RUGBY WORLD CUP 2011
OFFICIAL PARTNER

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18 July 2011

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Public version

Dear Gavin

SOUTHERN CROSS HOSPITALS LIMITED AND AORANGI HOSPITAL LIMITED - DRAFT DETERMINATION TO APPLICATION FOR AUTHORISATION

1. We are writing in response to the Draft Determination by the Commerce Commission ("**Commission**") in relation to the authorisation of a business acquisition involving Southern Cross Hospitals Limited ("**SCHL**") and Aorangi Hospital Limited ("**Aorangi**") (together the "**Applicants**") released on 1 July 2011.

2. The Applicant's application ("**Application**") seeks authorisation to acquire shares in a joint venture company ("**JV Co**") and for JV Co to acquire the business assets of SCHL and Aorangi's Palmerston North hospitals (the "**Acquisition**").

Executive summary

3. The Applicants agree with the Commission's preliminary decision to authorise the Acquisition. However, in addition to the benefits identified by the Commission in the Draft Determination, the applicants submit that:

   (a) substantial benefits will arise from the increased capital expenditure by JV Co following the Acquisition;

   (b) the Commission has underestimated the benefits that will arise from the alternative use [ ], and the cost savings that will arise from access to SCHL's buyer network.

4. The Applicants also submit that the Commission has overstated the likely level of price increases and the ability of JV Co to price discriminate, for the following reasons:

   (a) surgeons, insurers and patients will all resist such significant price increases and/or price discrimination;

   (b) SCHL's non-profit motives will temper the ability of JV Co to make such significant price increases; and

   (c) there is no evidence of such significant price discrimination in other New Zealand regions where there is only one private hospital provider.

Assessment of merger benefits

5. The Applicants submit that the Commission has given insufficient weight to a number of the benefits that will arise as a result of the Acquisition. In particular, it has disregarded the substantial benefits that will arise from the increased capital expenditure by JV Co (such as the creation of an HDU) following the Acquisition.

Capital expenditure incentive

6. The Commission concludes in the Draft Determination that JV Co would have a greater ability to invest in new technology and facilities, but queries whether JV Co will have an increased incentive to invest. In coming to this view, [

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Planning for additional capital expenditure such as the development of an HDU is expected to start almost immediately upon formation of the joint venture[1], and the Commission should not use the [ ] as a reason to dismiss the possibility of capital expenditure following the Acquisition.[2]

7. The analysis in section 5 of the NERA report shows that JV Co will have an incentive to invest post-merger. A key reason for such investment is a desire to grow the market for elective surgery in Palmerston North by expanding the range of procedures that can be provided in the region. As the Commission will be aware from the 2008 Application, a number of patients currently leave Palmerston North to undertake elective surgery that is not currently available in the region. The NERA report demonstrates that JV Co will have the necessary incentive to provide for these patients, benefiting both those patients, and existing patients in Palmerston North.

8. As set out in the NERA report (see Table 4.1), there is ample evidence of investment by single providers of private hospital services in other New Zealand regions similar in size to Palmerston North. Such investment includes facilities such as HDUs/ICUs, high tech imaging and/or high tech theatres, all facilities that the Applicants have indicated that they would like to pursue post-Acquisition. An example of investment by a single private hospital is SCHL's joint venture in Tauranga (Grace Hospital). Major capital investment since the joint venture includes:

    - the purchase of a high tech 'Da Vinci' surgical robot for [ ] in May 2008 to attract urology work to Tauranga. While Grace Hospital already provided urology procedures at the hospital, a failure to purchase this piece of equipment would have resulted in a number of

[1] A parallel can be made with the "wool superstore" in the Wool Authorisation, accepted by the Commission as a benefit despite it being "still in its planning stage".

[2] [

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patients choosing to travel to Auckland for some urology procedures; and

- the expansion of Grace Hospital's radiology department to add high tech imaging (CTs and MRIs). This took place in 2010 at a [ ].

9. The comment by MidCentral DHB at paragraph 52 of the Draft Determination expressly recognises the benefits to the region of a single viable private hospital to the region.

Timing and quantum of capital investment benefits

10. Benefits will accrue immediately upon the formation of the joint venture, and will continue to accrue for some time into the future. One reason why the Commission appears not to have included the benefit of any capital investment (ie a wider range of procedures available in Palmerston North, better facilities for existing patients, attracting skilled health professionals to Palmerston North) in its balancing of benefits and detriment is that it will not accrue during the five year period analysed by the Commission in the Draft Determination.

11. While the quantifiable benefits of the Acquisition were assessed by the Applicant over a five year period, this was consistent with the five year period of the merger model (created by the Applicants independently of the Application). Contrary to paragraph 93 of the Draft Determination, the Applicants did not propose that a period of five years is appropriate for the analysis and calculation of detriments and benefits in relation to the Acquisition. In fact, the Applicants submit that the expected benefits of the Acquisition (and in particular, the benefits arising from increased capital expenditure) will extend long beyond this period of five years.

12. While the Applicants acknowledge that the detriments and benefits may become increasingly less "quantifiable" over time, the Commission's decision in New Zealand Wool Services/Cavalier Wool Holdings Determination[3] ("**Wool Authorisation**") considered instances where a five year time period may not be appropriate. In particular, the Commission explicitly recognised that the five year period was not appropriate where significant benefits and/or detriments will accrue outside of the five year period. To address this issue in the Wool Authorisation, the Commission undertook a 20 year timeframe analysis of the detriments and benefits, as a cross check on its five year analysis. The Applicants submit that a timeframe longer than five years is appropriate with respect to the expected benefits of the Acquisition.

13. In addition, while any benefit from increased capital expenditure is difficult to quantify, this should not prevent the Commission considering the benefit when balancing benefits and detriments. In the Wool Authorisation the Commission acknowledged that the quantification process is simply a tool that enhances the Commission's final qualitative judgement, and that rigid balancing of quantified detriments and benefits is not appropriate without applying wider qualitative analysis.[4] However, in paragraph 161 of the Draft Determination the Commission has applied a rigid quantitative approach to the assessment of benefits and detriments in the Draft Determination, inconsistent with both its statements in the Wool Authorisation and its emphasis on qualitative

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[3] Commerce Commission Decision 725: *Cavalier Wool Holdings Limited/New Zealand Wool Services International Limited.*

[4] Ibid at paragraph 216.

assessments in the *Streamlined Authorisation Process Guidelines.* Applying a wider qualitative analysis in this case, consistent with the Commission's statement in the Wool Authorisation,[5] requires the Commission to consider the range of benefits that will arise from the increased capital expenditure by JV Co.

Other issues in relation to benefits

14. In addition to the issues discussed above, the Applicants have the following comments regarding the quantification of benefits arising from the merger:

    (a) in paragraph 153 the Commission determines that the benefit from the alternative use of the [ ], based on [ ]. However, this [ ] As set out in the Application, [ ].

    (b) at paragraph 144 the Commission dismisses as a wealth transfer the cost savings arising from access to SCHL's buyer network. However, SCHL purchases an overwhelming majority of consumables from overseas parties. This is illustrated in Schedule 1, which contains a list of SCHL's top 10 consumable suppliers, and the origin of the goods supplied. Hence, consistent with Commission practice,[7] nearly all of these cost savings should be included as a public benefit.

Assessment of merger detriments

15. The Commission concludes at paragraph 128 of the Draft Determination that approximately [ ] of patients could be subject to potentially significant price increases in the factual, and models price increases ranging from 10% to 50%. The Applicants submit that the potential for any price rise, and the proportion of patients that would be affected even if JV Co would have the incentive and ability to raise prices, has been overstated by the Commission.

Lack of an ability and/or incentive to raise price

16. There are a number of factors which will mitigate against the ability and/or incentive of JV Co to significantly increase prices generally, or to a certain subset of patients, following the Acquisition. These reasons are set out in the Application, or in subsequent correspondence with the Commission. However, some of these factors are considered in further detail below.

17. **Countervailing power of surgeons**: as set out in our email to Gavin McNeill of 8 June 2011, surgeons have, for ethical reasons, previously resisted any attempts to charge different prices to patients for the same surgery, dependant on whether or not they are insured. We would expect there to be strong resistance from doctors to any price discrimination, particularly anything close to the 30% to 50% suggested by the Commission. In respect of JV Co, many of

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[5] Ibid.

[6] [ ]

[7] Decision 511, *Air New Zealand/Qantas* 23 October 2003 at paragraph 34.

the surgeons will be shareholders in Aorangi, which would give them considerable ability to directly resist any measures to impose such price discrimination. The Applicants are not aware of any hospital in New Zealand that charges a subset of patients up to 30% to 50% more than others for the same procedure (see further Table 1 below).

18. As set out in the draft determination, the Southern Cross Medical Care Society ("**Southern Cross Insurance**") Affiliated Provider scheme acts as a constraint on potential price rises by JV Co. The Applicants submit that, once prices are negotiated under the Affiliated Provider scheme, these prices provide protection to privately funded patients. This was illustrated in our email of 8 June 2011, which stated that due to resistance from surgeons, following the agreement of an Affiliated Provider price for cataract surgery, Aorangi was unable to charge any significant price difference between those patients who obtain cataract surgery under Southern Cross Insurance's Affiliated Provider scheme, and other private patients. Similarly, there is no significant difference between the prices charged to Affiliated Provider patients and other privately funded patients for other procedures subject to the Affiliated Provider scheme. These patients ([

]) should be excluded from the percentage of patients vulnerable to price increases (paragraph 128 of the Draft Determination).

19. **Cost savings will mitigate price rises:** As the Commission correctly notes at paragraph 144 of the Draft Determination, if a cost saving is merely a wealth transfer it should not be counted as a public benefit (although see paragraph 14(b) above). However, variable cost reductions, whether transfers or not, have an effect on prices and thus offset any allocative detriment resulting from the merged entity raising price. This is recognised by the Commission in its own *Mergers and Acquisitions Guidelines* where it states:[10]

> In the context of an acquisition, the combined entity might be able to make efficiency gains that are not obtainable by other means, such that its incremental cost of production would decline. **Such gains could have the effect of blunting the impact of a rise in prices post-acquisition, as any increase in the margin of price over incremental cost arising from a lessening of competition would, in effect, be added to a lower level of cost.** An efficiency gain could turn a price increase that would otherwise be regarded as lessening competition into one that is not. [emphasis added]

20. Therefore, to the extent that the cost savings in the present context are considered variable, they should be taken into account as a mitigating factor when calculating the allocative detriment.

21. **Reaction from insurers:** At paragraph 84 of the Draft Determination, the Commission comments that, other than the Affiliated Provider contracts with Southern Cross Insurance, insurers do not have the ability to respond to an increase in price in the factual due to their low market share and inability to punish SCHL in other regions. While this might be the case for a small price increase, the Applicants submit that a price increase in the region of 30% to 50% for patients using private health insurers is likely to prompt a strong reaction from these insurers. There is nothing that would prevent other health insurers from adopting programmes similar to the Affiliated Provider scheme.

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[10] Section 7.4 of the *Mergers and Acquisitions Guidelines*.

Traditionally, smaller insurers have tended to follow Southern Cross Insurance initiatives in this regard, and apart from the administrative costs involved, a low market share is not a barrier to setting up a scheme (nor is it a barrier to adopting policy terms which would deter patients from using SCHL in areas where there are a number of private hospital providers). The Commission has also underestimated the impact of 'reasonable charges' clauses. While hospitals can increase prices above the insurer's reasonable charge and pass this price increase onto the patient, such a policy, particularly in the event of a 30 - 50% price difference would have significant reputational implications and be met with considerable resistance from surgeons (see paragraphs 17 and 18 above). In any event, [

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22. **Profit motives:** The Commission accepts that SCHL does not have profit maximisation as its primary drive (paragraph 115), consistent with evidence from [ ]. However, at paragraph 119 of the Draft Determination, the Commission states that the non-profit nature of SCHL is unlikely to moderate the incentives of the joint venture. The Commission's conclusion in paragraph 119 of the Draft Determination assumes away any influence SCHL will have over the day-to-day activities of the joint venture, despite its role as a 50% shareholder (which is likely to translate into a 50% representation on the board of JV Co). At the very least, such a shareholding, combined with the non-profit nature of SCHL (acknowledged by the Commission), suggests that SCHL would be in a position to strongly resist price increases of the magnitude suggested by the Commission.

23. At paragraph 118 of the Draft Determination the Commission also states that [

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No evidence of price discrimination

24. If the Commission is correct in its conclusion that JV Co will have both the ability and incentive to price discriminate between various groups of patients, in respect of the same procedures, then it would expect to see some evidence of such price discrimination in other New Zealand regions where there is only one private hospital. However, the Applicants are not aware of any hospital that price discriminates in favour of some patients in the manner, or to the extent, suggested by the Commission in the Draft Determination. In fact, there is strong evidence that the pricing behaviour suggested in the Draft Determination is not present in regions with only one private hospital.

25. With the exception of separately negotiated ACC and Affiliated Provider contracts, rates for Aorangi Hospital and all SCHL hospitals are based solely on the price list circulated to surgeons (examples of which were provided in Appendices I and J of the Application). These price lists are based on a combination of the time in surgery and the total time spent at the hospital. While these rates are not published, they are provided to each of the specialists using the hospital, who may use them when advising patients on

their course of treatment. Both Aorangi and SCHL also recommend that patients call the hospital prior to admission for an estimate of the total hospital cost for surgery and treatment. In providing an estimate, neither of the Applicants will enquire as to the patients' insurance status, although such information is be included on a patients' subsequent pre-admission form so that the hospital is aware of who they should seek payment for the surgery.

26. Consistent with our email of 8 June, any price difference between Affiliated Provider prices and prices for other privately funded patients will typically be less than [ ], and will largely reflect the administrative savings from the Affiliated Provider scheme. The Applicants encourage the Commission to speak to hospitals in regions outside Palmerston North to confirm that price discrimination between patients of up to 30% to 50%, based on funding source, is simply not a realistic option, even in regions where there is only one private hospital.

27. Table 1 shows pricing at various SCHL hospitals, and Wakefield and Mercy Ascot, for one hour of theatre time and an overnight single room, as these make up the bulk of the price charged to a patient. We have used a one hour rate for the theatre price, although a declining per minute rate is generally applied depending on the total theatre time.

Table 1: price comparison between various New Zealand private hospitals

Hospital	Theatre rate (1 hour)	Overnight single room
SCHL owned		
North Harbour Hospital	[ ]	[ ]
Northern Surgical Centre (North Shore)	[ ]	[ ]
Brightside Hospital (Auckland)	[ ]	[ ]
Auckland Surgical Centre	[ ]	[ ]
Hamilton Hospital	[ ]	[ ]
New Plymouth Hospital*	[ ]	[ ]
Palmerston North Hospital	[ ]	[ ]
Wellington Hospital	[ ]	[ ]
Christchurch Hospital	[ ]	[ ]
Invercagill Hospital*	[ ]	[ ]
SCHL joint venture		
Grace Hospital (Tauranga)*	[ ]	[ ]
Southern Cross QE (Rotorua)*	[ ]	[ ]
Not SCHL owned		
Wakefield Hospital (Wellington)+	[ ]	[ ]
Mercy Ascot (Auckland)+	[ ]	[ ]
Aorangi (effective 1 August 2011)	[ ]	[ ]

Key
* only private hospital in the region
+ estimates only

28. The table shows that there is no significant price difference between hospitals in areas where there is only one private hospital and those hospitals where there are a number of private hospitals. In fact, those areas where there are a

number of private hospitals tend to have the highest rates. At the very least, these prices do not reflect a 30% to 50% price uplift for hospitals in monopoly areas, even accounting for the small cost and service differences between the various hospitals.

29. SCHL has specifically considered pricing at Southern Cross QE following the joint venture between SCHL and QE Hospital Limited. Prior to the Southern Cross QE joint venture, the SCHL hospital charged a one hour theatre rate of [ ] and a bed day rate of [ ]. Post merger, rates were not amended until July the following year, rising to a one hour theatre rate of [ ] and a bed day rate of [ ]. This is a [ ] and [ ] price rise respectively, consistent with the price rises at other SCHL hospitals, and reflects increased costs rather than the exercise of any market power. Subsequent price rises have continued to primarily reflect cost increases, and even comparing pre joint venture rates to today's rates, the increases fall far short of a 50% price increase (approximately [ ] and [ ] respectively).

Other issues

30. In paragraphs 27, 35 and 38 of the Draft Determination, the Commission states that the Applicant agrees with the Commission on market definition and counterfactual respectively. However, the Applicants' position is that, while their views differ from the Commission's on both of these issues, they are content for the Commission to assess the Acquisition on the basis of these market definitions and counterfactuals respectively. We would be grateful if the Applicants' position could be reflected in the final decision.

Confidentiality

31. Confidentiality is sought for the information in this submission which is contained in square brackets. Confidentiality is sought due to the commercially sensitive nature of the information provided, and because, consistent with section 9(2) of the Official Information Act, disclosure of the information would likely unreasonably to prejudice the commercial position of the parties.

32. The Applicants request that they be advised of any request made to the Commission under the Official Information Act 1982 for release of confidential information in the submission, and that the Commission seek the view of the Applicants before any decision on disclosure is made by the Commission.

33. Please do not hesitate to call if you have any questions regarding the issues discussed above.

Yours faithfully
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Schedule 1

SCHL's top 10 consumable suppliers by annual spend

[the contents of this Schedule are confidential to SCHL]