers.

44. Publicly funded elective surgery accounts for about 25% of the surgery undertaken in private hospitals. As already noted at para 38, publicly funded surgery is organised differently from privately funded surgery. This means the product, with respect to publicly funded operations, is the provision of the surgery and facilities, whereas, with respect to privately funded operations, it is just the provision of the facilities.

45. Secondly, private hospitals are directly competing with public hospitals for publicly funded work, whereas only a small amount of privately funded work is undertaken in public hospitals.[3] Therefore, for publicly funded operations, public and private institutions are in the same market, whereas, for privately funded operations that is not the case. For these reasons, in the context of this application, the Commission considers there are separate markets for publicly and privately funded surgery.

46. The Commission acknowledges that this differs from its stance in Decision 331, where it noted that though "the provision of publicly funded secondary services is the major activity of HHSs {public hospitals}…due to the evolving nature of health service funding and delivery there is the potential for blurring of the boundaries between public and private services and facilities." Consequently, it specified a combined private and publicly funded secondary healthcare services market. However, in the three years since Decision 331, health policy has shifted away from that blurring, with the current policy discouraging the carrying out of private work in public hospitals.

47. Consequently, it is now appropriate to define separate markets for publicly and privately funded elective surgical work. Both private and public hospitals operate in the public funded market, whereas only private hospitals operate in the privately funded market.

48. However, even though public hospitals are not included in the privately funded market, it is acknowledged that the public system does have some influence on private provision. This influence has three dimensions.

[3] An exception to this is a contract held by Greenland hospital to provide cardiac surgery to Tahitian patients.

49. First, there remains the potential for public facilities to undertake private work, even though this would require a change in Government policy to be a significant influence in the market.

50. Second, the public system occasionally contracts out work to the private system, for instance to reduce surgical waiting lists. This appears not to be happening at present, but did in the year 2000. Public hospitals are funded for surgery according to independently derived case-weight formulae; these tend to set the benchmark for how much the public funders will pay private providers. In turn, private funders, such as the insurance companies, will expect hospitals to undertake privately funded surgery for similar prices.

51. Finally, and most influentially, patients can chose to be treated in either the public or private system. The service dimension, especially timeliness, favours the private provision while price favours the public. If the price in the private system becomes too great, the patient has the option of trying to have that work undertaken in the public system.

52. For these reasons, though public hospitals are not considered part of the privately funded elective surgery market, they are acknowledged as a constraint on that market.

Supply-side substitution

53. Close substitute products on the supply-side are those between which suppliers can easily shift production, using largely unchanged production facilities and little or no additional investment in sunk costs, when they are given a profit incentive to do so by a small change in their relative prices.

54. There are two such issues that arise when defining the markets in which the hospitals are functioning: whether to distinguish between acute and elective surgery, and whether to distinguish between secondary and tertiary services.

55. Acute surgery is usually urgent cases that require immediate treatment, while elective surgery is for non-urgent conditions which do not require immediate attention. Although there are aspects common to the provision of both services (e.g. clinical staff and facilities), there is a difference in the timeframes over which the services may be delivered. Acute services are required more urgently than elective surgery and there is little or no control over their volume. In general, only elective surgery is provided at Ascot and Mercy.

56. Parties spoken to agreed that it was meaningful to distinguish between secondary and tertiary surgery. This is on the basis of the more specialised equipment, nursing staff and other staff required for tertiary surgery (e.g. the need for intensive care units or coronary care units). From a supply perspective, facilities suitable for tertiary surgery can be used for secondary surgery, but not vice versa.

Undifferentiated/Differentiated Products

57. In some instances, market definition problems arise because of the differentiated nature of the goods or services involved in a business acquisition, caused by differing technical specifications, branding, packaging, warranties, distribution channels and other factors.

58. Where a significant group of buyers within a relevant market is likely to be subject to price discrimination, the Commission will consider defining additional relevant markets based on particular uses for a good or service, particular groups of buyers, or buyers in particular geographic areas. In other cases, the primary focus may switch to the extent to which a business acquisition eliminates competition between the products brought together by the acquisition.

59. Provision of surgical services has elements of being a differentiated service. The surgeon, the style and nature of facilities and the location of the hospital are all factors that influence the patient's choice. However, some of these factors are either outside the market (the surgeon) or are already catered for within the proposed market definition (distinction between secondary and tertiary services). The Commission therefore does not propose to further define the market on the basis of differentiated products for the purposes of this fact situation. It notes, however, that within the market there is some degree of differentiation.

Geographic Extent

60. The Commission will seek to define the geographical extent of a market to include all of the relevant, spatially dispersed, sources of supply to which buyers can turn should the prices of local sources of supply be raised. For each good or service combination, the overlapping geographic areas in which the parties operate are identified. These form initial markets to which a ssnip is applied. Additional geographic regions are added until the smallest area is determined within which the hypothetical monopolist could profitably impose a ssnip.

61. Generally, the higher the value of the product to be purchased, in absolute terms or relative to total buyer expenditure as appropriate, the more likely are buyers to travel and shop around for the best buy, and the wider the geographic extent of the market is likely to be.

62. Where transport costs are high relative to the final value of a product, a narrower geographic market is more likely to be appropriate. Where product perishability and other similar practical considerations limit the distance that a product may be transported, this may limit the geographic extent of the market. The timeliness of delivery from alternative geographic sources is similarly relevant.

63. Although buyers and sellers of a particular good or service may interact in markets that are apparently local or regional in extent, those markets may themselves overlap and interrelate so as to form a market covering a larger geographical area. In these situations, the larger market is likely to be the appropriate one for analysing the competitive effects of a business acquisition.

64. The Commerce Act defines a market to be a "market in New Zealand". However, in many markets New Zealand buyers purchase products from both domestic and from overseas suppliers. Where imported products are close substitutes for domestic products, the overseas suppliers will be part of the relevant market. In such circumstances the Commission, in order to comply with the wording of the Act, is likely to define a national market and then, as discussed later in the competition analysis, to consider the extent to which overseas suppliers exercise a competitive constraint on the participants in the domestic market.

65. The applicant has submitted that with respect to the surgical services and facilities market the geographical area is Auckland, while for angiography and endoscopy services market the geographic area is Auckland or the upper North Island. In a subsequent submission, the applicant claimed the appropriate geographic area for cardiac surgery (i.e. tertiary services) extends beyond Auckland and could well be national.

66. The Commission agrees with an Auckland wide market for secondary surgery. This is consistent with decision 331 which adopted a Bay of Plenty geographic area for the secondary market. It also considers this is the relevant area for publicly funded surgery, given that the ACC allocates funds by region.

67. The Commission has given considerable thought to the geographic area for the tertiary market. On the one hand, doctors and surgeons spoken to as part of this investigation agreed that Auckland GPs would not recommend their Auckland patients travel outside the region for treatment. Also, Southern Cross said it would not generally expect Auckland patients to travel to other centres, such as Hamilton, for treatment. This points to facilities outside Auckland potentially being outside the Auckland market.

68. On the other hand, the applicant has informed the Commission that over the 6 months from June to November 2001, [ ] of its cardiac surgery patients came from outside the Auckland geographic area. Similarly, Mercy supplied figures that over the same period [ ] of its cardiac patients came from outside the Auckland region. These patients would come from both north and south of Auckland, but it is likely that over half of them come from the south, that is from the Waikato, Bay of Plenty and Taranaki regions.

69. The Anglesea Cardiovascular Services ("Anglesea"), located in Hamilton, is a private hospital that provides the full range of cardiovascular services. Anglesea is a feasible alternative for patients in the Waikato - Bay of Plenty – Taranaki regions to Ascot and Mercy, so could be considered part of the same market as them – at least for the proportion of patients coming from this area.[4]

70. Faced with this range in possible geographic areas, the Commission has decided to adopt a narrow market definition for its analysis, in that if the application can be cleared under this definition, it would certainly be cleared under a wider definition. However, in adopting an Auckland only market for tertiary services and therefore excluding Anglesea from that market, it recognises the potential constraint that Anglesea can exert in the Auckland market.

71. Specifying an Auckland only geographic market differs from the approach adopted in Decision 331, where the geographic market for tertiary services and facilities was defined as the North Island. However, that decision concerned the amalgamation of two health providers in the Bay of Plenty, and it was noted that " Most residents in the Bay of Plenty who require tertiary healthcare services usually travel to Health Waikato's hospital facility at Hamilton, or to one of the other tertiary care providers". The circumstances are different for Auckland residents, who have access to public and private tertiary services in their region.

[4] An even wider market was suggested by the applicant. We note that the Manager of Anglesea commented that Taranaki patients sometimes chose to go to the Wakefield Clinic in Wellington, suggesting, via a chain of substitutions, that a North Island market could be considered.

72. With respect to angiography, the applicant has estimated that 95% of its patients come from the Auckland region. This figure is broadly consistent with an estimate by cardiologists at Mercy Angiography who considered that 90% of patients came from the Auckland region. Because of this high proportion of patients from within the Auckland region, and the arguments above with respect to the unwillingness of patients to travel outside the region for treatment, the Commission considers the geographic area is Auckland.

73. Similarly, it considers the relevant geographic market for endoscopy services, a cheaper and more widely provided service than angiography, is also Auckland.

Conclusion on Market Definition

74. The Commission concludes that the relevant markets are:

- The provision of hospital facilities and related non specialist services for elective secondary surgery to private patients in the Auckland region;

- The provision of hospital facilities and related non specialist services for elective tertiary surgery to private patients in the Auckland region;

- The provision of elective secondary surgery for publicly funded patients in the Auckland region;

- The provision of angiography services to private patients in the Auckland region; and

- The provision of endoscopy services to private patients in the Auckland region.

COMPETITION ANALYSIS

Substantially Lessening Competition

75. Section 47 of the Act prohibits particular business acquisitions. It provides that:

> A person must not acquire assets of a business or shares if the acquisition would have, or would be likely to have, the effect of substantially lessening competition in a market.

76. Section 2(1A) provides that substantial means "real or of substance". Substantial is taken as meaning something more than insubstantial or nominal. It is a question of degree.[5] What is required is a real lessening of competition that is not minimal. The lessening needs to be of such size, character and importance to make it worthy of consideration.[6]

---

[5] *Commerce Commission v Port Nelson Ltd* (1995) 6 TCLR 406, 434; *Mobil Oil Corporation v The Queen in Right of NZ* 4/5/89, International Centre for Settlement of Investment Disputes, Washington DC, International Arbitral Tribunal ARB/87/2 (paras 8.2, 19, 20).

[6] *Dandy Power Equipment Ltd v Mercury Marina Pty Ltd* (1982) ATPR 40-315, 43-888; *South Yorkshire Transport Ltd v Monopolies & Mergers Commission* [ ] 1 All ER 289.

77. Section 3(2) provides that references to the lessening of competition include references to the hindering or preventing of competition.[7]

78. While the Act defines the words "substantial" and "lessening" individually it is desirable to consider the phrase as a whole. For each relevant market, the Commission will assess:

    - the probable nature and extent of competition that would exist in a significant section of the market, but for the acquisition (the counterfactual);

    - the nature and extent of the contemplated lessening; and

    - whether the contemplated lessening is substantial.[8]

79. In interpreting the phrase "substantially lessening competition", the Commission will take into account the explanatory memorandum to the Commerce Amendment Bill (No 2). The memorandum notes that:

> Two of the 3 key prohibitions are strengthened to bring New Zealand into line with Australian competition law, which will facilitate a more economic approach to defining anti-competitive behaviour.

and, in relation to s47:

> This proposed new threshold is the same as the threshold for these types of acquisitions in section 50 of the Trade Practices Act 1974 (Australia).

80. For the purposes of the analysis, the Commission takes the view that a lessening of competition and a strengthening of market power may be taken as being equivalent, since they are the two sides of the same coin. Hence, it uses the two terms interchangeably. Thus, in considering whether the acquisition would have, or would be likely to have, the effect of substantially lessening competition in a market, the Commission will take account of the scope for the exercise of market power, either unilaterally or through co-ordination between firms.

81. When the impact of enhanced market power is expected predominantly to be upon price, the anticipated price increase relative to what would otherwise have occurred in the market has to be both material, and able to be sustained for a period of at least two years, for the lessening, or likely lessening, of competition to be regarded as substantial. Similarly, when the impact of increased market power is felt in terms of the non-price dimensions of competition, these also have to be both material and able to be sustainable for at least two years for there to be a substantial lessening, or likely substantial lessening, of competition.

---

[7] For a discussion of the definition see *Commerce Commission v Port Nelson Ltd*, supra n 6, 434.

[8] See *Dandy*, supra n 5, pp 43–887 to 43-888 and adopted in New Zealand: *ARA v Mutual Rental Cars* [ ] 2 NZLR 647; *Tru Tone Ltd v Festival Records Retail Marketing Ltd* [ ] 2 NZLR 352; *Fisher & Paykel Ltd v Commerce Commission* [ ] 2 NZLR 731; *Commerce Commission v Carter Holt Harvey*, unreported, High Court, Auckland, CL 27/95, 18/4/00.

The Counterfactual

82. The Commission will continue to use a forward-looking, counterfactual, type of analysis in its assessment of business acquisitions, in which two future scenarios are postulated: that with the acquisition in question, and that in the absence of the acquisition (the counterfactual). The impact of the acquisition on competition can then be viewed as the difference between those two scenarios. It should be noted that the status quo cannot necessarily be assumed to continue in the absence of the acquisition, although that may often be the case. For example, in some instances a clearly developing trend may be evident in the market, in which case the appropriate counterfactual may be based on an extrapolation of that trend.

83. In establishing the status quo we have noted that the Sisters of Mercy, Mercy's owners, want to sell. The hospital no longer provides employment for the Sisters of Mercy - only two of the order work at the hospital out of a staff of over 400. The current focus of the hospital, namely the provision of surgery for the relatively better off with medical insurance, is not part of the Sisters of Mercy's mission. Finally, the hospital itself is an old building that requires constant and substantial maintenance and upgrading.

84. The Sisters of Mercy require resources to fund their social programmes. In addition, they have a number of elderly members with high health needs. Consequently, the Sisters of Mercy no longer want to own the hospital.

85. Options for the Sisters of Mercy are to sell or close the facility. (The Sisters of Mercy recently closed the Mercy Hospital in Whangarei.) If the hospital were put up for sale, the Commission expects there would be interest in buying it and continuing to run it as a going concern. [

] The Sisters of Mercy had some non-monetary concerns with respect to the sale; they sought compatibility with the new owners on spiritual grounds and also sought assurances that the outreach programmes operated by the hospital would be maintained. [

]

86. Consequently, we consider that even given the Sisters of Mercy's wish to end their involvement with the hospital, there would be potential purchasers other than Ascot. Though an alternative purchaser would most likely be another healthcare provider, we consider it would be feasible for an investor to purchase the hospital and maintain it as a going concern.

87. Therefore, for the purposes of this application, we have considered the appropriate counterfactual to be the status quo as regards facilities and services, even though it is acknowledged that the status quo with respect to ownership of Mercy would not be maintained.

88. During the investigation, some parties suggested that the rationalisation and site specialisation that is envisaged with Ascot's purchase of Mercy is consistent with international trends for hospital organisation. While acknowledging this, the Commission does not think that such a development is inevitable, and so has not factored this into the counterfactual.

Conclusion – Competition Analysis Principles

89. The Act prohibits business acquisitions that would be likely to have the effect of substantially lessening competition in a market. The Commission makes this assessment against a counterfactual of what it considers would be likely to happen in the absence of the acquisition. In the present case the counterfactual is considered to be the status quo. A substantial lessening of competition is taken to be equivalent to a substantial increase in market power. A business acquisition can lead to an increase in market power by providing scope either for the combined entity to exercise such power unilaterally, or for the firms remaining in the market to co-ordinate their behaviour so as to exercise such power.

90. In broad terms, a substantial lessening of competition cannot arise from a business acquisition where there are sufficient competitive constraints upon the combined entity. The balance of this Decision considers and evaluates the constraints that might apply in the various markets under the following headings:

    – existing competition;

    – potential competition from entry; and

    – other competition factors.

91. We have previously identified separate markets. The levels of competition and therefore constraints within those markets are markedly different. Therefore, we have analysed each of those markets separately. The first market analysed is the market for privately funded secondary elective surgery. This corresponds to the core activities of Ascot and Mercy, and much of this analysis also informs the analysis of the other markets. We then present supplementary analyses highlighting relevant aspects of the other markets.

THE PROVISION OF FACILITIES AND SERVICES FOR SECONDARY ELECTIVE SURGERY TO PRIVATE PATIENTS

ANALYSIS OF EXISTING COMPETITION

Introduction

92. One consequence of a merger between competitors is that the number of firms competing in a market is reduced or, put another way, concentration is increased. This raises the possibility that competition in the market may be substantially lessened through the exercise of unilateral or coordinated market power. These are the subject of the analysis in this section.

Scope for Unilateral Market Power

Introduction

93. An examination of concentration in a market post-acquisition can provide a useful guide to the constraints that market participants may place upon each other, including the combined entity. Both structural and behavioural factors have to be considered. However, concentration is only one of a number of factors to be considered in the

assessment of competition in a market. Those other factors are considered in later sections, as noted above.

94. Market shares can be measured in terms of revenues, volumes of goods sold, production capacities or inputs (such as labour or capital) used. All measures may yield similar results in some cases. Where they do not, the Commission may, for the purposes of its assessment, adopt the measure which yields the highest level of market share for the combined entity. The Commission considers that this will lead to an appropriately conservative assessment of concentration, and that the factors which lead to the other different market share results are more appropriately considered elsewhere during the assessment of the acquisition.[9]

95. In determining market shares, the Commission will take into account the existing participants (including 'near entrants'), inter-firm relationships, and the level of imports. This is followed by a specification of the Commission's 'safe harbours', an estimation of market shares, and an evaluation of existing competition in the market. Each of these aspects is now considered in turn.

Existing Participants

96. The participants in the Auckland surgical market are shown in Table 1. The applicant has proposed that market shares be measured by bed numbers. However, during this investigation, the Commission has formed the view that a more appropriate measure is the number of operating theatres, so uses that measure in the table below.[10]

97. Within the table, hospitals are divided into two groups. All hospitals within the list are licensed to perform surgery. However, those in the latter part of the list are restricted to day surgery (that is the patient can only stay at the hospital for a maximum of 23 hours). Because of the development of surgical techniques, the Commission considers all these hospitals are within the same market, but notes that in some respects those in the upper part of the table could be considered closer substitutes compared with those in the latter part.

98. It is acknowledged that operating theatres are not a perfect measure of market share. Surgical procedures vary considerably by complexity, time and cost, so the output of one theatre may be very different from the output of another. Similarly, the theatres may have different equipment or be set up with different procedures in mind. However, to the extent that surgical facilities can be used across a variety of branches of medicine (notwithstanding the distinction between secondary and tertiary care) the number of theatres is a useful proxy to market share.

---

[9] For example, where market share measured in terms of capacity produces a significantly lower share of the market in the hands of participants than a measure in terms of sales volumes, the constraint on a combined entity from that unemployed capacity might be taken into account when identifying near entrants or the constraint from new market entry. In some cases, the model of market power being used may influence the choice as to which market share measure is used.

[10] A consistent theme of market participants spoken with during the investigation of this application was that the nature of surgery has changed considerably in recent years. Advances in anaesthesia, and the development of micro-invasive surgical techniques mean that many surgical procedures can be performed as day-patient treatment rather than requiring in-patient care. This has altered the optimum ratio of beds to operating theatres, and made theatres the more relevant measure of capacity.

Table 1
Participants and Market Shares for Auckland Private Hospital Surgery

Hospital	Number of Operating Theatres	Proportion of Total (%)
Mercy	7[11]	16
Ascot	12	28
Navy Hospital	2	5
Southern Cross Hospital Trust – Brightside	3	7
Southern Cross Hospital Trust – North Harbour	4	9
Gillies Hospital (50% SCHT)	3	7
Day Stay Hospitals[12]		
Auckland Surgical Centre	4	9
Northern Surgical Centre	2	5
Endoscopy Auckland	2[13]	5
North Shore Day Surgery	2	5
Artemis surgical centre	2	5
Total	**43**	

Source: NZ Private Hospitals Association and Industry Participants

Inter-firm Relationships

99. Companies that are part of the same corporate grouping, or that have similar strong relationships, cannot be relied upon to provide an effective competitive constraint to one another. Other less formal relationships between companies may also give rise to limitations on the extent of rivalry between them. Relationships between persons in the relevant market and other businesses may also affect rivalry in a market.

100. Laparoscopy Auckland and Endoscopy Auckland are 50% owned by IHL, the major parent of Ascot. Dr Levy, Chief Executive of Ascot, is on both Boards (one of three Directors for Endoscopy Auckland and one of two Directors for Laparoscopy Auckland). The Commerce Act at s 47(3) provides that:

> *" a person is associated with another person if that person is able, whether directly or indirectly, to exert a substantial degree of influence over the activities of the other."*

101. Though the Chief Executive of Endoscopy Auckland described Dr Levy as adopting a "hands-off" approach to management, the Commission considers that the shareholding

[11] The applicant has signalled that after the acquisition it plans to reduce the number of theatres at Mercy to [ ].
[12] The Dilworth Hospital which is about to close is not included.
[13] Endoscopy Auckland includes the facilities of Laparoscopy Auckland.

combined with the Board representation is sufficient to make Endoscopy Auckland associated with Ascot.

102. Another question of association arises with respect to CHPT and Ascot. CHPT owns the buildings and land of Ascot and is therefore its landlord. It is also a 15% shareholder of Ascot. The issue of association arises in assessing whether other hospital buildings that CHPT owns (Artemis Medical and Surgical Centre and Endoscopy Auckland) or other hospital developments with which CHPT is associated, should be aggregated with Ascot's market share.

103. CHPT is a property trust (specialising in healthcare facilities), with no long term strategic interest in developing or operating the services within those facilities. It owns a range of other healthcare related buildings in the North Island and Australia.

104. CHPT has 1 seat on the 7 person Ascot Board. It has no special voting rights associated with its shareholding. The lease agreement between CHPT and Ascot is at arms length, as evidenced by a dispute between the two parties having been the subject of formal mediation. The Commission found no evidence of CHPT having any substantial influence over Ascot's operations.

105. CHPT's role with respect to the other facilities it owns is purely that of landlord.

106. The Commission therefore concludes that Ascot is not associated with the other facilities where the property is owned by CHPT. It notes that this conclusion is based on the particular circumstances of this fact situation, and that in other circumstances a similar shareholder with a common director could lead to a finding of association.

107. Because of their common ownership, the Commission considers the three SCHT facilities are interconnected. Therefore their market shares are aggregated for market concentration analysis.

Imports

108. Though on occasions patients travel overseas for medical treatment, imports are not considered important to this analysis.

Safe Harbours

109. The Commission has defined 'safe harbours' for competition analysis. Under these safe harbours, a business acquisition is considered unlikely to substantially lessen competition in a market where, after the proposed acquisition, either of the following situations exist:

- where the three-firm concentration ratio - C3 - (with individual firms' market shares including any interconnected or associated persons) in the relevant market is below 70%, the combined entity (including any interconnected or associated persons) has less than in the order of a 40% share; or

- where the three-firm concentration ratio (with individual firms' market shares including any interconnected or associated persons) in the relevant market is above 70%, the market share of the combined entity is less than in the order of 20%.

110. On the basis of the figures in Table 1 (and allowing for the aggregation of Endoscopy Auckland with the merged Ascot and Mercy, and the aggregation of the SCHT facilities), the C3 is 81%, while the combined entity has a market share of 49%. This puts the acquisition outside the defined safe harbours.

111. However, market shares are insufficient in themselves to establish whether competition in a market has been lessened. It is the interplay between a number of competition factors, of which seller concentration is only one, that has to be assessed in determining the impact of a business acquisition on competition.

State of Existing Competition

112. The market for private secondary surgery was commonly described by industry participants as competitive. Much of this reflects the strong countervailing powers held by ACC, insurance companies and surgeons, and these are discussed subsequently. However, it also reflects the significant number and range of competitors in the market.

113. There are two substantial competitors, the Southern Cross facilities plus the Auckland Surgical Centre. In addition there are the smaller hospital and surgical facilities, not to mention a range of specialised clinics not included in Table 1. These other hospitals are all regarded as vigorous competitors in the secondary surgery market.

Conclusions – Unilateral Market Power

114. Therefore, aside from any countervailing factors, the Commission concludes that the merged entity would not be able to exercise unilateral market power.

Scope for the Exercise of Coordinated Market Power

Introduction

115. A business acquisition may lead to a change in market circumstances such that coordination between the remaining firms either is made more likely, or the effectiveness of pre-acquisition coordination is enhanced. Firms that would otherwise compete may attempt to coordinate their behaviour in order to exercise market power by restricting their joint output and raising price. In extreme cases, where all firms in the market are involved and coordination is particularly effective, they may be able to behave like a collective monopolist. Where not all firms are involved, and market share in the hands of the collaborators is reduced, coordinated market power becomes more difficult to exercise because of competition from the independent firms in the market.

116. In broad terms, successful coordination can be thought of as requiring two ingredients: ‘collusion’ and ‘discipline’. ‘Collusion’ involves the firms individually coming to a mutually profitable expectation or agreement over coordination; ‘discipline’ requires that firms that would deviate from the understanding are detected and punished (thereby eliminating the short-term profit to be gained by the firm from deviating).

117. When assessing the scope for coordination in the market during the consideration of a business acquisition, the Commission will evaluate the likely post-acquisition structural and behavioural characteristics of the relevant market or markets to test whether the potential for coordination would be materially enhanced by the acquisition. The intention

is to assess the likelihood of certain types of behaviour occurring, and whether these would be likely to lead to a substantial lessening of competition.

Collusion

118. "Collusion" involves firms in a market individually coming to a mutually profitable expectation or agreement over coordination. Both explicit and tacit forms of such behaviour between firms are included.

119. The structural and behavioural factors that are usually considered to be conducive to collusion are set out in the left-hand column in Table 2. The significance of these is explained more fully in the Commission's *Practice Note 4*. The right-hand column of the Table then assesses the extent to which those factors are present, or are likely to be enhanced post-merger, in the privately funded elective secondary surgery market. A high proportion of 'yes' responses would suggest that the market was particularly favourable to 'collusion'; a high proportion of 'no' responses the reverse.

TABLE 2
Testing the Potential for 'Collusion' in the
Privately Funded Elective Secondary Surgical Facilities Market

Factors conducive to collusion	Presence of factors in the market
High seller concentration	Yes
Undifferentiated product	Partially
New entry slow	No
Lack of fringe competitors	No
Price inelastic demand curve	Variable
Industry's poor competition record	No
Presence of excess capacity	Yes
Presence of industry associations/fora	No

Explanation of Table 2

120. The high seller concentration reflects the way surgery is organised, in that there are relatively few surgeons and relatively specialised facilities are required so that it makes sense to aggregate activity to a few sites.

121. As discussed at para 59, the product has characteristics of differentiation and undifferentiation. In terms of the full surgical service, the principal point of differentiation is the surgeon, which is not part of the current consideration. However, the facilities are perceived on a number of non-price dimensions, such as quality, reputation and location. A price schedule supplied by the applicant for different private hospitals indicates a small range within the fees for room rates and operating theatre charges. We therefore conclude that the market is not driven solely by price and there is some differentiation.

122. For the secondary surgical market, we do not consider new entry to be slow. The past four years has seen the establishment of the Auckland Surgical Centre, Ascot, Laparoscopy Auckland and the Northern Surgical Centre, in addition to the redevelopment of Brightside Hospital. Because surgeons are not contracted to any particular hospital, any new facility is competing on a relatively even playing field with incumbent operators.

123. In addition to the establishment of surgical centres, there has been significant growth in the number and range of facilities providing more minor surgery. Ophthalmic surgery, ear nose and throat and plastic surgery are amongst the branches of surgery where specialist clinics have been established. We conclude there is a vigorous range of fringe competitors.

124. People value their health highly, so it could be assumed that demand for health care would be inelastic. However, that is not necessarily the case for elective surgery. By definition, elective surgery is non-urgent, therefore patients may have the choice between immediate surgery and delay. Sometimes surgery will be one amongst a range of treatment options (pharmaceuticals might be another) and cost will be a factor as to which of these options to pursue. Health insurance will make many patients less price sensitive, but in turn heightens the price sensitivity of the insurer. And finally, patients have a choice between the public and private system, and will be driven to the public system if the price of the private system is too high. None of these factors may in itself be particularly influential, but in aggregate they explain why we do not characterise demand as being inelastic.

125. The Commission has, from time to time, investigated groups of specialists with respect to potentially anti-competitive practices. However, there is no track record of investigations of the hospitals themselves.

126. Several parties spoken to as part of this investigation said they thought there was excess capacity in the market. Ascot's entry in 1999 greatly expanded supply of private surgical facilities. Almost simultaneously, the change in Government health policy made it less likely that public work would be contracted out to the private sector. The closure of the Adventist Hospital in December 1999 was attributed to the over supply of facilities and, in a related way [ ]

127. There is an industry forum, namely the NZ Private Hospitals Association. However, because SCHT is not a member, for competition analysis purposes we have characterised the market as not having an industry forum.

128. Overall, there is only a weak suggestion that the market is likely to be susceptible to collusion after the acquisition. The presence of a range of participants means that it would make it difficult to establish coordinated behaviour.

Discipline

129. Because of the above finding with respect to collusion, we have not further investigated the scope for discipline.

Conclusions – Co-ordinated Market Power

130. We conclude that co-ordinated market power is not likely.

Conclusions – Existing Competition

131. The Commission considers that the scope for the exercise of unilateral or co-ordinated market power would not be enhanced by the acquisition.

CONSTRAINTS FROM MARKET ENTRY

Introduction

132. A business acquisition is unlikely to result in a substantial lessening of competition in a market if behaviour in that market continues to be subject to real constraints from the threat of market entry.

133. Where barriers to entry are clearly low, it will not be necessary for the Commission to identify specific firms that might enter the market. In other cases, the Commission will seek to identify likely new entrants into the market.

134. The Commission will consider the history of past market entry as an indicator of the likelihood of future entry. The Commission is also mindful that entry often occurs on a relatively small scale, at least initially, and as such may not pose much of a competitive constraint on incumbents within the relevant time frame.

Barriers to Entry

135. The likely effectiveness of the threat of new entry in constraining the conduct of market participants, following a business acquisition that might otherwise lead to a substantial lessening of competition in a market, is determined by the nature and height of barriers to entry into that market.

136. The Commission considers that, for the purpose of considering this issue, a barrier to entry is best defined as an additional or significantly increased cost or other disadvantage that a new entrant must bear as a condition of entry. In evaluating the barriers to entry into a market, the Commission will generally consider the broader 'entry conditions' that apply, and then go on to evaluate which of those constitute entry barriers.

137. It is the overall obstacle to entry posed by the aggregation of the various barriers that is relevant in determining whether entry is relatively easy or not, and therefore whether or not potential entry would prevent a substantial lessening of competition.

138. For entry to act as an antidote to a substantial lessening of competition stemming from a business acquisition, it must constrain the behaviour of the combined entity and others in the market.

The "LET" Test

139. In order for the threat of market entry to be such a constraint on the exercise of market power as to alleviate concerns that a business acquisition could lead to a substantial lessening of competition, entry of new participants in response to the exercise of market power must be likely, sufficient in extent and timely (the *let* test). If they are to act as a constraint on market participants following a business acquisition which might otherwise lead to a substantial lessening of competition in a market, entry must be relatively easy, or to put it another way, barriers to entry must be relatively low.

Likelihood of Entry

140. The mere possibility of entry is, in the Commission's view, an insufficient constraint on the exercise of market power to alleviate concerns about a substantial lessening of competition. In order to be a constraint on market participants, entry must be likely in commercial terms. An economically rational firm will be unlikely to enter a market unless it has a reasonable prospect of achieving a satisfactory return on its investment, including allowance for any risks involved.

141. In general, it is the pre-merger price that is relevant for judging whether entry is likely to be profitable. That in turn depends upon the reaction of incumbents to entry in terms of their production volume, together with the output volume needed by the entrant in order to lower its unit costs to the point where it can be competitive.

142. The Commission considers the likelihood of entry into the surgery market is high. In its 2001 Annual Report, CHPT discusses its plans for Waitemata Private, a medical and surgical facility to be located adjacent to North Shore Public Hospital.

143. In addition to this facility, the Commission notes that over the past 5 years there has been a range of new entrants into the private surgical facilities market. It therefore considers the likelihood of entry into the market as relatively high.

Extent of Entry

144. If entry is to constrain market participants, then the threat of entry must be at a level and spread of sales that is likely to cause market participants to react in a significant manner. The Commission will not consider entry that might occur only at relatively low volumes, or in localised areas, to represent a sufficient constraint to alleviate concerns about market power.

145. Small-scale entry into a market, where the entrant supplies one significant customer, or a particular product or geographic niche, may not be difficult to accomplish. However, further expansion from that "toe-hold" position may be difficult because of the presence of mobility barriers, which may hinder firm's efforts to expand from one part of the market to another. Where mobility barriers are present in a market, they may reduce the 'extent' of entry.

146. The proposed Waitemata Private facility will have "three operating theatres for day surgery procedures and associated recovery beds"[14]. It is significantly smaller than

[14] Calan Healthcare Properties *Trust Annual Report 2001*, p10.

Ascot, but is of similar size to many of the other private hospitals in the Auckland region. The Commission considers it would be of sufficient size to be a constraint in the market.

Timeliness of Entry

147. If it is effectively to constrain the exercise of market power to the extent necessary to alleviate concerns about a substantial lessening of competition, entry must be likely to occur before customers in the relevant market are detrimentally affected to a significant extent. Entry that constrains must be feasible within a reasonably short timeframe from the point at which market power is first exercised.

148. In some markets where goods and services are supplied and purchased on a long-term contractual basis, buyers may not immediately be exposed to the detrimental effects stemming from a potential substantial lessening of competition. In such cases, the competition analysis, in a timing sense, begins with the point at which those contracts come up for renewal.

149. Private hospitals incorporating surgical facilities require significant planning and investment, which in general could count against any possible entry being considered within a relevant timeframe. However, in the case of Waitemata Private, though the decision to go-ahead with Waitemata Private has not yet been made, the Chairman of CHPT indicated that a decision was likely by [ ] and the facility could be ready for patients by [ ].

150. The Commission considers this is within the timeframe for entry to constrain the market.

Conclusion on Barriers to Entry

151. The Commission concludes that the barriers to entry are low and the prospect of entry is sufficiently tangible for the threat of entry to be a real constraint on the merged entity in the market for the provision of facilities and services for secondary elective surgery to private patients.

OTHER COMPETITION FACTORS

Elimination of a Vigorous and Effective Competitor

152. Sometimes an industry contains a firm that is in some way non-typical, or has different characteristics, or is an innovator, or is regarded as a maverick. The independent or less predictable behaviour of such a firm may be an important source of competition in the market, and may undermine efforts by other firms to engage in coordination. Such a firm need not be large to have an impact on competition out of proportion to its relative market size. Should it become the target of a business acquisition, the resulting elimination of a vigorous and effective competitor could have the effect of substantially lessening competition in the market (especially if there are barriers preventing the entry of new, effective competitors).

153. Mercy is a profitable venture with an impressive track record and reputation. However, we do not consider it to be a maverick or non-typical competitor.

Constraint from Buyers or Suppliers

154. The potential for a firm to wield market power may be constrained by countervailing power in the hands of its customers, or alternatively, when considering buyer (oligopsony or monopsony) market power, its suppliers. In some circumstances, it is possible that this constraint may be sufficient to eliminate concerns that a business acquisition may lead to a substantial lessening of competition.

155. Where a combined entity would face a purchaser or supplier with a substantial degree of market power in a market affected by the acquisition, the Commission will consider whether that situation is such as to constrain market participants to such an extent that competition is not substantially lessened.

156. The Commission has closely considered the constraints that buyers can effect in this market, and concludes that they are significant. These constraints arise from the role of ACC and insurance companies as significant purchasers and funders in the market, and the potential competition from public hospitals. As well surgeons and other healthcare providers have a degree of influence, and incentives to keep hospital prices down.

157. These are explained in more detail with respect to the tertiary surgery market at paras 175-190.

Efficiencies

158. The Commission recognises that there may be circumstances where efficiencies are relevant to an application for clearance.[15] In the context of a business acquisition, the combined entity might be able to make efficiency gains that are not obtainable by other means, such that its unit cost of production would decline. This could result in the entity reducing its price below that obtaining prior to the acquisition, even though with the acquisition it would otherwise be considered to have substantially lessened competition, and would be able to raise price above costs.

159. Where the applicant can make a sound and credible case that such efficiencies will be realised, that they cannot be realised without the acquisition, and that they will enhance competition in the relevant market, the Commission will include them in the broader analysis of all of the competitive effects of the acquisition in the course of assessing whether or not competition is likely to be substantially lessened. However, the Commission envisages that efficiency claims of the required magnitude and credibility will only very rarely overturn a finding that competition would otherwise be substantially lessened.

160. The applicant has suggested that efficiencies are relevant. The process of amalgamating Ascot and Mercy's activities will enable specialisation of different surgical

---

[15] In *Fisher & Paykel*, considered under s 27, the Court held that in assessing "substantial lessening of competition", a net approach to assessing anti-competitive effects was required: "The majority correctly accepted that it had to 'net out' the pro and anti-competitive effects and that, if it could be shown that the net effect of the EDC was to promote competition, then there could be no substantial lessening of competition." *Fisher & Paykel v Commerce Commission* [ ] 2 NZLR 731 at 740. See also: *Commerce Commission v Port Nelson*, supra n 6,433; *Shell (Petroleum Mining) Company Ltd v Kapuni Gas Contracts Ltd*, (1997) 7 TCLR 463, 531.

procedures at each site. [ ] will mean an increasing throughput at each theatre of the merged entity.

161. [

]

162. Lower prices as a result of efficiencies may be possible. However, the evidence is not conclusive. For this application, the Commission has not placed any weight on the possibility that lower prices will result as a result of efficiencies.

OVERALL CONCLUSION

163. The Commission has considered the probable nature and extent of competition that would exist in the market for privately funded secondary elective surgical facilities and related services. The Commission considers that the appropriate benchmark for comparison is the status quo.

164. The proposed acquisition would result in the merged entity obtaining a market share which falls outside the Commission's safe harbour guidelines.

165. The Commission has also considered the nature and extent of the contemplated lessening, in terms of the competitive constraints that would exist following the merger from:

- existing competition;
- potential competition from entry; and
- other competition factors.

166. The Commission is satisfied that the proposed acquisition would not have, nor would be likely to have, the effect of substantially lessening competition in the market for privately funded secondary elective surgical facilities and related services.

THE PROVISION OF FACILITIES AND SERVICES FOR TERTIARY ELECTIVE SURGERY TO PRIVATE PATIENTS

ANALYSIS OF EXISTING COMPETITION

Introduction

167. Tertiary surgery covers many branches of medicine. However, with respect to the activities of Ascot and Mercy the relevant branch is that of cardiac surgery. Therefore, the following analysis focuses solely on cardiac surgery.

Existing Participants

168. Currently within this market the only participants are Ascot and Mercy. Therefore, the acquisition clearly falls outside the safe harbours and presents significant potential for

a potentially substantial lessening of competition as a result of unilateral market power, even recognising the constraint that Anglesea may exert on the market.

CONSTRAINTS FROM MARKET ENTRY

Barriers to Entry

The "LET" Test

169. In order for the threat of market entry to be such a constraint on the exercise of market power as to alleviate concerns that a business acquisition could lead to a substantial lessening of competition, entry of new participants in response to the exercise of market power must be likely, sufficient in extent and timely (the *let* test). If they are to act as a constraint on market participants following a business acquisition which might otherwise lead to a substantial lessening of competition in a market, entry must be relatively easy, or to put it another way, barriers to entry must be relatively low.

170. The applicant considers that entry is sufficiently likely to be a relevant factor. It proposes that [ ] are likely entrants into the market. The Commission agrees that this is a plausible scenario and that these parties have the ability, in terms of expertise and experience to access finance and facilities to make entry feasible.[16] The separation of Mercy Angiography from Ascot, as provided by the applicant's amended application, is viewed by the Commission as having benefits for the competitiveness of the cardiac surgery market as well as the angiography market.

171. The Commission in its investigations was not able to establish any other party as a likely entrant into the cardiac surgery market. It is noted that this is not a feature of the proposed Waitemata Private facility that CHPT might build.[17] However, it considers [ ] as having sufficient potential for entry to be considered likely.

172. Should such entry occur, based on discussions with [ ], it would be of sufficient extent to provide competition to Ascot. [ ]

173. However, in terms of fully satisfying the LET test, we have doubts about timeliness. For a start, the planning and construction of a surgical facility is not a quick procedure. With respect to Waitemata Private, where a significant amount of the planning has already been completed, CHPT estimated it would not be until [ ] before patients were being treated. Addition of a cardiac surgery facility to an existing hospital would be quicker [ ].

[16] [ ]

[17] Calan Healthcare Properties Trust Annual Report 2001.

174. Perhaps even more importantly, we consider there to be a supply/demand imbalance that will slow the prospect of entry in the immediate future. It is widely perceived that Ascot's entry has contributed to over capacity in the market. In time, population growth combined with an ageing population will cause demand to grow, so as to balance that over supply. But in the meantime, the demand for additional cardiac surgery facilities is perceived as low.[18]

Conclusion on Barriers to Entry

175. The Commission concludes that the barriers to entry for tertiary surgical facilities are not necessarily high, and the potential for competitive entry in the longer term is high. In the longer term, the Commission considers competitive entry likely. However, the perception of over capacity in the market diminishes the likelihood of entry within the next two years, which is the timeframe which the Commission usually adopts for assessing the prospects for entry. It therefore considers that the potential for new entry is at best a weak constraint in the context of this application.

OTHER COMPETITION FACTORS

Constraint from Buyers or Suppliers

176. The potential for a firm to wield market power may be constrained by countervailing power in the hands of its customers, or alternatively, when considering buyer (oligopsony or monopsony) market power, its suppliers. In some circumstances, it is possible that this constraint may be sufficient to eliminate concerns that a business acquisition may lead to a substantial lessening of competition.

177. Where a combined entity would face a purchaser or supplier with a substantial degree of market power in a market affected by the acquisition, the Commission will consider whether that situation is such as to constrain market participants to such an extent that competition is not substantially lessened.

178. The Commission has closely considered the constraints that buyers can effect in this market, and concludes that they are significant. These constraints arise from the role of the insurer as a significant purchaser/funder in the market, and the potential competition from public hospitals. As well surgeons and other healthcare providers have a degree of influence, and incentives to keep hospital prices down.

179. Ascot estimates that approximately [ ] of its total revenue came from insured patients. For cardiac surgery the proportion could be higher since cardiac procedures are generally highly priced so it is less likely that patients would proceed privately without insurance. Southern Cross represented [ ] of the insurance revenue, [ ]. This means that at least [ ] of its cardiac surgery revenue will come from Southern Cross, or in other words Southern Cross is a significant funder in the market.

[18] [

]

180. Southern Cross is able to gain access to information from a variety of sources that it can use to assess the reasonableness of hospital fees. Because it operates nationally, Southern Cross is able to benchmark against other hospitals providing cardiac surgery. SCHT has a hospital facility in Christchurch which undertakes cardiac surgery.

181. Sometimes public hospitals will contract out overflow work, for instance if there is pressure to reduce waiting lists in the public system. This occurred in 2000. Public hospitals will not want to pay more than the funding they receive from the public funders, which is based on pre-determined case-weighted funding per procedure. Southern Cross is aware of the levels of funding for this surgery and expects to be charged similarly.

182. [ ] of Southern Cross patients have some form of shared care policy, which involves the patient paying a set percentage excess, plus any amounts in excess of specified rates. Therefore, increased prices would translate into both increased pay outs by Southern Cross and increased payments by the patient. Either case is unsatisfactory to Southern Cross so it will use all its influence to avoid hospital prices from rising.[19]

183. Cardiologists potentially play a "buying" role in the market, as almost all cardiac surgery is referred by cardiologists. The bulk of the cardiologists operating privately in the Auckland area are in the Auckland Heart Group, many of whom work for, and are shareholders in, Mercy Angiography. [

]

184. Cardiac surgeons also pose a constraint. If patients are price sensitive and opt not to have surgery, the surgeon loses out. The surgeon therefore has some incentive for prices not to rise. In some circumstances, the surgeon may be able to switch patients to the public system.

185. Also, surgeons are not tied by contract to any hospital and are capable of leaving one hospital to set up at another.[20] Ascot would therefore want to keep the allegiance of its cardiac surgeons so as to minimise the risk of these surgeons shifting to a rival facility when one is established.

186. In addition to these constraints from private funders and specialists, the constraints posed from the public system have to be recognised. As described at para 51, if prices rise in the private sector, some patients, at least, will opt to go public.

187. The public system has shown a greater willingness to shift patients outside geographic areas than perhaps is the case in the private system. Some years ago, the Wakefield facility in Wellington outbid Mercy in a substantial cardiac services contract with North Health[21], suggesting that any hospital in the Auckland market has to consider the

---

[19] [

]

[20] [ ] raised the possibility that in the future surgeons might become tied by contract to a particular hospital. Though this is a possibility, it would represent a significant change from the way the market currently operates. The Commission thinks surgeons would strongly resist any such move.

[21] North Health was responsible for healthcare funding in the area from Auckland north between 1993 and 1998.

constraint posed by hospitals outside its region. Anglesea is a further constraint in this regard.

188. The competitive constraint of the public system is also demonstrated by the contract Greenlane Hospital has with Tahitian authorities to provide around $4.5 million per annum of cardiac services to Tahitian residents, a contract for which Ascot would be keen to compete.

189. These constraints are difficult to quantify and, in general, it could be argued that constraints from buying power will only operate where the buyer has choice and be less effective if the buyer has no choice. However, there is some evidence that these constraints have been effective, at least in the past.

190. For many years. Mercy was the only private sector hospital undertaking cardiac surgery work in the Auckland region. During this time, prices were constrained as demonstrated by Mercy winning some public tenders. In addition, Mercy has stated that it did not alter its pricing when Ascot entered the Auckland market in 1999.

191. We therefore conclude that the cumulative impact of these constraints, coupled with the longer term threat of competitive entry, will be effective at preventing Ascot exercising the unilateral market power it will gain with respect to cardiac surgery as a result of the acquisition.

Efficiencies

192. The efficiency arguments advanced with respect to secondary surgery market (paras 158-162) apply equally to this market.

OVERALL CONCLUSION

193. The Commission has considered the probable nature and extent of competition that would exist in the market for privately funded tertiary elective surgical facilities and related services. The Commission considers that the appropriate benchmark for comparison is the status quo.

194. The proposed acquisition would result in the merged entity obtaining a market share which falls outside the Commission's safe harbour guidelines.

195. The Commission has also considered the nature and extent of the contemplated lessening, in terms of the competitive constraints that would exist following the merger from:

- existing competition;
- potential competition from entry; and
- other competition factors.

196. The Commission is satisfied that the proposed acquisition would not have, nor would be likely to have, the effect of substantially lessening competition in the market for privately funded tertiary elective surgical facilities and related services.

THE PROVISION OF SECONDARY ELECTIVE SURGERY FOR PUBLIC PATIENTS

ANALYSIS OF EXISTING COMPETITION

197. Though the Commission has considered the publicly funded market as separate from the privately funded market, much of the previous analysis for privately funded secondary market is relevant. The Commission does not consider that the different way services are provided, namely the aggregation of facilities with the surgery services in the public system, has a significant bearing on the competition analysis.

198. The primary difference is that for publicly funded elective surgery, public hospitals are active in the market. The bulk of publicly funded work is provided by ACC. Currently, within the Auckland region, Mercy has the largest contract, followed by South Auckland Health and A+.

199. The public hospitals are strong active players in the market. This market is more competitive than the privately funded secondary elective surgery market. The Commission therefore concludes the acquisition will not cause any lessening of competition in this market.

200. The Commission is satisfied that the proposed acquisition would not have, nor would be likely to have, the effect of substantially lessening competition in the market for secondary elective surgery for public patients.

THE PROVISION OF ANGIOGRAPHY SERVICES TO PRIVATE PATIENTS

201. In its initial application, the applicant included the purchase of Mercy's 1/3 shareholding of Mercy Angiography in the proposed transaction. IHL, which is the ultimate majority owner of Ascot, is 50% owner of Ascot Angiography. Therefore, the issue of potential association between Mercy Angiography and Ascot Angiography was considered.

202. Between IHL and Ascot there is a significant relationship; IHL owns 100% of HHL, which in turn owns 82% of Ascot.

203. IHL has a less direct relationship with Ascot Angiography, owning only 50% and directly appointing one out of four directors. Ascot Angiography and Ascot reportedly operate at arms length. Nonetheless, the substantial common shareholding by IHL in Ascot and Ascot Angiography points to an association between these two. They are close to being interconnected.

204. Mercy Angiography is owned 1/3 each by Southern Cross Healthcare Trust, Mercy and cardiologists. If Ascot acquired Mercy's 1/3 shareholding of Mercy Angiography, Ascot would be entitled to two directors out of six. This would not give it direct control, but would give it access to business plans, pricing and other commercial information. Moreover, substantial decisions (that is those that would change the provisions of the Joint Venture Agreement between the shareholders) require 75% approval, so any one

shareholder could block these. As a consequence, Ascot could exert an influence over Mercy Angiography, at least over substantial issues.

205. For these reasons, we would consider Mercy Angiography and Ascot to be associated companies, and by extension, would consider Mercy Angiography and Ascot Angiography to be associated.

206. On that basis, the transaction would have created complete aggregation of angiography services in the Auckland area, as Mercy Angiography and Ascot Angiography are the only private providers in the region. Furthermore, the Commission's enquiries did not establish any prospective entrant.[22]

207. However, these concerns with regard to aggregation ceased when the applicant amended the application such that "the applicant will not acquire the Mercy Angiography shareholding".

208. The remaining concern was whether the aggregation at the hospital facilities and services level would adversely affect competition in the angiography market.

The relationship between angiography and cardiac surgery

209. Traditionally, angiography has been carried out on the same site as cardiac surgery. This reflects two factors:

- There is a close relationship between angiography and cardiac surgery. Approximately one third of patients who have angiograms (the diagnostic aspect of angiography services) go on to have cardiac surgery.

- A very small proportion of angioplasties (the treatment aspect of angiography services) develop complications that require cardiac surgery.

210. However, the complication rate has fallen over time[23] and the trend is now towards requiring cardiac back up (that is a cardiac capable theatre and access to a cardiac surgeon, but the surgeon could be off site).

211. Therefore, [ ] claimed that angiographies could still be performed at Mercy Hospital even if rationalisation of services as between Ascot and Mercy meant that there was no cardiac surgery being performed at the Mercy site. SCHT noted that angioplasties are carried out in the SCHT hospital in Christchurch when no cardiac surgery is occurring.

212. In addition to the specialised cardiac back up, the angiography service requires access to hospital beds for recovery post angioplasties. If these were not available at Mercy Hospital, the angiography service would not be able to remain there. However, these services were described as non-specialist and potentially available elsewhere.

213. Consequently, as a result of the amended application, the Commission is satisfied that the proposed acquisition would not have, nor would be likely to have, the effect of

[22] The application states that a new angiography laboratory is planned for the Quay Park Medical and Surgical Centre but Salus Health, the provider of cardiac care services within that facility could not confirm this.
[23] Estimated as [ ] for Mercy Angiography.

substantially lessening competition in the provision of angiography services to private patients in the Auckland region.

THE PROVISION OF ENDOSCOPY SERVICES TO PRIVATE PATIENTS

214. In its application, the applicant estimates that 50% of endoscopy procedures are performed by individual surgeons in their own rooms, and that the market shares for the combined entity in this market would be within the Commission's safe harbours.

215. The Commission has confirmed that endoscopy is widely carried out. Though the precise market share figures are difficult to pin down, it is satisfied the acquisition would not affect competition in this market.

216. The Commission is satisfied that the proposed acquisition would not have, nor would be likely to have, the effect of substantially lessening competition in the provision of angiography services to private patients in the Auckland region.

DETERMINATION ON NOTICE OF CLEARANCE

217. Accordingly, pursuant to section 66(3)(a) of the Commerce Act 1986, the Commission determines to give clearance for the acquisition by the Ascot Hospital and Clinics Limited of the assets (but excluding the St Joseph's Mercy Hospice and excluding Mercy Hospitals shareholding in Mercy Angiography Limited) or shares of Mercy Hospital Auckland Limited.

Dated this 14th day of December 2001

Paula Rebstock
Deputy Chair