PUBLIC VERSION

COMMERCE ACT 1986: BUSINESS ACQUISITION SECTION 67: NOTICE SEEKING AUTHORISATION

24 May 2011

The Registrar
Business Acquisitions and Authorisations
Commerce Commission
PO Box 2351
WELLINGTON

Pursuant to s67(1) of the Commerce Act 1986 notice is hereby given seeking **authorisation** of a proposed business acquisition.

1. SUMMARY OF APPLICATION

1.1. Southern Cross Hospitals Limited ("**SCHL**") and Aorangi Hospital Limited ("**Aorangi**") (together "**the Applicants**") seek authorisation to acquire shares in a joint venture company ("**JV Co**") and for JV Co to acquire the business assets of SCHL's and Aorangi's Palmerston North hospitals ("**the Acquisition**").

1.2. The primary rationale for the Acquisition is the desire to ensure investment in a quality private hospital facility in Palmerston North. Both Aorangi and SCHL are experiencing declining revenues and decreasing levels of return in Palmerston North. SCHL's hospital ("**SCHL Palmerston North**") operates at an unsustainable loss, with considerable operating losses in each of the last three years. [

]. Patient numbers have steadily declined with forecast patient numbers in 2011 [ ] less than 2005 and [ ] less than 2006. At the same time, Aorangi is not achieving sufficient returns to attract investment from new specialists, which is vital to its operating model. Both hospitals are operating below capacity.

1.3. This lack of financial certainty has prevented both hospitals from undertaking the necessary capital investment either to maintain their facilities at an optimal level, or invest in developing medical technology which would significantly increase the scope and quality of services provided. The lack of investment is illustrated by the fact that there has been no major capital expenditure by either SCHL Palmerston North or Aorangi since 2008. Both hospitals lack a High Dependency Unit, high-tech imaging, and high-tech digital theatres which would improve both the scope of procedures available at the hospital and the quality of existing procedures. An illustration of the consequences of deferred investment is the [

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1.4. In Decision 650 the Commission considered whether SCHL would close its Palmerston North hospital in the absence of a joint venture with Aorangi. While SCHL Palmerston North has not yet exited the market, its potential to be a viable competitor in Palmerston North (whether or not it remains in the market) is considerably less likely than in 2008. In fact, the financial situations of both of the Applicants have become particularly acute since the Applicants' application for clearance for a similar transaction in 2008. Declining revenue has been caused by a combination of:

(i) a reduction in DHB funding, caused primarily by the expansion of MidCentral DHB's elective surgery capacity. The scale of this increase can be illustrated by comparing the increase in elective discharges (an increase of 700 discharges and total discharges of 5,109) to SCHL Palmerston North's total discharges in the same period ([ ]);

(ii) a recent reduction in ACC funding, which has meant that ACC revenue for both Aorangi and SCHL Palmerston North has decreased substantially;

(iii) a reduction in the amount of private insurance cover, caused by a combination of the global financial crisis and the Government's stated policy to increase public surgery output and reduce waiting times; and

(iv) the exercise of buyer power by private insurers, including the expansion of affiliated provider and reasonable charge schemes.

1.5. Both hospitals, and in particular SCHL Palmerston North, have undertaken a number of measures to increase revenue and decrease costs since 2008. These include [

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1.6. The Acquisition will reduce the number of private hospital providers in Palmerston North from two to one, and will be likely to lessen competition in the relevant markets. However, any lessening of competition will be limited by two factors: the current lack of any significant competition between the Applicants and the continuing constraints on the Applicants following the merger.

1.7. Competition between hospitals is a function of quality as well as price, and the financial position of each of Aorangi and SCHL has limited their ability to improve the quality of their facilities. This is illustrated by each Applicant's focus on cost cutting rather than revenue generation, [ ] and the lack of investment in new technology. Therefore, even if Aorangi and SCHL will remain as separate competitors in the counterfactual, the level of competition between them is unlikely to be vigorous or effective.

1.8. The merged entity will also face a number of constraints following the merger, all of which will limit the extent to which JVCo will be able to exercise market power following the Acquisition. The most significant of these factors are:

(i) the contestability of a significant number of short-stay/day-stay procedures currently undertaken by the Applicants. As well as existing competitors in Palmerston North (The Palms and Broadway Surgery), there is also the possibility of more specialist clinics being established (examples of such entry in other regions includes Rotorua Eye, Bridgewater Hamilton Eye Clinic, Endoscopy Auckland and Auckland Eye);

(ii) the proportion of revenue that will be derived from fixed price arrangements. SCHL estimates that this proportion is currently around [ ] in Palmerston North. The merger will not increase the applicants' ability to negotiate alternative fixed price arrangements with insurers, the DHB and ACC; and

(iii) the drift away from private health insurance given the improvements made to the public health system, and in particular the Government's stated policy to provide faster and better quality elective surgery.

1.9. Any competitive detriments that do arise from the Acquisition will be outweighed by the benefits to the public that the Acquisition creates. The most readily identifiable benefit is the significant cost savings that can be achieved by the two hospitals operating as one. These include [

]. While not as easily quantifiable, increased investment is likely to provide the major benefit for patients in Palmerston North. Such investment is likely to both increase the range of private hospital procedures available in Palmerston North, and improve the quality of existing procedures. This will ensure that the private hospital facilities in Palmerston North match those available in other, similarly populated, regions, and attract senior staff and medical specialists to the region.

1.10. The benefits of the Acquisition must be weighed against the competitive detriment which will be limited by the factors described in paragraph 1.7 and 1.8 above. In relation to allocative inefficiencies, the significant number of constraints or potential constraints that would continue to exist in the factual will limit the ability of JV Co to set prices above

competitive levels. The potential for productive inefficiencies will also be limited by these constraints, as well as the declining patient numbers in Palmerston North and the current replication of costs that is likely to continue in the counterfactual. Finally, given the low level of investment currently being undertaken by the Applicants, which is likely to continue while both parties remain in the market, there is little scope for dynamic inefficiencies to arise as a result of the Acquisition. Such an outcome should be contrasted with the primary rationale for the Acquisition, which is to create a high quality private hospital facility in Palmerston North.

PART 1: TRANSACTION DETAILS

1. Provide the name of the acquirer (person giving notice), and the name and position of the individual responsible for the notice.

(a) This notice is given jointly by Southern Cross Hospitals Limited ("**SCHL**") and Aorangi Hospital Limited ("**Aorangi**") (together the "**Applicants**").

Southern Cross Hospitals Limited
Level 10, AMP Centre,
29 Customs Street West
PO Box 5341
Wellesley Street
AUCKLAND 1010

Attention: Terry Moore
Chief Executive Officer
Southern Cross Hospitals Limited
Telephone: 09 925 5344 / 021 946 786
Email: terry.moore@southerncrosshospitals.co.nz

Aorangi Hospital Limited
175 Grey Street
PO Box 788
PALMERSTON NORTH 4410

Attention: Lorna Grové
Acting CEO
Telephone: **06 350 1200**
Email: lorna@aorangihospital.co.nz

(b) All correspondence and notices in respect of the application should be directed in the first instance to:

Russell McVeagh
Barristers & Solicitors
PO Box 8
AUCKLAND 1140

Attention:	Andrew Peterson, Partner / Chris Bowden, Senior Solicitor
Telephone:	09 367 8315 / 09 367 8862
Fax:	09 367 8595
Email:	andrew.peterson@russellmcveagh.com / chris.bowden@russellmcveagh.com

2. Provide the name of the other merger parties, and the name/position of the relevant individual within the relevant merger parties.

(a) The Applicants (or their respective nominees/subsidiaries) intend to acquire a new company to be incorporated (referred to here as "**JV Co**"), details of which are yet to be finalised.

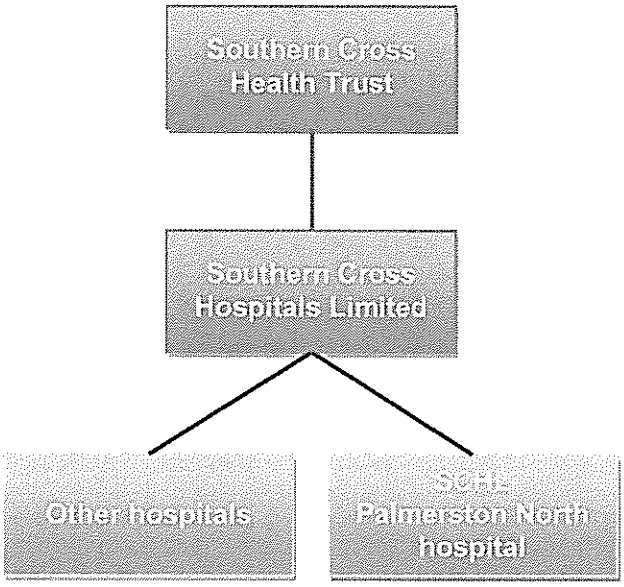
3. With respect to the merger parties, list the relevant companies and the person or persons controlling these directly or indirectly. Please use organisational charts

or diagrams to show the structure of the ownership and control of the acquirer and participant(s) to the acquisition.

SCHL

3.1 The organisational chart below illustrates the structure of the relevant ownership and control of SCHL.

Figure 1 - Organisation chart showing relevant ownership and control of SCHL



3.2 The trustees of SCHL are registered as a Board under the Charitable Trusts Act 1957.

3.3 SCHL is 100% owned by Southern Cross Health Trust.[1] The business assets of SCHL include nine wholly owned private hospitals,[2] including Southern Cross Palmerston North, and (via subsidiary companies) shareholdings in a number of other private hospital joint ventures and specialist facilities.[3]

3.4 SCHL also owns 100% of Southern Cross Benefits Limited, trading as Southern Cross Travel Insurance ("**SCTI**"). SCTI provides insurance for leisure and business travel, as well as international students studying in New Zealand.

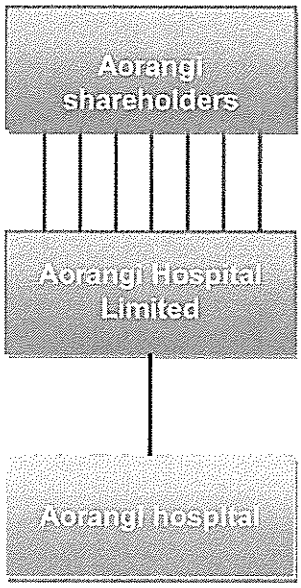
3.5 As already noted, this application concerns SCHL's Southern Cross Hospital Palmerston North ("**SCHL Palmerston North**"), located at 21 Carroll Street, Palmerston North.

Aorangi

3.6 The organisational chart below illustrates the structure of the relevant ownership and control of Aorangi.

[1] Note that Southern Cross Hospitals Limited is one of a number of subsidiaries of Southern Cross Health Trust.
[2] Auckland Surgical Centre (Auckland), Brightside (Auckland), North Harbour (Auckland), Hamilton, New Plymouth, Palmerston North, Wellington, Christchurch, Invercargill.
[3] Gillies Hospital Ltd (Auckland), Mercy Angiography Unit Ltd (Auckland), Grace Hospital Ltd (Tauranga), Southern Cross QE Ltd (Rotorua) and Ormiston Hospital (Auckland). SCHL also has interests in Waitemata Endoscopy, Southern Endoscopy and Auckland Radiation Oncology

Figure 2 - Organisation chart showing relevant ownership and control of Aorangi



3.7 Aorangi operates the Aorangi Hospital, at 175 Grey St, Palmerston North. It leases the land and premises of the hospital from The Players Company (see further below).

3.8 Aorangi is privately owned and operated by a group of medical specialists. 1,254,328 Aorangi shares are on issue in total. The shareholders, in descending order, are set out in **Appendix A**.

3.9 In addition to its current issued shares, Aorangi has issued convertible notes in its 2005 and 2006 financial years. 30,916 of these notes remain outstanding. All of these notes are held by current shareholders in Aorangi. The notes carry an option, in favour of the note holder, to convert the principal of the notes to shares at the end of a five year term (which will expire in 2011).

The Players Company

3.10 The Players Company owns the land and buildings for Aorangi Hospital Ltd.[4] JV Co will not acquire the land and buildings from The Players Company.

The Southern Cross Medical Care Society (the "Society")

3.11 The Society is **not** a party to this transaction.

3.12 The Society is New Zealand's largest health insurer, and operates:

(a) Southern Cross Health Insurance;

(b) Activa Health Limited; and

(c) Southern Cross Health Services Limited (trading as Care Advantage), a claims and rehabilitation management company in the workplace accident insurance sector.

[4] According to the Companies Office website, there are twenty shareholders of The Players Company Ltd, each holding an equal 5% interest.

3.13 SCHL and the Society are separate legal entities and operate at "arm's length" from each other.

4. Provide details on what is to be acquired.

4.1 The precise structure of the joint venture between SCHL and Aorangi has not been settled; however, it will involve the following:

(a) JV Co will be formed and will issue shares.

(b) SCHL (or nominee) and Aorangi (or nominee) will each acquire 50% of the shares in JV Co.

(c) Aorangi (or nominee) will own 50% of the shares in JV Co. Aorangi may also issue some shares in Aorangi to specialists who are not current shareholders in Aorangi. The SCHL nominee will be a company in which SCHL holds 100% of the shares.

(d) JV Co (or one or more subsidiaries of JV Co) will buy the Palmerston North hospital assets from both SCHL and Aorangi. This will not include the SCHL land and buildings ("**the Acquisition**").

5. Fully explain the commercial rationale for the proposed merger. Specify whether this is part of an international merger.

SCHL's reasons

5.1 As set out in the 2008 Application, SCHL Palmerston North is not profitable, and shows no sign of becoming profitable. Section 15 below describes in further detail how SCHL Palmerston is running at significant undercapacity, with decreasing revenues and a lack of investment relative to comparative hospitals. All of these factors have worsened since the 2008 Application and the SCHL Board is currently exploring options for the closure of SCHL Palmerston North in the event that the arrangement with Aorangi does not go ahead.

5.2 As well as the considerable cost savings that the merger would realise (see paragraph 26.3), SCHL sees the transaction as an opportunity to maintain its presence in Palmerston North, and work with Aorangi to begin again to invest in private hospital facilities in the region to match those in other parts of New Zealand. The merger would allow the Applicants to pool their investment resources, particularly with regards to new medical equipment. As described further in paragraphs 15.14 - 15.17, SCHL Palmerston North has undertaken little in the way of capital investment since the 2008 Application. The services and facilities available at SCHL Palmerston North are below the standards of comparable SCHL facilities. Both SCHL Palmerston North and Aorangi lack comparable facilities to similarly sized New Zealand regions.

Aorangi's reasons

5.3 Aorangi's reasons for wishing to enter into the proposed transaction are also relatively similar to the rationale described in the 2008 Application. While Aorangi is not experiencing the levels of losses suffered by SCHL, its ability to offer its shareholders a competitive return on their investment has been affected by a number of factors, all of which are discussed further in Part 4 below:

(a) since July 2009 Aorangi has done no DHB work and it is unlikely that it will undertake any DHB work in the foreseeable future;

(b) Aorangi is experiencing a reduction in ACC funding; and

(c) Aorangi has seen the increased costs of private health insurance reduce the number of insured patients, and believes that this trend will continue at least in the medium term.

5.4 Aorangi's ownership structure provides an added incentive to enter into the transaction. This structure is based on the shareholders of Aorangi being predominantly medical specialists who also use the Aorangi facilities. In the 2008 Application, it was noted that [ ]. Since the 2008 Application [ ]. The ability of Aorangi to attract new medical specialists to the region (and hence new shareholders) is made particularly difficult by the current low return on ownership interests in Aorangi and the inability to invest in new medical equipment or provide the range of services available in comparable regions.

5.5 Asset replacement remains a challenge for Aorangi. It made a number of major investments in 2002/03 which are approaching the end of their life, and will need to be upgraded or replaced.[5] New technology will also be required in the short/medium term. [ ]. The ability of Aorangi to finance this asset replacement is limited by their ownership structure.

6. Provide copies of the final or most recent versions of any document bringing about the proposed merger.

6.1 The Memorandum of Understanding between SCHL and Aorangi is enclosed in **Appendix B**.

7. If any other jurisdiction's competition agency has been (or will be) notified of the proposed merger, please list each competition agency notified (or to be notified) and the date of the notification.

7.1 Not applicable. This is a transaction that only affects New Zealand.

PART 2: THE INDUSTRY

8. Describe the relevant goods or services supplied by the merger parties (it is sufficient to refer in general terms to activities in which there will be no aggregation).

8.1 Both SCHL and Aorangi are active in the provision of private hospital facilities in Palmerston North. Each provide facilities for private elective surgery for short-stay patients and in-patients. The Commission will be familiar with both of the Applicants from the 2008 Application, although a brief description of the activities of the Applicants is set out below.

[5] These include anaesthetic machines, anaesthetic ventilators, anaesthetic monitors, camera stacks, ultrasound machine, endoscopy surgical equipment, floor coverings, air-conditioning plant, freezer and fridges, ENT and ophthalmology microscopes and a diathermy machine.

SCHL

8.2 As already noted, this application concerns SCHL Palmerston North, located at 21 Carroll Street, Palmerston North.

8.3 SCHL Palmerston North is a private hospital with two operating theatres and 26 in-patient beds, as well as a seven chair short-stay / day-stay unit and six consulting rooms. A range of services are offered to patients by specialists using the SCHL Palmerston North facilities, including:

(a) plastic surgery;

(b) orthopaedics (to a minor extent);

(c) ear, nose and throat surgery;

(d) cardiology (to a very minor extent);

(e) gastroenterology;

(f) gynaecology;

(g) ophthalmology (to a minor extent);

(h) anaesthesiology;

(i) general surgery;

(j) endoscopy;

(k) dental surgery;

(l) urology; and

(m) oral and maxillo-facial surgery.

8.4 Of these specialties, endoscopy forms the largest share of procedures ([ ]) and gynaecology the largest share of revenue ([ ]).

8.5 Approximately [ ]–[ ] of SCHL Palmerston North's procedures are short-stay / day-stay; the remaining [ ]–[ ] are in-patient procedures.

8.6 SCHL owns the SCHL Palmerston North land and buildings.

Aorangi

8.7 As set out above, Aorangi operates the Aorangi Hospital, at 175 Grey St, Palmerston North, on land and premises leased from The Players Company.

8.8 Aorangi has four operating theatres, 32 beds and a number of consulting rooms. A range of services are offered to patients by specialists using these facilities, including:

(a) plastic surgery;

(b) orthopaedics;

(c) ear, nose and throat surgery;

(d) gynaecology;

(e) urology;

(f) endoscopy;

(g) ophthalmology;

(h) anaesthesiology;

(i) general surgery;

(j) oral and maxillofacial surgery and dental;

(k) cardiology (excluding interventional);

(l) dermatology,

(m) medical oncology; and

(n) general and rehabilitative medicine.

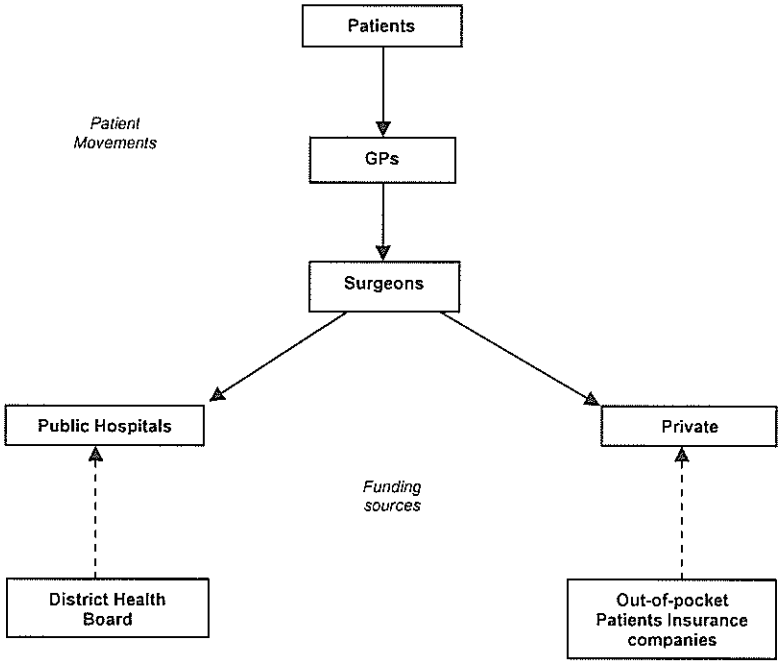
8.9 Of these treatment types, the largest proportion of Aorangi's revenue comes from orthopaedics. It also has consistent revenue from general surgery and urology.

8.10 Approximately [ ]–[ ] of Aorangi's procedures are short-stay / day-stay; the remaining [ ]–[ ] are in-patient procedures.

9. Describe the industry or industries affected by the proposed acquisition. Where relevant, describe how sales are made, the supply chain(s) of any product(s) or service(s) involved, and the manufacturing process. If relevant, provide a glossary of terms and acronyms.

9.1 The Commission will be familiar with the operation of private hospital facilities from the 2008 Application. We do not propose to repeat the industry background in this submission, instead referring to paragraphs 19 - 25 of Decision 650, repeated below.

> 19. In New Zealand, healthcare is provided by a range of medical practitioners and facilities. The main industry participants relevant to his proposed acquisition are shown in the diagram box.



20. 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.

21. When a surgeon recommends private elective surgery the decision as to which private hospital will be used will be heavily influenced by the hospital (or hospitals) where that surgeon normally operates. Typically, patients follow their surgeon's recommendation about where the surgery is to be performed.

22. Factors that influence surgeons' choice of hospital include:

- whether or not they have a shareholding in a facility (as is the case with Aorangi);
- the ability to schedule surgery at a convenient time for the surgeon at a particular private hospital; and
- the particular private hospital's charges for the provision of the necessary facilities.

23. Private hospitals provide facilities, namely, patients rooms and medical equipment, as well as the related non-specialist services such as administration staff and nursing 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.

24. Private hospitals focus almost exclusively on providing elective surgery. Elective surgery is defined as non-emergency treatments (including diagnostic services) where the condition is not life threatening and does not require immediate surgery.

25. Demand for the provision of elective surgery in the public system generally outstrips supply so rationing is required. The private system caters for those patients who would not otherwise receive

> treatment in the public system, or who want to receive private treatment for reasons such as timeliness.

10. Describe the current industry trends and developments including the role of imports and exports, emerging technologies, and/or changes in supply and demand dynamics.

10.1 As set out above, the Commission will be familiar with the operation of private hospitals from the 2008 Application. However, particular industry trends and developments that are relevant to the Acquisition are set out below.

Decreasing revenues for private hospitals

10.2 MidCentral DHB has recently undertaken a number of internal restructuring initiatives that have allowed them to cope internally with their elective surgery requirements. As set out in their 2009/10 Annual Summary,[6] MidCentral DHB increased the number of elective procedures it performed in-house by 19% in 2009/10. We understand that this was achieved through a number of initiatives designed to remove blocks in their internal systems, which had previously hindered their ability to provide elective services:[7]

> Previously, MidCentral Health's internal systems had hindered its ability to provide contracted service levels and it had to outsource just over 10% of its work. During 2009/10 we systematically removed blocks in the system. A new Medical Assessment & Planning Unit was established, as was a Women's Surgical Unit. The location of beds was adjusted, reducing the spread of these throughout the hospital for medical staff and so freeing up their time for direct patient care. Pre-admission processes were also reviewed.

10.3 As a result, MidCentral DHB's capacity to provide elective services "grew almost overnight", and it delivered over 700 more elective discharges (5,109 total elective discharges) in 2009/10 than in 2008/09):[8]

> The benefit of these changes was many-fold. Beds were freed up for elective surgery, emergency department waiting times reduced, and the average length of stay for medical patients fell by over half a day (2009/10:5.15 days, 2008/09: 4.55 days). The changes also saw the end of theatre sessions being cancelled due to lack of beds. In 2008/09, 43 sessions were cancelled for this reason. MidCentral Health also achieved all five Elective Service Patient Flow Indicators (or ESPIs as they are known within the sector). These measure patient flow processes and we were unable to achieve them over 12 months ago.

10.4 MidCentral DHB intends to further increase elective throughput in 2010/11, delivering an additional 278 discharges. As discussed further in paragraphs 15.10 and 15.11 this has had a significant effect on the revenues of both SCHL Palmerston North and Aorangi. As a result of the extra capacity, MidCentral DHB has also indicated that they intend to tender for elective surgery with ACC:[9]

> [MidCentral DHB funding manager Mike Grant] said the DHB did not have elective services agreements with ACC, but was in talks to secure one. This would allow elective surgeries, such as hip replacements, to be carried out at Palmerston North Hospital, with ACC funding.

10.5 If the MidCentral DHB does commence tendering for ACC work, it will be actively competing for ACC funding with SCHL and Aorangi. However, it will do so in a declining

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[6] MidCentral District Health Board, *Annual Summary*, 2009/10, p4. Available online at: http://www.midcentraldhb.govt.nz/NR/rdonlyres/78AC03BC-0F87-463A-8754-7E9990468BC2/0/AnnualSummary2010Web.pdf.
[7] Ibid.
[8] Ibid.
[9] http://www.stuff.co.nz/manawatu-standard/news/5025089/Clampdown-hits-DHB-in-pocket.

market. As the Commission may be aware, the number of surgery requests accepted by ACC has dropped substantially in the last three years, with media reports suggesting that the number has dropped from 42,500 to 35,000 a year between 2008 and 2010.[10] MidCentral DHB's financial revenues from ACC fell by over 20% in the period June 2009/2010 (from $18,855,000 to $14,715,000).[11] This also has a direct effect on the revenues of private hospitals, as ACC often contracts directly with private hospitals for the provision of surgical services (see further at paragraph 15.12).

10.6 The landscape with regards to private health insurance has also changed significantly since the 2008 Application. The impact of the global financial crisis has caused some people to drop health insurance altogether, or reduce the extent of any health insurance. This has been exacerbated by the Government's stated policy to increase surgery output and reduce waiting times,[12] meaning that many people are choosing to use the public system rather than utilising an insurance policy that may require a co-payment. Health Minister Tony Ryall has stated that the Government's policy goal to increase the total number of operations nationally by 4000 each year has been exceeded significantly, and DHBs are now performing 20,000 more operations annually (this equates to 400 operations a week) than they were in 2008.[13] According to statistics from the Health Funds Association of New Zealand, there was a reduction of 17,400 people covered by comprehensive insurance policies in 2010.[14] Many of these will have reduced their coverage to the more limited elective surgical and specialist cover, evidenced by the increase of 7,200 people with such cover (leaving a net 10,200 decrease in lives covered over the year). While precise figures are unavailable, estimates from the Society suggest that they are currently observing in excess of [ ] net policy downgrades a month. If this is reflective of the industry as a whole, the current rate of downgrades for the industry would be significantly larger. The recent budget announcement will only serve to increase this trend with the Government announcing it will deliver an additional $2.2 billion boost to public health services over the next four years, with $68 million allocated to increase funding for elective surgery.[15]

10.7 Another consequence of the pressure on private health insurance is increased efforts by insurers to lower their costs, partially as a response to the increasing demand for procedures that have been made increasingly less invasive by developments in medical technology. The Society's Affiliated Provider Scheme is by far the largest in New Zealand and continues to grow. The scheme involves the Society contracting with lead providers (usually hospitals but also specialists) to provide a procedure at a total fixed price which is generally set at a national level. The insured is then encouraged to use affiliated providers, the financial benefit to the insured being a lower, or zero, co-payment. The benefit to the provider could be more volume, but the downside is a fixed price that can't be increased without approval from the Society.

10.8 The Affiliated Provider Scheme has been extended in recent years. Historically the scheme had been limited to new or high cost technology or procedures that could be

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[10] See NZ Herald, *The ACC files: Govt defends hardline over surgery cover*, 18 December 2010; NZ Herald, http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10695030; *Thousands miss out on surgery after ACC cuts*, 20 January 2011, http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10700804 ; and stuff.co.nz *ACC cuts surgery to thousands*, 20 January 2010, http://www.stuff.co.nz/national/health/4559543/ACC-cuts-surgery-to-thousands.

[11] Supra at footnote 4, p68.

[12] See Ministry of Health website for targets for increasing discharges for elective surgeries by 4,000 per year: http://www.moh.govt.nz/moh.nsf/indexmh/healthtargets-targets-electiveservices#w; and NZ Herald, *Faster Elective Surgery Promised,* 28 April 2011; NZ Herald, http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10722036

[13] See Beehive website for Heath Minister Tony Ryall's comments on increases in funding for elective surgeries in the 2011 Budget announcement: http://beehive.govt.nz/release/68m-more-elective-surgery-operations.

[14] Media Release, 31 January 2011, Health insurance drops 10,000 in 2010 - HFANZ. Available online at: http://www.healthfunds.org.nz/pdf/2010DecHealthInsuranceStatistics.pdf.

[15] See Beehive website for Heath Minister Tony Ryall's comments on increases in funding to boost public health services: http://beehive.govt.nz/release/22b-extra-boost-public-health-services.

deemed cosmetic in nature and where the Society was naturally trying to manage an uncertain financial risk. However, recently they have added several high volume procedures where they have observed significant price variation (ie differences in cost) across providers. While the Society currently has the most developed Affiliated Provider Scheme, the Applicants expect other insurers to become more active on this issue.

10.9 A number of insurers also have a "reasonable charges" policy. These are charges for healthcare services determined by the insurer. If the actual cost for supplying the services exceeds the reasonable charge, the policyholder is responsible for paying the balance of the cost, although in practice Aorangi and SCHL Palmerston North will rarely charge above reasonable cost.

The importance of quality

10.10 As the Commission has previously acknowledged,[16] 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 described in more detail in the 2008 Application (see paragraphs 9.15 - 9.25 of the 2008 Application attached as **Appendix C**), a key element of this choice is the quality and range of technology available. If a hospital does invest in technology that is particularly useful for a certain speciality, there is a good chance that it will obtain the majority of the specialists, and patients, in that speciality until such time as its rival can match that investment. This principle applies not just to facilities enabling new procedures, but also for technology that improves the safety and quality of existing procedures. Therefore, competition on technology available and the quality of facilities is a key element of competition.

10.11 For a number of reasons, the price of hospital facilities is a relatively minor consideration compared to the technology and quality of facilities available at a particular hospital. First, the overriding concern for both the specialist and the patient will be the patient's welfare, such that the best available treatment is likely to trump price considerations. Secondly, the price of the hospital facilities will only make up part of the overall cost of the procedure. Finally, treatments are often funded, whether in whole or in part, by someone other than the patient (eg ACC, private health insurance, or publicly funded).

10.12 As set out in the 2008 Application, this means that the acquisition of technology is a major feature of competition between hospitals. New technology increases the range of procedures available at a hospital and the safety of existing procedures, and thereby attracts surgeons and specialists. As discussed further below, the ability of SCHL Palmerston North and Aorangi to invest in new technology has been curtailed by their respective financial positions relative to other private hospitals within the wider region.

10.13 The quality of hospital services provided by both public and private hospitals in a particular region is also important, and public and private hospitals are increasingly interdependent on each other, particularly within less-populated regions. In the MidCentral DHB region, neither the public or private facilities have sufficient demand to employ all of their specialists full time, so MidCentral DHB therefore relies on high quality private hospitals in which these specialists can work for their remaining time, and vice versa. While some specialists will visit the hospitals in Palmerston North on a rota system, in addition to other hospitals in the wider region having specialists available in Palmerston North fulltime provides significant advantages over specialists visiting on an occasional basis. **Appendix D** shows the general flow of specialists into and out of the region, and between hospitals, in the last five years. The Appendix shows a general decline in the total number of specialists practicing in the region, although the decline in total numbers does not show the extent of the loss. Many new specialists have less local reputation and will require time to build a significant private practice. In addition, the Applicants have observed that many of the younger arrivals are showing a greater

[16] Decision 650, paragraph 20.

commitment to the public system, who are now paying significantly higher salaries. The Applicants note that the average age of the top ten earning surgeons for Aorangi is **[ ]**, and for Southern Cross, **[ ]**, meaning that attracting new surgeons to each hospital will be a significant issue in the near future.

11. Please highlight any relevant mergers that have occurred in this industry over the past three years.

11.1 As the Commission will be aware, there have been two acquisitions notified to the Commission in the last five years:

(a) the 2008 Application, which was declined by the Commission on 4 September 2008 (Decision 650); and

(b) the acquisition by SCHL of QE Hospital Limited, which was cleared by the Commission on 17 February 2005 (Decision 546).

11.2 The Applicants are not aware of any other acquisitions that have occurred in the past three years, although SCHL recently sold its shareholding in the Oxford Clinic in Christchurch and has been involved in the establishment of the new Ormiston Hospital in Auckland, Southern Endoscopy (a stand-alone single line service in Christchurch), and Auckland Radiation Oncology (a single service line, radiotherapy facility).

PART 3: MARKET DEFINITION

Horizontal Aggregation

12. For each area of aggregation of market shares, please define the relevant market(s).

12.1 The Acquisition will give rise to aggregation between the Applicants in respect of the provision of private hospital facilities. In Decision 650 the Commission found that the relevant markets were:

(a) The provision of private short-stay hospital facilities and related non-specialist services for elective secondary surgery in the MidCentral DHB region (the "**short-stay market**"); and

(b) The provision of private in-patient hospital facilities and related non-specialist services for elective secondary surgery in the MidCentral DHB region (the "**in-patient market**").

12.2 For the reasons set out in the 2008 Application, the Applicants consider that that relevant geographical market extends to include Masterton, Whanganui and Wellington, and possibility Napier/Hastings, or that significant competitive constraints are present from facilities in these locations. However, the Applicants have assessed the competitive affect of the Acquisition consistent with the markets identified by the Commission in Decision 650.

13. Where relevant, please explain how products or services are differentiated within the market(s).

13.1 Product differentiation in the market has not changed materially since the 2008 Application. Product differentiation can occur in a number of respects:

(a) by geographical location;

(b) by quality of facilities and level of service;

(c) by level of investment technology; and

(d) governance structure.

Vertical Integration

14. Provide details of any creation or strengthening of vertical integration that would result from the proposed merger. Please use organisational charts or diagrams to illustrate the structure of the ownership and/or control of the participants and the vertical relationships in question.

14.1 No vertical effects arise as a result of this merger. As set out in the 2008 Application, there is the potential for vertical disaggregation as a result of the merger, with the Aorangi shareholders having reduced control over JV Co than they currently have over the Aorangi hospital.

PART 4: COUNTERFACTUAL

15. In the event that the proposed merger does not take place, describe what is likely to happen to the business operations of the merger parties and the market/industry.

15.1 In Decision 650, the Commission found that there were two possible counterfactuals:

(a) that, due to the financial situation of its Palmerston North Hospital, SCHL would close its Palmerston North Hospital in the relevant period, and therefore would not remain as a competitor in the relevant markets for a period of at least two years ("**counterfactual one**").

(b) that Southern Cross Palmerston North would remain as a competitor in the relevant markets for at least two years ("**counterfactual two**").

15.2 Although SCHL Palmerston North has not closed since the 2008 Application, as set out below the significant financial losses, deferred investment and losses of key staff mean that there is little active competition between SCHL Palmerston North and Aorangi. The section below looks at the performance of SCHL Palmerston North in the period since Decision 650 and concludes that, even if SCHL Palmerston North remains as a competitor in the relevant market in the counterfactual, there will be little ongoing competition between SCHL Palmerston North and Aorangi.

Continued financial losses are unsustainable

15.3 As set out in the 2008 Application, SCHL Palmerston North operated at a financial loss for five of the seven years to June 2007. These losses have escalated since then. As the Commission was made aware shortly before Decision 650, SCHL Palmerston North

made a loss of [ ] in the financial year to June 2008. This was followed by further substantial losses of [ ] in the financial year to June 2009 and [ ] in the financial year to June 2010. In the 2011 financial year to date ten months to the end of April 2011, SCHL Palmerston North has made a loss of [ ]. [

]. Management accounts for SCHL Palmerston North for each of the financial years ended 2008-2010, and for the ten months to April 2011, are attached as **Appendix E**.

15.4 The figures in paragraph 15.3 above include the network services charge and depreciation as part of the profit/loss assessment. As the Commission will be aware, the network services charge is a contribution from the operating profit to the cost of SCHL's national office and other overheads. In Decision 650, the Commission deemed that only those head office costs that would be avoidable were relevant to an assessment of SCHL's operating profit. The Commission identified these avoidable costs as the salary of the general manager of SCHL Palmerston North, information systems costs and staff travel costs.

15.5 SCHL has attempted to estimate those aspects of the network charge that would be avoided upon the closure of SCHL Palmerston North, as specified by the Commission in Decision 650. These would include the salary of the General Manager [

], reduction in information systems costs (user licences, IT equipment and related support services) and travel costs. SCHL also believes that the reduction in general administration of SCHL as a result of the closure of SCHL Palmerston North would allow it to have one less employee in its head office (from a total staff of [ ]). Recalculating operating profit/loss to exclude non-avoidable network charges, Southern Cross would still be making losses in each of the three financial years since the 2008 Application with these losses reducing over time.

15.6 Finally, as noted in the 2008 Application, SCHL Palmerston North's losses set out above are likely to be artificially low, as [

]

15.7 The substantial losses over the last three financial years have prompted the SCHL Board to consider whether to continue operating SCHL Palmerston North. As detailed further below, the SCHL Board does not consider that the levels of losses described above are sustainable for the continued operation of SCHL Palmerston North. . [

].

Operating revenue has not improved

15.8 Patient numbers continue to fall at SCHL Palmerston North. Patient discharges in February 2011 numbered only [

]. The reasons for this significant drop are related to the industry developments described in section 10 above, and the effect of these changes on the Applicants is described below.

15.9 The drop in patient numbers is reflected in the theatre utilisation rates of the two hospitals. The current theatre lists for each of Aorangi and Southern Cross are attached

as **Appendix F**. Both hospitals operate substantially below capacity, illustrated by theatre utilisation rates:

(a) **Aorangi: [ ];**

(b) **SCHL Palmerston North: [ ]**[17].

15.10 *DHB funding:* At the time of the 2008 Application the Commission placed some emphasis on the MidCentral DHB announcement in June 2008 that it did not have the capacity to carry out all elective surgery for which it had funding, and that additional elective surgery valued at around $3.7 million could be contracted out in 2008/2009. The potential for increased revenue from obtaining a proportion of this funding was material to the Commission's counterfactual assessment, and indeed the Applicants were both hoping to obtain some of this funding. However, as noted at the time of the 2008 Application, this extra funding was a maximum amount only, and the DHB would only contract out the work to the extent that it did not have the capacity, despite the additional funding. In actual fact, the Applicants received no extra DHB funding as a result of this announcement.

15.11 In addition to the lack of revenue derived from MidCentral DHB contracted services in 2008/2009, MidCentral DHB advised SCHL Palmerston North that they would not be outsourcing any volumes in the 2009/2010 financial year. Aorangi has received no funding from MidCentral DHB since July 2009, and does not envisage obtaining any further funding in the foreseeable future. As set out in paragraph 10.2, restructuring and other initiatives undertaken by the MidCentral DHB have allowed them to cope internally with their elective surgery requirements over the last eighteen months. The scale of the increase in elective surgery undertaken by MidCentral DHB can be illustrated by comparing the increase in elective discharges (over 700), and total dischargers (5,109) at Mid Central DHB to SCHL Palmerston North's total patient numbers in the same period ([ ]). This reduction in revenue from contracted out services is likely to be a permanent change, resulting in no contracting out to the private sector in the future.[18]

15.12 *ACC Funding:* As a result of the recent tightening of ACC funding (see paragraph 10.5 above), Aorangi's funding budget for July 2010/2011 is [ ], compared to [ ] for the year ended July 2009/2010. After accounting for a [ ] increase in the level of individual ACC payments, the real decrease in budget is [ ]. Similarly, the budget for 2012 is [ ] and after taking into account that individual prices have been increased by [ ] this represents a reduction of [ ] in total budget. SCHL's revenues from ACC are [ ] less than budgeted for the seven months ending January 2011.

15.13 *Private insurance:* While it is too early to assess the financial impact, both Aorangi and SCHL have experienced a recent reduction in patients with private insurance cover (its largest funding stream) (see paragraph 10.6 above). In addition, the Society has recently expanded its Affiliated Provider Program. This, together with "reasonable charges" initiatives, has fixed the prices for a large number of procedures (see paragraphs 10.7-10.8 and 23.1(a)). Aorangi predicts that this will reduce their net profit before tax by [ ] for 2011, and in future years, and that more fixed price procedures are likely to be introduced in the future, further reducing profit.

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[17] SCHL Palmerston North figures are based on the year to June, and calculated based on billed utilisation ie. chargeable to a patient.

[18] This has been exacerbated by the Government's recent budget increases. Health Minister Tony Ryall estimated that total number of DHB discharges will increase from 118,000 in 2008 to an expected 142,000 in 2011/2012: http://beehive.govt.nz/release/68m-more-elective-surgery-operations.

Staff and capital investment

15.14 In Decision 650 the Commission observed that SCHL had undertaken a range of initiatives to generate new business and increase the profile of the hospital. As set out above, this capital investment has failed to improve the revenue of SCHL Palmerston North. No substantive infrastructure investment has occurred at SCHL Palmerston North since the 2008 Application. For the financial years from 2009 - 2011 (to date), [

]
Purchases of new equipment have also been delayed. As an example, SCHL Palmerston North has [

]. In addition to the obvious reduction in the quality of SCHL's facilities, these deferred purchases have other drawbacks. [

].

15.15 Aorangi has also undertaken no substantive infrastructure investment since the 2008 Acquisition. [

]. This is likely to continue while SCHL Palmerston North remains in the market.

15.16 In addition to the lack of capital investment, the decline in revenue has required further aggressive cost cutting measures by SCHL Palmerston North. SCHL Palmerston North has made the equivalent of approximately five full time employees redundant, saving approximately [ ]. Several key staff have left ([
]).[19] SCHL believes that the reason for those departing is the continued uncertainty regarding the future of SCHL Palmerston North. [

]. This has significant short and medium term consequences. First, as the Commission will be aware, specialists drive the demand for hospital facilities, and specialists value the quality of a hospital facility as much, if not more, than the price of the facility. Therefore, any perceived drop in hospital quality will make the hospital less attractive to them. Secondly, the lack of up to date technology at even one hospital in Palmerston North affects the ability of the region to attract surgeons and specialists, as specialists will often work across the different hospitals (both public and private) in a region.

15.17 The need to attract medical specialists is particularly pertinent to Aorangi. As discussed in paragraphs 5.5 and 5.4 above, Aorangi is owned by a group of medical specialists. The ownership model relies on Aorangi replacing departing shareholders with specialists who wish to become part of the Aorangi ownership structure. [

]. However, these are likely to be difficult to replace, reflecting both the lack of profitability at Aorangi and the lack of adequate facilities (at both Aorangi and SCHL Palmerston North) to attract specialists to the region. Actual

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[19] [
].

examples of Aorangi shareholders departing (or seeking to depart) are attached in **Appendix H**.

Recent price increases and projections for future SCHL Palmerston North revenue

15.18 Consistent with the Commission's recommendation in Decision 650, SCHL Palmerston North has raised the price for its facilities. These price increases took effect on 1 July 2010, and are listed in **Appendix I**, current fees for each of Southern Cross and Aorangi are included in **Appendix I** and **Appendix J**. **[**

]. In addition, such price increases do not sit comfortably with SCHL's mission, as a charitable trust, to achieve the best possible health outcomes rather than maximise profits.

Possible sale of the SCHL Palmerston North facilities.

15.19 In the 2008 Application (at paragraph 6.3) it was noted that for some time SCHL has recorded an "alternative use" valuation for its Palmerston North hospital land and building. This reflected the fact that SCHL is likely to be able to provide greater benefits to its beneficiaries from selling the assets at market rates to, for example, the neighbouring Metlifecare retirement village or the Mid-Central DHB, allowing Aorangi to continue to provide private hospital services in Palmerston North, and investing the proceeds elsewhere.

15.20 The Palmerston North hospital land and buildings continue to be valued on an alternative use valuation. Since the 2008 Application, SCHL has also taken further steps to make the land more attractive to purchasers. **[**

].

Board documents

15.21 The continued financial problems faced by SCHL Palmerston North have been the subject of substantial discussion by SCHL at senior management level. The relevant Board extracts are attached in **Appendix K**. They record SCHL's concerns regarding:

(a) Insufficient patient volumes and a general decline in revenues:

[

]

[

]

[

]

(b) an increasing concern for the unsustainability of the losses at, and the viability of, SCHL Palmerston North. [
]:

[

]

[

]

(c) reductions in full time staff through resignations and redundancies and attempts at aggressive cost management ([
]).

15.22 The CEO Commentaries, also attached in **Appendix K** reflect similar sentiments:

[

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[

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[

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[

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[

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[

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Counterfactual - conclusion

15.23 Consistent with Decision 650, the Applicants consider that the exit of SCHL from Palmerston North is a likely counterfactual. Although SCHL Palmerston North has not exited the market since the 2008 Application, the potential for SCHL Palmerston North

to remain as a viable competitor in Palmerston North is considerably less likely than it was in 2008.

15.24 SCHL believes that the only commercially viable option for SCHL Palmerston North absent the Acquisition is exit from the market[

]. Notwithstanding these points, the Applicants are content for the Commission to assess the Acquisition on the basis that counterfactual two is a relevant likely counterfactual for the purposes of the competition assessment.

15.25 Any review of the merger on the basis of counterfactual two must, however, incorporate the following features of the relevant markets which the Applicants believe are crucial to the competitive assessment:

(a) while price may be a factor in choosing between hospitals with similar facilities, the most powerful method of increasing revenue at private hospitals is investing in new technology to allow a wider range of services to be provided;

(b) as set out in paragraph 15.14 above, the financial position of each of the Applicants restricts their ability to invest in new equipment for their respective hospital facilities. Given the revenue projections of the Applicants, and the focus on aggressive cost cutting, this lack of dynamic competition is likely to remain while both of the Applicants remain in Palmerston North.

(c) the Applicants' recent lack of investment mean their respective facilities and technology are not at a standard commensurate with similarly sized towns with only one private hospital. This situation is unlikely to change while there are two private hospitals in Palmerston North; and

(d) the decline in patient numbers and private hospital revenues in Palmerston North means that there is significant over-capacity at both SCHL Palmerston North and Aorangi, and the similar facilities at the two hospitals mean that there is significant duplication of costs between the two hospitals.

PART 5: COMPETITION ANALYSIS

EXISTING COMPETITORS

16. Identify all of the relevant competitors in the market(s), including near competitors and importers in the market(s), and describe how they all compete in the market(s).

16.1 Table 4 of the 2008 Application set out a list of private hospitals offering short-stay/day-stay and/or in-patient facilities in the Lower North Island. This table is repeated below as Table B, amended to show the changes to competitors since the 2008 Application.

Table B: Other existing day stay/in-patient private hospitals in Lower North Island

Name of Hospital	Operator	Location	Day stay?	In-patient?	Number of theatres	Road dist from Palm Nth (km)	Appx drive time (mins)
Wakefield Hospital	Wakefield Health Ltd	Florence Street, Newtown, WELLINGTON	Yes	Yes	Six; infrastructure in place for seventh.	145	104
Bowen Hospital	Wakefield Health Ltd	94 Churchill Drive, Crofton Downs, WELLINGTON	Yes	Yes	Three	139	102
Boulcott Hospital	Boulcott Clinic Limited	High Street, LOWER HUTT	Yes	Yes	Three, plus two more planned.	138	110
Selina Sutherland Hospital	The Selina Sutherland Trust	Te Ore Ore Road, MASTERTON	Yes	Yes	Masterton Hospital has three theatres, which Selena Sutherland can use when not otherwise in use.	91.3	70
Royston Hospital	Wakefield Health Ltd	500 Southland Road, Southland, HASTINGS	Yes	Yes	Three	157	117
Belverdale Private Surgical Hospital	Owned by 6 family trusts and 2 individuals	5 Campbell Street, WANGANUI	Yes	Yes	One	74.5	55
Dannevirke Community Hospital	Community trust	Barraud Street, DANNEVIRKE	Yes	Yes	Nil theatres, procedure rooms unknown	54.1	41
The Palms + Caci Clinic	Owned by 2 family trusts and 3 individuals	445 Ferguson St, PALMERSTON NORTH	Yes, for minor procedures	No	Capable of easy upgrade to two theatres	0	0
Southern Cross Wellington	SCHL	Hanson St, Newtown, WELLINGTON	Yes	Yes	Four, with one more planned.	127	104
Parkside Hospital	Dr Gornoori and Mary Krishnayya	522 Kennedy Road NAPIER	Unlikely to present a constraint.			171	140
Broadway Surgery	Mr Murdoch, Mr Leung, Mr Broadbent	Broadway Ave, PALMERSTON NORTH	Yes	No	Procedure rooms, one of which is equipped for possible general anaesthesia	0	0

16.2 The 2008 Application sets out how the competitors in Table B compete (see sections 10.9 to 10.13 of the 2008 Application):

> *In-patient market*
>
> 10.10 In the in-patient market, there are currently four private hospitals in the 75km area, each with separate operators. In both the factual post-acquisition, and the counter-factual, this will drop to three. As a result, there will be no aggregation in this market relative to the counterfactual.

10.11 If the market is as broad as the Lower North Island, there are currently eleven private hospitals in this market, operating under eight operators. In the counterfactual, there will be ten hospitals, operating under seven operators. However, in the factual, post-acquisition, there will also be ten hospitals, also operating under seven operators.

Short-stay / day-stay market

10.12 In the status quo, there are five private hospitals in the 75 km area providing short-stay / day-stay facilities. Post-acquisition, there will be four. However, in the counterfactual, there will also likely be four.

10.13 If the short-stay / day-stay market is as broad as the Lower North Island, the total number of facilities will shrink from twelve (with eight operators) to eleven (with seven operators) in both the factual and counterfactual.

16.3 Since the 2008 Application there has been significant expansion of services in the Wellington region. Boulcott Hospital has recently completed an expansion of its facilities to include a new Specialist Centre.[20] This facility will accommodate consultants in the areas of orthopaedics, plastics and reconstructive surgery, gynaecology/obstetrics, ENT, head and neck surgery, general surgery, rheumatology and gastroenterology. The Specialist Centre also caters for visiting specialists in the areas of urology, ophthalmology, paediatric surgery, vascular surgery and cardiology.

16.4 Bowen Hospital in Wellington has recently completed the first phase of a redevelopment, involving new radiology, endoscopy and consulting facilities,[21] additional parking and a new service block for the hospital. The second phase of the redevelopment will involve the construction of a new theatre, recovery unit, sterilising department and admissions facility.

16.5 SCHL has also recently expanded its Southern Cross Wellington hospital, creating an addition theatre, and one more theatre is planned.

16.6 Broadway Surgery improved its facilities around 2008, although essentially the same services are provided at the surgery. The complex has procedure rooms and general anaesthesia is done by one of the resident surgeons. Broadway Surgery's primarily carries out dental extractions and orthodontics.

17. To what extent do you consider that the merged entity would be constrained in its actions by the conduct of existing competitors in the markets affected?

17.1 The identity of existing competitors in the relevant markets, and the competitive dynamics, have not changed significantly since the 2008 Application. However, the Applicants set out below some observations on likely constraints on JV Co following the Acquisition.

Competition for the provision of short-stay/day-stay facilities and its relationship with the provision of in-patient market facilities

17.2 The nature of short-stay/day-stay facilities is such that there is both more existing competition for the provision of these facilities, and entry and expansion is relatively easy. This is reflected by the presence of The Palms, which offers consulting rooms and a broad range of procedures that could be performed at SCHL Palmerston North or Aorangi, some of which would have required an overnight stay. Consulting facilities

[20] www.boulcotthospital.co.nz/gpnews/building-developments/
[21] www.bowen.co.nz/about-us/news/221-contract-for-phase-2-of-the-redevelopment-of-bowen-hospital

which extend to the provision of minor procedures can be added quickly and at low cost to existing facilities. As set out above, Broadway Surgery, has recently improved its services, and offers a number of procedures currently offered by the Applicants. This provides an example of how relatively complex dental extractions can be performed at relatively lower cost consulting facilities.

17.3 The Palms and Broadway Surgery are examples of an increasing trend towards specialised clinics for day-stay procedures. Other examples nationwide include Rotorua Eye Clinic, a private Ophthalmology clinic in Rotorua, Bridgewater Hamilton Eye Clinic, Hamilton's Angelsea Procedure Centre, Endoscopy Auckland and Auckland Eye. All of these facilities are examples of private clinics, generally set up by specialists as an alternative to undertaking these procedures at private hospital facilities. Palmerston North is particularly amenable to such competition, as the average age of its surgeons (see paragraph 10.13) suggests that it will need to rely on the arrival of new specialists in the region, who do have not ties to either SCHL or Aorangi, and as such are more likely to set up new facilities.

17.4 As suggested by the above examples, endoscopy and ophthalmology are two categories of procedure that are capable of being performed by specialist operators in small clinics (as opposed to large private facilities). Similarly, oral and maxillofacial procedures, as illustrated by the development of Broadway Surgery, and ear, nose and throat procedures are also susceptible to competition from specialist providers. The relative simplicity of many of the procedures and the nature of the equipment required to complete these procedures, make them obvious targets for specialist clinics.

17.5 The importance of the constraint provided by The Palms and Broadway Surgery, and the potential for further losses of day stay procedures to specialist clinics, is illustrated by the Applicants' reliance on these procedures for revenue. **Appendix L** sets out the number of procedures for each speciality undertaken by each of Aorangi and Southern Cross. Around **[ ]** of Southern Cross Palmerston North and Aorangi's day-stay patients involve endoscopy, ophthalmology, oral and maxillofacial or ear, nose and throat procedures. This is a relatively high proportion and reflects the relatively low level of investment at Southern Cross Palmerston North and Aorangi, which has prevented them from carrying out a broader range of procedures.

17.6 Despite being separate markets, there remains a relationship between competition for short-stay/day-stay facilities and for in-patient facilities. Both facilities are used by specialists, who typically have the biggest role in the choice of hospital facility. Because a specialist may be inclined to use the one hospital for both short-stay/day-stay and in-patient facilities, competition for the provision of in-patient facilities is a function of competition for short-stay/day-stay facilities. As an example, the Commission will be aware from the 2008 Application that Southern Cross Palmerston North added a number of consulting rooms in 2007, and has promoted these at subsidised prices to encourage surgeons to operate in their theatres. Southern Cross Palmerston North has continued with this initiative, although as illustrated above it has not coincided with an increase in the facilities revenues.

Developments in the wider region

17.7 Developments in the wider region are related to the issue of technology as a competitive feature in the market. As set out in section 12 of this Application, the Applicants do not intend to revisit the Commission's conclusions on geographical market definition in Decision 650. However, SCHL Palmerston North continues to view the drift of patients to the Wellington region as its biggest concern, given the increasing number of surgeons in the Wellington region and the increasing gulf in technology. As set out in paragraphs 16.3 and 16.4, both Bowen and Boulcott Hospitals have made significant improvements to their facilities recently.

17.8 Hospitals in the wider Wellington region provide procedures that are not available in Palmerston North, including intensive care or high dependency units, cath labs for non invasive surgery (cardiology and vascular), brachytherapy and lasers (for prostate cancer), equipment for complex eye surgery and complex spinal equipment. Notwithstanding the Commission's view on the geographic market in Decision 650, if the gulf in quality between Palmerston North hospitals and other hospitals in the region continues to grow, surgeons and patients will increasingly look at options outside the Palmerton North area.

POTENTIAL COMPETITION

Conditions of Entry

18. Please explain the requirements for new entry and/or importers in the relevant market(s).

There is no possibility of imports competing in the relevant markets. In the 2008 Application we concluded that, due to surplus capacity "greenfields" entry is considered unlikely in the near future in relation to either the in-patient or short-stay/day-stay markets. However, the possibility of niche entry and expansion in the short-stay/day-stay market is discussed in response to question 17 above.

19. Include a full discussion on any factors that could impede entry; and what might prompt new entry post-merger.

No new factors have arisen since the 2008 Application

LIKELIHOOD, EXTENT AND TIMELINESS OF ENTRY (THE LET TEST)

20. Please name any likely businesses (including overseas businesses) you are aware of that do not currently supply the market but which you consider could supply each of the relevant market(s). Discuss the likelihood of such entry.

While the Commission found in Decision 650 that expansion by other competitors in the relevant markets would be unlikely to provide competition that could constrain JV Co in the factual, the Applicants continue to believe that expansion may be possible by an existing specialist clinic or by the MidCentral DHB allowing the use of its facilities by private hospitals, particularly in relation to in relation short-stay/day-stay patients. The establishment of The Palms and Broadway Surgery in Palmerston North illustrate that establishing a specialist clinic is relatively easy.

21. To what extent do you consider that potential entry would be sufficient to constrain the merged entity in the markets affected?

As set out in response to question 17, SCHL Palmerston North and Aorangi rely to a significant extent on short-stay/day-stay procedures, and this will continue to be the case for JV Co, although as set out below the Applicants hope to diversify their offering as a result of the Acquisition. The potential for a specialist or group of specialists providing one of these procedures (eg endoscopy, ophthalmology, oral and maxillofacial or otolaryngology), particularly specialists that would, absent entry, practice at JV Co, would also be sufficient to constrain the merged entity in respect of the procedures they offer.

22. How long would you expect it to take for entry to occur, and for market supply to increase, in respect of each of the potential entrants named in question 21 above?

22.1 The speed at which entry will occur will depend to some extent on the type of procedure being undertaken. However, should a specialist or group of specialists wish to set up a specialist clinic of the type discussed above, entry would be comfortably within the two year time frame set out in the Commission's merger guidelines.[22]

COUNTERVAILING POWER OF BUYERS

23. To what extent do you consider that the merged entity would be constrained in its actions by the conduct of buyers in the markets affected?

23.1 In Decision 650, the Commission concluded that major purchasers were unlikely to provide a competitive constraint on JV Co in the factual. However, the Applicants continue to consider that the strength of the DHB, ACC, and private health insurers is relevant to the competitive assessment, and that private hospitals have limited ability to dictate price for a large proportion of their services. The following factors are relevant in this regard:

(a) The Applicants have little negotiating power in relation to ACC and DHB contracts. Options available to Mid Central DHB in response to an attempted price rise include carrying out the procedures at their own facilities, by either delaying those procedures that are not time-sensitive and/or expanding their existing capacity. The ability of Mid Central DHB to undertake further procedures in-house has been aptly illustrated by their recent expansion.

(b) Similar to health insurers, ACC also prices its procedures on a national basis, generally on a 'take it or leave it' basis. In addition to an ability to penalise SCHL in other regions for any price increases by JV Co, ACC could also move procedures to private providers outside the Mid Central DHB region. In addition, while it does not currently contract with Mid Central DHB, MidCentral has indicated that it intends to tender to ACC for elective surgery (see paragraph 10.4 above). MidCentral DHB will therefore act as a constraint on the Applicants in respect of ACC funded surgery, and ACC will be able to trade off between the DHB and JV Co in the factual, particularly given the recent increase in capacity at Palmerston North Hospital.

(c) As discussed in paragraph 10.7, the Society has attempted to keep claims inflation down through the Affiliated Provider Scheme, and insurers have introduced "reasonable charge" schemes, contracting with hospitals to agree prices for certain procedures, a practice which has increased since the 2008 Application. The insured is then encouraged to use affiliated providers, the benefit being a lower, or zero, co-payment. These maximums are an attempt to standardise costs for procedures nationwide, and JV Co will not have any increased ability to negotiate increases to these charges in Palmerston North.

(d) While the maximum charges applied by insurers may not stop JV Co from charging above the maximum price to customers for some procedures, who are then required to pay the difference themselves, requiring patients to 'top up' their insurers payment will simply mean that patients will consider obtaining surgery out of town, through the public system (see paragraph 10.6) or simply delay the procedure.

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[22] Commerce Commission, *Mergers and Acquisitions Guidelines*, section 6.3.

(e) While the Commission stated in Decision 650 that major purchasers would have no option but to accept price increases from JV Co, given its monopoly status, this does not recognise that insurers can penalise SCHL for such price increases in other regions where the insurer has a choice of health care provider. It also ignores the fact that some procedures are contestable by existing providers in Palmerston North (The Palms and Broadway Surgery) and the possibility of the type of niche entry described in response to question 17 above.

23.2 **Appendix L** provides a breakdown of patient numbers for each of Aorangi and Southern Cross, based on the source of income for each patient (ie DHB, ACC, private insurer, self funded). SCHL estimates that approximately [ ] of SCHL's revenue is currently under some form of fixed price arrangement, requiring considerable negotiation to change. This includes Affiliated Provider Schemes and ACC and DHB procedures, which are typically offered on a "take it or leave it" basis. [

]. Of this Aorangi estimates that around [ ] of it health insurance revenue is subject to fixed price contracts (as well as its ACC and, historically, its DHB revenues).

PART 6: OTHER FACTORS

24. Where relevant, provide a description of any other features of the market(s) that should be taken into account in considering the effect of the proposed acquisition.

25. Please provide a copy of the most recent annual report for each of the merger parties. If an annual report is not available, please provide a copy of the audited financial statements of the merger parties (profit and loss account, showing total turnover and profit before tax, and balance sheet). If the acquisition only relates to a segment of the business of the merger parties, please also provide a copy of any management accounts for the relevant business segment.

25.1 See **Appendix M** and **Appendix N**.

PART 7: PUBLIC BENEFITS AND DETRIMENTS

26. With reference to the Notes to this form (at Appendix 1), please provide evidence to support the public benefits you are claiming, both qualitatively and quantitatively.

26.1 The Acquisition will result in such benefits to the public that it should be permitted by the Commission. A detailed analysis of these benefits is set out in the NERA report, attached as **Appendix O**, and are summarised below.

26.2 As the Commission provides in *Cavalier Wool/New Zealand Wool Services* draft determination[23] (***"Wool Draft Determination"***) the authorisation procedure requires the Commission to identify and weigh the detriments likely to flow from the acquisition and to balance those against the identified and weighed public benefits likely to flow from the

[23] Commerce Commission Draft Determination, *Cavalier Wool Holdings Limited and New Zealand Wool Services International Limited* 13 April 2011.

acquisition as a whole. The assessment is not made on a market-by-market basis[24], nor do the benefits need to arise in the market or markets affected by the Acquisition.

Cost savings

26.3 The most readily quantifiable benefits that will arise as a result of the Acquisition are the significant cost savings from the two hospitals operating as one. These are described in the NERA report and include [

] Similar cost savings have been recognised on a number of occasions as a public benefit in the context of collective negotiation agreements authorised by the ACCC.[25] None of these cost savings would be achieved in the absence of the Acquisition.

26.4 [

].

26.5 [

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Increased investment

26.6 The primary rationale for the Acquisition is the desire to ensure investment in a quality private hospital facility in Palmerston North. As set out in paragraphs 15.14 - 15.17 and further discussed in the NERA report, no substantive infrastructure investment has occurred at SCHL Palmerston North or Aorangi since the 2008 Application. In fact, the decline in revenue at both hospitals has required cost cutting measures, which has meant that investment which would ordinarily be undertaken has been deferred.

26.7 This lack of investment means that neither SCHL Palmerston North nor Aorangi has been able to operate to the standard of comparable private hospitals in New Zealand. It means that the private hospital facilities available to consumers in Palmerston North are generally below those available in other similarly populated regions in New Zealand, which benefit from facilities such as a High Dependency Unit ("**HDU**"), an Intensive Care Unit ("**ICU**"), high tech imaging and/or high tech theatres. The NERA report shows that similar investments have been made in regions of a similar size to Palmerston North and which have only one private hospital.

26.8 The Acquisition will increase both the ability and incentive of the Applicants to invest in facilities, allowing for a broader range and better quality of services. The ability of the

[24] In other words, it is not necessary to show that the competitive detriment in each market is outweighed by benefits that arise in that particular market.

[25] See, for example, ACCC Decision C2008/1289, *St Vincent's Health Australia Limited* 29 January 2009 and ACCC Decision C2000/24, *Inter-Hospital Agreement involving the Alwyn Rehabilitation Hospital, Wolper Jewish Hospital, Hornsby Day Surgery Centre and others* 15 August 2001.

Applicants to invest will be increased by the creation of a single profitable hospital with better access to investment resources. The incentive to invest will arise from the removal of the current investment inertia in the MidCentral DHB region, characterised by the game theory analysis in section 5.2 of the NERA report.

26.9 The ACCC has previously recognised that efficient private hospitals, with an incentive to invest, provide direct and indirect benefits to the communities in which they operate, including:[26]

- The choice and convenience provided to local patients;
- Employment opportunities for medical, nursing and support staff;
- The provision of infrastructure necessary to attract specialists; and
- Other wiser regional benefits such as purchasing local services In general terms, the Commission considers that if suppliers

26.10 The size of the benefit arising from the increase in investment in the region is difficult to quantify, although the benefits of, for example, HDU or ICU facilities are likely to be significant. An HDU facility is likely to be the most important immediate investment, both in terms of growth and safety of existing patients, although the Applicants expect that the HDU will be supplemented by a number of other pieces of new technology which are currently being requested by specialists, such as digital/high tech theatres and digital imaging, and general improvements to existing technology.

26.11 HDUs provide for patients who need more intensive observation, treatment and nursing care than is possible in a general ward. HDU are generally associated with fewer cardio respiratory complications, and shorter hospital stays, than non-HDU hospitals.

26.12 The benefits of such a facility (or an ICU, which provides an even greater standard of care than an HDU) are threefold:

(a) it will increase the quality of existing procedures, as patients will benefit from access to the greater level of care provided by an HDU. Currently, patients that require HDU care are transferred from Aorangi to Palmerston North Hospital. While actual numbers of patients transferred are fairly low ([ ]), this reflects the fact that the HDU prevents Aorangi and Southern Cross from operating on patients who may require the use of an HDU (see further at (b) below). It is also likely that a number of patients who suffer complications that were not sufficiently serious to require them to be transferred to Palmerston North hospital would nonetheless benefit from the existence of an on-site HDU;

(b) it will allow the Applicants to provide procedures to a wider range of patients. For a variety of reasons (for example, insulin dependence, obesity, and age) some patients are more high risk than others. Many of these high-risk patients will require post-operative care in an HDU due to the greater risk of complications following a procedure. While Aorangi currently does undertake some procedures for these high-risk patients, an HDU would allow it to undertake a far greater number,

(c) it will broaden the range of procedures that can be provided in Palmerston North, meaning that fewer patients will have to travel outside of Palmerston North for these procedures. While it will take a period of time to alter the case-mix at the hospital, and to recruit new specialists in respect of some procedures, a number of more complex procedures will be able to be performed as a result of the introduction of an HDU. These include bariatric (or weight loss) surgery, upper

[26] ACCC Decision A30203, *Inter-Hospital Agreement involving the Alwyn Rehabilitation Hospital, Wolper Jewish Hospital, Hornsby Day Surgery Centre and others* 15 August 2001.

GI (gastrointestinal) surgeries, major bowel surgery, complex end of major joint surgery (particularly revisions), complex spine surgery, advanced urological such as cystectomies and nephrectomies, major cancer reconstructions such as neck dissections, complex vascular procedures (such as stents and grafts), and complex plastics such as extensive abdominoplasty.

26.13 The benefits of an HDU are illustrated in the SCHL's guideline for its North Harbour Intermediate Care Facility (SCHL's most recent HDU addition). The facility is described in SCHL's guidelines for the facility as designed to care for:

- *Firstly* Patients who require close monitoring of their physiologic parameters post-operatively. For pre-existing pathophysiology, or after prolonged, but uneventful surgery
- *Secondly* Patients who have undergone surgery where it is expected they might have complicated fluid balance issues, frequent medication requirements, and require close monitoring of overall organ function
- *Thirdly* Patients requiring support of a single organ failure, who are not subject to any other declination criterion

26.14 In addition to the obvious benefits for patients, the Acquisition will also have benefits for the wider Palmerston North region. As set out in paragraph 10.13, medical specialists will be attracted to a region by the overall quality of private hospitals in the particular region. While Palmerston North Hospital is a leading public hospital, the standard of SCHL Palmerston North and Aorangi relative to private hospitals in similar sized regions has been a barrier to attracting specialists to the region. As discussed above, both SCHL and Aorangi have had difficulties finding and retaining staff and specialists for their respective hospitals. The increased investment resulting from the Acquisition will therefore attract senior staff and medical specialists to the region, and give those specialists already in Palmerston North the opportunity to broaden their existing practice. As set out in paragraph 15.17, Aorangi's ownership model also relies on attracting specialists to make a commitment to the region by investing in the Aorangi business.

26.15 [

].

However, a larger hospital with better technology would over time attract new specialists who would want to expand the surgical offering with new or advanced surgical techniques. The development of Grace Hospital in Tauranga, and the expansion of clinical services at the new hospital facility since it was built, is a good practical illustration of these points.

27. With reference to the Notes to this form (at Appendix 1), please provide evidence of any detriments that may result from the proposed acquisition, both qualitatively and quantitatively.

27.1 As with the public benefits, a detailed analysis of the extent of these detriments is set out in the NERA report, attached as **Appendix O**. However, the findings in the report are summarised below.

Allocative inefficiency

27.2 Allocative inefficiency manifests itself in the ability of the merger to set prices above competitive levels.

27.3 As set out in the NERA report, there are a number of factors which mitigate against the possibility of price increases (and accordingly allocative inefficiency) as a result of the

Acquisition, many of which have been discussed in sections 15, 17 and 23 of the Application. They include:

(a) competition in the day-stay market;

(b) the countervailing buyer power of insurance providers and ACC;

(c) the increasing capacity of MidCentral DHB to carry out elective surgery at its own facility;

(d) the threat of entry by new specialists to the region, or specialists currently working with SCHL Palmerston North or Aorangi setting up their own specialists clinics; and

(e) the non-profit nature of SCHL.

27.4 Given the above factors, the Applicants consider that there will be little ability or incentive to raise prices as a result of the Acquisition.

Productive inefficiency

27.5 Productive inefficiency measures the extent to which a business's costs are above the minimum necessary to produce a given output. As noted in the *Wool Draft Determination*, the weight that can be given to productive efficiency concerns arising from a merger is quite speculative. The Applicants do not believe that the Acquisition will lessen incentives to minimise costs.

27.6 In the *Wool Draft Determination*, one factor cited by the Commission as reducing productive inefficiency, a declining market, applies equally to the provision of private hospital facilities in Palmerston North. As Figure 2.1 of the NERA report illustrates, Aorangi and SCHL Palmerston have both been experiencing a decline in patient numbers since the 2008 Application, which has required them to take a number of measures to keep costs at a minimum (see the examples in paragraphs 15.14 - 15.17). This pressure to reduce costs is likely to continue following the Acquisition.

27.7 Assuming that productive inefficiencies will arise as a result of the Acquisition also ignores the nature of private hospital facilities. This requires the purchase of a substantial volume of equipment that is not generally fully utilised, but which is required to maintain the standards and quality of care required of a private hospital facility (for example, a back-up instrument washer). The merger will eliminate the duplication of such equipment, the net result being that private hospital services in the MidCentral DHB area would be provided using fewer resources in the factual than the counterfactual.

27.8 Finally, despite the reduction in the number of private hospital facilities arising as a result of the merger, as noted in paragraph 27.2 above the Applicants will continue to be constrained by a number of factors post-Acquisition. As such, they will continue to have an incentive to minimise costs.

Dynamic inefficiency

27.9 Dynamic inefficiencies arise in the merger context when the merged entity has less incentive to innovate than it might absent the merger. However, the Acquisition is likely to increase, rather than decrease, the level of innovative in the provision of private hospital facilities in Palmerston North.

27.10 As set out in 15.25(b), and discussed in more detail in section 2.3 of the NERA Report, neither Aorangi or SCHL Palmerston North currently have the ability or incentive to

innovate, due to the relatively small population base and declining patient numbers in Palmerston North and the likely reaction of the other party to any investment decision. What little innovation has taken place recently (for example, the offer of consulting rooms) has been unsuccessful, merely reinforcing the current inertia of the Aorangi and SCHL Palmerston North. As a result, SCHL Palmerston North and Aorangi lack many of the facilities available at private hospitals in similarly sized New Zealand regions. This will continue to be the case in the absence of the merger.

PART 8: IDENTIFICATION OF INTERESTED PARTIES

28. Please provide the contact details of likely interested parties, such as customers and suppliers, and any other relevant market participants, in the form of the example table shown below:

	Name of company	Contact details	Relevant contact person
Competitors	**Wakefield Health Ltd** Owns Wakefield Hospital	Florence Street, Newtown, WELLINGTON	Andrew Blair CEO 04-3818100
	Owns Bowen Hospital	94 Churchill Drive, Crofton Downs, WELLINGTON	Andrew Blair CEO 04-3818100
	Owns Royston Hospital	500 Southland Road, Southland, HASTINGS	Andrew Blair CEO 04-3818100
	Boulcott Hospital Owned by Boulcott Clinic Limited	High Street, LOWER HUTT	Richard Grenfell CEO 04-5761703
	Selina Sutherland Hospital Owned by The Selina Sutherland Trust	Te Ore Ore Road, MASTERTON	Lesley O'Hara Nurse Manager 06-3770277
	Belverdale Private Surgical Hospital Owned by 6 family trusts and 2 individuals	5 Campbell Street, WANGANUI	Bronwen Butchart Hospital Manager 06-3481182
	Dannevirke Community Hospital Owned by Community trust www.midcentraldhb.govt.nz/Patients Visitors/DannevirkeCommunityHospital/	Barraud Street, DANNEVIRKE	Chrissy Sheed Hospital Manager 06-374 5691
	The Palms + Caci Clinic Owned by 2 family trusts and 3 individuals www.radiusmedical.co.nz/The-Palms-Medical-Centre/	445 Ferguson St, PALMERSTON NORTH	The Palms – Tel: 06-354 7737 Dr Ralph Saxe – 027 249 5219 Caci Clinic – 06-357 9408 Christine Crawshaw - manager
	Parkside Hospital Owned by Dr Gornoori and Mary Krishnayya	522 Kennedy Road NAPIER	Hospital has closed
	Broadway Surgery Owned by Mr Murdoch, Mr Leung, Mr Broadbent	266 Broadway Ave, PALMERSTON NORTH	Mr Murdoch Tel: 06-359 0242 Mobile: 027 443 3150
Customers	**Southern Cross Medical Care Society**	Level 1. Ernst Young Building Cnr Galway and Gore Auckland CBD	Peter Tyan Chief Executive 09-9256926

Other	**The Players Company Limited** Owned by 2 companies and 18 individuals	220 Broadway Avenue, PALMERSTON NORTH	Mr Gerald Haddon Tel: 06-355 4890
	Accident Compensation Corporation (ACC) http://www.acc.co.nz/	165 Broadway Avenue PALMERSTON NORTH	Jackey Marriott Programme Manager Elective Services 04-9187615
	MidCentral District Health Board http://www.midcentraldhb.govt.nz	Gate 2 Heretaunga Street PO Box 2056 PALMERSTON NORTH	Murray Georgel – CEO Tel: 06-356 9169 Email: murray.georgel@midcentraldhb.govt.nz
	Grace Hospital Tauranga	281 Cheyne Rd Oropi Tauranga	Michael Ludbrook Managing Director 07-5115280 021-2408989

PART 9: CONFIDENTIALITY

28.1 Confidentiality is sought for the information in this application that is contained in square brackets.

28.2 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.

28.3 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 application, and that the Commission seek the view of the Applicants before any decision on disclosure is made by the Commission.

THIS NOTICE is given by Terry Moore of Southern Cross Hospitals Limited.

I hereby confirm that:

- all information specified by the Commission has been supplied;
- if information has not been supplied, reasons have been included as to why the information has not been supplied;
- all information known to the applicant which is relevant to the consideration of this application has been supplied; and
- all information supplied is correct as at the date of this application/notice.

I undertake to advise the Commission immediately of any material change in circumstances relating to the application/notice.

Dated 24 May 2011

Terry Moore, Southern Cross Hospitals Limited

I am a director/officer of the company and am duly authorised to make this application/notice.

THIS NOTICE is given by Lorna Grové, Aorangi Hospital Limited.

I hereby confirm that:

- all information specified by the Commission has been supplied;
- if information has not been supplied, reasons have been included as to why the information has not been supplied;
- all information known to the applicant which is relevant to the consideration of this application has been supplied; and
- all information supplied is correct as at the date of this application/notice.

I undertake to advise the Commission immediately of any material change in circumstances relating to the application/notice.

Dated 24 May 2011

Lorna Grové, Aorangi Hospital Limited

I am a director/officer of the company and am duly authorised to make this application/notice.

PUBLIC VERSION

APPENDIX A

List of Aorangi shareholders

AORANGI HOSPITAL SHAREHOLDERS – 31 December 2010		
Shareholders	**No of Shares**	**Names of Trustees/Members**
Bester Family Trust	125,000	Johannes Cornelius Bester Elizabeth Reyneke
Brougham No.2 Family Trust	100,000	David Ian Brougham Julie Claire Brougham McKenzie McPhail Corp Trustees Ltd
Mercer Family Trust Partnership	100,000	John Dunstan Mercer Sharyn Anne Mercer Anthony Alexander Cochrane
Young Family Trust	75,000	Michael Koi Young Tania Young Anthony Alexander Cochrane
Promaldon Trust	50,000	Ashley Neil Pollock Grant Selwyn Pollock Andrew Lawrence Schnauer Craig Kester Pollock
Brent Boon Family Trust and Dianne Boon Family Trust	50,000	Brent Patrick Boon Dianne Margaret Boon
T and K Ellingham Family Trust	50,000	Thomas Richard Ellingham Karen Patricia Ellingham McKenzie McPhail Corp Trustees Ltd
AJEJS Chrisp No. 2 Family Trust	54,328	John Montague Barry Chrisp Patricia Anne Chrisp John Stuart Thompson
Brian Crichton	50,000	
Kevin John Davey	50,000	
Michael Hodges	50,000	
Peter Kei Yan Leung & Bruce Murdoch	50,000	
Love Orthopaedic Surgery Trust	50,000	Broken Bones Limited – Timothy William Love
The Reiche Family Trust	100,000	Barbara Louise Reiche Bruce Charles Reiche Colin Ross Patrick Neil Gregory Poskitt
J & M Sendall Family Trust	50,000	John Sendall Megan Sendall Rowan Philip McNab
A D Spiers Family Trust – 25,000 S M Spiers Family Trust – 25,000	50,000	Andrew Duncan Spiers Susan Mary Spiers Donald Grant Spiers
Ponniah Sri Ragavan	50,000	
H R Stegehuis & C M Collins Family Trust	50,000	Hans Stegehuis Carole Margaret Collins Shane Michael O'Brien
Annette Mary Turley	50,000	
C P & P M Williams Orthopaedic Trust	50,000	Christopher Prior Williams Pauline Margaret Williams
	1,254,328	

APPENDIX B

Memorandum of Understanding

(See attached)

[Confidential]

APPENDIX C

Paragraphs 9.15 - 9.25 of the 2008 Application

Quality and range of technology

The role of the GP and specialist

9.15 A further complicating factor is that a hospital's location is very unlikely to be a material factor for a patient in deciding where to obtain treatment. A patient will receive impartial advice:

(a) about which specialist to use, from his or her general practitioner (or other primary care provider, e.g. a dentist, optometrist or physiotherapist) ("**GP**"); and

(b) about which hospital to use, from his or her specialist;[27]

The patient's decision will therefore be an informed one, and search costs are not likely to be a factor.

9.16 However, in practice often the specialist will already have operating theatre time-slots "booked" at a particular private hospital, and a patient will often be told (accurately) that there will be a delay if the patient wishes to use another hospital. As a result, in practice a GP's views about the best specialist to consult, and a specialist's own views and preferences about the preferred hospital, will largely determine a patient's choice of a hospital.

9.17 The primary competition dynamic between private hospitals is therefore not competition for individual patients, but competition to be the preferred hospital for well-regarded specialists. Patients will generally follow their specialists' recommendations, even if it involves significant travel.

9.18 A specialist will, of course, need to choose the hospital that he or she consider offers the best treatment for his or her patient. Price and convenience may play some role in this analysis but, given the specialist's overriding concern for the welfare of his or her patient, the specialist will likely give primacy to the place that he or she considers will offer the best treatment for his or her patients and offers the most suitable equipment. Effectively, if a specialist has a preferred hospital, it means that that specialist's patients' decisions will tend to be made on the basis of what is best for the specialist's patients *as a whole*, rather than best for any particular patient.

9.19 For procedures that do not *need* to be performed in a major city, the specialist will likely recommend a nearby hospital at which he or she routinely works if there is no reason to distinguish it from other hospitals. As a result, it is common to see a patient visit her local GP, who refers her to a local specialist, who refers her to the hospital at which he routinely practices.

9.20 However, a number of factors will cause this "local GP → local specialist → local hospital" flow to break.

(a) a patient's insurance contract may require that work be done by a specialist or hospital approved by that insurer;

[27] By Rule 32 of the *New Zealand Medical Association Code of Ethics*, "Doctors should not allow their standing as medical professionals to be used inappropriately in the endorsement of commercial products. When doctors are acting as agents for, or have a financial or other interest in, commercial organisations, their interest must be declared to patients" (www.nzma.org.nz/about/ethics/codeofethics.pdf).

(b) the local GP may refer the patient to a specialist other than the most convenient local specialist. This may happen if, for example, the GP has reason to be dissatisfied with a local specialist (for example, price or reliability), or wants to refer his patient to "the best" or somebody with specialised knowledge in a particular area, or to a specialist associated with a hospital with a strong reputation for the relevant specialty;

(c) there may be no local specialist or hospital (for example, for patients based in the Kapiti Coast/Horowhenua area). The GP will be able to choose between the specialist/hospital offerings within a wider geographical range. As a result, for example (and as already mentioned), the Boulcott Hospital has opened a clinic in Paraparaumu, and SCHL Palmerston North has carried out advertising in the area, promoting its services to local GPs (see paragraph [8.20 of the 2008 Application]);

(d) if there is some reason (e.g. price, quality, standard of care) for the specialist to be dissatisfied with the local hospital (for example, an optometrist in Palmerston North is known to refer people to Auckland to have cataract surgery done, in part because the procedure is less expensive there);

(e) the equipment available and surgical techniques able to be performed at the local hospital are less ideal for the procedure than equipment and techniques able to be performed elsewhere (see example at [paragraph 8.32 of the 2008 Application]); or

(f) staff at that hospital are less experienced in assisting with the procedure in question than staff at another hospital.

9.21 These factors are relatively common. In each case, the competitive offering of the local hospital is outweighed by the competitive offering of a more remote, but for other reasons more desirable, hospital. More significantly, the fact that a more remote hospital can be more desirable than a closer hospital means that each acts as a competitive constraint on the other.

Competition on technology

9.22 As described at [paragraph 8.31 of the 2008 Application]], a major dimension on which competition occurs between hospitals is technology. If a hospital does invest in technology that is particularly useful for a certain specialty, there is a good chance that it will obtain the majority of the specialists, and patients, in that speciality until such time as its rival can match that investment.

9.23 Crucially, a hospital with a technology advantage in a certain speciality will attract patients from outside the immediate vicinity, if hospitals closer to those patients offer only an inferior treatment. Where the technology investment is not clearly beyond the scope of provincial hospitals, but merely requires a trade-off of investment and profit, it is reasonable to say that there is competition between those hospitals on the basis of technology. Indeed, given the relatively small role that price likely pays in a patient's choice of hospitals, and the limited scope for hospitals reducing quality given patient and insurer (and regulatory) expectations, competition on the basis of technology represents the major basis on which private hospitals attempt to get an advantage on their rivals. That competition occurs on an inter-regional basis.

9.24 Examples of technology competition are:

(a) Prostatectomies: see [paragraph 8.32 of the 2008 Application]; and

(b) Hip replacements: see [paragraph 8.33 of the 2008 Application].

9.25 As a result of this competition on technology, particular hospitals will often develop a "niche" as the preferred hospital for a particular speciality. (For example, SCHL Palmerston North currently has particular strength in gynaecology, general surgery (breast), gastroenterology, plastic surgery, while Aorangi has particular strength in orthopaedics, general surgery (colorectal), ophthalmology and oral and maxillofacial surgery.) A rival hospital can, realistically, only "take on" this niche by investing significantly in equipment (and staff expertise) to lure specialist staff to it; as is commonplace in technology-dominant markets, this will most likely happen by investing in the next generation of equipment.

APPENDIX D

Specialist movements over the last five years

[Confidential]

[Confidential]

APPENDIX E

SCHL Palmerston North Management Accounts

(See attached)

[Confidential]

APPENDIX F

Theatre lists for each of SCHL Palmerston North and Aorangi

(See attached)

[Confidential]

APPENDIX G

Aorangi Hospital - Budgets for capital expenditures approved 2007, 2008, and 2009

(See attached)

[Confidential]

APPENDIX H

Aorangi shareholder movements

[Confidential]

1. [
   ];
2. [
   ];
3. [

   ].

APPENDIX I

SCHL Palmerston North fee schedule and recent fee increases

(See attached)

[Confidential]

APPENDIX J

Aorangi Hospital fee schedule

(See attached)

[Confidential]

APPENDIX K

Southern Cross Board and CEO extracts

[Confidential]

Palmerston North/Aorangi
Extract For SCHL Board Minutes

[Confidential]

Palmerston North
Extract from CEO Commentary

APPENDIX L

SCHL Palmerston North and Aorangi Patient Numbers by Revenue Source and Speciality

[Confidential]

Table J1: PATIENTS BY REVENUE SOURCE SCHL PALMERSTON NORTH						
Funding Source	**2008-09[28]**		**2009-10**		**2010-2011 YTD April 2011**	
	Patient numbers	**Revenue**	**Patient numbers**	**Revenue**	**Patient numbers**	**Revenue**
ACC	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
DHB	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Insurer fixed price[29]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Other private (self or insurer) funded	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
TOTAL	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Table J2: PATIENTS BY REVENUE SOURCE AORANGI						
Funding Source	**2008**		**2009**		**2010**	
	Patient numbers	**Revenue**	**Patient numbers**	**Revenue**	**Patient numbers**	**Revenue**
ACC	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
DHB	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Other private (self or insurer funded)[30]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
TOTAL	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

[28] [ ].

[29] [ ].

[30] [ ].

Table J3: PATIENT NUMBERS/REVENUE BY SPECIALITY SCHL PALMERSTON NORTH						
Speciality	2009		2010		2010-2011 YTD April 2011	
	Patient numbers	Revenue	Patient numbers	Revenue	Patient numbers	Revenue
ENDOSCOPY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
ENT	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
GENERAL SURGERY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
GYNAECOLOGY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
OPHTHALMOLOGY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
ORAL & MAXILLOFACIAL SURGERY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
ORTHOPAEDIC SURGERY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
OTHER/MISCELLANEOUS	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
OTOLARYNGOLOGY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
PLASTICS	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
UROLOGY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
TOTAL REVENUE[31]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Table J4: PATIENT NUMBERS/REVENUE BY SPECIALITY AORANGI HOSPITAL						
Speciality	2008		2009		2010	
	Patient numbers	Revenue	Patients numbers	Revenue	Patient numbers	Revenue
ENDOSCOPY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
ENT	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
GENERAL SURGERY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
GYNAECOLOGY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
OPHTHALMOLOGY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
ORAL & MAXILLOFACIAL SURGERY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
ORTHOPAEDIC SURGERY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
OTHER REVENUE/MISCELLANEOUS	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
OTOLARYNGOLOGY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
PLASTICS	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
UROLOGY	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
TOTAL REVENUE	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

[31] [ ].

APPENDIX M

Southern Cross Health Trust Annual Report 2010

(See attached)

Available at:
http://www.southerncross.co.nz/Portals/0/Group/Corporate/Southern%20Cross%20Health%20Trust%20Annual%20Report%202010.pdf

APPENDIX N

Aorangi Hospital Annual Report 2010

(See attached)

[Confidential]

APPENDIX O

NERA Economic Report

(See attached)