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COMMERCE COMMISSION

Decision No. 492

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

WAKEFIELD HOSPITAL LIMITED

and

BOWEN HOSPITAL LIMITED

The Commission:	PR Rebstock PJM Taylor DR Bates QC
Summary of Application:	Wakefield Hospital Limited has sought clearance to acquire all of the shares on issue in Bowen Hospital Limited and all of the land and buildings situated at 114 Churchill Drive, being all the land and buildings (including plant, fixtures and fittings) on the Bowen site, including any undeveloped areas.
Determination:	Pursuant to section 66(3)(a) of the Commerce Act 1986, the Commission determines to give clearance for the proposed acquisition.
Date of Determination:	19 February 2003

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THE PROPOSAL

1. On 24 December 2002 the Commission registered a notice pursuant to section 66(1) of the Commerce Act 1986 ("the Act") from Wakefield Hospital Limited ("Wakefield"). The notice sought clearance for Wakefield to acquire:
   - All of the shares on issue in Bowen Hospital Limited ("Bowen"); and
   - All of the land and buildings situated at 114 Churchill Drive, being all the land and buildings (including plant, fixtures and fittings) on the Bowen site, including any undeveloped areas.

THE PROCEDURES

2. Section 66(3) of the Act requires the Commission either to clear or to decline to clear a notice given under section 66(1) within 10 working days, unless the Commission and the person who gave notice agree to a longer period. Two extensions of time were sought by the Commission and agreed to by the applicant. Accordingly, a decision on the application was required by 20 February 2003.

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

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

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

THE PARTIES

Wakefield

6. Wakefield is a private hospital in Wellington, formerly known as Calvary hospital. The hospital was bought and renamed in 1989 by a group of private investors and was listed on the New Zealand Stock Exchange in September 2001.

7. Wakefield's business activities are the provision of facilities, staff and equipment for medical and surgical healthcare for both secondary and tertiary elective surgery.

8. Wakefield owns 10% of the shares in Boulcott hospital.

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

Bowen

9. Bowen hospital is a private hospital in Wellington. Bowen became Bowen Hospital Limited in 1999 and is jointly owned by the Bowen Hospital Charitable Trust and medical practitioners.

10. Bowen's business activities are provision of facilities, staff and equipment for medical and surgical healthcare for secondary elective surgery. Bowen also operates a specialist sleep disorder clinic.

OTHER RELEVANT PARTIES

Southern Cross

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

    - The provision of indemnity health insurance; and

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

Boulcott

12. Boulcott Hospital Limited ("Boulcott") is a private hospital in Lower Hutt. Boulcott was opened in 1985 as day surgery clinic. In 1994 extensions were made which allowed Boulcott to operate as a hospital.

13. Boulcott's business activities are provision of facilities, staff and equipment for medical and surgical healthcare for secondary elective surgery

Public Hospitals

14. The public hospitals are owned by the District Health Boards (DHBs). There are two DHBs in the Wellington region. Capital & Coast DHB owns Wellington Public and Kenepuru Public Hospitals (and is in the process of a $300million upgrade at Wellington Public Hospital). Hutt Valley DHB owns Hutt Public Hospital.

New Zealand Private Hospitals Association

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

16. The NZPHA acts as a forum for issues in the private hospital market and as a lobby group to government.

Other Insurers

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

INDUSTRY BACKGROUND

Healthcare Financing in New Zealand

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

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

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

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

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

The Choice of Hospitals

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

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

MARKET DEFINITION

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

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

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

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

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

- the goods or services supplied and purchased (the product dimension);
- the level in the production or distribution chain (the functional level);
- the geographic area from which the goods or services are obtained, or within which the goods or services are supplied (the geographic extent); and
- the temporal dimension of the market, if relevant (the timeframe).

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

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

The Commission's Previous Decisions

31. The Commission has previously considered the markets for the provision of hospital services. In Decision 449, the Commission cleared the acquisition of Mercy Hospital Limited by Ascot Hospital and Clinics Limited - two private hospitals operating in the Auckland region. In Decision 331, the Commission cleared the merger of Eastbay Health Limited and Western Bay Health Limited - two geographically separate public hospitals.

32. In Decision 331, the Commission considered that the relevant markets were:

- the provision of primary healthcare services and/or facilities separately in the eastern and western Bay of Plenty regions;
- the provision of acute secondary healthcare services and/or facilities separately in the eastern and western Bay of Plenty regions;
- the provision of elective secondary healthcare services and/or facilities in the Bay of Plenty region; and
- the provision of tertiary healthcare services and/or facilities in the North Island.

33. However, In Decision 449, the Commission reconsidered the issue of whether public and private hospitals compete in the same market, concluding that for private patients they were not. The relevant markets in Decision 449 were therefore:

- The provision of hospital facilities and related non specialist services for elective secondary surgery to private patients in the Auckland region;
- The provision of hospital facilities and related non specialist services for elective tertiary surgery to private patients in the Auckland region;
- The provision of elective secondary surgery for publicly funded patients in the Auckland region;
- The provision of angiography services to private patients in the Auckland region; and
- The provision of endoscopy services to private patients in the Auckland region.

Product Dimension

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

35. The Commission takes the view that the appropriate time period for assessing substitution possibilities is the longer term, but within the foreseeable future.[2] The Commission

[2] In *Tru Tone Ltd v Festival Records Retail Marketing Ltd* [1988] 2 NZLR 351 Smellie J and the Court of Appeal on appeal approvingly quoted an earlier decision of the Commerce Commission in *Edmonds Food Ind Ltd v W F Tucker & Co Ltd* (Decision 21, June 1984) where the Commission had ruled: "A market has been defined as a field of actual or potential transactions between buyers and sellers amongst whom there can be strong substitution, at least in the long run, if given a sufficient price incentive". See also *News Limited v Australian Rugby Football League Limited &Ors* (1996) ATPR at 41,687, where Burchett J stated: "Long term prospects that can be more or less clearly foreseen are, to that extent, a present reality, from the point of view of identifying the constraints upon commercial action. This fact emphasises the importance of the principle . . .

considers this to be a period of one year, which is the period customarily used internationally in applying the 'ssnip' test to determine market boundaries. The Commission will take into account recent, and likely future, changes in products, relative prices and production technology in the process of market definition

Defining the Product

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

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

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

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

40. The applicant has accepted the Commission's categorisation in Decision 449 that the separate facilities and services the hospital provides can be bundled together to form one aggregate market for surgical services/facilities, rather than considering separate markets for nursing services, surgical equipment and the like.

41. Decision 449 also considered that the surgical facilities and services are fungible across medical specialities, so that general "surgical" markets can be defined rather than specific markets for each branch of medicine. The Commission considered that an exception to the substitutability across medical specialities existed in the distinction between secondary and tertiary services (see para 63).

42. It is also noted that there is an exception to the market definition concept established at para 39, which arises with surgical contracts provided by ACC or another public provider (ACC provides the bulk of this publicly funded work). In these circumstances, ACC selects and contracts with a "lead provider" who organises all aspects of the surgery. Generally, the lead provider is a hospital, though it is sometimes a medical practitioner. Where the hospital is the lead provider, it contracts with one or more surgeons to fulfil the surgical requirements.

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that substitution possibilities in the longer run may be very significant for market delineation." Also *Re Tooth & Co Ltd v Tooheys Ltd* (1979) 39 FLR 1 emphasises longer run substitution possibilities.

43. The Commission therefore concludes that, generally:

- the separate facilities and services that hospitals provide can be bundled together to form one aggregate market for surgical services/facilities; and

- surgical facilities and services are fungible across medical specialities, so that general "surgical" markets can be defined.

Demand-side substitution

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

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

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

<u>The Public/Private Distinction</u>

47. In Decision 449, the Commission defined separate markets for private and publicly funded elective surgical work. The Commission considered that both private and public hospitals operate in the publicly funded market, whereas only private hospitals operate in the privately funded market. In defining the market in this way, the Commission noted the following market characteristics:

- The bulk of work undertaken by private hospitals such as Ascot and Mercy is privately funded;

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

- Private hospitals are directly competing with public hospitals for publicly funded work, whereas only a small amount of privately funded work is undertaken in public hospitals.[3] Therefore, for publicly funded operations, public and private institutions are in the same market, whereas, for privately funded operations that is not the case.

48. The applicant has disagreed with the Commission's view in Decision 449 that the market is limited to private patients in private hospitals. Wakefield submits that public hospitals present a significant constraint and are appropriately considered as part of the same market. Wakefield has made the following arguments in support of its submissions:

    - Of the range of procedures that Wakefield and Bowen provide, similar facilities are available in public hospitals.

    - Wakefield accepts that the nature of the substitution between private and public hospital facilities may be difficult to quantify precisely as the "prices" involved in moving from one to the other are expressed differently. Access to private hospital services is paid for in dollar terms (through out of pocket expenditure or through insurance). In comparison, the price of obtaining hospital facilities for elective secondary surgery in a public hospital is expressed in terms of uncertainty and delay.

    - Wakefield submits that, when a patient is advised that he or she requires secondary elective surgery, the patient will consider public and private hospital facilities together. Whether the patient eventually receives surgery in a public or private hospital will depend on how they value timeliness/availability of the facility, whether they have insurance (and if so, how much of the procedure is covered by insurance), and the opinion of the relevant surgeon.

    - In addition, the conduct of the government (through its DHBs) indicates that the government considers private and public facilities together as equal alternatives. When waiting lists for procedures at state-owned hospitals get too long, the government (through DHBs) either increases capacity within the relevant state-owned hospital(s), or contracts out work to private facilities like Wakefield.

    - The bundling of services in the public and private sectors also differs. The elements of services obtained in the private sector are generally separated (facilities, surgeons' time, consumables, etc are charged for separately), whereas in the public sector the funder purchases these items as one, and in bulk. These factors obscure the nature of the substitution but do not eliminate it.

    - The substitutability of public hospital facilities for private is also greatly affected by Government policies and funding of public hospitals. Wakefield accepts that the degree of substitutability between public and private hospitals can vary significantly over time.

    - Nevertheless, when the appropriate medium term view is taken, the degree of substitutability is such that public hospitals are participants in the market for provision of hospital facilities for elective secondary surgery. At the very least the

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

public hospital system must be recognised as a very significant constraint on the actions of all private hospital facilities.

49. In its investigations, all parties spoken to by the Commission, with the exception of Wakefield and Bowen, considered that it is valid to distinguish between the private and public provision of secondary health care facilities and therefore separate market definitions were justified. This distinction was justified on the grounds of government policy.

50. Government policy actively discourages the carrying out of private work in public hospitals, and in any event there is little excess capacity in public theatres. Policy also discourages the carrying out of public work in private hospitals. An example of this is Wakefield's loss of the cardiac contracts from Capital & Coast DHB. Capital & Coast DHB stated that no publicly funded surgeries are currently being carried out by them in private hospitals.

51. An exception occurs in the Hutt Valley, where the Hutt Valley DHB has a close relationship with their neighbour, Boulcott Hospital, and actively use its secondary elective services for work such as gynaecology and orthopaedics. Boulcott suggested this relationship existed due to the level of expertise at Boulcott in these areas and the financial incentives for Hutt Hospital not having to provide these services, as well as the logistical sense in using operating facilities located on the same campus.

52. An exception also occurs with respect to ACC, which accounts for the bulk of publicly funded secondary elective surgery carried out in private hospitals. ACC funds between [ ] of the work carried out in Boulcott, Bowen and Southern Cross, and around [ ] of the work at Wakefield. [

]. ACC contracts with a 'lead provider', which tenders for ACC work on the basis of hospital *and* surgical costs. This is a different system than that used for privately funded operations, where it is just the provision of hospital services, *and not* surgical services that is provided. This means that there is a distinction between the product for publicly funded operations (where the product is the provision of hospital facilities and surgeons) and the product for privately funded operations (where the product is only the provision of hospital facilities).

53. Although the distinction between the private and public markets is blurred, on the supply side there is generally a distinction between public hospitals undertaking public work and private facilities undertaking private work (with ACC funded surgery being the exception). While there is potential for supply side substitution, government policy actively discourages this. On the demand side, going public is to a degree an alternative to private treatment and visa versa, and patients do switch at the margin. However, there is limited demand-side substitution because the cost of the private system means that for most patients the public system is not substitutable, while the delay associated with the public system make it an imperfect substitute for patients with private insurance. While elective treatment is available from both the public and private healthcare, the latter offers additional, and valued, services in terms of higher standards of hospital accommodation, greater choice of consultant and earlier treatment.

54. While private hospitals compete with public hospitals directly for work in relation to ACC funding, only a small amount of private work (if any) is carried out in public

hospitals. Therefore, for *publicly* funded operations, private and public hospitals may be in the same market, where as for *privately* funded operations they are not.

55. The Commission considers that although the public hospitals provide an element of price constraint, the willingness of consumers to pay for private elective healthcare is an indication of private hospitals being in a different market from public hospitals.

56. However, while public hospitals are not included in the privately funded market, the Commission considers that they pose a constraint in terms of the three factors identified in Decision 449, namely:

- Public hospitals have potential to carry out private work, even if this would require a change in government policy;
- Public work can be contracted out to private hospitals to reduce waiting lists. Funding for public surgery is determined according to independently derived formula which tend to set the benchmark for how much public providers will pay private providers; and
- Patients can choose to be treated in either the private or the public health system. If the price in the private system becomes too great patients have the option of having the work done in the public system. While the timeliness favours the private system, price favours the public system.

57. In addition to the factors listed above, the Commission considers that private healthcare is complementary to public healthcare. As public perception of the coverage of the public system in terms of the length of waiting lists waxes and wanes, so too does the extent of the available market for private hospitals. Therefore, waiting lists for public hospitals are an immediate driver of demand for private hospital services. This relationship acts as a constraint on the private hospital system as the success of a private hospital is to a large extent determined by government policy, as changes to policy or policy initiatives targeted to reduce waiting lists impact on the success of the private hospital system.

58. Public hospital systems also provide a degree of constraint upon the private health care market, such that should private hospitals fail to maintain their standards of service or should their costs rise inordinately, people could cease to subscribe to private health insurance.

59. The result of these factors is that the Commission considers that public hospitals act as a constraint on the behaviour of private hospitals in the market for secondary elective surgery. However, the Commission does not consider that private and public hospitals compete in the same market for the provision of hospital facilities and services for elective secondary surgery to private patients. This delineation also reflects the conservative approach the Commission adopts when considering market definition.

Supply-side substitution

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

61. There are three such issues that arise when defining the markets in which the hospitals are functioning: whether to distinguish between acute and elective surgery, whether to distinguish between secondary and tertiary services, and whether angiography and endoscopy are part of the tertiary and secondary markets respectively.

62. Decision 449 considered that acute and elective surgery are not part of the same market. The Commission considered that although there are aspects common to the provision of both services (e.g. clinical staff and facilities), there is a difference in the timeframes over which the services may be delivered. Acute services are required more urgently than elective surgery and there is little or no control over their volume. In general, only elective surgery is provided at Wakefield and Bowen.

63. As in Decision 449, parties spoken to by the Commission agreed that it was meaningful to distinguish between secondary and tertiary surgery. This is on the basis of the more specialised equipment, nursing staff and other staff required for tertiary surgery (e.g. the need for intensive care units or coronary care units). From a supply perspective, facilities suitable for tertiary surgery can be used for secondary surgery, but not vice versa. The applicant has accepted the Commission's categorisation of separate secondary and tertiary markets.

64. As Bowen only provides secondary elective surgery, the Commission considers that it is appropriate to limit the competition analysis to the consideration of aggregation in the market for secondary elective surgery only.

65. The applicant submits that the provision of angiography and endoscopy services are part of the tertiary and secondary markets respectively. In Decision 449, the Commission considered that there were separate markets for (each of) the provision of angiography services and provision of endoscopy services. The Commission considers that the current situation is distinguishable from Decision 449 because, unlike in the Ascot/Mercy situation, neither Wakefield nor Bowen has separate business relating specifically to endoscopy and angiography. The Commission considers that in the current situation these services are provided as part of the services provided in the tertiary and secondary market, and therefore agrees with the applicant's submission that angiography and endoscopy should correctly be included within the tertiary and secondary markets respectively for the purposes of this application.

Undifferentiated/Differentiated Products

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

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

68. Whether the market is properly classified as undifferentiated is unclear. Price is likely to be of particular relevance to health insurers and some patients. Wakefield submits that [

] of their surgical procedures are covered by health insurance. Price is also an important factor in winning tenders and contracts from ACC. These factors suggest a more undifferentiated market where price dominates decision-making.

69. Surgeons and other specialists are influential gatekeepers and determine consumer behaviour. The attractiveness of hospital facilities to users is assessed on a number of non-price dimensions, such as quality, reputation and location. Furthermore, a price schedule provided by Southern Cross indicates only a small range of prices across hospitals for operating theatre charges. To the extent that the market is characterised by the decision making of surgeons and specialists, location, competence of staff and the reputation of others operating at a hospital, the market is not driven solely by price - suggesting a differentiated market.

70. However, some of these factors are either outside the market (the surgeon) or are already catered for within the proposed market definition (distinction between secondary and tertiary services). The Commission therefore does not propose to further define the market on the basis of differentiated products for the purposes of this fact situation. It notes, however, it appears that within the market there is some degree of differentiation.

Geographic Extent

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

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

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

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

75. The Commerce Act defines a market to be a "market in New Zealand". However, in many markets New Zealand buyers purchase products from both domestic and from overseas suppliers. Where imported products are close substitutes for domestic products, the overseas suppliers will be part of the relevant market. In such circumstances the

Commission, in order to comply with the wording of the Act, is likely to define a national market and then, as discussed later in the competition analysis, to consider the extent to which overseas suppliers exercise a competitive constraint on the participants in the domestic market.

76. The applicant submitted that the relevant geographic market is the greater Wellington region, being the region consisting of Wellington (including Porirua and the Hutt Valley) and the Wairarapa.

77. Parties spoken to do not consider Selina Sutherland, a private hospital located in Masterton, to be a competitor in the Wellington market as proposed by the applicant. Furthermore, Selina Sutherland do not see themselves as competing with Wellington in the provision of hospital services. There is no evidence of patients travelling from Wellington to the Wairarapa for surgery, or that surgeons would recommend patients travel to the Wairarapa for treatment.

78. There is some evidence of patient movement from the Wairarapa to Wellington, but this is predominantly for private surgery that is not catered for by Selina Sutherland. Also, to some extent, the supply of hospital services in other regions may be substitutable for services provided in the Wellington region, such as for procedures requiring the skills of a leading surgeon in a field. However, these factors would not make a *ssnip* applied to the Wellington region unprofitable and should therefore be excluded from the market definition.

79. The Commission therefore considers that the relevant geographical market is the Wellington Region, including Porirua and Lower Hutt, but excluding the Wairarapa.

Conclusion on Market Definition

80. The Commission concludes that the relevant market is.

- The provision of hospital facilities and related non-specialist services for elective secondary surgery to private patients in the Wellington region (excluding the Wairarapa).

COMPETITION ANALYSIS

Substantially Lessening Competition

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

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

82. Section 2(1A) provides that substantial means "real or of substance". Substantial is taken as meaning something more than insubstantial or nominal. It is a question of degree.[4] What is required is a real lessening of competition that is not minimal. The lessening needs to be of such size, character and importance to make it worthy of consideration.[5]

83. Section 3(2) provides that references to the lessening of competition include references to the hindering or preventing of competition.[6]

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

- the probable nature and extent of competition that would exist in a significant section of the market, but for the acquisition (the counterfactual);
- the nature and extent of the contemplated lessening; and
- whether the contemplated lessening is substantial.[7]

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

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

and, in relation to s47:

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

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

87. When the impact of enhanced market power is expected predominantly to be upon price, the anticipated price increase relative to what would otherwise have occurred in the market has to be both material, and able to be sustained for a period of at least two years,

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

[5] *Dandy Power Equipment Ltd v Mercury Marina Pty Ltd* (1982) ATPR 40-315, 43-888; *South Yorkshire Transport Ltd v Monopolies & Mergers Commission* [1993] 1 All ER 289.

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

[7] See *Dandy*, supra n 5, pp 43–887 to 43-888 and adopted in New Zealand: *ARA v Mutual Rental Cars* [1987] 2 NZLR 647; *Tru Tone Ltd v Festival Records Retail Marketing Ltd* [1988] 2 NZLR 352; *Fisher & Paykel Ltd v Commerce Commission* [1990] 2 NZLR 731; *Commerce Commission v Carter Holt Harvey*, unreported, High Court, Auckland, CL 27/95, 18/4/00.

for the lessening, or likely lessening, of competition to be regarded as substantial. Similarly, when the impact of increased market power is felt in terms of the non-price dimensions of competition, these also have to be both material and able to be sustainable for at least two years for there to be a substantial lessening, or likely substantial lessening, of competition.

The Counterfactual

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

89. The present state of competition in a market can be referred to in order to illuminate the future state of the market where there is a range of possible scenarios should a merger not proceed.[8]

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91. Despite an extensive Australasian search Bowen has not been able to find an interested purchaser other than Wakefield. The potential for an alternative purchaser has been explored and exhausted to an extent that indicates that in absence of the acquisition Bowen would continue to operate as a hospital but with an anticipated life of between [ ].

92. Bowen has not suggested that it is a failing company; rather, [ ]. Therefore, for the purposes of a competition analysis, the Commission considers that Bowen will remain viable as an effective competitor for the duration of the timeframe usually considered when determining the competitive effects of a proposed acquisition. For the purposes of the acquisition, the Commission therefore considers that the appropriate counterfactual is the status quo.

Conclusion – Competition Analysis Principles

93. The Act prohibits business acquisitions that would be likely to have the effect of substantially lessening competition in a market. The Commission makes this assessment against a counterfactual of what it considers would be likely to happen in the absence of the acquisition. In the present case the counterfactual is considered to be the status quo.

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[8] *Stirling Harbour Services Pty Ltd v Bunbury Port Authority* (2000) ATPR 41 at paras 113 & 114.

A substantial lessening of competition is taken to be equivalent to a substantial increase in market power. A business acquisition can lead to an increase in market power by providing scope either for the combined entity to exercise such power unilaterally, or for the firms remaining in the market to co-ordinate their behaviour so as to exercise such power.

94. In broad terms, a substantial lessening of competition cannot arise from a business acquisition where there are sufficient competitive constraints upon the combined entity. The balance of this Decision considers and evaluates the constraints that might apply in the market for privately funded, secondary elective surgery under the following headings:

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

ANALYSIS OF EXISTING COMPETITION

Introduction

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

Scope for Unilateral Market Power

Introduction

96. An examination of concentration in a market post-acquisition can provide a useful guide to the constraints that market participants may place upon each other, including the combined entity. Both structural and behavioural factors have to be considered. However, concentration is only one of a number of factors to be considered in the assessment of competition in a market. Those other factors are considered in later sections, as noted above.

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

[9] For example, where market share measured in terms of capacity produces a significantly lower share of the market in the hands of participants than a measure in terms of sales volumes, the constraint on a combined entity from that unemployed capacity might be taken into account when identifying near entrants or the constraint

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

Existing Participants

99. The participants in the Wellington surgical market are shown in Table 1. The applicant has proposed that market share be measured by theatre numbers.

100. Capacity measures are appropriate when the relevant market is characterised by relatively undifferentiated services (and the constraint on a merged entity from competition is measured by the ability of competitors to expand). The Commission considered in Decision 449 that the number of theatres is a useful proxy to market share. In order to assess the usefulness of this proxy, market share figures by theatre numbers have been compared with market share figures by bed numbers, total revenue and procedure numbers. A percentage figure for theatre capacity usage has also been used to establish whether capacity utilisation is similar between parties, thus increasing the validity of measuring market share by theatre numbers.

Table 1:
Participants and Market Shares for Wellington Private Hospital Secondary Elective Surgery

Hospital	Theatres	Beds	Use of existing Capacity	Number of Procedures	Revenue($)
Wakefield	4 (33.3%)	53 (34.9%)	[ ]**	[ ]	[ ]
Bowen	3 (25%)	42 (27.6%)	[ ] *	[ ]	[ ]
Merged Entity	*7 (58%)*	*95 (63%)*	*N/a*	*[ ]*	*[ ]*
SCHT	2 (16.7%)	30 (19.7%)	[ ]**	[ ]	[ ]
Boulcott	3 (25%)	27 (17.8%)	[ ]**	[ ]	[ ]
Total	**12**	**152**	**N/a**	**[ ]**	**[ ]**

*Based on a 10hr day Mon-Fri.
**Based on an 8hr day 48wks/yr.
NB: Procedure and revenue figures relate only to Secondary procedures 2001-2.

101. Based on the comparison of market share data above, the Commission considers that theatre capacity is a valid proxy to market share.

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from new market entry. In some cases, the model of market power being used may influence the choice as to which market share measure is used.

Inter-firm Relationships

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

103. Wakefield has a 10% shareholding in Boulcott. Common directorships between the two hospitals ended four years ago when both parties considered that their respective competitive positions were being undermined by the presence of a competitor on their board. Wakefield has no rights with respect to appointments to the board of Boulcott outside of the normal shareholders rights. There is not intention from either party to re-establish this relationship.

Imports

104. Though on occasion patients travel overseas for medical treatment such instances are rare and occur primarily at the tertiary level. As such imports are not considered important to the present analysis.

Safe Harbours

105. Once the relevant market has been defined, the participants have been identified, and their market shares estimated, the Commission's 'safe harbours' can be applied. Under these safe harbours, a business acquisition is considered unlikely to substantially lessen competition in a market where, after the proposed acquisition, either of the following situations exist:

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

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

106. Based on the figures in Table One the acquisition will result in a three firm concentration ratio of 100% of which the combined entity will have a market share of approximately 60% post acquisition based on theatre numbers. This puts the acquisition outside of the defined safe harbours.

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

State of Existing Competition

108. Despite Wakefield's strong position within the market, industry participants commonly described the market for private secondary surgery as competitive and likely to remain so post-acquisition. This reflects the strong competitive position of Boulcott and SCHT as alternate providers of private secondary elective surgery. It is also indicative of the strong countervailing powers held by ACC, insurance companies and surgeons, which will be discussed later. Participants did not see the acquisition of Bowen as greatly altering the competitive dynamic.

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Conclusions – Unilateral Market Power

110. The Commission considers that, aside from any countervailing factors, the merged entity would not be able to exercise unilateral market power.

Scope for the Exercise of Coordinated Market Power

Introduction

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

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

113. When assessing the scope for coordination in the market during the consideration of a business acquisition, the Commission will evaluate the likely post-acquisition structural and behavioural characteristics of the relevant market or markets to test whether the potential for coordination would be materially enhanced by the acquisition. The intention is to assess the likelihood of certain types of behaviour occurring, and whether these would be likely to lead to a substantial lessening of competition.

Collusion

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

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

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

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

<u>High Seller Concentration</u>

116. The high seller concentration reflects the way hospital services are provided: there are only a small number of surgeons, and facilities are specialised so that aggregation to a limited number of sites makes economic sense. As discussed earlier, the secondary elective surgery market in Wellington consists of four players, which will become three post-acquisition.

<u>Undifferentiated Product</u>

117. As discussed above under market definition, whether the market is properly classified as undifferentiated is unclear. The Commission considers that the market exhibits a degree of differentiation.

Speed of new entry

118. For the secondary surgical market, the Commission does not consider new entry to be slow. The experience in Auckland over the last four years has seen de novo entry by four market participants. Although the Auckland experience is not entirely indicative of Wellington market conditions, the Commission considers this analogy useful with respect to speed of entry. In Auckland, Ascot Hospital took two years to establish, while day surgeries have taken between 6-12 months. Because surgeons are not contracted to any particular hospital, any new facility can compete on a relatively even playing field. However, to a degree the mobility of surgeons may be restricted by their shareholdings in, and loyalty to, private hospitals. This is discussed further in the analysis of countervailing power below.

Lack of fringe competitors

119. Constant improvement in surgical techniques has led to a growth in the range and number of facilities capable of providing minor secondary surgery. Ophthalmic (eye) surgery, ear nose and throat and minor plastic surgery are amongst the branches of secondary surgery where clinics have been established in existing consultation rooms.

120. Private hospitals also face direct competition from public hospitals in the segment of the market where competition exists for ACC contracts. This accounts for [ ] of Boulcott's, SCHT's and Bowen's revenue, and [ ] of Wakefield's total revenue. In this market segment, public hospitals and private hospitals compete for contracts for ACC funded surgery. At the very least, public hospitals will impose competitive pressure on private hospitals in this market segment.

Price inelastic demand curve

121. Price elasticities in regard to the health care system generally are often difficult to quantify, but are consistently found to be price inelastic. International literature has estimated price elasticity to be approximately -0.17, which equates to a 0.17% reduction in expenditure for every corresponding 1% increase in price[10]. Some literature suggests that inpatients may be even less price sensitive.[11] There is also a suggestion that health care generally is relatively income inelastic, with increases in income corresponding to positive, but small increases in expenditure.

122. People value their health highly, so it could be assumed that demand for health care would be inelastic, as the literature suggests. However, that is not necessarily the case for elective surgery. By definition, elective surgery is non-urgent, therefore patients have the choice between immediate treatment and delay. Sometimes surgery will be one amongst a range of treatment options (pharmaceuticals might be another) and cost will be a factor in deciding which of these options to pursue. Patients with health insurance are likely to be less sensitive to price than those without insurance. Patients also have a choice between the public and private system, and may be driven to the public system if the price of the private system is too high. None of these factors may be particularly influential

[10] Ringel, Hosek, Vollaard, Mahnovski, *'The Elasticity of Demand for Health Care'*, National Defense Research Institute.
[11] Iwamoto, Kishida, *'An Estimation of the Price Elasticity of Medical Care Demand'*, 2001.

disjunctively, but in aggregate they suggest that demand may be characterised as having variable elasticities.

Industry's poor competition record

123. The Commission has, from time to time, investigated groups of specialists with respect to potentially anti-competitive practices, and there exists a close relationship between specialists and hospitals. However, there is no track record of investigations into the hospitals themselves.

Presence of excess capacity

124. Several parties spoken to as part of this investigation considered that there was excess capacity in the market. However, figures provided by Wakefield, Bowen, Southern Cross and Boulcott indicate that capacity is approximately [ ]%, which is considered optimum in order to allow flexibility for more urgent surgery. Furthermore, a reduction in operating capacity would be likely to incur negative repercussions from surgeons as their preferences for operating times may not be able to be met, prompting migration to other hospital service providers. The Commission does not consider that excess capacity is likely to contribute to coordination.

Presence of industry associations/fora

125. There is an industry forum, namely the NZPHA. The NZPHA acts as a forum for issues in the private hospital market and as a lobby group to government.

Conclusions - Collusion

126. Overall, the Commission considers that there is a suggestion that the market could be susceptible to collusion after the acquisition. Therefore, the potential for discipline in the post-acquisition market is considered below.

Discipline

127. For coordination to be successful, deviations of individual firms from the collusive behaviour have to be discouraged by being detected swiftly and punished by the other firms.

128. The structural and behavioural factors that are usually considered to be conducive to 'discipline' in co-ordinated markets are set out in the left-hand column in Table 3. Again, the significance of these is explained more fully in the Commission's *Practice Note 4*. The right-hand column of the Table then assesses the extent to which those factors are present, or are likely to be enhanced post-merger, in the Wellington market for secondary elective surgery. A high proportion of 'yes' responses would suggest that the market was particularly favourable to 'discipline; a high proportion of 'no' responses the reverse.

TABLE 3
Testing the Potential for "Discipline" in the
Privately Funded Elective Secondary Surgical Facilities Market

Factors conducive to discipline	Presence of factors in the market
High seller concentration	Yes
Sales small and frequent	No
Absence of vertical integration	Yes (with exception of SCHT)
Demand slow growing	Varies across specialities and depending on government policy.
Firms have similar costs	Yes
Price transparency	Variable

High seller concentration

129. As discussed above under Collusion, there is a high seller concentration.

Sales small and frequent

130. The sales of hospital services are large and infrequent. The cost of the surgical facilities to each patient varies depending on the length of the operation and the type of equipment needed. The variation in the sizes of sales of hospital services may make successful discipline difficult to sustain.

Absence of vertical integration

131. The private hospitals servicing the Wellington region, with the exception of Southern Cross, are not vertically integrated. [

]. To the extent that Southern Cross is vertically integrated, the capacity to discipline deviations in coordinated prices in the market is undermined.

Demand slow growing

132. As discussed below in barriers to entry, demand is growing asymmetrically and therefore the demand for secondary elective procedures varies between specialities. Demand will also vary depending on public hospital waiting lists. To the extent that demand is slow growing, discipline to enforce coordination may be possible. However, the degree to which this is possible is undermined by the asymmetric growth of certain secondary elective procedures as technological change reduces the risks and increases the ease of surgery.

Firms have similar costs

133. Boulcott, Wakefield and Southern Cross are likely to have similar cost structures for secondary elective surgery as the costs of operating individual theatres in terms of staff wages, disposables and equipment are broadly similar. Costs are likely to vary between the specialities within secondary elective surgery as each may require specialised equipment or use disposable resources at different rates, e.g. the equipment used for endoscopy is unique to this speciality. However, this is likely to have a minimal impact on the overall cost of theatre use.

134. [

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135. The Commission considers that the costs of competing private hospitals in the secondary elective market are likely to be broadly similar.

Price transparency

136. Private hospitals charge a fixed rate for theatre use that varies with the time required to complete the surgery. SCHT provided a schedule of these prices to the Commission for Wakefield, Bowen and SCHT. The cost of hospital facilities for surgery will vary according to the complexity and length of time required to complete the operation, which may vary between similar procedures; to this extent the price per surgery cannot be fixed in advance. However, quoted prices are available to patients and the Commission considers that hospitals would have a thorough understanding of their competitor's fees.

137. ACC contracts for secondary surgery are set through a tendering process, where parties are invited to tender for an ACC contract. ACC awards contracts on the basis of price, with an increasing proportion of work being allocated to providers as price decreases. Because hospital charges to ACC are largely an outcome of a bargaining process and they *(a)* reflect the bargaining strength and abilities of the two sides (rather than necessarily the underlying structure of supply costs); and *(b)* are known only to the parties concerned, they are therefore not transparent to the market as a whole.

138. There are some non-price factors that contribute to the decision of a provider of hospital services. The importance of surgeons as 'gatekeepers' makes it less obvious that referrals are being allocated on the basis of price. Also, ACC indicated that they take non-price factors into account when allocating contracts to lead providers.

139. Overall, there seems to be a varied price transparency within the market. However, the Commission considers that the degree of price transparency that exists may be likely to support discipline.

Conclusions - Discipline

140. The high degree of seller concentration post-merger indicates that the number of firms to be monitored would be small, they would have similar costs and there would be a degree of price transparency that favours the potential for discipline. However, other factors appear to be unfavourable. The lumpiness of sales, a degree of vertical

integration, and a lack of price transparency with respect to ACC contracts would make monitoring difficult and undermine the ability to discipline coordinators within the market.

Conclusions – Co-ordinated Market Power

141. The Commission considers that the potential for coordinated market power is undermined by low barriers to entry and the close monitoring of prices and countervailing power of insurance providers and ACC. Therefore, the scope for the exercise of co-ordinated market power would not be enhanced by the proposed acquisition.

CONSTRAINTS FROM MARKET ENTRY

Introduction

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

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

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

Barriers to Entry

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

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

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

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

The "LET" Test

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

Likelihood of Entry

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

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

Barriers to Entry on the Supply Side

152. Some industry participants did not consider there was a high probability that a de novo hospital facility would open in Wellington given the competitiveness of current market players. There was also a suggestion by SCHT that practitioner involvement in the ownership/administration of hospitals in the Wellington region is fairly prevalent compared with Auckland. A consequence of this high level of involvement might be to reduce the incentive for practitioners to establish new hospital facilities.

153. However, participants did consider it possible that surgeons could open competing day surgery facilities should they become dissatisfied with the service at private hospitals, or if a venture of this type would be more profitable than their existing surgery at private hospitals.

154. The key requirement for a successful hospital is attracting surgeons. Surgeons are not contracted to any particular hospital and often operate across two or more hospitals. Parties spoken to differed in opinions as to the extent to which surgeon shareholdings in private hospitals may influence the mobility of surgeons and patient referrals. All agreed that it would have at least some influence and may vary according to the size of the shareholding. However, Wakefield submitted that all but two of their surgeons also operate at Bowen, Southern Cross or both, which lends credibility to the suggestion that the shareholdings of surgeons do not necessarily determine their referral patterns. Although it is economically rational for surgeons to refer patients to hospitals in which they have a shareholding, it should be noted that a surgeon's return on a shareholding is likely to be small in comparison to their return on surgical procedures. Also, non-price factors such as reputation, quality, location or the presence of a leader in a given surgical field may influence surgeon referral patterns.

155. Wakefield orthopaedic surgeon Dr Welsh, indicated that it may be theoretically in a surgeon's best interests to only support hospitals in which they have a vested interest, although such considerations would always be subordinated to patient well being. Dr. Welsh also suggested that one particular surgeon, who holds a substantial shareholding in Wakefield, performs no more work there than he performs elsewhere.

156. However, these statements are largely anecdotal and the Commission must take a conservative view and assume that surgeons will behave as economically rationale actors. This implies that they will prefer to use the services of the hospital in which they have a financial interest in and, all other factors being equal, this therefore reduces their overall mobility.

157. There are no structural or regulatory barriers that constitute a material barrier to new entry into the Wellington market. Industry participants do not consider the Resource Management Act 1991 constitutes a barrier to the expansion of existing market participants or new entry.

158. There was a suggestion from industry participants the capital costs involved in setting up a new private hospital, and an expectation of relatively low return on capital may act as a disincentive to the establishment of a new full service private hospital. However, the Commission considers that the capital costs of establishing a new hospital are not sufficiently high to constitute a material barrier to entry in the absence of other tangible barriers, and that the low return on capital is correctly regarded as a sign of a competitive market where any market rents have been eroded by competitive forces.

159. The applicant submitted that Auckland and Christchurch should be considered as near entrants due to the decreasing cost of air travel. Most industry participants rejected this suggestion outright, pointing to the additional cost that consultation in another main centre would add, the preference of patients to be treated close to their families, and the fact that a GP or surgeon is highly unlikely to refer a patient to a specialist outside of their geographic region for a secondary procedure.

Barriers to Entry on the Demand Side

160. A barrier to entry may exist due to the relatively small population base within the defined geographic market and the consequent potential for growth in demand for hospital services to be static or low. Low growth in demand poses a barrier to entry when there are economies of scale and scope captured by incumbent operators, such that a new entrant may find it difficult to compete.

161. Parties spoken to generally consider growth in demand for private healthcare to be 2-3% over the last few years. Most considered that the mix in population contributed to geographical trends in demand, but saw it as having little effect on the growth of demand in the industry. In relation to possible new entry into the market, parties spoken to were of the opinion that the Wellington region was well covered by existing private hospitals in terms of geographic spread and meeting the demands of the population.

162. However, the Ministry of Health has stated that total nominal health and disability expenditure in 2001 had risen 10.4% from the previous year. Private healthcare expenditure had increased 16.9% during the same period, and healthcare insurance

expenditure, having risen steadily over the past decade, exhibited an increase of 8.8%.[12] In real per capita terms, a growth of 1.8% per annum in private healthcare expenditure is predicted over the next 50 years. This is a result of population ageing adjustments and the trend in health spending growth over the last 20 years (of around 1.3% p.a.).[13] These figures are nationally based and no figures have been obtained that apply directly to the Wellington region.

163. The growth in demand for secondary elective surgery is also growing asymmetrically, both in response to the needs of the community and the reduction in costs and risks associated with certain secondary procedures, of which ophthalmology is an example. As technological change impacts positively on the ease and costs of secondary procedures, demand for these procedures is growing and provides incentives for new entry or expansion.

164. The Commission considers that there may be sufficient growth in demand for hospital services to sustain new entrants or expansion by existing participants. Also, elective procedure intervention rates in New Zealand are low by international standards, and in comparison with Australia, which suggests there is some scope for growth in demand in the New Zealand market.

165. With respect to economies of scale, a study completed by Schuffham, Devlin and Jaforullah (1996) using a sample of public hospitals found that, on average, there were almost constant returns to scale. The results applied to whole hospitals, with the exception that there were economies of scale for some individual services (e.g. heart surgery). To the extent that costs in private and public hospitals are broadly similar (as suggested by a number of market participants), the presence of constant returns to scale suggests that incumbent operators are not advantaged compared to new entrants, even should the growth in demand be considered to be low.

Conclusion – Likelihood of Entry

166. The Commission considers that there are not significant barriers to entry into the hospital services market that would prevent entry or expansion. While the threat of de novo entry of a hospital is low, the merged entity is likely to be constrained by the threat of expansion by an existing competitor and by the potential entry of day surgeries. Therefore, the Commission considers it likely that a new entrant would enter the market or an existing participant would expand if the merged entity attempted to exercise market power.

Extent of Entry

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

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[12] Johnston, Teasdale, '*Population Aging and Health Spending 50-Year Projections'* Occasional paper no.2, Ministry of Health, 1999.
[13] NZ Ministry of Health, *'Health Expenditure Trends in New Zealand 1990-2001'*

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

169. Entry is more likely into specific secondary procedures rather than into the secondary market as a whole. Expansion by existing market participants into secondary procedures that they do not currently perform is also possible

170. A new day surgery is most likely to occur in the secondary market where the volume of operations is high and the degree of sophistication is low; such as for ear, nose and throat surgery, ophthalmology or low complexity orthopaedic and general surgical procedures. In some cases procedures may be undertaken in a surgeon's consulting room. Entry of this sort may be categorised as niche, and therefore the extent to which a day surgery could constrain the merged entity would be limited to its area of specialisation and the potential for expansion into other secondary procedures, which is determined by the degree of sophistication of the day surgery's theatre. However, as technological advances increase the speed with which surgery can be performed and the post-operative recovery time, day surgeries are becoming increasingly popular and the range of secondary procedures capable of being performed safely is increasing.

171. Industry participants considered that expansion by an existing hospital is possible. [

]. Boulcott indicated that they considered there were low barriers to expansion. Boulcott and Southern Cross also have existing day surgery capabilities that could be expanded, requiring less capital expenditure than a new theatre.

172. The Commission considers that entry or expansion in the market would be sufficient in extent to constrain the merged entity should it attempt to exercise market power.

Timeliness of Entry

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

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

175. Boulcott considered that a new day surgery could be operational within 6 – 12 months with capital costs of approximately $1 million. However, facilities and equipment can be leased, thus reducing the capital cost associated with them. The experience of Ascot in Auckland suggests that de novo entry of a significant scale can be accomplished within two years of planning being commenced. Furthermore, the experience in Auckland in the

last 6 years where there has been entry by four surgical centres indicates that entry into the secondary surgical market is not slow.

176. The Commission considers that, in the event of the merged entity attempting to exercise market power, entry is likely to be within the necessary timeframe for entry to constrain any exercise of market power.

Conclusion on Barriers to Entry

177. The Commission concludes that the barriers to entry are low and the prospect of entry in the event of the merged entity attempting to exercise market power is sufficiently tangible to be a constraint on the merged entity in the post-acquisition market.

OTHER COMPETITION FACTORS

Elimination of a Vigorous and Effective Competitor

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

179. While Bowen actively competes for customers in the market, it is not markedly different from any other firm in that respect. The Commission does not consider Bowen to be a maverick or non-typical competitor.

Constraint from Buyers or Suppliers

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

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

182. The Commission considers that the constraints that buyers can effect in the market are significant. These constrains arise from the role of ACC and insurance companies as significant purchasers and funders in the market, and the potential competition from public hospitals. Surgeons and other healthcare providers also have a degree of countervailing power.

Surgeons

183. Surgeons, doctors and patients have a degree of influence. Privately funded surgery will generally occur at a hospital where the surgeon has an established relationship. Patients, in conjunction with their GPs, may chose a surgeon based on where that surgeon operates. The degree to which surgeons are price sensitive for their patients is difficult to quantify. There is some suggestion that surgeons have incentives to keep hospital prices down, especially if patients are price sensitive and opt not to have surgery or use the public health system. There is also anecdotal evidence from most hospitals that a small proportion of patients ask for quotes for elective surgery. However, some market participants also suggested that surgeons do not consider prices when determining which hospital to operate at, but instead take into account personal preference, quality and existing relationships. The Commission considers that although the degree of countervailing power surgeons possess is difficult to quantify, it nevertheless will pose a degree of constraint on the behaviour of the merged entity.

ACC

184. ACC contracts provide a significant throughput of surgical work. As discussed above, ACC allocates funding by competitive tender, where tenders are compared against ACC's assessment of benchmarked prices. Because of the value of this work to the hospitals, and the competition from the public sector for this work, hospitals are price takers, and thus ACC has significant countervailing power.

Insurers

185. Wakefield estimates that approximately [ ] of its total revenue comes from insured patients. Southern Cross represents [ ] of this insurance revenue, which means that Southern Cross is a significant purchaser.

186. Southern Cross is able to gain access to information from a variety of sources that it can use to assess the reasonableness of fees. Because it operates nationally, Southern Cross is able to benchmark against other hospitals providing secondary elective surgery.

187. Southern Cross sets maximum reimbursement fees for some procedures, thereby providing disincentives for hospitals to set fees above this level. [ ] of Southern Cross patients have some form of shared care policy that involves the patient paying a set percentage of fees, plus any amount in excess of Southern Cross' specified rate. Increases in prices would translate into both increased payouts by Southern Cross and increased co-payments by patients. Either case would be unsatisfactory.

The Public Hospital System

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

Conclusion – Countervailing Power

189. These constraints are difficult to quantify in terms of their ability to constrain an increase in price. However, the cumulative impact of these constraints, coupled with low

entry barriers, will be an effective constraint to prevent the merged entity from exercising market power.

Efficiencies

190. The Commission recognises that there may be circumstances where efficiencies are relevant to an application for clearance.[14] In the context of a business acquisition, the combined entity might be able to make efficiency gains that are not obtainable by other means, such that its unit cost of production would decline. This could result in the entity reducing its price below that obtaining prior to the acquisition, even though with the acquisition it would otherwise be considered to have substantially lessened competition, and would be able to raise price above costs.

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

192. The applicant has not argued that efficiencies are relevant to this application for clearance. The Commission does not consider that it is necessary to form a view on efficiency gains in the context of this application.

OVERALL CONCLUSION

193. The Commission has considered the probable nature and extent of competition that would exist in the market for the provision of hospital facilities and related non-specialist services for elective secondary surgery to private patients in the Wellington region. The Commission considers that the appropriate benchmark for comparison is status quo.

194. The Commission has considered the nature and extent of the contemplated lessening. The proposed acquisition would result in the merged entity obtaining a market share which falls outside the Commission's safe harbour guidelines.

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

- existing competition;

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

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

196. The Commission has made the following conclusions:

- existing competition is sufficient to prevent the merged entity exercising unilateral market power;
- the potential for coordinated market power is low;
- barriers to entry are low and entry is likely if the merged entity attempted to exercise market power; and
- the countervailing power of funders and insurance companies will provide an additional constraint on the behaviour of the merged entity.

197. The Commission is therefore satisfied that the proposed acquisition would not have, nor would be likely to have, the effect of substantially lessening competition in the provision of hospital facilities and related non-specialist services for elective secondary surgery to private patients in the Wellington region.

DETERMINATION ON NOTICE OF CLEARANCE

198. Accordingly, pursuant to section 66(3)(a) of the Commerce Act 1986, the Commission determines to give clearance for the acquisition by Wakefield Hospital Limited of the shares on issue in Bowen Hospital Limited and all of the land and buildings situated at 114 Churchill Drive, being all the land and buildings (including plant, fixtures and fittings) on the Bowen site, including any undeveloped areas.

Dated this 19th Day of February 2003

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Paula Rebstock
Deputy Chair