COMMERCE ACT 1986: BUSINESS ACQUISITION SECTION 66: NOTICE SEEKING CLEARANCE

Date: **28 March 2008**

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

Pursuant to s 66(1) of the Commerce Act 1986, notice is hereby given seeking **clearance** of a proposed business acquisition.

Section A: Overview

EXECUTIVE SUMMARY

0.1 Southern Cross Health Trust ("**SCHT**") (or nominee) and Aorangi Hospital Ltd ("**Aorangi**") seek clearance to acquire shares in a joint venture company ("**JV Co**") and for JV Co to acquire the business assets of SCHT's and Aorangi's Palmerston North hospitals (as more specifically described in the body of the application).

0.2 This acquisition will essentially reduce the number of full service private hospitals in Palmerston North from two to one. However, the acquisition is nonetheless unlikely to lessen competition. This is because:

(a) *Financial viability*: in the counterfactual, at least one of the two hospitals, most likely SCHT Palmerston North, will shut down of its own accord. SCHT Palmerston North is unprofitable and has generated a loss for SCHT in six of the last eight years. There is no real prospect of the situation improving for either hospital in the counterfactual: indeed, a number of factors point to a further decline. The city is simply too small to support and sustain two full service private hospitals. As a result, there is no material difference between the factual and the counterfactual.

(b) *Broad geographic market:* there is evidence suggesting that the geographic market is not restricted to Palmerston North. Since 2004, nearly 50% of SCHT Palmerston North's patients have come from outside Palmerston North. As such, private hospitals in Wanganui, Dannevirke, Masterton, Hastings, and a number of private hospitals in Wellington within a relatively short drive, will act as a meaningful constraint on the merged entity post-acquisition. This is particularly so given that the main avenue of competition between hospitals in the current environment is through investing in new technology and developing specialist "niches". As a result, consumers are willing to travel longer distances to acquire modern treatments with fewer side effects and greater prospects of success.

0.3 This notice develops these two key submissions in some depth. The financial viability submission is developed primarily in section 8. In essence, no provincial centre in New Zealand has been able to sustain more than one private surgical hospital, and Palmerston North is no exception. Both hospitals are operating

unsustainably. A number of factors mean that the situation is likely to worsen. As a result, it is no solution to:

(a) sell either hospital as a going concern (indeed, the most likely purchaser, Wakefield, has recently rejected the notion of doing so without a joint venture involving all three parties);

(b) increase prices; or

(c) confine the hospital just to short-stay / day-stay.

Instead, SCHT and Aorangi have been investigating other options for use of their sites. These options would likely be pursued in the counterfactual.

0.4 The submission on the relevant geographic market is developed primarily in section 9, with reference to a detailed analysis of the nature of decision-making in the health sector, and an extensive set of "patient origin" data derived from SCHT.

0.5 The application, however, ultimately turns on the lack of difference between the counterfactual and factual. Nevertheless, in the factual there are a number of existing competitive constraints, and there are significant opportunities for new entry, particularly in the short-stay / day-stay market.

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PART I: DETAILS OF THE PROPOSED TRANSACTION

1. THE BUSINESS ACQUISITION

1.1 This notice is given jointly by:

(a) Southern Cross Health Trust ("**SCHT**"); and
(b) Aorangi Hospitals Ltd ("**Aorangi**")

(the "**Applicants**").

1.2 Clearance is sought for:

(a) SCHT (or nominee) to acquire at least 50% of the shares, and Aorangi (or nominee) to acquire up to 50% of the shares, in a new company to be incorporated (referred to here as "**JV Co**"); and

(b) JV Co to acquire (either directly, or through 100% subsidiaries) the Palmerston North hospital business assets of:

(i) SCHT (land and buildings at 21 Carroll St, Palmerston North, and other related hospital business assets);

(ii) The Players Company Ltd (land, including hospital buildings, at 175 Grey St, Palmerston North) (subject to negotiating and reaching a suitable sale and purchase agreement); and

(iii) Aorangi (other business assets relating to the hospital at 175 Grey St, Palmerston North).

1.3 The Applicants have not yet agreed a sale and purchase agreement or joint venture agreement; however, it is anticipated that these may be entered into (conditional on clearance) prior to the Commission making its decision on this application. The Applicants will advise the Commission if this occurs.

1.4 The precise split of the shareholding in JV Co is yet to be determined, as it will depend on valuations and other factors; however, SCHT or its nominee is expected to acquire at least a 50% shareholding.

1.5 A "before" and "after" structure diagram is attached as **Appendix 3**.

1.6 All correspondence and notices in respect of this application should be directed in the first instance to:

Russell McVeagh
Level 25, Vero Centre
48 Shortland Street
PO Box 8
AUCKLAND 1140

Attention: Andrew Peterson / Andrew Fincham
Telephone: 09 367 8315 / 09 367 8039
Facsimile: 09 367 8592
E-mail: andrew.peterson@russellmcveagh.com / andrew.fincham@russellmcveagh.com

2. CONFIDENTIALITY

2.1 Confidentiality is sought in respect of all items deleted from the public copy of this application ("**confidential information**"). The items are **Appendix 4**, the entire contents of which are confidential, and those items indicated in the non-public version in square brackets ("**[ ]**").

2.2 In respect of the confidential information, confidentiality is claimed under section 9(2)(b)(ii) of the Official Information Act 1982, on the grounds that the information is commercially sensitive and valuable information which is confidential to the participants, and disclosure of it is likely to give unfair advantage to competitors of the participants and/or unreasonably to prejudice the commercial position of the persons involved.

2.3 Southern Cross Health Trust and Aorangi Hospital Limited request that they be notified of any request made to the Commission under the Official Information Act for release of the confidential information, and that the Commission seeks their views as to whether the information remains confidential and commercially sensitive, at the time responses to such requests are being considered.

3. DETAILS OF THE PARTICIPANTS

Southern Cross Health Trust ("SCHT")—Vendor

3.1 Contact details:

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

Attention: Terry Moore
Chief Executive Officer
Southern Cross Health Trust
Telephone: 09 925 5344 / 021 946 786
E-mail: terry.moore@southerncrosshospitals.co.nz

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

3.3 The SCHT owns 100% of Southern Cross Hospitals Limited. The business assets of SCHL include nine wholly owned private hospitals,[1] including Southern Cross Palmerston North, and (via subsidiary companies) shareholdings in five private hospital joint venture companies.[2]

3.4 The SCHT 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.

[1] Auckland Surgical Centre (Auckland), Brightside (Auckland), North Harbour (Auckland), Hamilton, New Plymouth, Palmerston North, Wellington, Christchurch, Invercargill.
[2] Gillies Hospital Ltd (Auckland), Mercy Angiography Unit Ltd (Auckland), Grace Hospital Ltd (Tauranga), Oxford Clinic Hospital Ltd (Christchurch) and Southern Cross QE Ltd (Rotorua).

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

3.6 SCHT Palmerston North is a small 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 SCHT Palmerston North facilities, including:

(a) plastic surgery;
(b) orthopaedics (to a minor extent);
(c) ear, nose and throat surgery (otolaryngology);
(d) cardiology (to a 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.

3.7 Of these specialties, gynaecology forms the largest share of both procedures (**[ ]**% of patient volume) and revenue (**[ ]**% of total surgical revenue).

3.8 Approximately **[ ]**%–**[ ]**% of SCHT Palmerston North's procedures are short-stay / day-stay; the remaining **[ ]**%–**[ ]**% are in-patient procedures.

3.9 SCHT owns the SCHT Palmerston North land and buildings.

History in Palmerston North

3.10 The present SCHT Palmerston North hospital was officially opened in May 1987. At the time of construction, the facility contained 37 beds and two theatres. It was built as a replacement facility for the ageing Northcote Private Surgical Hospital, which had been purchased by Southern Cross a few years earlier. The facility's profitability has always been variable.

3.11 In 2002–2003 SCHT Palmerston North established a short-stay / day stay unit, with the aim that it would allow for reduced operating expenses[3] and thus increased profitability. In 2007, SCHT has also added consulting rooms in order to attract surgeons to operate at the facility.

Aorangi Hospital Limited ("Aorangi")—Vendor

3.12 Contact details:

Aorangi Hospital
175 Grey Street
PO Box 788
PALMERSTON NORTH

Attention: Johan Bester
Chief Executive Officer

[3] By removing the need for day-stay patients to incur the significant costs (for example, cleaning and laundry) associated with caring for a patient in a traditional ward.

Telephone: 00 61 4 2416 4863
E-mail: jbester@gosfordclinic.com.au

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

3.14 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 (to a minor extent);
(b) orthopaedics;
(c) ear, nose and throat surgery (otolaryngology);
(d) gynaecology;
(e) urology;
(f) endoscopy;
(g) ophthalmology;
(h) anaesthesiology;
(i) general surgery; and
(j) oral and maxillofacial surgery.

3.15 Of these treatment types, the largest proportion of Aorangi's revenue comes from orthopaedics. It also has consistently high volumes in general surgery and urology.

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

Ownership

3.17 Aorangi Hospital Limited ("**Aorangi**") is privately owned and operated by a group of medical specialists. Only one shareholder, the Bester Family Trust, owns more than 10% of Aorangi shares. 1,250,000 Aorangi shares are on issue in total. The shareholders, in descending order, are set out in **Appendix 1**.

3.18 In addition to its current issued shares, Aorangi has issued convertible notes in its 2005 and 2006 financial years. 92.5% of these notes are held by current shareholders in Aorangi. (The remaining 7.5% are held by a dermatologist who practices at Aorangi.) The notes carry an option of converting the principal of the notes to shares at the end of a five year term.

Interests

3.19 A shareholder of Aorangi, Dr Michael Young, is a clinical director of surgical services at the Mid-Central DHB. In addition, the Chairman of the Aorangi board of directors, Jim Jeffries, is an elected member of the Mid-Central DHB.

History

3.20 Aorangi was formed in 2000 when Aorangi purchased the Palmerston North Mercy hospital from the Sisters of Mercy. Aorangi sold the property to The Players Company Ltd in a "leaseback" arrangement to finance the purchase.

3.21 In 2003/2004, Aorangi underwent significant redevelopment, including two additional operating rooms (from two to four), and expanded recovery area, additional patient rooms, and an upgrade to the day surgery facilities. To assist in financing this redevelopment, a finance company, Finmed (AHL) Limited was

formed. As well as providing Aorangi with a loan, Finmed owned and leased medical equipment to Aorangi.

3.22 Further details of the Aorangi Hospital building and site are available on the Aorangi Hospital website.[4]

The Players Company Ltd—Vendor

3.23 The Players Company Ltd owns the land and buildings for Aorangi Hospital Ltd.[5] Although no agreement has been negotiated, the joint venture company may acquire the land and buildings, either as part of the overall transaction to form the joint venture, or at a later date.

JV Co—Purchaser

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

(a) A joint venture company ("**JV Co**") will be formed and will issue shares.

(b) SCHT (or nominee) and Aorangi (or nominee) will each acquire shares in JV Co. The relative shareholding has not yet been settled, but it is expected that SCHT (or its nominee) will not have less than 50%.

(c) The Aorangi nominee may also issue some shares to specialists who are not current shareholders in Aorangi; however, Aorangi will own the large majority of the shares. The SCHT nominee will be a company in which SCHT 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 SCHT and Aorangi, and will also seek to purchase the Aorangi Hospital site and building from The Players Company Ltd.

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

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

3.26 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.

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

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[4] www.aorangihospital.co.nz.

[5] According to the Companies Office website, there are twenty shareholders of The Players Company Ltd, each holding an equal 5% interest. The shareholders are: Colin Terence Campbell, Shayne Philpott, Tabs Matson, Christine Bell, Grant Fairbairn, Filo Tia Tia, Gordon Brooker, Leon MacDonald, Andrew Turner, Phillip O'Reilly, Julian Smith, Philip Squibb, Martin Dowson, Dion Waller, Desmond Stephen Park, Des Park Anton Aust, Tim Henshaw, Rimu Investments, Louise Reiche and Maple Investments.

3.28 In a past decision, the Commission has taken the view that SCHT and the Society ("**the Society**") were "associated persons" for the purposes of section 47(3) of the Commerce Act: *Decision 536* (*Southern Cross Oxford Hospital Ltd / The Oxford Clinic*, 11 Nov 2004). Notwithstanding this, SCHT considers that it is not associated with the Society. However, it is not necessary for the Applicants to pursue the issue in this application, and they do not propose to do so.

4. BENEFICIAL INTERESTS

4.1 Neither SCHT nor Aorangi, nor any of their interconnected bodies corporate, has any beneficial interest or entitlement to any shares or pecuniary interest in the other.

4.2 The shareholders of Aorangi, being largely medical specialists (or family trusts or people closely related to medical specialists), also carry out work in either or both hospital, and the other private and public hospitals in the region. The specialists also carry out consultation work for patients, either at the consulting rooms at the hospitals, or at other consulting rooms and clinics in the region.

4.3 However, no shareholder of Aorangi holds any legal or beneficial interest in any other private hospital in New Zealand**.**

5. LINKS BETWEEN COMPETITORS

5.1 There are no common directorships between Aorangi and SCHT, nor any of their subsidiaries.

5.2 Formal agreements are in place between SCHT and the Mid-Central DHB, and between Aorangi and the Mid-Central DHB, to allow the three Palmerston North hospitals to share some surgical equipment (for a fee) in certain circumstances. The agreement is primarily designed to allow equipment to be borrowed where there is, for example, a breakdown or temporary shortage.

5.3 For the year to June 2008, SCHT and Aorangi have both obtained contracts from Mid-Central DHB for elective orthopaedic surgery in relation to joints (**[ ]** for SCHT, **[ ]** for Aorangi).

5.4 A small number of specialists, including some who are shareholders in Aorangi, work at both SCHT Palmerston North and Aorangi Hospital. These specialists are identified as part of **Appendix 2**.

5.5 Wakefield Health Ltd, operator of the Wakefield, Bowen and Royston Hospitals, owns 11.9% of the shares in Boulcott Clinic Ltd.

6. THE REASONS FOR THE PROPOSAL

SCHT's reasons

Current losses not sustainable:

6.1 As described in section 8 below, SCHT Palmerston North is not profitable, and shows no signs of becoming profitable. It is operating considerably under capacity, and there are no realistic signs that its profitability will improve in the short or medium term. In other cities (particularly Tauranga and Rotorua), a joint

venture with a neighbouring hospital has proved a useful way of cutting costs and making both facilities financially sustainable.

Situation unlikely to improve

6.2 The current situation is unlikely to improve. SCHT has pursued a number of initiatives in an attempt to improve the performance of the hospital (see [8.7] below), but none have succeeded. Profitability has declined further in recent years (for the reasons described at [8.4]–[8.49] below), and is likely to continue to do so.

Alternative is closure:

6.3 For SCHT, the alternative to proceeding with this acquisition is closing the hospital and selling the land and buildings. For some time SCHT has recorded an "alternative use" valuation for its Palmerston North hospital land and building (it is the only SCHT hospital treated in this way). SCHT 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. It has, however, taken the view that, if the Palmerston North facilities could be made to operate profitably by a joint venture, this would better align with its objects as a charitable trust.

Considerable ongoing investment required

6.4 To keep its facilities at the standard required in the private market, and keep pace with modern developments in healthcare, SCHT Palmerston North has needed to carry out substantial capital investment, and will need to continue this over the next year. Additional expenditure is also anticipated, and the resulting depreciation expense will further harm overall profitability.

6.5 In the next one to two years, SCHT Palmerston North is likely to need to invest in:

(a) **[ ]**;

(b) **[ ]**;

(c) **[ ]**;

(d) **[ ]**; and

(e) **[ ]**.

6.6 None of these investments are expected to generate material new revenue for SCHT Palmerston North.

Aorangi's reasons

Unsustainably low profit

6.7 Since it opened Aorangi Hospital in 2000, Aorangi has been unable to generate a competitive return on investment for its investors. Because its shareholders are also, for the most part, the surgeons using its facility, Aorangi has been to some extent insulated from needing to generate a reasonable return on investment. This position is unsustainable: its shareholders can now earn considerably more money with the value of their shares on term deposit than invested in Aorangi.

6.8 **[ ]**. Aorangi faces a real dilemma in continuing a marginal non-sustainable business model.

6.9 **[ ]**.

Substantial ongoing investment required

6.10 In the next one to two years, Aorangi is likely to need to invest in:

(a) **[ ]**; and

(b) medical equipment, on an ongoing basis. **[ ]**. This means that Aorangi will require large capital expenditure to replace its existing equipment in future.

Cost savings from merger

6.11 A merger of the Aorangi and SCHT Palmerston North hospitals will allow for considerable cost savings and other efficiencies. In particular, these savings include:

(a) **[ ]**;

(b) **[ ]**;

(c) **[ ]**;

(d) **[ ]**;

(e) **[ ]**.

6.12 In addition, the greater scale from a merger will make it more likely that JV Co can make the kinds of investment in equipment and build the kinds of expertise that have been developed in the major city private hospitals.

Limited ability to raise prices or reduce quality

6.13 In the factual, there will be one less competitor in the market compared to the status quo (but not compared to the counterfactual: see below). However, for the reasons set out at [14.9]–[14.10] below, the merged entity will have only limited ability to increase price, and is unlikely to want to do so. This is not a driver for the proposed joint venture.

Section B: Framework for Analysis

PART IA: FACTUAL AND COUNTERFACTUAL SCENARIOS

7. FACTUAL SCENARIO

7.1 In the factual, a joint venture company, JV Co, will be formed, and the Palmerston North hospital assets of SCHT, Aorangi and The Players Company Ltd (possibly at a later stage) will be transferred into it (or subsidiaries). (See [1.2] above and **Appendix 3** below for more details of the proposal.) **[ ]**.

7.2 The JV Co hospitals will be operated on a for-profit basis, with dividends split according to relative shareholdings.

7.3 The factual will allow for considerable cost savings to be implemented (as outlined at [6.11]), and generate economies of scale (see [6.12]).

7.4 In the factual, the JV Co will face considerable competitive constraints on its market conduct. These constraints are described at [13.2] below.

8. COUNTERFACTUAL SCENARIO(S)

8.1 The Applicants consider that there are two possible counterfactual scenarios: either SCHT Palmerston North or Aorangi will close down entirely as a surgical hospital, with its facilities used for other purposes.

No provincial centres have been able to sustain more than one private hospital

8.2 In nearly all other parts of New Zealand other than Auckland, Hamilton/Waikato, Wellington and Christchurch/Canterbury (which contain the country's major public hospitals and population bases, and hence a developed healthcare infrastructure and significant demand for private surgery), there is only a single private surgical hospital (or, in one case, no hospital):

Table 1: Private Surgical Hospitals in New Zealand regions

City/region	Population[6]	No of full service private hospitals	Name(s)
Whangarei/Northland	150,000	1	Kensington
Tauranga/Bay of Plenty	200,000	1	Grace
Rotorua/Taupo	102,000	1[7]	Southern Cross/QE joint venture
Gisborne/Eastland	44,500	1	Chelsea
Hawkes Bay	151,000	1[8]	Royston
Masterton / Wairarapa	39,500	1	Selena Sutherland[9]
New Plymouth/Taranaki	105,000	1	Southern Cross
Wanganui	63,000	1	Belverdale
Palmerston North/ Manawatu/Horowhenua	158,838	3	Southern Cross, Aorangi, Dannevirke
Blenheim/Marlborough	43,200	1	Churchill Trust[10]
Nelson	87,500	1	Manuka Street
Timaru/South Canterbury	54,000	1	Bidwell
Dunedin/Otago	182,000	1	Mercy Dunedin
Invercargill/Southland	110,000	1	Southern Cross
West Coast	32,000	0	N/A
Auckland Region	1,387,000	At least 8	Brightside, Southern Cross North Harbour, Gillies, MercyAscot, Auckland Surgical Centre, Northern Clinic, Quay Park, Navy.
Hamilton/Waikato	353,460	3	Southern Cross, Braemar, Anglesea
Wellington/Hutt/Kapiti	418,000	4	Wakefield, Bowen, Boulcott, Southern Cross.
Christchurch/Canterbury	479,000	At least 3	Southern Cross, Oxford, St George's.

8.3 In the last 10 years, SCHT has implemented a number of closures or mergers of other loss-making or barely profitable hospitals: in Wanganui, Hastings, Tauranga and Rotorua. Palmerston North is now the only provincial city in New Zealand with more than one full-scale private hospital.

[6] Most population figures are taken from www.moh.govt.nz/moh.nsf/wpg_index/About-DHBs#7 (others from local District Health Board or district/city council websites).
[7] As cleared by the Commission in *Decision 620* (*Southern Cross Health Trust / QE Hospital Ltd*, 28 Sep 2007), the SCHT Rotorua and QE Health hospitals have now merged into a single business operating under a joint venture. See SCHT/QE Hospital Ltd joint Press Release, 6 Dec 2007; available at www.southerncross.co.nz.
[8] In addition to the large Royston hospital in Hastings, there is a small private hospital called "Parkside". However, the Applicants understand that Parkside operates on a small scale, performing relatively minor day-stay and a small number of in-patient procedures. In late 2007 its owner was found guilty of professional misconduct by the Health Practitioners Disciplinary Tribunal. The hospital closed after that occurred, although it has since reopened. It is now actively for sale.
[9] The Selena Sutherland Hospital in Masterton shares surgical facilities with Wairarapa Hospital, operated by the Wairarapa District Health Board.
[10] The Churchill Trust Hospital in Blenheim shares surgical facilities with Wairau Hospital, operated by the Marlborough District Health Board.

Both Palmerston North hospitals are operating unsustainably

8.4 Both Palmerston North hospitals are operating unsustainably and cannot rationally continue to stay open.

SCHT Palmerston North

8.5 SCHT's Palmerston North hospital has been operating for just over 20 years. Notwithstanding the major changes in health funding and provision over that period, over this time it has been, at best, a marginally profitable hospital. Indeed, **[**

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Table 2: SCHT Palmerston North Net Profit/Loss

Year to…	No of Patients	Net Profit/(Loss)
Jun 2001	[ ]	[ ]
Jun 2002	[ ]	[ ]
Jun 2003	[ ]	[ ]
Jun 2004	[ ]	[ ]
Jun 2005	[ ]	[ ]
Jun 2006	[ ]	[ ]
Jun 2007	[ ]	[ ]
Jun 2008 (to 29 Feb)		[ ]
Total		[ ]

8.6 SCHT is not a for-profit organisation: it is a charitable trust, operating its private hospitals for the benefit of effectively all New Zealanders.[11] Its charitable trust status does, not, however allow SCHT to carry on a loss-making business. It must still generate sufficient revenue to cover its day-to-day costs and its share of head-office costs. SCHT invests its surpluses in medical technologies, professional development of staff, and hospital upgrades.[12] Effectively, when SCHT Palmerston North makes a loss, the SCHT must forego necessary investments in its other hospitals; its continued cross-subsidisation of SCHT Palmerston North is contrary to the interests of other beneficiaries.

8.7 With this trade-off in mind, the SCHT Board is required to act in what it considers to be the best interests of its beneficiaries as a whole. On at least two previous occasions, the SCHT Board has seriously considered negotiating a merger with Aorangi or its predecessor.[13] In each case, the Board gave the hospital another opportunity to become profitable. Since 2003, the hospital has put forward a number of proposals for expanding its customer base, cutting costs or generating additional revenue.[14] Those proposals assessed as feasible have been implemented, but they have failed to make any significant impact on the hospital's profitability.

[11] A copy of the trust deed for the Southern Cross Health Trust is available on request, or at www.companies.govt.nz/cms/other-registered-entities/banner_template/OBSEARCH.
[12] At this webpage, available at www.southerncrosshospitals.co.nz. Further information here.
[13] See Minutes of a Meeting of the Trustees of Southern Cross Hospital Trust, 7 June 2000. Similar steps were taken in 2003, when closure of SCHT was also directly contemplated: see Minutes of a Meeting of the Trustees of Southern Cross Health Trust, 5 August 2003.
[14] The proposals are set out in a variety of strategy papers dating from 2003. These are available on request.

8.8 With SCHT Palmerston North unprofitable for five of the last seven financial years (and incurring a loss of over $**[ ]** so far for the first eight months of the current financial year), it is unrealistic to expect SCHT Palmerston North's financial performance to improve.

8.9 As part of that merger process, SCHT has commissioned PricewaterhouseCoopers to carry out an indicative valuation of SCHT. PricewaterhouseCoopers has not finalised its report, but has circulated a draft valuation. That draft valuation was carried out on a net-assets approach, rather than the more normal "earnings multiple" approach. The draft valuation report explains this decision:

- [

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Aorangi

8.10 Like SCHT Palmerston North, Aorangi has failed to generate a reasonable rate of return on investment since its formation in 2000. Its profitability is summarised in **Table 3**:

Table 3: Aorangi net profit/loss

Year to…	No of Patients	Net Profit/(Loss)
Dec 2001	[ ]	[ ]
Dec 2002	[ ]	[ ]
Dec 2003	[ ]	[ ]
Dec 2004	[ ]	[ ]
Dec 2005	[ ]	[ ]
Dec 2006	[ ]	[ ]
Dec 2007	[ ]	[ ]
Total	[ ]	[ ]

8.11 Aorangi was initially set up with a streamlined structure. It did not itself own the hospital facilities: it sold them to and leased them back from The Players Company Ltd (and continues to do so). Nor did it own most medical equipment: it leased the equipment from a company, Finmed (AHL) Limited, established for that purpose (and to finance the equipment purchases required to compete in the in-patient market). (Even some of its management is to some extent "outsourced": its Chief Executive Officer, Dr Bester, is also Managing Director of "The Gosford Clinic", a private surgical hospital in Gosford, New South Wales, and a Director of "Dalcross Private Hospital" in Killara, Sydney, New South Wales.)

8.12 However, it has proved very difficult to operate Aorangi on this basis. Aorangi was faced with two very large fixed facilities and equipment costs (plus its own staff costs), and insufficient demand (and hence revenue) to meet these costs. To

lower its cash outflows, in 2006, Aorangi purchased its hospital assets from Finmed (AHL) Ltd and refinanced the loans from Finmed, resulting in a lower interest charge and improved cashflow. Aorangi's financial performance has, however, remained unsatisfactory.

8.13 PricewaterhouseCoopers has also carried out a draft indicative valuation of Aorangi. Although PricewaterhouseCoopers has valued Aorangi on a "market multiples" approach, the draft valuation recognises that Aorangi has in previous years traded at a loss, and with only "marginal profitability" in the financial year 2007. The draft valuation also notes that planned capital expenditure for the financial year 2008 is only **[ ]**% of depreciation, reflecting Aorangi's concerns about the ongoing viability of its business.

New low-cost competition in the region

The Palms

8.14 In the past eighteen months, a new low-cost treatment centre has opened in Palmerston North called The Palms. The Palms operates on a different business model to SCHT and Aorangi, with bundled facilities and specialist services, radio advertising and aggressive pricing. It operates from a lower cost base, because it caters to a more specialised range of services, its integrated structure (bundling use of its facilities and specialist services) provides efficiencies, its buildings and equipment are newer and their overall level of quality is generally slightly lower.

8.15 In particular, The Palms features:

(a) 18 general practitioner consulting rooms;
(b) a procedure room, designed for easy upgradeability to a full operating theatre. The Applicants understand that the Palms has plans to carry out this upgrade in the near future;
(c) a further procedure room easily extended into a minor operating theatre;
(d) an accident and medical centre, with eight beds;
(e) a further suite of four consulting rooms for oral surgeons;
(f) consulting space for visiting surgeons (who could refer patients to Wellington);
(g) a full pharmacy;
(h) a further six consulting room specialist centre;
(i) an orthotics facility;
(j) a Caci Clinic with ten further consulting rooms and additional procedure rooms;
(k) a physiotherapy clinic;
(l) a training centre; and
(m) a radiology centre.

8.16 The Palms provides more than "procedure rooms" of the kind described in *Decision 546.*[15] Although some procedures performed at The Palms (and particularly the Caci Clinic) would be minor in nature, among the procedures known to be currently performed at The Palms are:

(a) dental extraction;
(b) oral surgery;
(c) hand and foot surgery (e.g. removal of ingrown toenails);
(d) removal of foreign bodies from cornea, ear canal and nose;
(e) reduction of some fractures and dislocations;
(f) incision and drainage of abscesses;

[15] *Decision 546* (*SCHT / Auckland Surgical Centre Ltd*, 17 February 2004), at [76].

(g) excision of lipoma
(h) vasectomies
(i) cosmetic procedures;
(j) circumcisions; and
(k) removal of minor skin lesions (lumps and bumps).

8.17 Much of this work would once have been performed at SCHT Palmerston North or Aorangi, and some could have involved an overnight stay.[16] As well as increasing competition, this has reduced the total number of (non-DHB) procedures that are carried out in SCHT Palmerston North and Aorangi.[17] With day-stay comprising some **[ ]**% of SCHT Palmerston North's and **[ ]**% of Aorangi's procedures, this is a key financial vulnerability for each hospital. SCHT Palmerston North and Aorangi have been forced to spread their fixed costs over a smaller number of procedures, reducing their profitability.

Belverdale Hospital

8.18 In 2001, the former Southern Cross Hospital in Wanganui re-opened as Belverdale Hospital. Belverdale has diverted a significant share of private healthcare market from SCHT Palmerston North and Aorangi to it since it is the more convenient location for the 63,000 residents in the Wanganui DHB region who would previously have made the short drive to Palmerston North (or longer drive to New Plymouth or Wellington) for treatment.

8.19 The opening of Belverdale was not anticipated, and has undertaken a number of procedures that would otherwise have gone to SCHT Palmerston North and Aorangi.[18] It too has impacted the profitability of the Palmerston North hospitals, and will continue to do so.

The Boulcott Clinic

8.20 The Kapiti Coast/Horowhenua is a large and fast growing region (over 76,000 people,[19] comparable to the population of Palmerston North[20]) with a relatively elderly population. No private hospitals are in the immediate area. Potential private patients on the Kapiti Coast must travel either north to Palmerston North, Wanganui (or beyond) or south to Wellington for treatment.

8.21 As a result, the Kapiti Coast/Horowhenua is, at present, easily "contested" territory between the hospitals in Palmerston North and Wellington. SCHT Palmerston North and Aorangi have both carried out promotional activity in the area.[21]

8.22 Boulcott Clinic Ltd (operator of the Boulcott Hospital, a significant private hospital in Lower Hutt) recently opened a clinic, the Boulcott Clinic, in Paraparaumu.[22] This clinic provides consulting rooms for the Boulcott Hospital's specialists on the Kapiti Coast, and makes it more likely that patients seen by those specialists will

[16] For example, a procedure (such as a vasectomy) that would be performed under general anaesthetic at SCHT Palmerston North would typically be performed under local anaesthetic at the Palms. In addition, the Palms tends to use a resident experienced General Practitioner for minor surgical procedures, rather than a specialist.
[17] Refer patient numbers in **Table 2** for the most recent financial years.
[18] Refer patient numbers in **Table 2** for the 2002, 2003 and 2004 financial years (volumes increased in 2006 due to higher DHB volumes only). In addition, according to a SCHT board report of 31 May 2000, prior to the closure of the Southern Cross Wanganui hospital in 2000, some 28.9% of Wanganui patients insured with the Society travelled to Palmerston North for treatment.
[19] See www.horowhenua.govt.nz/District/About+Our+District and www.kapiticoast.govt.nz/About Kapiti.htm.
[20] 78,100: see www.pncc.govt.nz/City/AboutUs/AboutCity.htm.
[21] For example, in October/November 2007 SCHT Palmerston North developed a flyer and mailed it to GPs down the Kapiti Coast. Aorangi has also written to GPs in the area. SCHT Palmerston North has also carried out radio advertising reaching down to the Kapiti Coast.
[22] Wakefield Health also holds a small shareholding in the Boulcott Clinic: see [5.5] above

use the Boulcott Hospital's facilities. As a result of this clinic, the Applicants believe that a material number of patients who could have travelled to Palmerston North for treatment have instead travelled to Wellington, impacting the Applicants' revenue.

Public funding increases unlikely

8.23 In the past four years, the only financial year in which SCHT Palmerston North made a small profit was the year to June 2006, mainly due to a first-time contract that year from the Mid-Central District Health Board ("**Mid-Central DHB**"). That extent of funding is unlikely to repeat itself: while there is some funding for public elective orthopaedic surgery to occur in private hospitals,[23] there appears to be little Ministry of Health support for extending this to other procedures. Further, even in the 1990s, when there was considerably more political and Ministry support for the use of private hospitals for public services, SCHT Palmerston North was not greatly more profitable than it is now.

8.24 In addition, the DHB now has the option of having simple procedures performed, where feasible, at lower-cost facilities such as the Palms.

8.25 A recent development is the review of contract arrangements at the neighbouring Hawkes Bay DHB.[24] However, the use of private hospitals by that DHB is on a very small scale, and it is likely that many DHBs will proceed cautiously in respect of outsourcing, at least for the foreseeable future.

Situation likely to worsen

8.26 As already mentioned, a number of factors have recently either worsened the position for SCHT Palmerston North and Aorangi, or make it likely that the situation will worsen in the foreseeable future.

Shortages of specialists

8.27 The well documented national shortage of well-qualified medical specialists is particularly acute in provincial parts of New Zealand, which lack the large full-service public hospitals found in Auckland, Hamilton, Wellington and Christchurch, and do not have sufficient populations to support advanced specialties. Palmerston North is no exception; for example:

(a) the Mid-Central DHB has had an unfilled vacancy for a urologist for over three years;

(b) an oral maxillofacial surgeon who died four years ago has not been replaced;

(c) the number of FTE gynaecologists in the Mid-Central DHB region is lower than in 1989, with no recruits on the horizon;

(d) senior specialists continue to leave the region for Australia: for example, Dr S Ragavan (an anaesthetist), Dr A Mackillop (an ophthalmologist), and Dr A Turnley (an anaesthetist) all left for Australia in 2007. None have been replaced.

8.28 Many of the specialists in the city are **[**

[23] This is effectively a "hip replacement waiting list" commitment that was a condition of the United Future party's confidence and supply arrangement with the Labour party.
[24] See [8.45(a)] below.

]. This is a particularly significant problem for Aorangi, because cl 2.1 of the Aorangi Constitution restricts ownership of the shares in Aorangi to medical practitioners or related parties.

8.29 SCHT Palmerston North has also found it difficult to recruit specialists to Palmerston North to carry out surgery at its hospital. This is symptomatic of general difficulties SCHT is facing recruiting specialists in all regional centres. Indeed, a number of SCHT's specialists now work "on circuit" between Palmerston North, Wellington, and other lower North Island centres. For example:

(a) Urologist Quentin King works in private at SCHT Palmerston North, works in public at the Palmerston North Hospital, and works in Masterton Hospital (for the Wairarapa DHB) covering its urology;

(b) Dr Amil Sharma, an obstetrician and gynaecologist, covers Masterton Hospital. Dr Steven Grant, another obstetrician and gynaecologist, provides cover for Masterton Hospital from time to time;

(c) Professor Vinton Chadwick works at Wakefield Hospital in Wellington, and comes to SCHT Palmerston North two out of three weeks, on Thursdays and Fridays, to do gastroenterology work;

(d) Dr Ross Hayton travels to Levin to do a weekly gastroenterology clinic on Fridays;

(e) Dr Geoff Duff lives and has a regular clinic in Wanganui. He has other clinics in Levin and Fielding, and has a clinic in Palmerston North once a month. He operates in Palmerston North;

(f) Several of the orthopaedic surgeons travel to Levin for regular clinics;

(g) Dr David Wilde, an obstetrician and gynaecologist, works for the Wanganui DHB on Mondays and Tuesdays, does private surgery in Palmerston North on Wednesdays, and has clinics in Marton and Palmerston North on Thursday / Friday;

(h) Dr Clive Soloman, a general surgeon from Wanganui, has begun to carry out endoscopy work at SCHT Palmerston North.

8.30 Short of a significant increase in remuneration for public hospital work it is unlikely that this situation will improve.

Technology race

8.31 Besides competition on price and quality of hospital treatment and care, a major dimension on which competition occurs is technology. For any particular injury or ailment, there are likely to be a variety of remedies that a specialist can provide. The remedies will vary in a number of respects, such as likely result, risk, cost and side-effects. However, they will also vary in terms of the equipment and technology required to perform them.

8.32 For example, if a urologist assesses a patient as requiring a prostatectomy (prostate operation), a number of options are available:

(a) standard surgical removal: while comparatively inexpensive and not requiring any particular technology, considerable nerve damage can often result, and the complications (including impotence, infection and bleeding and incontinence) can be substantial;

(b) use of laser equipment: this typically results in few complications and better patient outcomes than traditional surgical removal. However, the equipment is expensive and its purchase is difficult for Aorangi and SCHT Palmerston North to justify given patient volumes. It will inevitably lead to losses of patients seeking treatment at Wellington (or Hamilton);

(c) brachytherapy: this involves the shrinking of the prostate by the injection of radioactive beads. The procedure is expensive, requires a specifically trained urologist, specialist equipment, a licence to handle the radioactive beads, and is available only at select private hospitals in Auckland, Tauranga, Wellington and Christchurch. (The DHBs are only now introducing the technology to their tertiary hospitals);

(d) engineering assisted or robotically controlled surgery. The capital cost for this equipment is approximately $4–5 million; however, it allows much more precise visualisation of the blood supply and nerve bed, and thus a reduction of surgical complications.

8.33 A further example is the technology required for a hip replacement. This is a high volume routine for Aorangi. A new technique uses minimum invasive surgery, with reduced prospects of side effects, but requires high cost equipment. Should Aorangi (and likewise SCHT Palmerston North) not provide this equipment it will lose a large portion of its work, as patients are directed or elect to travel to more profitable hospitals in Wellington (or possibly Hamilton or Auckland) with the latest equipment. In addition, in the Christchurch private hospitals at present, a patient's hip replacement is now aligned using the latest "Stryker" operating room equipment. The computerised equipment allows for improved realignment of the implant. This reduces joint wear and tear and extends the life of the implant. The Palmerston North hospitals will also need to invest in this expensive equipment or lose patients (and specialists) to other hospitals.

8.34 The Applicants can provide other examples of technology competition on request.

8.35 As a general rule, if a patient is informed that there is a more modern treatment available, he/she will want to obtain that treatment even if it is only marginally more profitable for the hospital.

8.36 As a result, it is common to see competition between hospitals to obtain the latest equipment necessary to attract specialists and therefore patients. Increasingly, the cost of state-of-the-art equipment is such that it is beyond the scale a provincial private hospital can justify given its patient numbers; in that case patients must (and do) travel to a major centre for treatment. Even where a technology investment is within the scope of provincial hospitals, the investment required is substantial. Except where a technology investment offers an opportunity to "trump" a rival's expensive but now not state-of-the-art technology, it is unlikely the technology investment will significantly increase market share.

8.37 Given the cost of investing in new technology, it is highly unlikely that either SCHT Palmerston North or Aorangi would be able to undertake such investments.

Over-capacity

8.38 Even when only considering SCHT Palmerston's and Aorangi's facilities, six operating theatres (and two procedure rooms), the city has an over-capacity of full service private hospital facilities. The problem is exacerbated by the increased costs for health insurance. This is a relevant factor, especially when considered along with the fact that Palmerston North/Wanganui is the region with the second

lowest median income in New Zealand (after Northland).[25] As a result, SCHT Palmerston North has only a **[ ]**% theatre utilisation rate.[26] Aorangi has an even lower **[ ]**% theatre utilisation rate.[27]

Increased regulatory requirements

8.39 The Health and Disability Sector Standards NZS8134 (2001; into effect c 2002) have also imposed considerable direct costs and compliance costs on the hospitals, particularly in respect of:

(a) complaints management;
(b) patient pre-entry and entry to the hospital;
(c) service delivery requirements;
(d) medical records management;
(e) food handling;
(f) cleaning;
(g) infection control;
(h) waste management;
(i) natural lighting;
(j) ventilation;
(k) heating;
(l) sterilisation;
(m) preparing, consulting on and applying restraint minimisation standards;

8.40 As a result of these standards, SCHT has needed to employ at least one FTE staff to carry out quality, sterilisation and infection control. Aorangi has two staff responsible for quality control work (1.2 FTE).

Restrictions on DHB contracting

8.41 There are few prospects of obtaining significant contracts from the Mid-Central DHB (the only contract that Aorangi and SCHT Palmerston North currently have with the Mid-Central DHB is for joints). Indeed, the main Mid-Central DHB hospital, Palmerston North Hospital, is understood **[ ]** (but is constrained by staffing numbers). It is understood that the Mid-Central DHB has plans to open a new "super clinic" in Palmerston North in the short to medium term. Should this occur, the DHB could have further available capacity.

8.42 This excess capacity makes it unlikely that the Mid-Central DHB will need to resort to private-sector tendering for hospital surgical services (or specialist services), except where there is a surgeon shortage (such as in orthopaedic surgery).

Equipment requirements for large contracts and ongoing replacement

8.43 Approximately **[ ]**% of SCHT Palmerston North's surgical revenue, and **[ ]**% of Aorangi's turnover, depends on a small number of large contracts the hospital has with:

(a) the Accident Compensation Corporation; and

(b) Mid-Central and other District Health Boards.

[25] Statistics NZ, 2007.
[26] Year to June 2007. This rate has increased from **[ ]**% in 2005, due to SCHT obtaining a low-margin bulk DHB contract.
[27] Financial year ending 2007. In the financial year ending 2005, the rate was under **[ ]**%.

(A further significant share of SCHT Palmerston North's surgical revenue depends on a number of fixed price contracts, primarily with insurance companies.)

8.44 The hospitals need to retain as many of these contracts as possible to spread their costs. Given, however, that the ACC and DHBs have monopsony power in the tendering process for these contracts, the private hospitals have little choice other than to meet the ACC's and DHB's increasing qualitative requirements, which in turn increase the hospitals' costs. In particular:

(a) ACC has suggested that its private hospitals should move beyond Ministry of Health certification and meet the additional standards for "accreditation": this is expected to impose materially higher compliance costs;

(b) in order to win new contracts, considerable equipment investment or specialist availability is often required. For example, to win the neurology and cardiology DHB contracts in 2005 and 2006, SCHT Palmerston North had to obtain treadmills and obtain the services of neurologists.

Competitive tendering and inter-city competition has largely removed margin from large contracts

8.45 In addition, competition for large contracts (usually tenders run by DHB's and ACC) has become more competitive, affecting hospital margins. It is common for the large contracting parties to seek tenders from hospitals located beyond the immediate vicinity of the patients to be treated. For example:

(a) the Hawkes Bay DHB has recently sought tenders from SCHT Palmerston North and Aorangi for the provision of some otolaryngological and gynaecological elective surgery to Hawkes Bay residents. SCHT understands that **[ ]**. In early March 2008 it determined to award a portion of the contract to SCHT Palmerston North. (As a result, Hawkes Bay DHB patients will be required to travel to Palmerston North for this surgery); and

(b) the Wanganui DHB has, likewise, **[ ]**;

(c) funding for ACC contracts is allocated by region (with Palmerston North falling in a region covering the lower North Island). SCHT Palmerston North and Aorangi are effectively competing for that money against all other hospitals in the Lower North Island.

8.46 The Commission made similar observations of the extent of DHB tendering in *Decision 620* (*SCHT/QE Hospital Ltd*, 28 Sep 2007). It concluded that the geographical extent of the market for public elective surgery should (at least) include the Hamilton and Lakes DHB areas (at [54]–[55]).

8.47 This inter-DHB-area competition has only become commonplace only in the past three or four years. It has further made the contracts to large contracting parties less profitable.

8.48 By way of example of the tightening of margins, SCHT Palmerston North was awarded the first gynaecology contract put out to tender from the Mid-Central DHB in the financial year to June 2006. However, it failed to win the second contract (Aorangi did) **[ ]**.

High interest rates

8.49 As the Commission will be aware, interest rates are particularly high at the moment, and are forecast to continue at relatively high levels for at least the short (and likely the medium) term. For Aorangi, at least, interest is a significant expense, **[ ]**.

A sale as a going concern would not fix matters

8.50 The situation in Palmerston North would not be remedied by selling SCHT Palmerston North (or Aorangi) to a (hypothetical) alternative buyer: SCHT's difficulty is not lack of access to capital,[28] or poor management, or an inefficient organisation. Rather, in the current health environment, Palmerston North is simply too small a city to sustain two full private surgical hospitals.

8.51 This has been recognised from as early as 2000: for example, minutes of a SCHT trustee meeting on 7 June 2000 record:

> The Palmerston North market can only support one operator and for this reason Southern Cross propose to rationalise the market by acquiring the Mercy Hospital business.

8.52 Similarly, in a letter to the trustees dated 6 June 2000, Dr Lesley McTurk, the then General Manager Healthcare Delivery for SCHT, noted that the prospect of a surgeon group acquiring the Mercy Hospital:

[

]

8.53 Besides SCHT, the other major operator of hospitals in New Zealand is Wakefield Health Limited ("**Wakefield**"). **[**

]:

[

]

The hospital sites are more profitably utilised for alternative purposes

8.54 A Metlifecare retirement village adjoins SCHT Palmerston North. On a number of occasions, **[**

].

[28] As was the case with, for example, Mana Coach Services Ltd in *Commerce Commission v NZ Bus Ltd* (2006) 11 TCLR 679, [190].

8.55 In addition, the Mid-Central DHB **[**

].

Price increases would not improve matters

8.56 It is no answer for SCHT Palmerston North simply to raise its prices. This would not be consistent with the national pricing that SCHT broadly attempts to apply, nor with its stated objective of providing affordable access to healthcare services. Nor would it be likely to succeed: if SCHT attempted to raise its prices materially, it seems unlikely that Aorangi (with its greater ability to loss-lead, and higher current profitability) would need to match the increases. SCHT would lose market share to Aorangi, Belverdale and also to the other hospitals in Wellington, Masterton, Dannevirke and Hawkes Bay.

Short-stay / day-stay only would not improve matters

8.57 It would not be viable for SCHT Palmerston North or Aorangi to exit just the in-patient market, and become a standalone short-stay / day-stay hospital:

(a) only **[ ]**% of SCHT patients (generating a significantly smaller share of total revenue) are short-stay / day-stay patients; losing the in-patient business would cost the hospital **[ ]** its patients and **[ ]** its revenue.

(b) there would not be a corresponding reduction in cost: SCHT would still incur the costs for operating the full hospital building, and it would still need a similar number of staff for all functions other than overnight nursing shifts.

(c) SCHT Palmerston North would be seen as less desirable to specialists and short-stay / day-stay patients than Aorangi, because SCHT would lack the ability to perform the full range of procedures, and would lack the ability to keep patients overnight if complications arose.

(d) SCHT does not presently operate short-stay / day-stay-only hospitals under its brand. It has a reputation as a full-service private hospital operator, and it would not wish to damage that reputation;

(e) By providing short-stay / day-stay only, SCHT would be competing directly with the lower cost and purpose-built The Palms—**[ ]**;

8.58 Similar considerations apply for Aorangi.

Conclusion

8.59 Both hospitals have essentially exhausted their options for generating new business, implementing cost savings, or raising prices. A sale as a going concern would not improve matters. As noted, the region is simply too small to support two private hospitals. In these circumstances, if the merger is not permitted to proceed, the only rational outcome in the short- to medium-term is that either SCHT Palmerston North or Aorangi will close down entirely as a surgical hospital, and its facilities be devoted to a use other than a private surgical hospital.

PART II: IDENTIFICATION OF MARKETS AFFECTED

9. MARKET DEFINITION ISSUES

Previous Decisions

9.1 In *Decision 620* (*SCHT/QE Hospital Ltd*, 28 Sep 2007) the Commerce Commission ("**the Commission**") defined the following markets:

> 56. As a starting point for its competition analysis, the Commission in this case will consider the markets for:
>
> - the provision of private short-stay hospital facilities and related non-specialist services for non-DHB elective secondary surgery in the Rotorua region (the short-stay market);
> - the provision of private in-patient hospital facilities and related non-specialist services for non-DHB elective secondary surgery in the Rotorua region (the in-patient market); and
> - the provision of hospital facilities and related non-specialist services for DHB contracts in the Waikato and Lakes DHB catchment areas (the DHB contracts market).

9.2 The short-stay and in-patient market definitions have also been developed in a line of previous Commission decisions: *Decision 537 (Southern Cross Oxford Hospital / The Oxford Clinic,* 11 Nov 2004), *Decision 518 (Pacific Radiology Limited / Wakefield Radiology Ltd,* 28 Feb 2004); *Decision 492* (*Wakefield Hospital Ltd / Bowen Hospital,* 19 Feb 2003); and *Decision 449* (*The Ascot Hospital and Clinics / Mercy Hospital Auckland Ltd,* 14 Dec 2001).

9.3 The Applicants consider that most aspects of these market definitions, as applied to the markets around Palmerston North, are correct. However, they:

(a) do not accept that there is a separate market for DHB contracts (on the basis that there is near-perfect supply-side substitutability); and

(b) consider that, in the context of this application, the relevant geographic market boundaries should extend to include Fielding, Dannevirke, Wanganui, Levin and Wellington (and that, in any event, facilities in those towns act as a strong constraint on those in Palmerston North).

9.4 The question of whether there is a market for treatment under DHB contracts separate from the market for treatment under ACC contracts, treatment under private insurance contracts and treatment of private uninsured does not seem to be material to this application (on the basis that it does not materially change market share figures or numbers of competitors;[29] and competition is unlikely to be substantially lessened in any geographically broad DHB contracts market). The Applicants do not pursue this issue in this notice of application.

[29] The Dannevirke Community Hospital is a small private surgical hospital within the Mid-Central DHB area that primarily provides services to the DHB. While its role as a constraint in the short-stay / day-stay and in-patient markets would depend to some extent on whether there is a separate DHB market, in either case it is unlikely on its own to be a major constraint post-acquisition.

9.5 However, the Applicants consider that the issue of the geographical extent of the private in-patient and private short-stay / day-stay patient market is potentially relevant to this application. This point is addressed in the next subsections.

Relevant geographical boundaries

Market definition and patient flows

9.6 The "ssnip test" is the usual analysis to determine the correct geographic market boundary. In this case, the Applicants observe that price is not the main factor in patient choice: factors like quality and hospital technology are usually far more important factors, for reasons developed below. As a result, it may make more sense to modify the ssnip test slightly to take into account competition on factors other than price; that is, to find the smallest region within which a hypothetical hospital with a monopoly over that region would be able to profitably implement either a small but significant and non-transitory increase in price, or a comparable decrease in quality, or a comparable failure to invest in technology.

9.7 Patient "flow" information does not ordinarily by itself answer this question: if a market is already in equilibrium, then relatively low inter-city flows would be expected irrespective of the size of the market. The question is whether these flows would be materially greater *if the hospital(s) in a particular city, but not other cities, tried to implement a ssnip*, to such an extent that the ssnip became unprofitable.

9.8 Around SCHT Palmerston North and Aorangi, however, there is actual evidence of significant patient flows. Analysis conducted by NERA and annexed in **Appendix 4** indicates that nearly **[ ]**% of SCHT Palmerston North's customers since 2004 have come from outside Palmerston North. Of those, a significant percentage have come from beyond the immediate proximity of Fielding, Bulls, Ashhurst and Palmerston North. There are significant patient flows:

(a) between Wanganui and Palmerston North;

(b) between Palmerston North and Wellington; and

(c) from the Kapiti/Horowhenua area to hospitals in both Palmerston North and Wellington.

9.9 The Applicants consider that the relevant in-patient and short stay markets clearly extend to include at least Levin, Wanganui, Palmerston North, Fielding and Dannevirke, (the "**75 km region**"). They also submit that the markets extend further to include Masterton and Wellington (the "**150 km region**"), and possibly slightly further to include Napier/Hastings (although this is unlikely to be material to the analysis if Wellington is already in the market). The Applicants have identified competitors on that basis.

9.10 This section explains why the patient flows are at these levels, and why the market should be defined in either way.

Patients: Human geography

9.11 Much like Hamilton and Christchurch, Palmerston North is the centre of a large farming region that is relatively densely populated, with intensive agriculture and relatively short distances between cities and towns on generally straight roads. Other than the 8km road through the Manawatu Gorge, there are no major natural barriers or unpopulated areas. (By contrast, Rotorua, the subject of *Decision 620*,

is surrounded by forest in all directions, with the largely unpopulated Kaimai and Mamaku Ranges separating Rotorua from the western Bay of Plenty and Waikato).

9.12 Partly as a result of this, Palmerston North is well integrated into the economy of the surrounding rural areas, cities and towns. Almost half (47.9%) of the population of the Manawatu-Wanganui region lives outside the two major cities.[30] Statistics NZ has defined most of the area between Palmerston North, Wanganui and Levin as meeting[31] the criteria for "rural area with high urban influence" or "rural area with moderate urban influence":[32]

> (1) if a large percentage of the resident employed population works in a minor or secondary urban area, or (2) if a significant percentage work in a main urban area…

Patients: Relative insignificance of travel costs

9.13 It goes without saying that elective surgery is a major event for most patients. In purely financial terms, it is expensive, and the hospital fees are only one component of the overall cost. Even for insured patients, who are not exposed directly (or completely) to out-of-pocket costs, there is a significant cost in time, inconvenience and the need for recovery and rehabilitation. In some cases, the downside risks are significant; in almost all cases, the likely upside benefits from a successful operation are substantial.

9.14 In this context, the relative cost of travel to a private hospital should not be overestimated. Even the opportunity cost of, say, 200 km of car travel each way is likely to be insignificant in the context of the total cost of an operation. This has two consequences:

(a) patients are willing to travel to a distant hospital (in Auckland or Christchurch, or even overseas[33]) when a local hospital is unable to cater for the required procedure.[34]

(b) however, even where a local hospital and specialist are able to provide a particular type of treatment, patients are still prepared to travel some distance in order to obtain a perceived cost or clinical advantage. As a general rule, for any procedure that is not routinely performed at a local hospital, the patient will generally prefer to travel a further distance to a hospital where the procedure is more routinely performed. (See further [9.22] et seq.)

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:

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[30] Statistics NZ, *New Zealand: An Urban/Rural Profile*, data table "Manawatu/Wanganui Region / Estimated Residential Population at 30 June 2001-2004", available at www.stats.govt.nz/urban-rural-profiles/default.htm. By contrast, 37.2% of the Bay of Plenty region lives outside the major cities, and much of this population would be on the coastal plain.

[31] Statistics NZ, *New Zealand: An Urban/Rural Profile*, map "Urban/Rural Profile Categories: Manawatu/Wanganui Region", available at ibid.

[32] Statistics NZ, *New Zealand: An Urban/Rural Profile*, at 8; copy available at ibid.

[33] For example, SCHT Christchurch performs approximately a dozen gender reassignment operations per year, for customers from around the world.

[34] For example, it is necessary for a patient to travel to a major centre for neurosurgery, open heart surgery, anything requiring intensive care, stomach stapling, complex bowel surgery.

(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;[35]

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;

(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.

[35] 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).

As a result, for example (and as already mentioned), the Boulcott Hospital has opened a clinic in Paraparaumu, and SCHT Palmerston North has carried out advertising in the area, promoting its services to local GPs (see paragraph [8.20] above);

(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 [8.32] above); 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 [8.31], 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 [8.32] above; and

(b) Hip replacements: see [8.33] above.

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, SCHT 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.

Summary of relevant factors

9.26 The geographical area in which hospital facilities operate in Palmerston North/Manawatu therefore exhibits the following features:

(a) relatively dense population, relatively short travelling times between cities and an integrated economy;

(b) no natural physical barriers (except for the Manawatu Gorge);

(c) a material proportion of the population located between the major population centres;

(d) significant commuting from rural areas to urban areas for employment;

(e) private elective surgery is expensive for non-insured patients, and is in any event a significant event for patients and their families; transport costs are rarely significant in this context;

(f) much of the decision-making is in fact in the hands of GPs and specialists; if (as is common) the specialist has a preferred hospital a key element of competition is for that specialist to change his/her preferred hospital;

(g) search costs are accordingly minimal due to the availability of recommendations;

(h) however, a number of factors enable meaningful competition to occur notwithstanding specialists' preferences;

(i) a specialist's recommendation will turn far more on which hospital has the best expertise and equipment in the particular type of treatment in question; hence hospitals tend to specialise in a series of "niches";

(j) such competition for technology occurs on an inter-regional basis.

9.27 In these circumstances, the precise geographic market definition is not straightforward. In any event, whatever definition is adopted, the presence of substantial extra-market constraints must be acknowledged.

Possible market geographic boundaries

9.28 The potential geographical boundaries of the relevant hospital facilities markets are (in increasing size):

(a) the Mid-Central DHB area (would include Fielding, Levin, Marton, Bulls and Dannevirke);

(b) **75 km region:** facilities within 75 km of Palmerston North, or within the Horizons Regional Council area (would include Wanganui)—note that the hospitals in Wanganui and Palmerston North are both within 40 km of the area around Marton;

(c) **150 km region:** facilities within 150 km of Palmerston North (would include Wellington)—note that the substantial Kapiti Coast/Horowhenua population (over 70,000, close to Palmerston North's population) is relatively

equidistant between Wellington and Palmerston North—see discussion at (see [8.20] above); or

(d) **Lower North Island**: facilities within 180 km of Palmerston North (would include Napier and Hastings).

Analysis

9.29 The applicants are unaware of any situation in which an actual hospital with a local monopoly has attempted to implement a ssnip (or corresponding reduction in quality). However, it is relevant that hospital prices nationally, even in remote areas such as Gisborne, Otago and Invercargill, are broadly comparable, and possibly even lower in the small centres (in part due to lower costs).

9.30 In respect of technology competition and the development of "niches", the Applicants consider that this competition occurs on a "lower North Island" basis, in the sense that the Applicants will always look to what the hospitals at Wanganui, Hawkes Bay, Masterton and Wellington are doing and investing in, and attempting to identify opportunities. In particular:

(a) while it is rare for the Palmerston North hospitals to lose local patients due to new developments in, say, the Wanganui or Masterton public hospitals, a development at those hospitals could cause the Palmerston North hospitals to lose customers who would otherwise have been prepared to travel from Wanganui or Masterton;

(b) likewise, while the Palmerston North hospitals are rarely able to attract customers from Wellington (although they can from Horowhenua / Kapiti), the Palmerston North hospitals' investment in new technology (or facilities upgrades or staff initiatives) can allow them to compete against new technology investments (or facilities upgrades / staff initatives) by the Wellington hospitals and thereby retain Palmerston North customers who they would otherwise lose.

9.31 For these reasons, and with reference to the customer flow data and the factors listed at [9.26], the Applicants consider that the relevant market extends to include at least Levin, Wanganui, Palmerston North, Fielding and Dannevirke (the 75 km region). They also submit that significant constraints are present from facilities further away and which would include Masterton and Wellington (the 150 km region), and possibly slightly further to include Napier and Hastings.

10. MARKETS AFFECTED BY HORIZONTAL AGGREGATION

Product Space

10.1 There is a significant supply-side substitutability (for both patients and medical specialists) between short-stay and in-patient hospital facilities for elective surgery. However, the Applicants agree with the Commission's previous observation that these operate in different markets.

10.2 *Decision 620* is unclear as to whether hospital facilities for certain types of clinical procedures are properly in different markets. However, this application has proceeded on the assumption that facilities for different procedures are in the same market, with dynamic competition for investment in technology and development of niches.

Functional Dimension

10.3 In its previous decision, the Commission has considered the functional dimensions of the relevant markets. The Applicants are content to adopt those dimensions here,[36] but can provide more information if requested.

Customer dimension

10.4 *Decision 546* (applied in *Decision 620*) took the preliminary view that there are separate markets for public services in private hospitals and private services in public hospitals.[37] According to this view, while both private and public hospitals operate in the publicly funded market, only private hospitals operate in the privately funded market[38] and, taking a variety of factors into account, the Commission considered that the two were not economic substitutes.[39]

10.5 SCHT Palmerston North and Aorangi have been operating in the publicly funded market, as a result of outsourcing by the Mid-Central, Wanganui and Hawkes Bay DHBs. This contributes **[ ]**% of SCHT's income and approximately **[ ]**%[40] of Aorangi's income. SCHT and Aorangi therefore compete for public as well as private funding.

10.6 However, SCHT and Aorangi consider that no competition issues arise in the geographically broad public market, and do not consider this further.

10.7 The Applicants agree that, due to the supply-side substitutability, contracting with non-insured patients, private insurers and the Accident Compensation Corporation are all in the same market. Because hospital services are nearly perfect complements for a specialist's services, "fixed price" hospital-and-specialist contracts will also operate in this market (and in the market for specialist services).

Geographic space

10.8 As described at [9.31] above, the Applicants consider that the relevant markets for short-stay / day-stay and in-patient facilities should include at least Levin, Dannevirke and Wanganui (the 75 km region). They have also identified facilities that provide significant constraint in the area extending to include Masterton and Wellington (the 150 km region).

Current competitors in the markets for inpatient and day stay hospital facilities and non-specialist services

10.9 **Table 4** sets out the other private hospitals offering short-stay / day-stay and/or in-patient facilities in the Lower North Island.

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[36] However, the Applicants note for completeness that an issue arises with the definition at [56] of *Decision 620* of the market for the "provision of hospital facilities and related non-specialist services for DHB contracts". *Decision 620* does not appear to have considered whether the market should instead be defined as the market for the "provision of surgical procedures for DHB contracts…"; that is, to reflect the fact that DHBs contract with private hospitals for "all-up" procedures, including the surgical services.

[37] *Decision 546* at [52].

[38] Ibid. This statement does not preclude the ability of a private hospital to operate using the facilities of a public hospital, as occurs with the Selena Sutherland Hospital in Masterton (see note 9 above) and the Churchill Trust in Blenheim.

[39] Ibid, at [52]–[66].

[40] Aorangi has budgeted a DHB share of **[ ]**% in the 2008 year, as part of an effort to reduce reliance on DHBs.

Table 4: 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	Unknown, expansion planned.	139	102
Boulcott Hospital	Boulcott Clinic Limited	High Street, LOWER HUTT	Yes	Yes	Two, plus one under construction, 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	Unknown	54.1	41
The Palms	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	SCHT	Hanson St, Newtown, WELLINGTON	Yes	Yes	Three, with two more planned.	127	104
Parkside Hospital	Dr Gornoori and Mary Krishnayya	522 Kennedy Road NAPIER	Unlikely to present a constraint.[41]			171	140

Effect of acquisition in terms of horizontal aggregation

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

[41] See note 8 above.

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.

11. DIFFERENTIATED PRODUCT MARKETS

Extent of Product Differentiation

11.1 There is product differentiation in these markets in a number of respects:

(a) by geographic location: see **Table 4** above.

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

(c) by level of technology investment: see discussion at [9.22] et seq above;

(d) governance structure (some patients disapprove of doctors owning hospital; personality; good place to work; being well-known).

11.2 There is no longer any material differentiation along religious denomination.

12. VERTICAL INTEGRATION

12.1 No vertical effects arise as a result of this merger. If anything, with the Aorangi shareholders having reduced control over the JV Co than they currently have over the Aorangi hospital, there is some potential for vertical disaggregation.

13. PREVIOUS ACQUISITIONS AND COMMISSION NOTIFICATIONS

13.1 **Table 5** lists relevant acquisitions in the last three years:

Table 5: Commerce Commission notifications in the last three years

Dec'n No	Dec'n Date	Applicant	Target	Determination
620	28 Sept 2007	SCHT	QE Hospital Limited	Cleared
546	17 Feb 2005	SCHT	Auckland Surgical Centre Limited	Cleared

13.2 The Applicants are aware of two further hospital acquisitions that have occurred in New Zealand in the last three years:

(a) In November 2005, Wakefield Hospitals Ltd, owner of the Wakefield and Bowen hospitals in Wellington, amalgamated with Royston Hospital Ltd, owner of the Royston Hospital in Hastings;

(b) In May 2005, Integrated Hospitals Ltd purchased The Ascot Hospital & Clinics Ltd, operator of the Ascot Hospital in Auckland.

Section C: Competition analysis

IN-PATIENT MARKET

14. CONSTRAINTS ON MARKET POWER BY EXISTING COMPETITORS

Existing competitors

14.1 As described at [10.10]–[10.11], in the inpatient market there will be no reduction in the number of existing competitors relative to the counterfactual—either SCHT Palmerston North or Aorangi will shut down or withdraw from this market.

14.2 As a result, the constraints on market power by existing competitors will be the same as would constrain the surviving Acquirer in the counterfactual.

14.3 Within the wider Lower North Island, the merged entity will compete with the Belverdale Hospital in Wanganui, Wakefield and Bowen Hospitals in Wellington, Royston Hospital in Hastings, the Selina Sutherland Hospital in Masterton, and the Boulcott Hospital in Wellington (with a branch in Paraparaumu), all of whom currently offer in-patient hospital facilities. Within the 75km region, the JV Co will provide competition for the Belverdale and Danniverke Hospitals.

14.4 The Applicants are unaware of any capacity constraints that would affect any of these hospitals' ability to constrain JV Co in the factual scenario. In particular, the Belverdale Hospital in Wanganui currently operates on a reduced-shift schedule, operating as a short-stay / day-stay hospitals some weeks, and as an in-patient hospital other weeks. This gives it considerable ability to expand.

Conditions to and examples of expansion by existing competitors

14.5 Subject to site constraints, expansion is relatively straightforward. The Boulcott Hospital in Wellington is currently undergoing considerable expansion[42] and has opened a branch in Paraparaumu; Wakefield and Royston Hospitals have also recently expanded.[43] Existing competitors are likely to have sufficient capacity to constrain the JV Co.

14.6 There are not likely to be any other barriers to expansion. In particular, Wakefield is a large hospital operator, and could comfortably expand its facilities if there were capacity difficulties, or make new equipment investments if these were required.

Market characteristics relevant to potential for coodination

14.7 The proposed acquisition will not increase scope for the exercise of coordinated market power, relative to either the counterfactual or the status quo.

14.8 **Table 6, Table 7** and **Table 8** below comment on the market characteristics set out in the Commission's *Mergers and Acquisitions Guidelines*:

[42] See www.boulcotthospital.co.nz/gpnews/building-developments/.
[43] Wakefield Hospital Ltd, *2007 Annual Report*, at 2 and 6.

Table 6: Scope for co-ordinated market power

Feature	Comment
High seller concentration	Yes, but some small competitors in DHB region; plenty of competitors in Lower NI.
Differentiated product	Yes.
Static production technology	No—see [8.31] et seq above
Speed of new entry	Relatively rapid
Fringe competitors	Yes—refer competitors identified in **Table 4** above.
Acquisition of a maverick	No.
Price elastic market demand	No.
History of co-ordinated conduct	No.
Countervailing power of acquirers	Yes, strong countervailing power—the business of ACC and insurers (and DHBs to a lesser extent) are all vital to allow the hospitals to spread costs across sufficient volumes. Further, the patients' choice of hospital largely depends on a specialist's recommendation—this effectively "lumps together" a significant group of customers—see [9.16]–[9.18] above
Existence of excess capacity	Yes.
Industry associations/fora	New Zealand Private Surgical Hospital Association.

Table 7: Detection of deviation from co-ordination

Feature	Comment
Seller concentration	Yes, but some small competitors in DHB region; plenty of competitors in Lower NI.
Frequent sales	A high percentage of sales are negotiated in bulk contracts with DHBs, insurers and ACC. Therefore less ability to detect deviation.
Vertical integration	No vertical integration.
Growth in demand	Stable at best.
Cost similarities	Not in some respects; e.g. SCHT has bulk purchasing power for consumables; also differences. Average fixed costs will vary by scale of hospital.
Multi market contact	Other than the in-patient and day-patient markets in the 75 km region/Lower North Island, SCHT does not compete directly against any of the identified competitors. As a result, there is no real multi-market contract.
Price transparency	Most price information is reasonably easily available.

Table 8: Ability to retaliate

Feature	Comment
Credibility of threats to abandon collusion	Given that many contracts are negotiated on a long-term basis, it would be unlikely to be credible.
Availability of excess capacity	Yes.
Profit incentive from collusion	Unlikely to be a strong profit incentive—see discussion at [14.9]–[14.10] below.
Ability to disadvantage by dumping in deviator's allocated section of market	Given that many contracts are negotiated on a long-term basis, unlikely to be possible.

14.9 In addition, SCHT and many other hospital owners are not for profit trusts with a goal of advancing the public interest in healthcare. It is intrinsically unlikely that they would frustrate this interest by driving up the price of healthcare.

14.10 Further, many other hospitals are specialist-owned (the JV Co will be a combination of not-for-profit trust owned and specialist-owned). Given that specialist services are a complement for hospital services, it is highly unlikely that specialists would find it in their interests to drive up artificially the price of hospital services.

14.11 There is no evidence of past or current coordination by private hospitals.

14.12 Existing competition therefore provides a realistic constraint on any attempt to coordinate post-acquisition.

15. CONSTRAINTS ON MARKET POWER BY POTENTIAL COMPETITION

Conditions of Entry

15.1 Due to the surplus of capacity in the market, relatively slow growth, and undermining of profitability by those factors described in section 8, "greenfields" entry in the market, in either the status quo, factual or counterfactual is considered unlikely in the immediate future.

15.2 There are, however, some other ways in which entry could occur:

(a) a new private hospital facility could open on the Kapiti Coast or in Horowhenua. The demographics of this area are described at [8.20]. If a new private hospital were to open on the Kapiti Coast, this would provide a very strong position from which to take market share away from the JV Co.

(b) the Mid-Central DHB could adopt the strategy taken by the Wairarapa and Nelson-Marlborough DHBs, which have allowed the Selina Sutherland and Churchill Trust private hospitals to use the facilities at the Masterton and Wairau Hospitals for operating. Likewise, Mid-Central DHB could let a new private hospital use its Palmerston North Hospital or Horowhenua Hospital facilities and other resources when they are not being used for public treatment. In Levin, for example, the Kimberley Centre for people with intellectual disabilities is closing down;[44] this would provide a ready-made facility with easy access to Horowhenua Hospital.

[44] Refer executive.govt.nz/MINISTER/dyson/kimberley/pr.htm.

(c) The Palms could convert to providing in-patient care. With the building specifically designed for conversion of a procedure room into an operating theatre, this could occur easily, at a cost of less than $2 million. (The Applicants understand that The Palms building to date cost over $7m.)

16. OTHER POTENTIAL CONSTRAINTS

Constraints on market Power by the Conduct of Acquirers

16.1 As the Commission recognised in *Decision 620*,[45] and as discussed at [8.43] above, the large acquirers (particularly ACC and the insurers) act as a significant countervailing force in this market.

16.2 In addition, as noted at [14.9]–[14.10], the not-for-profit and specialist-owned nature of SCHT, Aorangi, JV Co means it is unlikely to be in the interests of the JV Co directors (even if fiduciary obligations permitted) to raise prices.

Constraints on market Power by the Conduct of Suppliers

16.3 Not relevant.

[45] *Decision 620* at [106]–[109].

SHORT-STAY / DAY-STAY MARKET

17. CONSTRAINTS ON MARKET POWER BY EXISTING COMPETITORS

Existing competitors

17.1 Similar to the in-patient market, there will be no reduction in the number of existing competitors relative to the counterfactual in the short-stay / day-stay market—either SCHT Palmerston North or Aorangi will shut down or withdraw from this market.

17.2 As a result, the constraints on market power by existing competitors will be the same as would constrain the surviving Acquirer in the counterfactual.

17.3 Within the 75 km region, the JV Co will be constrained by the Belverdale and Danniverke Hospitals, and by The Palms in Palmerston North (The Palms carries out a range of less complex day-stay procedures, and can easily accommodate general anaesthesia in the future, in direct competition with Aorangi and SCHT Palmerston North). Within the wider Lower North Island, the merged entity will also be constrained by the Wakefield Hospitals in Wellington, Wellington and Hastings, the Selina Sutherland Hospital in Masterton, Boulcott Hospital in Lower Hutt (and Paraparaumu), all of whom currently offer hospital facilities to in-patient elective patients.

17.4 The applicants are unaware of any current capacity constrains see [14.4].

Conditions to and examples of expansion by existing competitors

17.5 There are not likely to be any other barriers to expansion. In particular:

(a) The Palms is a large, newly built facility. It appears to have substantial excess capacity and appears to have plans to recruit specialists to its building. Although it does not currently have facilities for a general anaesthetic, its procedure rooms are designed to accommodate this equipment (and other operating theatre equipment) and, even without engaging in this investment, The Palms could easily expand the range of short-stay / day-stay services offered.

(b) as observed above, Wakefield could comfortably expand its facilities if there were capacity difficulties, or make new equipment investments if these were required. Its *2007 Annual Report* notes that Wakefield Hospital has a "seventh [operating theatre] available to be commissioned as soon as patient numbers justify".[46] Likewise, Boulcott Hospital plans to build a further two operating theatres.[47]

(c) the other competitors are also believed to have excess capacity.

Market characteristics relevant to potential for co-odination

17.6 The proposed acquisition will not increase scope for the exercise of coordinated market power, relative to either the counterfactual or the status quo. The discussion of the market characteristics (from the Commission's *Mergers and*

[46] See note 43.
[47] See www.boulcotthospital.co.nz/gpnews/building-developments/.

Acquisitions Guidelines) set out in **Table 6**, **Table 7** and **Table 8** at page 39 above, and paragraphs [14.9]–[14.10], also apply to the short-stay / day-stay market.

17.7 Likewise, there is no evidence of past or current coordination by private hospitals in this market.

17.8 Existing competition therefore provides a realistic constraint on any attempt to coordinate post-acquisition.

18. CONSTRAINTS ON MARKET POWER BY POTENTIAL COMPETITION

Conditions of Entry

18.1 The Commission has previously recognised that barriers to entry in the short-stay market are low.[48]

18.2 However, due to the surplus of capacity in the market, relatively slow growth, and lack of profitability, "greenfields" entry in Palmerston North itself, in either the status quo, factual or counterfactual is considered unlikely in the immediate future.

18.3 However, besides greenfields entry in Palmerston North, entry is possible by the following means:

(a) a cosmetic surgery clinic or other specialist clinic could increase the scope of its capabilities to provide short-stay / day-stay treatments to patients. Possible candidates for this are:

(i) Broadway Surgical Clinic, Palmerston North (already have a procedure room);
(ii) Broadway Radiology (capable of opening radiological service that does angiographic radiology); and
(iii) Pacific Radiology in Paraparaumu and Waikanae;

(b) a new Kapiti Coast facility, as described at [15.2(a)] above; and

(c) use of the Mid-Central Health Palmerston North or Horowhenua Hospital facilities for private treatment: see [15.2(b)] above.

19. OTHER POTENTIAL CONSTRAINTS

Constraints on market Power by the Conduct of Acquirers

19.1 As described at [16.1] countervailing power is a significant constraint.

19.2 In addition, as noted at [14.9]–[14.10], the not-for-profit and specialist-owned nature of SCHT, Aorangi, JV Co means it is unlikely to be in the interests of the JV Co directors (even if fiduciary obligations permitted) to raise prices.

Constraints on market Power by the Conduct of Suppliers

19.3 Not relevant.

[48] *Decision 546* (*SCHT / Auckland Surgical Centre Ltd*, 17 Feb 2004) at [141].

Section D: Signature

This Notice is given by:

Southern Cross Health Trust

The company hereby confirms that:
- all information specified by the Commission has been supplied;
- all information known to the company which is relevant to the consideration of this application/notice has been supplied; and
- all information supplied by the company is correct as at the date of this application/notice.

The company undertakes to advise the Commission immediately of any material change in circumstances relating to the application/notice.

Dated this 28 day of **March 2008**.

Signed by **Terence David Moore**

Terry Moore
CEO, Southern Cross Hospitals

Chief Executive Officer
Southern Cross Health Trust

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

This Notice is given by:

Aorangi Hospital Limited

The company hereby confirms that:
- all information specified by the Commission has been supplied;
- all information known to the company which is relevant to the consideration of this application/notice has been supplied; and
- all information supplied by the company is correct as at the date of this application/notice.

The company undertakes to advise the Commission immediately of any material change in circumstances relating to the application/notice.

Dated this 26 day of **March 2008**.

Signed by **Johannes Cornelis Bester**

JC Bester.

Chief Executive Officer
Aorangi Hospital Limited

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

Section E: Appendices

APPENDIX 1: Shareholdings

Table 9: Aorangi shareholdings and convertible note holdings

Name	Current shareholding		Convertible notes		Shares if notes redeemed	
	Number	%	Number	%	Number	%
Bester Family Trust	175,000	14.0%	27,250	2.7%	212,167	8.1%
Brougham No 2 Family Trust	100,000	8.0%	78,045	7.6%	204,309	7.8%
Mercer Family Trust Partnership	100,000	8.0%	78,501	7.9%	206,929	7.9%
Young Family Trust	75,000	6.0%	90,000	9.0%	199,071	7.6%
Brian Crichton	50,000	4.0%	71,267	7.1%	146,684	5.6%
Promoldon Family Trust (N Pollock)	50,000	4.0%	67,354	8.7%	170,258	6.5%
T and K Ellingham Family Trust	50,000	4.0%	114,499	11.5%	206,929	7.9%
Brent Boon and Dianne Boon Family Trust	50,000	4.0%	-	-	49,768	1.9%
Kevin John Davey	50,000	4.0%	92,000	9.2%	175,495	6.7%
MacKillop Family Trust	50,000	4.0%	40,000	4.0%	104,774	4.0%
J & M Sendall Family Trust	50,000	4.0%	60,000	6.0%	130,968	5.0%
M Hodges	50,000	4.0%	60,000	6.0%	130,968	5.0%
Annette Mary Turley/ Turley Family Trust	50,000	4.0%	100,000	10.0%	185,974	7.1%
John Chrisp	50,000	4.0%	27,709	2.8%	89,058	3.4%
C P + P M Williams Orthopaedic Trust	50,000	4.0%	-	-	49,768	1.9%
A D Spiers Trust	50,000	4.0%	-	-	49,768	1.9%
H R Stegehuis + C M Collins Family Trust	50,000	4.0%	-	-	49,768	1.9%
Ponniah Sri Ravgavan	50,000	4.0%	-	-	49,768	1.9%
Love Orthopaedic Surgery Trust	50,000	4.0%	-	-	49,768	1.9%
Peter Leung + Bruce Murdoch	50,000	4.0%	-	-	49,768	1.9%
Bruce and Louise Reiche	-	-	75,000	7.5%	102,155	3.9%
TOTAL	1,250,000	100%	999,625	100%	2,619,349	100%

APPENDIX 2: List of Specialists in Practice in Palmerston North

Occasional = once a month to once a year.

Table 10: Specialists in practice in Palmerston North

Name	Speciality	Aorangi S/holder	Uses Sthn Cross Hospital	Uses Aorangi Hospital	Public Hospital (PNH=Palm Nth WH=Wanganui)	Consulting/ Procedure Rooms
Dr Maria Au-Young	Anaesthesiology		Yes	Yes	PNH	
Dr Brent Boon	Anaesthesiology	Yes	Yes	Yes	PNH	
Dr Brian Crichton	Anaesthesiology	Yes	Yes	Yes	No	
Dr Alistair Gray	Anaesthesiology		Yes, but resigned in Mar 2008	Occasionally , but resigned in Mar 2008	PNH, resigning in Mar 2008	
Dr Mike Hodges	Anaesthesiology	Yes	Yes	Yes	PNH	
Dr Mhetusare Jachi	Anaesthesiology		Yes	Yes	PNH	
Dr Sarah Jackson	Anaesthesiology		Yes	Yes	PNH	
Dr Gerard McHugh	Anaesthesiology		Yes	Yes	PNH	
Dr John Mercer	Anaesthesiology	Yes	Yes	Yes		
Dr Murray Parkinson	Anaesthesiology		Yes	Yes	PNH	
Dr Neil Pollock	Anaesthesiology	Yes	Yes	Yes	PNH	
Dr Alberto Rodriguez-Ramirez	Anaesthesiology		Yes	Yes	PNH	
Dr Peter Schenk	Anaesthesiology		Occasional	Occasional	PNH	
Dr John Sendall	Anaesthesiology	Yes	Yes	Yes	PNH	
Dr Andrew Spiers	Anaesthesiology	Yes	Occasional	Occasional	PNH	
Dr Annette Turley	Anaesthesiology	Yes	Occasional, but on leave until Jan 09	Yes, but on leave until Jan 09	PNH, but on leave until Jan 2009.	
Dr Nigel Waters	Anaesthesiology		Yes	Occasional	PNH	
Dr Rob Whitta	Anaesthesiology		Occasional	Occasional	PNH	
Dr John Campbell-McDonald	Cardiology		Yes	No	PNH	Southern Cross & Aorangi
Dr Raffat Shameem	Cardiology		No	Yes		Aorangi
Dr Reiche Louise	Dermatology		No	Occasional	PNH	Aorangi
Dr Singh Darshan	Dermatology		No	Yes	PNH	Aorangi
Dr Vinton Chadwick	Gastroenterology		Yes— commutes from Wellington	No	Retired, but also works at Wakefield and Bowen	Southern Cross
Dr David Edge	Gastroenterology		Yes	No	Retired from PNH 2 years ago	Southern Cross
Dr Ross Hayton	Gastroenterology		Yes	No	Yes	
Mr David Dunlop	General surgery	No	Yes	Yes	Just retired from PNH	Aorangi
Mr Pravin Kumar	General surgery	No	Yes	Occasional	PNH	Southern Cross
Mr Bruce Rhind	General surgery	No	Yes	Yes	PNH	Own room for minor procedures
Dr Clive Solomon	General surgery	No	Occasional	No	WH	

Name	Speciality	Aorangi S/holder	Uses Sthn Cross Hospital	Uses Aorangi Hospital	Public Hospital (PNH=Palm Nth WH=Wanganui)	Consulting/ Procedure Rooms
Mr Colin Wilson	General surgery	No	Yes	Yes	PNH	Own room for minor procedures
Mr Mike Young	General surgery	Yes	Occasional	Yes	PNH	
Mr John Bourke	Geriatrics	No		Yes	PNH	Aorangi
Dr Glen Kirk	Military–dental	No	Yes		PNH (occasional)	
Dr Jacqueline Claridge	Military–medical	No	Yes		No	
Dr Ross Fountain	Military–medical	No	Yes		No	
Dr Peter Hurly	Military–medical	No	Yes		PNH (occasional)	
Dr Donald Stewart	Military–medical	No	Occasional			
Dr Ken Clark	Obstetrics and gynaecology	No	Yes	No	PNH (Medical Director)	
Dr David Cook	Obstetrics and gynaecology	No	Just resigned; occasional	No	Just resigned from PNH	
Dr Kathy Gillies	Obstetrics and gynaecology	No	Just resigned (most profitable surgeon)	No	Resigned from PNH in Feb 2008	
Dr Steven Grant	Obstetrics and gynaecology	No	Yes	Occasional	PNH	Southern Cross
Dr Digby Ngan-Kee	Obstetrics and gynaecology	No	Yes	Occasional	PNH, also Royston (works there more than at Aorangi)	
Dr David Wilde	Obstetrics and gynaecology	No	No	Yes	WH (but does not do private work at Belverdale)	Aorangi
Dr Alan Donoghue	Obstetrics and gynaecology		No	Yes	WH (but does not do private work at Belverdale)	Aorangi
Dr Nassar Shehata	Obstetrics and gynaecology	No	Yes	No	PNH	Southern Cross
Mr Nick Nedev	Oncology		No	Occasional	PNH	Aorangi
Mr Richard Isaacs	Oncology		No	Yes	PNH	Aorangi
Dr Geoffrey Duff	Ophthalmology		Yes	No		Southern Cross
Dr Tom Ellingham	Ophthalmology	Yes	No	Yes	Just retired from PNH	
Mr Archie Mackillop	Ophthalmology	No	No	Just resigned and left NZ	Just resigned and left NZ	Aorangi
Dr Richard Holmes	Ophthalmology		No	Yes	PNH	
Dr Kay Evans	Ophthalmology		No	Yes	PNH	
Dr Peter Leung	Oral maxillofacial surgery	Yes	Occasional, but has not in years	Yes	Retired	Shares a procedure room with Dr Murdoch

Name	Speciality	Aorangi S/holder	Uses Sthn Cross Hospital	Uses Aorangi Hospital	Public Hospital (PNH=Palm Nth WH=Wanganui)	Consulting/ Procedure Rooms
Dr Bruce Murdoch	Oral maxillofacial surgery	Yes	Occasional, but only when there is a DHB contract	Yes	Retired	Shares a procedure room with Dr Leung
Dr Ninian Peckitt	Oral maxillofacial surgery		About to start		PNH	
Mr Geoffrey Anderson	Orthopaedics	No	No	Yes	PNH	
Mr David Brougham	Orthopaedics	Yes	Occasional	Yes	PNH	
Mr Kevin Davey	Orthopaedics	Yes	No	Yes	Just retired from PNH	
Mr Richard Lander	Orthopaedics	No	Yes (1–2 lists/week)	Yes (1 list/week)	PNH	
Mr Tim Love	Orthopaedics	No	Occasional	Yes	PNH	
Mr Christopher Williams	Orthopaedics	Yes	Occasional	Yes	PNH	
Mr Dilhan Cabraal	Otolaryngology		Yes	Yes	PNH	
Mr Nadarajah Manoharan	Otolaryngology		Yes	Yes	PNH	
Mr Hans Stegehuis	Otolaryngology	Yes	Yes	Yes	PNH	
Mr Roger Broadbent	Plastic Surgery	No	Yes	Occasional	No	Shares a procedure room with Mr Chrisp
Mr Craig McKinnon	Plastic surgery	No	No	Occasional	Hutt Public Hospital	Aorangi
Dr Seeman Richard	Rehabilitation			Occasional	PNH	Aorangi
Dr Anthony Gear	Rheumatology				PNH	Aorangi
Dr Quinten King	Urology		Yes	Yes	PNH	Southern Cross
Mr John Chrisp	Urology	Yes	No	Yes	PNH	Shares a procedure room with Mr Broadbent
Mr Ranjan Rajaratnam	Urology		Yes, though minimal and retiring in 2008	Yes	PNH, but retiring in 2008	

APPENDIX 3: Joint Venture structure diagrams

Figure 1: Structure before joint venture

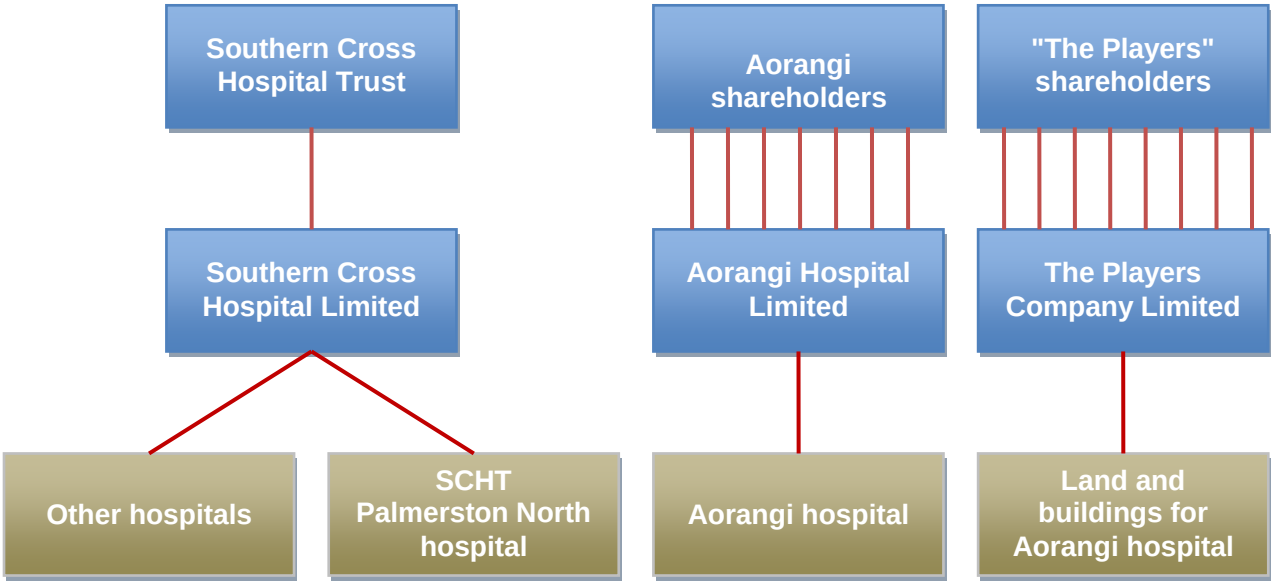

Figure 2: Structure after joint venture