Public Version
ISSN NO. 0114-2720
J6953

COMMERCE COMMISSION

Decision No. 546

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

THE SOUTHERN CROSS HEALTH TRUST

and

AUCKLAND SURGICAL CENTRE LIMITED

The Commission:	Paula Rebstock Denese Bates QC Peter JM Taylor
Summary of Application:	The acquisition by The Southern Cross Health Trust of the assets of the Auckland Surgical Centre Limited.
Determination:	Pursuant to section 66(3) (a) of the Commerce Act 1986, the Commission determines to give clearance to the proposed acquisition.
Date of Determination:	17 February 2004

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EXECUTIVE SUMMARY

1. A notice pursuant to s 66(1) of the Commerce Act 1986 (the Act) was registered on 24 December 2004. The notice sought clearance for the acquisition by The Southern Cross Health Trust (the Trust) or its interconnected body corporate of the assets of the Auckland Surgical Centre Limited.

2. For the purposes of the present application, the Commission considers the relevant markets to be the provision of private:

   - short-stay hospital facilities and related non-specialist services for elective secondary surgery in the Auckland region (the short-stay market); and
   - in-patient hospital facilities and related non-specialist services for elective secondary surgery in the Auckland region (the in-patient market).

3. For the in-patient market, the Commission considers that the number of in-patients at the Auckland Surgical Centre is negligible, compared to the Trust and MercyAscot. Consequently, given the minimal aggregation that would occur as a result of the proposed acquisition, the Commission considers that the proposed acquisition is unlikely to lead to a substantial lessening of competition in the in-patient market.

4. Accordingly, the Commission focused on the short-stay market. In this market, post-acquisition, the Commission considers that there would be sufficient existing competition from MercyAscot and sufficient excess capacity from smaller competitors that it is unlikely to lead to a substantial lessening of competition in the short-stay market.

5. The Commission considers that barriers to entering the short-stay market are low. However, the presence of excess capacity in this market is likely to deter new entry within the next two years.

6. In respect of countervailing power, the Commission considers that post-acquisition, insurance companies and DHBs would provide limited constraint on the combined entity, but that the ACC and surgeons are likely to continue to provide significant constraint on the combined entity.

7. In respect of the further vertical integration that would occur as a result of the proposal, the Commission is of the view that the proposed acquisition is unlikely to augment the market power of the Trust's associated entity, the Southern Cross Medical Care Society, in the health insurance market, such that it would give rise to a substantial lessening of competition in either the upstream health insurance market or the downstream short-stay market.

8. On balance, the Commission is satisfied that the proposed acquisition would not have, nor would be likely to have, the effect of substantially lessening competition, in either the short-stay market or the in-patient market.

9. Accordingly, pursuant to section 66(3) (a) of the Commerce Act 1986, the Commission determines to give clearance for the proposed acquisition by The Southern Cross Health Trust of the assets of the Auckland Surgical Centre Limited.

THE PROPOSAL

1. A notice pursuant to s 66(1) of the Commerce Act 1986 (the Act) was registered on 24 December 2004. The notice sought clearance for the acquisition by The Southern Cross Health Trust (the Trust) or its interconnected body corporate of the assets of the Auckland Surgical Centre Limited (the ASC).

PROCEDURE

2. Section 66(3) of the Act requires the Commission either to clear or to decline to clear the acquisition referred to in a s 66(1) notice within 10 working days, unless the Commission and the person who gave notice agree to a longer period. An extension of time was agreed between the Commission and the Applicant. Accordingly, a decision on the Application was required by 28 February 2005.
3. The Applicant sought confidentiality for specific aspects of the Application. A confidentiality order was made in respect of the information for up to 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 approach to analysing the proposed acquisition is based on principles set out in the Commission's Merger and Acquisition Guidelines.[1]

STATUTORY FRAMEWORK

5. Under s 66 of the Act, the Commission may grant a clearance for an acquisition where it is satisfied that the proposed acquisition would not have, nor would be likely to have, the effect of substantially lessening competition in a market. The standard of proof that the Commission must apply in making its determination is the civil standard of the balance of probabilities.[2]
6. The Commission considers that it is necessary to identify a real lessening of competition that is not minimal.[3] Competition must be lessened in a considerable and sustainable way. For the purposes of its analysis, the Commission is of the view that a lessening of competition and creation, enhancement or facilitation of the exercise of market power may be taken as being equivalent.
7. When the impact of market power is expected to be predominantly upon price, for the lessening, or likely lessening, of competition to be regarded as substantial, 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.

ANALYTICAL FRAMEWORK

8. The Commission applies a consistent analytical framework to all its clearance decisions. The first step the Commission takes is to determine the relevant market or markets. As acquisitions considered under s 66 are prospective, the

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[1] Commerce Commission, *Mergers and Acquisition Guidelines*, January 2004.
[2] Foodstuffs (Wellington) Cooperative Society Limited v Commerce Commission (1992) 4 TCLR 713-722.
[3] See Fisher & Paykel Limited v Commerce Commission (1996) 2 NZLR 731, 758 and also Port Nelson Limited v Commerce Commission (1996) 3 NZLR 554.

Commission uses a forward-looking type of analysis to assess whether a lessening of competition is likely in the defined market(s). Hence, an important subsequent step is to establish the appropriate hypothetical future with and without scenarios, defined as the situations expected:

- with the acquisition in question (the factual) ; and
- in the absence of the acquisition (the counterfactual).

9. The impact of the acquisition on competition is then viewed as the prospective difference in the extent of competition in the market between those two scenarios. The Commission analyses the extent of competition in each relevant market for both the factual and the counterfactual scenarios, in terms of:

- existing competition;
- potential competition; and
- other competition factors, such as the countervailing market power of buyers or suppliers.

INDUSTRY BACKGROUND

Parties

The Trust

10. The Trust is a charitable trust, established for the purposes of providing hospital care to the general public. The Trustees of the Trust are registered as a Board under the Charitable Trusts Act 1957. In New Zealand, the Trust owns nine hospitals[4] and has partnerships in another four[5]. Of particular relevance to this application are the Trust's Auckland hospitals: Southern Cross Brightside Hospital (Brightside), Southern Cross North Harbour Hospital (North Harbour), and its 50% share in Gillies Hospital Limited (Gillies).

11. In *Decision 537: Southern Cross Oxford Hospital Limited / The Oxford Clinic*, 11 November 2004 (the Oxford Decision), the Commission concluded that it would proceed on the basis that the Trust and the Health Insurer, the Southern Cross Medical Care Society (the Society) were "associated persons" within the meaning of s47(3) of the Commerce Act.

12. The Commission considers that since that Decision, nothing has altered materially such that it would change its view on the association of the Trust and the Society. Accordingly, for the purposes of this application, the Commission considers the Trust and the Society to be associated persons within the meaning of s47(3) of the Act.

13. Table 1 sets out the types of procedures performed at each of the Trust's Auckland facilities, and the ratio of short-stay/in-patients.

[4] Brightside, Christchurch, Hamilton, Invercargill, New Plymouth, North Harbour, Palmerston North, Rotorua and Wellington.
[5] Gillies Hospital (Auckland), Mercy Angiography Unit (Auckland), Norfolk Southern Cross Hospital (Tauranga), and Southern Cross Oxford Hospital (Christchurch).

Table 1: Surgical Procedures Performed at each of the Trust's Auckland Hospitals

Hospital	Procedures Performed	% Short-stay patients	% In-patients	Total
Brightside 4 theatres 53 in-patient beds	General surgery, orthopaedics, gynaecological, urological, oral and maxillofacial	[ ]	[ ]	100%
North Harbour 4 Theatres 63 in-patient beds	General surgery, orthopaedics, gynaecological, plastics and ENT	[ ]	[ ]	100%
Gillies Hospital 3 theatres 20 beds	ENT	[ ]	[ ]	100%

The ASC

14. The ASC is privately owned by a number of shareholders including medical specialists. The ASC provides facilities for the provision of secondary elective healthcare services in the Auckland region, primarily on a day or short-stay basis. The procedures performed at the ASC are orthopaedic, plastic, gynaecological, ear nose and throat (ENT), oral, paediatric, breast, urology and general surgery, with a strong focus on orthopaedic surgery.

15. Table 2 sets out the types of procedures performed at the ASC, and the ratio of day short-stay/in-patients.

Table 2: Surgical Procedures Performed at the ASC

Hospital	Procedures Performed	% Short-stay patients	% In-patients	Total
ASC 4 theatres 10 in-patient beds	Orthopaedics, plastics gynaecological, urological, oral and maxillofacial, ENT, paediatric, breast and general surgery	[ ]	[ ]	100%

Other Relevant Parties

MercyAscot

16. MercyAscot is a New Zealand owned private hospital and clinics facility, formed from the integration of two private surgical hospitals, Ascot Hospital and

Mercy Hospital[6]. Mercy Ascot is the only private healthcare facility provider in the Auckland region that offers complex tertiary medical procedures such as neuro-surgery. In addition, secondary elective healthcare procedures are carried out at the Mercy and Ascot facilities.

17. Table 3 sets out the types of procedures performed at the MercyAscot facilities and the ratio of day short-stay/in-patients.

Table 3: Surgical Procedures Performed at Ascot and Mercy Hospitals

Hospital	Procedures Performed	% Short-stay patients	% In-patients	Total
Ascot 12 theatres 68 in-patient beds, 5 ICU beds, 5 coronary care beds, 6 short-stay beds, 7-8 day surgery beds rotating patients through the day	Cardiac, breast, ophthalmological, general surgery, gynaecological, paediatric, spinal orthopaedics, and urological	[ ] Combined facilities	[ ] Combined facilities	100%
Mercy 7 Theatres – 2 endoscopy rooms 126 beds including 9 cardiac, 5 ICU/HDU, 3 coronary care, 15 day stay, 13 day beds - endoscopy	Cardiac, breast, ophthalmological, general surgery, gynaecological, paediatric, orthopaedic, urological, neurological, plastics, and colorectal			

Quay Park Surgical Centre (Quay Park)

18. Quay Park is situated on Beach Road, Auckland and was established in July 2001 by John Edwards, a maxillofacial and plastic surgeon, when the facilities from which he was practising became unavailable. Table 4 sets out the types of procedures performed at Quay Park and the ratio of day short-stay/in-patients.

[6] *Decision 449: The Ascot Hospital and Clinics Limited / Mercy Hospital Auckland Limited*, 14 December 2001.

Table 4: Surgical Procedures Performed at Quay Park

Hospital	Procedures Performed	% Short-stay patients	% In-patients	Total
Quay Park 3 theatres 4 in-patient beds	gynaecological, urological, oral and maxillofacial, plastics and some general surgery	[ ]	[ ]	100%

Northern Surgical Centre (NSC)

19. NSC is situated on the North Shore, Auckland and was established in 2001 by Robert Fris, a general and laparoscopic surgeon. Table 5 sets out the types of procedures performed at NSC and the ratio of short-stay/in-patients.

Table 5: Surgical Procedures Performed at NSC

Hospital	Procedures Performed	% Short – stay patients	% In-patients	Total
NSC 2 theatres 4 in-patient beds	General surgery, breast, ENT, ophthalmology, and gynaecological	[ ]	[ ]	100%

The Navy Hospital

20. The Navy Hospital is based in Devonport and primarily carries out procedures on military personnel. In 1999 the Navy Hospital became a commercial entity and as such, offers its facilities to private patients. Around [ ] % of procedures conducted at the Navy Hospital are on private patients. Table 6 sets out the types of private procedures performed at the Navy Hospital and the ratio of day short-stay/in-patients.

Table 6: Surgical Procedures Performed at the Navy Hospital

Hospital	Procedures Performed	% Short-stay patients	% In-patients	Total
Navy Hospital 1 theatres 12 in-patient beds	General surgery, ENT, orthopaedic, gynaecological and dental	[ ]	[ ]	100%

The Society

21. The Society is a "not for profit" health care organisation incorporated as a Friendly Society under the Friendly Societies and Credit Union Act 1982. It is New Zealand's largest private health insurer.

The Affiliated Provider Programme (APP)

22. The Society introduced the APP in 1998, and has developed it since that time to incorporate a number of medical practitioners/providers and a range of different procedures.

23. Under the APP, the Society enters into arrangements with certain medical practitioners, hospitals and facilities, called "affiliated providers", where the providers have independently agreed on a fixed price for carrying out particular medical procedures. The programme operates as follows:

    - the Society member makes an appointment with an Affiliated Provider (AP);
    - the AP then contacts the Society, and organises prior approval for the qualifying procedure;
    - once the procedure has been completed, the policyholder makes payment directly to the AP for his/her contribution towards the cost of the procedure. This is known as a co-payment and is the proportion of the charges not covered by the insurance policy; and
    - the Society makes payment directly to the AP/s for the procedure and any ancillary services (e.g. hospital accommodation, anaesthesia, diagnostic testing etc).

24. A member of the Trust is not bound to use an AP. The supposed advantages to a member of using an AP include greater certainty in respect of what the co-payment (if any) will be, the issue of one invoice which might lead to lower transaction costs, and possibly the containment of increases in insurance premiums.

25. The supposed advantage to medical specialists that choose to become APs is that they might increase their patient-base by being aligned with the country's largest health insurer, which recommends APs through its publication to its members, "Jump".

26. The AP agreements between the Society and APs do not constitute an employment contract, nor do they tie the specialist exclusively to a Trust facility. Rather they agree a price for use of the facilities and for the performance of a surgical procedure *if* the specialist wishes to use a particular Trust facility. AP agreements may be terminated by either party [ ].

Accident Compensation Corporation (ACC)

27. The ACC is a Crown agency responsible for the administration of the statutory insurance scheme for accident-related injuries and disabilities. The scheme was originally created by legislation in 1974.

28. Typically, the ACC contracts with private surgical facilities for the provision of elective, accident-related surgery and related services for a two year period up to a capped amount. In such contracts, the ACC sets out a schedule of procedures it is prepared to fund and lists a set price for each procedure. These prices are

inclusive of hospital charges and specialist fees. Of the ACC-funded procedures performed in private facilities, 85% are orthopaedic.

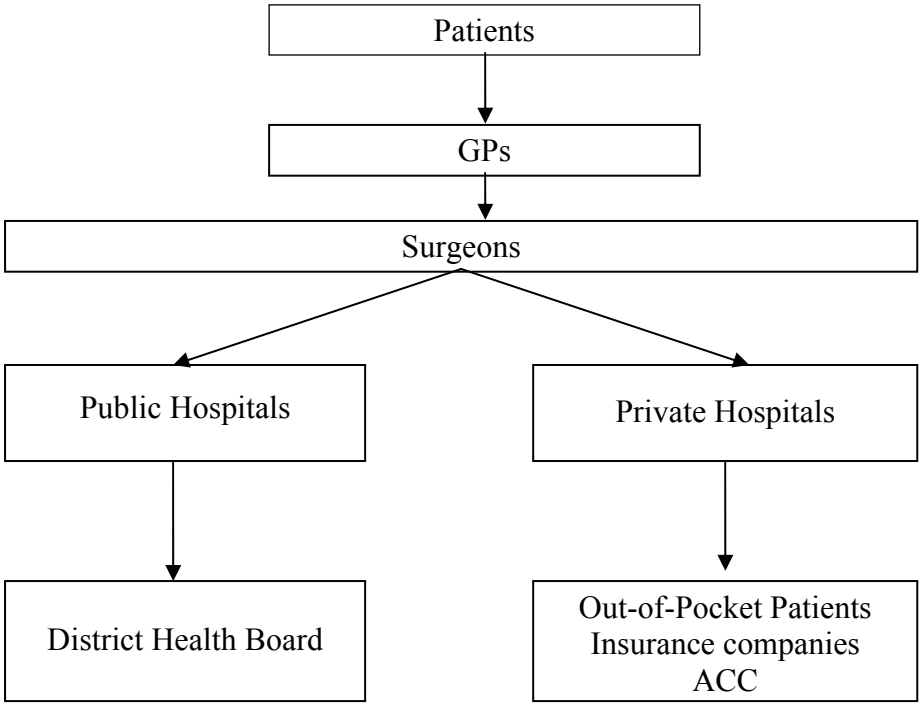
29. The facility then sub-contracts with various medical specialists for the performance of the procedure. The scheme operates thus:

- a non-acute accident victim visits their General Practioner, who refers them to a relevant specialist;
- after recommendation of surgery, the specialist contacts the ACC and organises prior approval to perform the procedure on the patient . Typically, the specialist will specify a facility with an ACC contract (for the procedure) at which they wish to perform the surgery;
- the specialist then makes arrangements with the facility for theatre and anaesthetist time so that they can perform the procedure. Post-procedure, the specialist will invoice the facility for their services and the facility in turn submits an invoice to the ACC. The ACC does not involve itself with what the facility on-pays for the individual components of the procedure, such as the surgeon's fee;
- where several facilities exist that have ACC contracts for the relevant procedures, the specialist is not compelled by the ACC to carry out procedures at any particular facility; and
- generally, such ACC contracts forbid the charging of co-payments for the procedures set out in the Schedule of Service Items and Prices.

New Zealand Health Sector

30. In New Zealand, healthcare is provided by a range of medical practitioners in public and private hospitals. The main industry participants considered in this proposed acquisition are shown in the diagram below.

Figure 1: Main Industry Participants in Healthcare



31. There is a relatively complex set of relationships leading to a particular patient being operated on by a particular surgeon in a particular hospital. As shown in Figure 1, patients are first seen by a *primary* healthcare provider (usually a GP). If surgery is warranted, or specialist consultation is required, the patient will be referred to a surgeon. Most GPs will have preferred surgeons to which they refer patients.

32. If the surgeon decides that surgery is appropriate, a decision will be made as to the hospital (*secondary* healthcare provider) where the surgery will be undertaken, depending on the hospital (or hospitals) where that surgeon operates.

33. Often the choice of hospital is influenced by the surgeon. The factors taken into account are cost, location, timeliness or anticipated quality of care. Sometimes the patient's insurer will have an influence on the choice of hospital, in that patients might be encouraged to select a particular option.

Medical Procedures

34. Elective surgery is non-emergency treatments (including diagnostic services) where the condition is not life threatening and does not require immediate surgery. The types of elective surgery affected by this proposed acquisition are orthopaedic, plastic and general surgery procedures.

Facilities and Services

35. Private hospitals provide facilities, namely, patient bedrooms and medical equipment, as well as related non–specialist services like administration staff and nursing staff. Specifically, they provide the operating theatres, equipment,

surgical supplies, wards, and nursing and other staff. Private hospitals typically do not provide surgeons or the ancillary specialist skills such as the anaesthetists or physiotherapists. These medical professionals contract directly with the patient and therefore bill the patient separately.

36. The relationship between the surgeon and the private hospital involves quality control of the surgeon by the hospital (credentialing). Only credentialed surgeons may operate at the private hospitals. While surgeons book operating theatre time at the private hospitals, there is no formal employment contract between the surgeon and private hospitals relating to the use of the operating theatres or throughput of patients that the surgeon will provide.

Funding

37. Healthcare is financed by a mix of public and private funding, with the majority being funded from public sources (tax funded Vote Health and the ACC).

38. 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.

39. 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.

40. The patient finances most elective surgery in private hospitals, either directly or via insurance. A small amount of publicly-funded elective services is provided by private hospitals on behalf of the public sector.

41. The main health insurance providers in New Zealand are:

- Southern Cross Medical Care Society (Society);
- Tower Health and Life (Tower); and
- Sovereign Assurance Company (Sovereign).

PREVIOUS COMMISSION DECISIONS

42. The Commission has considered a number of cases in the provision of healthcare services. They are:

- The Oxford Decision;
- *Decision 518: Pacific Radiology Limited / Wakefield Radiology Limited*, 28 February 2004 (the Pacific Radiology Decision);
- *Decision 492: Wakefield Hospital Limited / Bowen Hospital Limited*, 19 February 2003 (the Wakefield Decision); and
- *Decision 449: The Ascot Hospital and Clinics Limited / Mercy Hospital Auckland Limited*, 14 December 2001 (the Ascot Decision).

43. All of the above acquisitions were cleared. In addition, in each of the above decisions, the Commission considered private hospitals to be in a separate market to public hospitals.

44. In the Oxford Decision, the Commission cleared the proposed acquisition and considered the relevant markets to be those for the provision of day patient, and separately, in-patient hospital facilities and related non-specialist services for elective secondary surgery to private patients in Christchurch. The Commission concluded that the acquisition would not be likely to result in a substantial lessening of competition in this market, as the combined entity would be constrained by both existing and potential competition, and countervailing power from surgeons and health insurance companies.

MARKET DEFINITION

45. 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."[7]

46. For the purpose of competition analysis, the internationally accepted approach is to assume the 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 would be able to impose at least a small yet significant and non-transitory increase in price, assuming all other terms of sale remain constant (the SSNIP test). The smallest space in which such market power may be exercised is defined in terms of the dimensions of a market discussed below. The Commission generally considers a SSNIP to involve a five to ten percent increase in price that is sustained for a period of one year.

Product Market

47. The greater the extent to which one good or service is substitutable for another, on either the demand-side or supply-side, the greater the likelihood that they are bought and supplied in the same market.

48. 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.

49. 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 to their relative prices.

50. In the present application, the Applicant considers that the relevant product market is the provision of hospital facilities and related non-specialist services for elective secondary services in the Auckland region.

51. The Commission considered five possible dimensions of the relevant product market when defining the relevant market, for the purposes of the present application:

- public versus private surgery;
- hospital facilities versus surgical services;
- elective versus acute surgery and secondary versus tertiary surgery; and

[7] s 3(1) of the Commerce Act 1986.

- day/short-stay patient versus in-patient surgical facilities.

Public vs. Private Elective Surgery

52. In the Ascot, Wakefield and Oxford Decisions the Commission defined separate markets for private and publicly funded elective surgery. The Commission considered that both private and public hospitals operate in the publicly funded market, whereas only private hospitals operate in the privately funded market. Similarly, in the Pacific Radiology Decision separate markets were defined for private and publicly funded radiology work. In defining the market in this way, the Commission noted the following market characteristics:

    - the bulk of work undertaken by private hospitals is privately funded. At present, approximately only 6% of funding received by private hospitals originates from DHBs[8];
    - publicly funded surgery is organised differently from privately funded surgery. Surgeons and related surgical staff are contracted employees of public hospitals, hence the product, with respect to publicly funded surgery, is the provision of the surgery and facilities. In the case of privately funded surgery, however, the relevant product is the provision of the facilities alone; and
    - 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. Therefore, for publicly funded operations, public and private institutions are in the same market, whereas, for privately funded operations that is not the case.

53. In its investigations, all parties consulted by the Commission, with the exception of the Applicant, considered it valid to distinguish between the private and public provision of secondary healthcare facilities and that separate market definitions were justified. Industry participants also advised the Commission that although the Auckland DHBs have the technical capacity to perform private procedures, they are precluded from doing so by a shortage of funding.

54. On the supply-side, there is generally a clear distinction between public hospitals undertaking public work and private facilities undertaking private work (with ACC funded surgery being the exception). While there is potential for supply-side substitution, government policy actively discourages this.

55. In 2000, the Government introduced an initiative "Reduced Waiting Times for Public Hospital Elective Services" in an attempt to ensure that patients in the public sector wait no longer than six months for elective procedures. As such, public providers are obliged to reduce their waiting lists, rather than seek private business.

56. The Commission recognises that public surgical facilities may provide some degree of constraint on private surgical facilities in terms of two factors identified in the Ascot, Wakefield and Oxford Decisions, namely:

    - public hospitals have the potential to carry out private work, even if this would require a change in government policy; and

[8] New Zealand Private Hospital Association (2004) "The Role of New Zealand Private Hospital Association"

- public work can be contracted out to private providers to reduce waiting lists. Funding for public surgery is determined according to independently derived formulae, which tend to set the benchmark for how much public providers will pay private providers.

57. However, the Commission also considers that the key principle that guides market definition is the scope for substitution to occur between public and private surgical facilities.

58. The Commission recognises that on the demand-side, neither private nor public provision is costless for the patient. Public surgery is provided free of charge, but typically long waiting lists for procedures mean patients incur an opportunity cost for time. Patients who are unable to pay for their healthcare or who do not fall into ACC funding criteria are limited to public health services. The opportunity cost of time is not a consideration for these individuals.

59. For those patients who can afford to pay for their healthcare, private facilities offer quick service, however, these patients pay a premium for timeliness. Therefore, in general, patients whose opportunity cost of time outweighs their willingness and ability to pay for surgery will choose private facilities. Those who are willing to accept long waiting periods in order to save on the cost of procedures will typically choose public facilities. Hence, timeliness and the cost associated with public and private procedures make these services differentiable and imperfect substitutes for patients.

60. The substitutability between public and private surgical facilities will depend greatly on who bears the cost of treatment. In public facilities, the time opportunity costs associated with waiting lists are borne entirely by patients. However, for those patients who have a choice of public or private healthcare, the cost of treatment in private facilities is typically shared between those individuals who pay for services out-of-pocket, private insurers and the Government via ACC.

61. In the face of a SSNIP imposed by a private provider of surgical facilities, it is highly likely that only those individuals who bear some of the incremental cost associated with the price rise (those who pay for treatment out-of-pocket and those whose cost of treatment prior to the price increase exceeded the payment cap set by their health insurer by a significant amount) would consider substituting away from a private facility in favour of a public facility. Given that the proportion of individuals who fall into this category is relatively small,[9] it is the Commission's view that the overall substitutability between private and public surgical facilities is also likely to be small.

62. Considering the scope for constraints on the supply-side, in the Oxford Decision, the Commission found that DHBs do not take into consideration private hospital charges[10] when they allocate funding for public surgical procedures, so they are not constrained by the pricing behaviour of private hospitals. Instead, the volume of procedures performed, and therefore the extent of public hospital

[9] Approximately [ ] of patients at the Trust's Auckland facilities, [ ] of patients at MercyAscot and [ ] of patients at the ASC have self-funded surgical procedures.

[10] Hospital charges, in this context, consist of a bed rate for overnight stays, consumables and surgical supplies, and operating theatre fees.

waiting lists (the 'cost' borne by public patients) is directly determined by government funding policy initiatives.

63. In addition private hospitals do not actively respond to movements in public hospital waiting lists by adjusting their hospital charges. In the Oxford Decision, the Commission found that private hospitals do not actively take into consideration the extent of public funding and the length of public waiting lists when setting prices. All private hospitals interviewed during the course of this investigation concurred with this view.

64. [

]. Factors of greater importance when setting private hospital charges are the cost of inputs such as the nursing wages, consumables and medical supplies, etc. For example, [

].

65. Finally, during the course of its investigation, the Commission encountered the view from industry participants that private and public healthcare are complementary to one another, rather than substitutes in an economic sense. For instance, the Health Funds Association of New Zealand states:

> "The New Zealand public and private health systems are complementary. The public health system is the provider of high level emergency or acute care and non-urgent elective surgery. The private sector provides access to semi-acute and non-urgent but necessary healthcare assessment and treatment".[11]

66. Giving full consideration to all these factors, the Commission concludes that, for the purposes of the present Application, public and private surgical facilities should be considered as being in separate product markets.

Facilities vs. Surgical Services

67. The Applicant has accepted the Commission's categorisation in the Oxford, Wakefield and Ascot Decisions that the separate private hospital facilities and related non-specialist services (such as nursing) provided by the hospitals can be bundled together to form one aggregate market, rather than considering separate markets for nursing services and surgical equipment.

68. In those Decisions, the Commission also considered that surgical facilities and services are fungible across medical specialities, so that general "surgical" markets can be defined rather than specific markets for each specialty or procedure. Given that around [ ] % of the surgical procedures carried out at the ASC are orthopaedic, the Commission has explored whether the requirements for orthopaedic surgery might be substantially different from those for other surgical procedures, such that it might constitute a discrete market.

69. Industry participants advised the Commission that the distinguishing factor between theatres utilised by different specialists is the instrumentation required by each specialty. To some extent, there is a level of "common instrumentation" between specialties with each specialty then requiring unique instrumentation in

[11] Health Funds Association of New Zealand Inc., (2004), "The Role of Health Insurance", *Fact File*: Health Insurance in New Zealand.

order to undertake specific procedures. Therefore, the specific procedure dictates the instrumentation required. The cost of equipping an existing operating theatre currently used by another speciality to perform orthopaedic surgery will vary significantly based upon the types of orthopaedic procedures, which are to be performed. There is a continuum of orthopaedic procedures ranging from typical short-stay orthopaedic procedures (e.g. arthroscopy) to the more complex in-patient orthopaedic procedures (e.g. major joint replacement, spinal procedures).

70. Estimates provided to the Commission indicate that to equip an existing operating theatre currently used by another speciality to perform a range of short-stay orthopaedic surgery would be in the vicinity of $400,000. Broadly, this cost would be the cost of the specialised instrumentation, i.e., power tools, saws, drills, arthroscopic equipment (e.g. scopes and cameras). The Commission is of the view that this amount would not be prohibitive for an existing facility wishing to add orthopaedic procedures to its specialties and therefore, that orthopaedic surgery is likely to fall inside a general surgical market.

71. Further, the Commission previously considered that an exception to the substitutability across medical specialities existed in the distinction between secondary and tertiary services. In this proposal, the Commission considers that this still holds. The Commission therefore concludes that, for the purposes of the present application:

- the separate facilities and non-specialist services that hospitals provide can be bundled together to form one aggregate market; and
- surgical facilities and non-specialist services are fungible across medical specialities, so that general "surgical" markets may be defined.

Acute vs. Elective and Secondary vs. Tertiary Surgery

72. In the Oxford, Wakefield and Ascot Decisions, the Commission considered that acute and elective surgery are not part of the same market. The Commission considered that 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 by private hospitals in the Auckland region.

73. As in those Decisions, parties spoken to by the Commission agreed that it was meaningful to distinguish between secondary and tertiary surgery because more specialised equipment, nursing staff and other staff are 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. MercyAscot is the only private facility in the Auckland region at which tertiary procedures are performed.

74. As the Trust and the ASC only provide secondary elective surgery, the Commission considers that it is appropriate to limit the competition analysis to the consideration of aggregation in the market for secondary elective surgery only.

Day/Short-stay vs In-patient

75. The Applicant contended that there is a continuum of surgical procedures which can be performed in private facilities, ranging from procedure rooms to day-stay theatres to in-patient facilities, and that these should be considered to lie in a broad market for the provision of private hospital facilities and related non-specialist services for elective secondary surgery.

76. The procedure rooms to which the Applicant referred, such as the Skin Institute in Takapuna and the Eye Institute in Remuera, typically carry out significantly less complex procedures than those carried out at day-stay facilities such as the ASC. In addition, the procedures which they carry out are generally unlikely to be performed in a fully-equipped theatre such as those of the Trust and the ASC. Apart from the Applicant, all industry participants interviewed by the Commission considered that procedure rooms provided insufficient constraint on day-stay facilities to be considered to be part of the same market. Accordingly, the Commission considers that procedure rooms do not form part of the relevant market.

77. Industry participants also draw a distinction between day-patient facilities and in-patient facilities, citing the high cost of gearing up a purpose-built day patient facility to accommodate more complex in-patient surgical procedures. Industry participants informed the Commission that a private hospital operating primarily as a day-patient facility would need the following additional resources in order to perform in-patient procedures:

- overnight beds;
- night staff;
- evening meals; and
- more spacious facilities to accommodate overnight beds.

78. For example, [

]. In addition, it does not have the more sophisticated care facilities such as ICU and HDU beds. Hence, there is limited scope for substitution on the supply-side from day-patient facilities to in-patient facilities.

79. However, there is more scope for supply-side substitution from in-patient facilities to day patient facilities. For example, [

]. This indicates that the cost of switching from providing in-patient to day-patient work is not prohibitive, given that much of the infrastructure common to the two types of surgical work is already in place.

80. The Commission considers that, on the demand-side, there are a number of technical and informational limitations that may override a patient's personal preferences for either in-patient or day-patient surgery. The most significant of these is the medical opinion of the referring surgeon, whom the patient is likely to rely heavily upon. Given the strong asymmetry of information between surgeons and patients, it is highly likely that patients will accept the recommendation of the surgeon over whether an in-patient or day-patient

procedure would be the most appropriate course of treatment. Hence, normal considerations of price and personal preferences rarely factor into the patient's decision between in-patient and day-patient surgery. As a result, the two cannot be thought of as substitutes in the usual economic sense.

81. Furthermore, when patients require either in-patient or day-patient surgical work, they are selecting products with fundamentally different characteristics. In particular, when an in-patient procedure is opted for, the patient receives a bundle of services including an extended period of monitoring by medical staff, recovery time located within a medical facility where complications may be more readily addressed, a managed medication plan, etc.

82. When day surgery is selected, the patient receives the benefit of a shorter hospital stay and a less invasive treatment leading to a swifter recovery. These characteristic differences between in-patient and day-patient surgery are quite significant, suggesting that the products themselves are different, so therefore should be defined in separate product markets.

83. In the Oxford Decision, the Commission defined a market for day-patient hospital facilities and related non-specialist services for elective secondary surgery. During its investigation of this application, the Commission found the term day-patient to be ambiguous, as some "day" patients actually stayed overnight at the hospital facility. To this extent, the Commission considers that "short-stay" patient better describes such patients.

84. Private hospital facilities interviewed by staff, all referred to a 23 hour period as being the maximum stay for a short-stay patient. Although [ ] of ASC's patients stay overnight, those patients come under the international criterion of "short-stay" because they are discharged within 23 hours.

85. Surgical lists commence at 8am, and patients arrive at intervals throughout the day for their surgery. Typically, the first patient's operation takes 1.5 to 2 hours. Hence patients arrive in the "overnight ward" staggered throughout the day with the last patient arriving any time between 6 and 8pm. A number of patients admitted to the overnight ward do not in fact stay overnight. Those patients that do stay overnight in that ward all are discharged by 10am the next day. ASC advised staff that [ ] of ASC's patients are discharged well within the 23 hour criterion.

86. ASC also advised that its patients have all been chosen for procedures that do not necessitate in-patient stay. The reason ASC keeps them for an extended period is to maximise their post-operative pain management, control any nausea or vomiting, re-establish eating and drinking and then discharge them with take home medication.

87. ASC stated that day stay facilities without overnight beds could accommodate 90% of the "short-stay" procedures that are performed at ASC, although for some of those procedures it might need to be arranged that the surgery was first on the surgical list at 8am. Staff inquired as to the other 10% of patients and were advised by ASC that the 10% would include patients in for major upper limb surgery that required a nerve block as well as a general anaesthetic.

88. In these cases, the nerve block typically wears off long after the general anaesthetic, but as the pain associated with such surgery can be extreme, often the patient will require potent narcotics rather than oral analgesia to control the

pain. As such, the patients require closer monitoring and would be in the facility for longer than a patient undergoing, for example, an arthroscopic procedure on a knee.

89. This contrasts with the in-patient procedures performed at MercyAscot and the Trust's hospitals. This group of patients is captive by the nature of their surgery and has no choice but to stay for a number of days until the healing process and ongoing bleeding and pain relief is at a stage where they can be safely discharged. The main reasons for predictable in-patient stay are:

- predictable or potential ongoing bleeding for more than one day;
- use of wound drains (e.g. chest, abdomen, head and neck, major joints) which may not be removed for days;
- predictable severe post operative pain likely to persist for several days usually requiring narcotic pain pumps or ongoing epidural drug infusions until transfer to simpler regimes is possible;
- mobilisation after major surgery and appropriate physiotherapy in hospital prior to home discharge (e.g. joint replacements);
- requirement for High Dependency Unit (HDU) monitoring or Intensive Care Unit (ICU) monitoring;
- re-establishment of nutrition especially after major abdominal surgery; and
- observation of major wound healing and redressing following major surgery.

90. The type of procedures that this applies to include: joint replacements, spinal surgery, major abdominal surgery, thyroid surgery, hysterectomy and open intra abdominal gynaecology, urological procedures such as prostatectomy and major renal procedures, and major plastic surgery. ASC does not perform any of these in-patient procedures.

91. Hospitals with in-patient procedures have patients seven days per week, 24 hours per day to provide the infrastructure for this type of surgery. In contrast, ASC is open five days per week and ward nursing staff keep the ward open until midday Saturday, when it closes.

92. Acknowledging that there are arguments in favour of both a narrow and broad product market, the Commission considers that for the purposes of the present application, the relevant competition effects are best identified by defining separate product markets for in-patient and short-stay surgical facilities, due to the limited demand-side and supply-side substitutability. The Commission recognises that if competition concerns are not identified within a narrowly defined market, they are unlikely to arise in a more broadly defined market.

Conclusion on Product Markets

93. For the purposes of the present application, the Commission concludes the relevant product markets are the provision of private:

- short-stay hospital facilities and related non-specialist services for elective secondary surgery; and
- in-patient hospital facilities and related non-specialist services for elective secondary surgery.

Geographic Market

94. The Commission defines the geographic dimension of a market to include all of the relevant, spatially dispersed sources of supply to which buyers would turn should the prices of local sources of supply be raised.

95. The Applicant submitted that the relevant market be limited to the Auckland region. The Commission considered whether the Auckland region might contain two discrete markets, the North Shore and Auckland. However, during the course of its investigation, the Commission found sufficient evidence of both patients and specialists switching between the facilities on the northern and southern sides of the Harbour Bridge, such that it considers it unlikely that there is scope for a narrower geographic definition.

96. Accordingly, the Commission considers the relevant geographic market to be the Auckland region.

Conclusion on Market Definition

97. For the purposes of the present application, the Commission concludes that the relevant markets are the provision of private:

- short-stay hospital facilities and related non-specialist services for elective secondary surgery in the Auckland region (the short-stay market); and
- in-patient hospital facilities and related non-specialist services for elective secondary surgery in the Auckland region (the in-patient market).

COUNTERFACTUAL AND FACTUAL

98. In reaching a conclusion about whether an acquisition is likely to lead to a substantial lessening of competition, the Commission makes a "with" and "without" comparison rather than a "before" and "after" comparison. The comparison is between two hypothetical future situations, one with the acquisition (the factual) and one without (the counterfactual).[12] The difference in competition between these two scenarios is then able to be attributed to the impact of the acquisition.

Factual

99. In the factual scenario, there would be two major private hospital providers operating in the relevant market, the Trust and MercyAscot. In addition, there would be three smaller competitors: Quay Park, NSC and the Navy Hospital.

100. Post-acquisition, [

].

Counterfactual

101. The ASC informed the Commission that [

[12] Commerce Commission, *Decision 410: Ruapehu Alpine Lifts/Turoa Ski Resorts Ltd (in receivership), 14 November 2000*, paragraph 240, p 44.

].

102. In addition, [

].

103. Accordingly, the Commission considers the relevant counterfactual scenario to be that the ASC would continue to operate until an alternative buyer was found. In such a scenario, the state of competition would be the status quo.

COMPETITION ANALYSIS

Existing Competition

104. Existing competition occurs between those businesses in the market that already supply the product, and those that could readily do so by adjusting their product-mix (near competitors).

105. An examination of concentration in a market can provide a useful indication of the competitive constraints that market participants may place upon each other, providing there is not significant product differentiation. Moreover, the increase in seller concentration caused by a reduction in the number of competitors in a market by an acquisition is an indicator of the extent to which competition in the market may be lessened.

106. A business acquisition is considered unlikely to substantially lessen competition in a market where, after the proposed acquisition, either of the following situations exist:

- the three-firm concentration ratio (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 40% share; or
- 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%.

107. The Commission recognises that concentration is only one of a number of factors to be considered in the assessment of competition in a market. In order to understand the impact of the acquisition on competition, and having identified the level of concentration in a market, the Commission considers the behaviour of the businesses in the market.

The In-Patient Market

108. The existing competitors in the in-patient market are the Trust and MercyAscot with a minimal amount of competition offered by ASC. Table 7 shows the number of short-stay and in-patients attending each of these private facilities previously identified.

Table 7: Market Shares by Number of Short-stay and In-patients for Private Hospital Facilities for Elective Secondary Services for 2003/2004

Private Hospital	Short-Stay		In-Patients		Total
ASC	[ ]	[ ]%	[ ]	[ ]%	[ ]
The Trust	[ ]	[ ]%	[ ]	[ ]%	[ ]
Combined	*[ ]*	*[ ]%*	*[ ]*	*[ ]%*	*[ ]*
MercyAscot	[ ]	[ ]%	[ ]	[ ]%	[ ]
Quay Park	[ ]	[ ]%	[ ]	[ ]%	[ ]
NSC	[ ]	[ ]%	[ ]	[ ]%	[ ]
Navy Hospital	[ ]	[ ]%	[ ]	[ ]%	[ ]
Total	[ ]	100%	[ ]	100%	[ ]

109. Table 7 indicates that the number of in-patients at the ASC is negligible, compared to the Trust and MercyAscot. Therefore, given the minimal aggregation that would occur as a result of the proposed acquisition, the Commission is satisfied that there is unlikely to be a substantial lessening of competition in this market as a result of the acquisition. Accordingly, for the purposes of this application, the Commission does not intend to consider further this market.

The Short-Stay Market

110. The major competitors in the short-stay market are the Trust, MercyAscot and the ASC, with three smaller players: Quay Park, NSC and the Navy Hospital. Table 7 above shows the number of short-stay patients attending each of these facilities.

111. Post-acquisition, the combined entity would have a market share of [ ] % and the three-firm concentration ratio would be [ ] %, increasing from [ ] %, this is outside the Commission's safe harbours.

112. Presently, ASC, the Trust and MercyAscot offer similar procedures, including orthopaedics, and compete for specialists to perform those procedures at their respective facilities.

113. MercyAscot is an established provider of private healthcare, performs all forms of elective surgery, and is a strong competitor in the short-stay market. Based on theatre numbers, MercyAscot has the two largest facilities in Auckland; it has 12 theatres at its Ascot Hospital and 7 theatres at its Mercy Hospital (although these are also utilised for tertiary surgery). During its investigation of this application, the Commission was advised by several surgeons that MercyAscot is their preferred facility because of the high-tech equipment provided as well as the HDU, in the event that a procedure goes wrong. Accordingly, MercyAscot tends to be at the upper end of the price spectrum for the provision of private hospital facilities.

114. The Trust tends to be a provider at the lower end of the price spectrum. Through the Trust's association with the Society, there is a desire to keep costs at a

minimum such that healthcare insurance premiums can also be kept down (in the face of competition in the healthcare insurance market). This is evidenced in Southern Cross's marketing slogan "affordable healthcare".

115. Specialists using ASC's facilities advised the Commission that ASC is presently the cheapest facility in the Auckland region. This, they argued, was as a result of ASC being a more efficiently run operation.

116. In general, hospitals attempt to attract surgeons by catering to the demands and needs of surgeons by providing the most up-to-date technology and the best available equipment. In addition, in private secondary hospitals, nurses assist the surgeons in the operating theatre and, because there are no house surgeons or registrars, provide all the pre- and post-operative care for the patient. Surgeons informed the Commission that the nursing standards also reflected on the performance of the surgeon and a surgeon had to be comfortable in leaving the patient in the care of the nurses.

117. [ ] advised the Commission that competition between the hospitals is fierce for nursing staff and that once [ ] has attracted good nursing staff, it pays them a higher rate than competitors in order to maintain those quality staff. [ ] advised the Commission that it also behaves in this manner in order to maintain the number of specialists operating at its facility.

118. Many specialists perform surgical procedures at a number of facilities, dependent on which facility has which equipment, as well as proximity to the patient. Specialists can (and do) cease operating at certain facilities when there are changes to funding. For example, Brightside previously had only [ ] orthopaedic surgeons operating at its facilities, with its main speciality being urology. Recently it was awarded an ACC contract [ ] and it now has [ ] orthopaedic surgeons operating there.

119. Quay Park, NSC and the Navy Hospital provide less competitive constraint in the market, as they offer fewer procedures. Quay Park and NSC are relatively new facilities [ ]. As such, these facilities have significant excess capacity in respect of available theatre time. Table 8 shows the available and utilised capacity for the 2003/2004 year for each of the competitors in the short-stay market.

Table 8: Available and Utilised Capacity at Private Hospital Facilities for Elective Secondary Services in Auckland for 2003/04

Entity	No. of Theatres	Maximum Available Time (Hr)	Theatre Time Utilised(Hr)	Utilised Capacity (%)	Available Capacity (%)
ASC	4	[ ]	[ ]	[ ]	[ ]
The Trust	11	[ ]	[ ]	[ ]	[ ]
MercyAscot	19	[ ]	[ ]	[ ]	[ ]
Quay Park	3	[ ]	[ ]	[ ]	[ ]
NSC	2	[ ]	[ ]	[ ]	[ ]
Navy	1	[ ]	[ ]	[ ]	[ ]

120. ASC advised the Commission that it currently has little spare operating time and that its capacity figure of [ ] % is very high for a hospital facility. It estimated

that it could only operate on an additional [ ] patients per year at its current facilities. It stated further that the demand for theatre time is such that there have been some instances where operating lists, normally designated to individual surgeons, have been 'doubled up'. For example, if a surgeon was not completely filling the available time a second surgeon has been offered the spare time.

121. ASC has had two major expansions since it was initially built in 1985 which included doubling the theatre capacity by building two additional theatres. Although the ASC has spare land on its current location, it stated that any possible expansion of its present size would encounter infrastructure and logistical problems for the facility.

122. MercyAscot is also capacity constrained to a degree. MercyAscot advised the Commission that although it owns a sizeable parcel of land, the present layout of its sites means that it is unlikely to increase its theatre numbers in the foreseeable future.

123. However, the smaller competitors in the short-stay market have significant excess capacity. The Commission has considered the ability of Quay Park, the NSC and the Navy Hospital to expand their present operations.

124. [

]

125. The NSC also has excess capacity. [

] It does not currently perform any orthopaedic surgery at its facilities [

]

126. Both Quay Park and the NSC described the same scenario for moving into orthopaedic surgery; that it would involve getting commitment from a number of orthopaedic surgeons and an ACC contract. [ ] stated that if a group of orthopaedic surgeons wish to join it, and put in a proposal for an ACC contract then it would consider orthopaedic surgery because of the large number of cases which would result. [ ] stated that the instrumentation cost for orthopaedics was high, so it would not enter orthopaedics for one surgeon, but would consider it for a group of surgeons. Currently, [

].

127. The Navy Hospital in Devonport also has excess capacity and is actively seeking to increase the amount of private surgery it performs. Although primarily a military hospital it has been conducting private procedures for the past five years and has the capacity to do more. It stated that it could quite easily double the amount of private surgery it performs and it already does orthopaedic surgery. It also has an ACC contract which accounts for approximately [ ] % of its private elective surgery.

Conclusion on Existing Competition

128. The Commission concludes that presently, competition is vigorous in the short-stay market. Post-acquisition, that level of competition is likely to continue through MercyAscot's desire to protect its market share and through the level of excess capacity of the smaller competitors, their stated desire to expand, and their ability to do so.

POTENTIAL COMPETITION

129. An acquisition is unlikely to result in a substantial lessening of competition in a market if the businesses in that market continue to be subject to real constraints from the threat of market entry. The Commission's focus is on whether businesses would be able to enter the market and thereafter expand should they be given an inducement to do so, and the extent of any barriers they might encounter should they try.

Barriers to Entry

130. The likely effectiveness of the threat of new entry in preventing a substantial lessening of competition in a market following an acquisition is determined by the nature and effect of the aggregate barriers to entry into that market. The Commission is of the view that a barrier to entry is best defined as anything that amounts to a cost or disadvantage that a business has to face to enter a market that an established incumbent does not face.

131. The Commission was advised by industry participants that the main barriers to entering the short-stay market are:

- access to facilities and medical equipment;
- nursing staff; and
- the ability to attract surgeons to use the new facilities.

132. In the Wakefield Decision the Commission found that the capital costs of establishing a new hospital were not sufficiently high to constitute a material barrier to entry in the absence of other tangible barriers, and that the (suggested) low return on capital is correctly regarded as a sign of a competitive market where any market rents have been eroded by competitive forces.

133. In the Oxford Decision, and in speaking to industry participants in regard to the present application, the Commission found that the cost of a new theatre is approximately [ ] However, it was suggested that it was uneconomic to build a new single theatre clinic and that a two theatre clinic, such as the NSC or the ASC when it was originally built, would be more suitable. It has been estimated that the cost of a new facility of this size would be approximately [ ] Outfitting the theatre with the appropriate technology and equipment would increase the cost by another [ ], depending on the specialties catered for at the facility, giving a total estimated set-up cost of [ ]. Alternatively, land, buildings and equipment can be leased, thus reducing the capital investment required.

134. The Commission has found that there is a level of 'common instrumentation' between specialties with each speciality then requiring unique instrumentation in order to undertake specific procedures. In addition, as previously mentioned in

the section on market definition, in order to perform orthopaedic surgery, the cost of specialised orthopaedic equipment would be around $400,000.

135. All industry participants interviewed by the Commission indicated the ease with which specialists could access the capital required to establish a greenfield private day stay facility. [

].

136. Another requirement for entry into a private short-stay facility is the recruitment of adequately trained nursing staff. The Commission found that some industry participants find it difficult to retain appropriately trained nursing staff, in part due to the increased funding for nursing staff in the public sector, but also due to nurses leaving the industry in general. [

]. However, other market participants disagreed. [

]. The Commission does not consider that access to trained nurses represents a significant barrier to entry.

137. One of the key requirements for entry is the ability to attract surgeons to use the facilities. Surgeons are not contracted to any particular private facility and often operate across multiple facilities, whether they be short-stay, in-patient or public hospitals. A new entrant would need to invest time in establishing relationships with surgeons and would need to market the new facilities.

138. The Commission investigated whether the proposed acquisition would foreclose access to surgeons for a potential new entrant. [

]

139. In summary, the Commission does not consider the ability to attract surgeons to be a significant barrier to entry.

140. However, despite the barriers to entry being relatively low, given the excess capacity in the short-stay market, the Commission is of the view that de novo entry into this market is unlikely within the next two years.

Conclusion on Potential Competition

141. The Commission considers that barriers to entry into the short-stay market are low, but that the presence of excess capacity in this market is likely to deter new entry within the next two years.

COUNTERVAILING POWER

142. In some circumstances the potential for the combined entity to exercise market power may be sufficiently constrained by a buyer or supplier to eliminate concerns that an acquisition may lead to a substantial lessening of competition.

143. In its previous decisions, particularly the Wakefield Decision, the Commission has considered the ACC, insurance companies, and surgeons to have strong countervailing power. In the Wakefield Decision, it was concluded that the constraints from surgeons, ACC and insurers were difficult to quantify in terms of their ability to constrain an increase in price but the cumulative impact of these funders would provide sufficient constraint to the private hospitals. The Oxford Decision confirmed these views.

144. In this proposed acquisition, the Commission has considered the countervailing power of each of the funders of the existing competitors. The percentage of funding from each source for each private hospital owner in Auckland is shown in Table 9.

Table 9: Percentage of Funding Provided to Private Hospitals by Various Funding Agencies in the 2003/2004 Year

Revenue Source	Insurance Companies	ACC	Private Patients	District Health Boards	Other
ASC	[ ]%	[ ]%	[ ]%	[ ]%	[ ]%
The Trust	[ ]%	[ ]%	[ ]%	[ ]%	[ ]%
MercyAscot	[ ]%	[ ]%	[ ]%	[ ]%	[ ]%
Quay Park	[ ]%	[ ]%	[ ]%	[ ]%	[ ]%
NSC	[ ]%	[ ]%	[ ]%	[ ]%	[ ]%
Navy	[ ]%	[ ]%	[ ]%	[ ]%	[ ]%

The ACC

145. During its investigation of this application, the Commission found that for some types of elective procedures, mainly orthopaedic procedures, the ACC contracts provide a significant source of funding for some private hospitals. Approximately 85% of elective surgery purchased by the ACC each year is for orthopaedic work.

146. The ACC stated that as a purchaser of both private and public healthcare it is a price setter. The ACC has developed its own benchmark prices, and since last year the ACC has a set national price for all medical procedures. Prior to that the ACC set benchmark prices, but actual prices paid were discounted based on the volume of procedures carried out.

147. The Commission was made aware of a number of changes in the way that the ACC awards its surgical contracts. David Rankin, General Manager, ACC Healthwise, stated that there was a belief among clinicians that an ACC contract locked them into a 'pot of gold' for the length of the agreement. The ACC now has instigated a number of mechanisms that are aimed to encourage new entrants to apply for ACC funding for the provision of medical facilities and services. The ACC will now consider a new entrant at any time throughout the year[13]. In addition, hospitals are required to give consideration to any new, appropriately

[13]Previously the ACC had a policy that new entrants would not be considered until the contracts where renewed. The current contracts run from August 2004 to August 2006, whereas the previous contracts ran from 2000 to 2004.

qualified, surgeons wishing to use the hospitals services for ACC-funded surgical procedures.

148. Post-acquisition, the proportion of funding that the Trust receives from the ACC would increase because of the ASC's large ACC contract. Given that the ACC is a price setter, the combined entity would be constrained from increasing its prices post-acquisition. If it did not accept the national price offered by the ACC, then the ACC could award the contract to a competing facility. The Trust would then stand to lose a significant portion of its funding. In addition, the Trust would also risk losing a proportion of the specialists who operate at its facilities and also a proportion of those who operate at ASC.

Health Insurance Companies

149. Like the ACC, the health insurance companies are likely to provide some constraint on the proposed acquisition and this is unlikely to be affected by this acquisition. For instance, insurers use an historical database of claims to establish the "usual and customary" cost of treatment. This average cost is used to benchmark payouts. [ ] said that sometimes where it asks for prior approval for the cost of surgery for a particular patient and finds the cost to be out of line with its average price it would go back to the surgeon. If it found the prices to be high it would negotiate and may even refuse to pay the claim in its entirety.

150. However, the Commission notes that the Trust receives the majority of its insurance funding from its associated entity, the Society. The Society advised the Commission that in the event that the Trust increased prices for its facilities post-acquisition, the Society would discuss the matter with the Trust, but that essentially it would not have any mechanism, other than its affiliated provider programme, with which to negotiate prices down. However, the proposed acquisition is unlikely to reduce any countervailing power other insurance companies currently have.

151. The Commission considers that, on the whole, the health insurance companies would be likely to provide limited constraint on the combined entity post-acquisition.

DHB Funding

152. The Trust submitted that the three Auckland-based DHBs, Auckland, Waitemata and Counties Manukau, also pose a constraint on private hospitals through their ability to contract work out to these facilities. However, as indicated in Table 9 the proportion of funding for the Trust and MercyAscot, respectively, from DHBs is [ ].

153. Industry participants stated that DHB contracts were sporadic and unpredictable. [ ] indicated to the Commission that it would be unwise for any hospital to rely on DHB funding as a source of revenue due to its sporadic nature. [

].

154. The Commission considers that, on the whole, DHBs would be likely to provide limited constraint on the combined entity post-acquisition.

Surgeons

155. The Commission has previously found that surgeons take a range of factors into account when considering in which hospital to carry out a patient's surgery. If the patient is self-funding the procedure, or has to pay a substantial co-payment as a result of having a "shared cover" policy, then they will typically request the cheaper hospital. [

]. If the surgeon refused to switch hospitals, they would run the risk of the patient going to a surgeon who was operating at a cheaper facility.

156. If the procedure is to be ACC-funded, then the hospital would need to have an ACC contract in order for the surgeon to carry out the procedure at that hospital. Other factors that are taken into account are urgency of surgery, personal preference and theatre availability. As discussed in the section on existing competition, NSC, Quay Park and the Navy Hospital all have excess capacity and would welcome an increase in procedures performed at their facilities.

157. The Commission notes that surgeons can and do switch between private hospitals (see the example above of orthopaedic surgeons switching to Brightside hospital after it gained an ACC contract). In the event that, post-acquisition, the combined entity increased hospital charges or reduced the quality of its service, surgeons would have the option of switching to other facilities. Consequently, the threat of surgeons switching is credible and would be likely to provide a degree of constraint on the combined entity post-acquisition.

Conclusion on Countervailing Power

158. In conclusion, the Commission considers that post-acquisition, insurance companies and DHBs would provide limited constraint on the combined entity, but that the ACC and surgeons are likely to continue to provide constraint on the combined entity.

Co-ordinated Market Power

159. The Commission is of the view that where an acquisition materially enhances the prospects for any form of co-ordination between businesses in the market, the result is likely to be a substantial lessening of competition.

160. The proposed acquisition, would be likely to reduce the number of major players in the short-stay market from three to two, namely the Trust/ASC facilities and MercyAscot. However, there are also three smaller players with excess capacity who would undermine the ability of the major two competitors to collude on the price of their facilities and related non-specialist services in the short-stay market.

161. Given the countervailing power of the ACC and surgeons discussed above, the Commission considers it unlikely that any attempt by the Trust and MercyAscot to collude on prices would succeed.

Conclusion on Co-ordinated Market Power

162. The Commission concludes that the scope for coordinated market power in the short-stay market is unlikely to be enhanced by the proposed acquisition.

Vertical Integration

163. Vertical acquisitions are those that involve businesses operating at different functional market levels in the production of a particular good or service. Where a vertical acquisition also has horizontal implications, the Commission considers each aspect of the acquisition in its own right.

164. The Commission is of the view that, in general, the vertical aspects of acquisitions leading to vertical integration are unlikely to result in a substantial lessening of competition in a market unless market power exists at one of the affected functional levels. Where such a situation is found to exist, the Commission considers whether the acquisition would strengthen that horizontal position, or have vertical effects in upstream or downstream markets, and whether that change would substantially lessen competition.

165. Several parties advised the Commission that they were concerned that the proposed acquisition might afford the Trust's associated entity, the Society, the ability to cross-subsidise the Trust's private hospitals through the Society's market power in the health insurance market. In addition some parties suggested that The Trust's further vertical integration could foreclose entry into either the private hospital markets or the health insurance market.

166. In respect of cross-subsidisation, [ ] advised the Commission that in its opinion:

> Southern Cross is able to subsidise its loss making hospitals through profits made by its medical insurance business. As the Society is the main funder of private hospital procedures, Southern Cross has incentives to induce private hospitals to lower their charges by setting artificially low charges in its own hospitals, which other private hospitals are then compelled to match in the short term. As no other private hospitals are vertically integrated with an insurance provider there is no ability for any other private hospital to subsidise low costs in this way. Subsidising private hospital costs in those geographic areas where there is competition with Southern Cross hospitals could mean that, in the long term, other private hospitals will find it difficult to compete, which realistically could result in them exiting the market or new hospitals not being established.

167. As [ ] suggests, the Society holds a significant share of the health insurance market as shown in Figure 2.

Figure 2: Estimated Market Shares Based on Lives Covered of Health Insurers for the June 2002, 2003, and 2004 Years

[ ] Source data: Health Funds Association of New Zealand Inc., Members' Market Share Information

168. However, health insurers, [

]. This is also illustrated in Figure 2.

169. To this extent, the Commission is of the view that presently, the Society faces sufficient constraint on its pricing in the health insurance market from other health insurers, such as Tower and Sovereign, such that it is unlikely to be able to increase its insurance premiums in order to cross-subsidise its private hospitals. The Commission considers that the proposed acquisition is unlikely to

augment any market power the Society presently has in the health insurance market.

170. [ ] also conjectured that post-acquisition, the Society would have an enhanced ability to steer its members to Southern Cross private hospitals to the detriment of competing private hospitals. It said that the APP would be the vehicle that it would use to effect such a strategy. [ ] said:

> Through Affiliated Provider Programmes and joint ventures, Southern Cross has the ability to dictate what surgeons and hospitals policy holders use. The growth of Southern Cross, APP, and joint ventures over the last few years, and the real likelihood that they will continue to grow, considerably impacts (and will continue to impact) on the ability of non Southern Cross hospitals to compete in the markets.

171. The ability for the Society to direct its members to Southern Cross hospitals exists presently. [ ], Southern Cross Medical Care Society, advised the Commission that while the Society preferred members to use affiliated providers, it cannot and does not insist that they do so. He added that the Society has no arrangements, contractual or otherwise, which provide a member with a discount for using a Trust hospital or any other facility. The Commission considers that the proposed acquisition will not enhance the Society's ability to steer its members to the Trust's facilities and that sufficient competing facilities exist such that patients will continue to have a choice of private hospitals.

172. In addition, the Commission is aware that [

]

The Commission understands that [ ] in this regard.

173. In respect of foreclosure in the short-stay market, as discussed in the existing competition section, the Trust has faced new entry in the short-stay market in the past four years by Quay Park and NSC (neither of which has any particular affiliation with health insurers), despite its existing vertical link with the Society. The Commission is of the view that the Trust would continue to be constrained by the existing excess capacity of Quay Park and NSC in the short-stay market.

Conclusion on Vertical Integration

174. In conclusion, the Commission is of the view that the proposed acquisition is unlikely to augment the market power of the Trust's associated entity, the Society, in the health insurance market, such that the increased vertical integration that would be brought about by the proposed acquisition is unlikely to constitute a substantial lessening of competition in either the upstream health insurance market or the downstream short-stay market.

OVERALL CONCLUSION

175. The Commission has considered the probable nature and extent of competition that would exist, subsequent to the proposed acquisition, in the market for the provision of private short-stay hospital facilities and related non-specialist services for elective secondary surgery in the Auckland region.

176. The Commission considers that the counterfactual is the purchase of the ASC by a party not presently competing in the Auckland short-stay market.

177. In the short-stay market, the acquisition would increase the Trust's market share from [ ] and the three-firm concentration ratio from [ ]. This is outside the Commission's safe harbours.

178. The Commission is of the view that presently, competition is vigorous in the short-stay market. Post-acquisition, that level of competition is likely to continue through MercyAscot's desire to protect its market share and through the level of excess capacity of the smaller competitors, their stated desire to expand, and their ability to do so. The Commission considers that post-acquisition, the combined entity would face a degree of constraint from MercyAscot as well as the smaller competitors.

179. The Commission considers that barriers to entry into the short-stay market are low, but that the presence of excess capacity in this market is likely to deter new entry within the next two years.

180. In respect of countervailing power, the Commission is of the view that post-acquisition, insurance companies and DHBs would provide limited constraint on the combined entity, but that the ACC and surgeons are likely to continue to provide constraint on the combined entity.

181. The Commission concluded that the scope for coordinated market power in the short-stay market is unlikely to be enhanced by the proposed acquisition.

182. In respect of the further vertical integration that would occur as a result of the proposal, the Commission is of the view that the proposed acquisition is unlikely to augment the market power of the Trust's associated entity, the Society, in the health insurance market, such that it would give rise to a substantial lessening of competition in either the upstream health insurance market or the downstream short-stay market.

183. The Commission is therefore satisfied that the proposed acquisition would not have, nor be likely to have, the effect of substantially lessening competition in any of the affected markets.

DETERMINATION ON NOTICE OF CLEARANCE

184. Pursuant to section 66(3) (a) of the Commerce Act 1986, the Commission determines to give clearance for the proposed acquisition by The Southern Cross Health Trust of the assets of the Auckland Surgical Centre Limited

Dated this 17th day of February 2005

Paula Rebstock
Chair
Commerce Commission