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COMMERCE COMMISSION

Decision No. 559

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

NEW ZEALAND DIAGNOSTIC GROUP LTD

and

SONIC HEALTHCARE (NEW ZEALAND) LTD

The Commission:	Paula Rebstock Peter JM Taylor Denese Bates Anita Mazzoleni
Summary of Application:	The proposed merger of the diagnostic laboratory (pathology) services businesses of New Zealand Diagnostic Group Limited and Sonic Healthcare (New Zealand) Limited or their subsidiaries in six District Health Board districts through the establishment of three joint venture companies which will acquire the relevant businesses. The relevant DHB districts are those in the Hawke's Bay, Canterbury, South Canterbury, the West Coast, Otago and Southland.
Determination:	Pursuant to section 66(3)(b) of the Commerce Act 1986, the Commission determines to decline clearance to the proposed acquisition.
Date of Determination:	29 September 2005

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CONTENTS

EXECUTIVE SUMMARY

The Proposal

1. A notice pursuant to s 66(1) of the Commerce Act 1986 (the Act) was registered on 16 June 2005. The notice sought clearance for the proposed merger of the diagnostic laboratory (pathology) services businesses of New Zealand Diagnostic Group Limited and Sonic Healthcare (New Zealand) Limited or their subsidiaries (NZDG and Sonic respectively or the Applicants collectively) in six District Health Board (DHB) districts through the establishment of three joint venture companies that would acquire the relevant businesses. The relevant DHB districts are those in the Hawke's Bay, Canterbury, South Canterbury, the West Coast, Otago and Southland.

Relevant Markets

2. The Commission considers that the relevant markets for the purpose of analysing the proposed acquisition are:

   - regional markets for each of the Otago/Southland (Otago and Southland DHBs have collaborated to purchase pathology services for their respective regions), South Canterbury, Canterbury, West Coast, and Hawke's Bay DHB districts for the provision of community testing pathology services;
   - regional markets for each of the Otago/Southland and South Canterbury DHB districts for the provision of hospital testing pathology services; and
   - a national market for the provision of cervical screening tests.

3. Presently, there is a move by DHBs towards single provider contracts for the provision of pathology services. The Commission has assumed for the purposes of analysis that this will be the preferred method of contracting in the future. Consequently, competition will be for the market, rather than in the market (as it has been to date). Hence, the Commission considers that its market definition needs to recognise that:

   - competition for supply will not occur continuously as in the past, but rather at discrete and infrequent intervals; and
   - competition will result in the winning provider securing exclusive rights to provide services to a region for the duration of the contract period.

4. The Commission usually analyses the impact on competition over a two year time period. However, where a market is characterised by infrequent transactions, the Commission adopts a practice of defining a separate time dimension for the market. In particular, the Commission adopts a time dimension for the market that best exposes the impact of the proposed merger at the point in time at which it would have effect. In this case, that point in time is when the contracts are next tendered. Thus, the Commission considers the competitive effects of the proposed acquisition over ten years for Otago/Southland, five years for South Canterbury and the Hawke's Bay, and three to five years for Canterbury and the West Coast.

Single Provider Model

5. The relevant DHBs advised the Commission of the potential short-term savings that could be made as a result of the proposed mergers, in justifying their

support for the joint venture proposals. However, the savings identified by the DHBs are measured against the DHBs' current spend on pathology services, in a multiple provider fee-per-test contracting environment. The Commission recognises the DHBs' desire to reduce costs, eliminate duplication of testing, and remove operational inefficiencies related to the provision of pathology services. The Commission therefore understands the rationale for a single provider funding model and does not challenge the DHBs' decision to adopt this contracting model.

6. However, the Commission does challenge the assertion that the mergers of the two largest private pathology providers in New Zealand, in six DHB regions, are the only way to achieve these savings. The Commission considers that there are options that are consistent with a single provider model which could potentially achieve even greater savings to DHBs with respect to spending on pathology services than those envisaged by DHBs supporting the present proposals. These savings derive, in part, from maintaining competition in the long-run.

7. The Commission considers that, although the DHBs have indicated that they would achieve short-term savings as a result of the proposal, the DHBs may have achieved even greater savings had the parties bid separately for contracts. The Commission considers that the loss of competition may result in an increase in the costs of pathology services for DHBs in the long-run.

Counterfactual and Factual

8. The Commission considers that in both the factual (with the merger) and counterfactual (without the merger) scenarios, there is likely to be an exclusive contract with a single provider of pathology services offered by the DHBs, whether it be for community testing only, hospital testing, or community and hospital testing.

9. The Commission considers that the relevant factual scenario for each region is:

   - Sonic and NZDG would form a joint venture in Otago/Southland (O&S Newco), and would be the preferred bidder for the provision of all hospital and community testing in the Otago/Southland regions for a ten year term. O&S Newco would be the incumbent bidder in the next contracting round.
   - Sonic and NZDG would form a joint venture in Hawke's Bay (HB Newco), and would be offered a five year contract by the Hawke's Bay DHB for the provision of all community testing in that region. HB Newco would be the incumbent bidder in the next contracting round.
   - Sonic and NZDG would form a joint venture in Canterbury, South Canterbury and the West Coast (Canterbury Newco). Canterbury Newco would acquire an exclusive contract to provide all hospital and community testing in the South Canterbury DHB district until 2009, and would be the incumbent bidder in the next contracting round. Canterbury Newco would acquire Sonic and NZDG's current businesses in the Canterbury and West Coast regions. Canterbury Newco would bid for any future pathology contracts in the regions.

10. The Commission considers that the relevant counterfactual scenario is that:

- NZDG and Sonic would exist separately, and could bid for future contracts for community and/or hospital testing in each of the Otago/Southland, South Canterbury, Hawke's Bay, Canterbury and West Coast DHB regions.

Competition Analysis

11. As competition in the future will be for the market rather than in the market, the Commission has modified its standard analysis of "existing competition" and "potential competition" and has instead analysed the nature of competition by identifying the likely potential bidders for future contracts, and the extent of competition these bidders would likely provide under the factual and the counterfactual.

12. The potential future bidders identified in each region are:

    - Previous providers to the region: NZDG and Sonic in the counterfactual; and Newco (O&S, Hawke's Bay, or Canterbury) in the factual. NZDG and Sonic are currently the principle providers in New Zealand.

    And in both the factual and counterfactual:

    - New domestic bidders: Abano Healthcare Ltd, Medlab Taranaki Ltd, Northland Pathology Laboratory Ltd, and Pathology Associates Ltd. These bidders are present in other regions, but are relatively small operators;
    - International bidders: Mayne Pathology Ltd, St John of God Pathology Ltd and Healthscope Ltd;
    - DHB-owned hospital laboratories outside the region: Canterbury Health Laboratories Ltd and LabPLUS Ltd; and
    - The local DHB-owned hospital laboratory in the region.

13. The Commission identified a number of entry conditions that providers would likely face when attempting to enter a new region by bidding against an incumbent sole provider at the next bidding round. These entry conditions include:

    - access to scarce technical labour: eg pathologists, scientists, and highly specialised technicians;
    - capital: land, purpose-specific buildings, and equipment;
    - scale of operations;
    - incumbent knowledge; and
    - reputation and prior relationships with the purchasing DHB(s).

14. The Commission considers that these entry conditions in aggregate amount to an entry barrier, even for those firms that may already be present in other regions. They represent costs that would either be sunk, or relatively minor for the incumbent – the provider currently holding the contract – when contesting for work in its own region. Whilst the barriers discussed exist under both the factual and counterfactual scenarios, they impact on market participants to a greater or lesser extent. Some players may find these barriers insurmountable when attempting to enter a new region, whereas others may overcome them more readily.

15. The Commission considers that these entry barriers would be more readily overcome by NZDG and Sonic in the counterfactual than by smaller operators. The Commission concludes that under the counterfactual, NZDG and Sonic would provide a strong competitive constraint on one another. Under the counterfactual, NZDG and Sonic are likely to be vigorous competitors for future contracts in Otago/Southland, whereas in the factual, this competition would be lost.

16. The Commission concludes that both in the factual and counterfactual, new domestic bidders, international bidders, and DHB-owned laboratories outside the region would likely face high barriers to entry, and considers that these would likely be sufficient in extent to prevent entry. Therefore, the Commission considers that these categories of potential bidders would be unlikely to provide constraint in any of the relevant regions.

17. The Commission also considered a further category of potential bidders - DHB-owned laboratories within the region (ie the prospect of self-provision). The barriers to self-provision vary by region, as in some regions the hospital laboratory would no longer be operated by the DHB (eg Otago/Southland, the DHB would outsource hospital and community testing for ten years in the factual), whereas in other regions, the provision of hospital testing would continue to be provided by the DHB provider arm (eg Hawke's Bay).

18. In Otago/Southland and South Canterbury, the Commission considers that there would be significant risks to the DHBs in exercising the self-provision option. The Commission considers that the DHBs may accept a considerable price increase before they would be willing to take on the substantial risks and costs associated with bringing all testing back in-house.

19. In Hawke's Bay, Canterbury and West Coast, the Commission evaluated the likely level of constraint provided by the possibility of the DHB provider arm expanding to provide community testing in the relevant region. The Commission considers that although the DHB provider arms would be likely bidders for future contracts, they would likely be a "bidder of last resort" compared with either of NZDG and Sonic (in part due to the provider arms' capital constraints as publicly-owned organisations, and their lack of experience in the provision of community testing).

20. Accordingly, the Commission considers that there is likely to be a substantial difference in the competitive dynamics of the bidding process in the factual compared to the counterfactual. In the factual, likely bidders would include the joint venture and the provider arm (self-provision). The Commission considers that this would result in a substantially different competitive dynamic than under the counterfactual, where there would likely be two vigorous competitors, Sonic and NZDG, as well as a bid from the provider arm. The Commission considers that the proposed joint venture would have the effect of eliminating the strongest source of competitive tension that would otherwise exist in the counterfactual.

21. In addition, the Commission analysed the likely effect of the joint venture proposals on competition in other regional markets (those regions not included in the proposed joint venture arrangements). The Commission considers that under the factual, the characteristics and structure of the markets are likely to increase the likelihood of co-ordinated behaviour. In addition, the Commission

has some evidence that suggests that the proposed joint ventures would be likely to result in increased co-ordination. The Commission considers that the scope for co-ordinated behaviour in other regional markets would likely increase in the factual compared to the counterfactual, as a result of the proposed joint ventures.

Countervailing Power

22. In the past, DHBs have indirectly been price-setters, as the Ministry of Health previously set national 'schedule' prices for the list of schedule tests at which DHBs would purchase community testing. However, in the move to a bulk-funded single-provider model, the DHB would no longer set the price, and would instead rely on market forces (ie through competitive bidding) to determine the price. Under this new framework, the Commission considers that in the counterfactual, DHBs would have the ability to influence this price by playing various competitors off against one another. However, in the factual, with limited choice between providers, the countervailing power of DHBs, and therefore the ability to influence prices, would be dampened significantly.

23. In the factual, DHBs would likely have only one choice of private provider to contract with – the combined entity - whereas in the counterfactual, they would likely have the choice of two private providers, NZDG and Sonic, when contracting. Accordingly, the Commission considers that the countervailing power of the DHBs in each region would be significantly lessened in the factual, due to DHBs' loss of bargaining power.

24. The Applicants submitted that as DHBs are vertically integrated monopsonist purchasers (with a provider arm as well as a funder arm), their countervailing power would provide sufficient constraint on the joint ventures, through the DHBs' ability to self-provide pathology services.

25. However, as discussed above, the Commission considers that there would be significant difficulties faced by the DHBs in providing all pathology testing. Thus, in the factual compared to the counterfactual, the DHBs in each region would have their countervailing power dampened significantly by their inability to threaten credibly the proposed joint ventures with competitive re-entry of the DHB provider arm.

Overall Conclusion and Determination

26. The Commission concludes that the proposed acquisition would reduce the number of likely potential private provider bidders in each region from two vigorous competitors in the counterfactual, to one in the factual. In addition, the Commission considers that the DHB provider arm in each region is unlikely to provide constraint on the joint ventures.

27. For these reasons, the Commission cannot be satisfied that the proposed acquisition would not have, or would not[1] be likely to have, the effect of substantially lessening competition in the Otago/Southland, South Canterbury, Hawke's Bay, Canterbury, and West Coast community testing markets, and the Otago/Southland and South Canterbury hospital testing markets.

28. In addition, the Commission cannot be satisfied that the proposals would not enhance the likelihood of co-ordinated behaviour occurring in other regional

[1] *Brambles New Zealand Ltd v Commerce Commission* (2003) 10 TCLR 868, 877

markets, such that the proposals would not have, or would not be likely to have, the effect of result of substantially lessening competition in other regional markets for the provision of community testing.

29. Pursuant to section 66(3)(b) of the Commerce Act 1986, the Commission determines to decline clearance for the proposed merger of the diagnostic laboratory (pathology) services businesses of New Zealand Diagnostic Group Limited and Sonic Healthcare (New Zealand) Limited or their subsidiaries in six District Health Board districts through the establishment of three joint venture companies that would operate in the following DHB regions:

- Otago;
- Southland;
- South Canterbury;
- Hawke's Bay;
- Canterbury; and
- West Coast.

THE PROPOSAL

1. A notice pursuant to s 66(1) of the Commerce Act 1986 (the Act) was registered on 16 June 2005. The notice sought clearance for the proposed merger of the diagnostic laboratory (pathology) services businesses of New Zealand Diagnostic Group Limited and Sonic Healthcare (New Zealand) Limited or their subsidiaries (NZDG or Sonic respectively or the Applicants collectively) in six District Health Board (DHB) districts through the establishment of three joint venture companies which will acquire the relevant businesses. The relevant DHB districts are those in the Hawke's Bay, Canterbury, South Canterbury, the West Coast, Otago and Southland. The Commission has not seen details of the proposed agreements for sale and purchase of the businesses, as the proposed agreements have not been drafted, but assumes each relates to all the assets of the respective parties in each region.

2. Section 66(3) of the Act requires the Commission either to clear or to decline to clear the acquisition referred to in a s 66(1) notice within 10 working days, unless the Commission and the person who gave notice agree to a longer period. An extension of time was agreed between the Commission and the Applicant. Accordingly, a decision on the Application was required by 29 September 2005.

3. The Applicant sought confidentiality for specific aspects of the Application. A confidentiality order was made in respect of the information for up to 20 working days from the Commission's determination notice. When that order expires, the provisions of the Official Information Act 1982 will apply.

4. The Commission's approach to analysing the proposed acquisition is based on principles set out in the Commission's Mergers and Acquisitions Guidelines.[2]

STATUTORY FRAMEWORK

5. Under s 66 of the Act, the Commission is required to consider whether the proposal is, or is likely to have, the effect of substantially lessening competition in a market. If the Commission is satisfied that the proposal is not likely to substantially lessen competition then it is required to grant clearance to the application. Conversely if the Commission is not satisfied it must decline. The standard of proof that the Commission must apply in making its determination is the civil standard of the balance of probabilities.[3]

6. The substantial lessening of competition test was considered in *Air New Zealand & Qantas v Commerce Commission,* where the Court held:

> We accept that an absence of market power would suggest there had been no substantial lessening of competition in a market but do not see this as a reason to forsake an analysis of the counterfactual as well as the factual. A comparative judgment is implied by the statutory test which now focuses on a possible change along the spectrum of market power rather than on whether or not a particular position on that spectrum, ie dominance has been attained. We consider, therefore, that a study of likely outcomes, with and without the proposed Alliance, provides a more rigorous framework for the comparative analysis required and is likely to lead to a more informed assessment of competitive conditions than would be permitted if the inquiry were limited to the existence or otherwise of market power in the factual.[4]

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[2] Commerce Commission, *Mergers and Acquisitions Guidelines*, January 2004.
[3] *Foodstuffs (Wellington) Cooperative Society Limited v Commerce Commission* (1992) 4 TCLR 713-722.
[4] *Air New Zealand & Qantas Airways Ltd v Commerce Commission,* unreported HC Auckland, CIV 2003 404 6590, Hansen J and K M Vautier, Para 42.

7. In determining whether there is a change along the spectrum which is significant the Commission must identify a real lessening of competition that is not minimal.[5] Competition must be lessened in a considerable and sustainable way. For the purposes of its analysis the Commission is of the view that a lessening of competition and creation, enhancement or facilitation of the exercise of market power may be taken as being equivalent.

8. When the impact of market power is expected to be predominantly upon price, for the lessening, or likely lessening, of competition to be regarded as substantial, the anticipated price increase relative to what would otherwise have occurred in the market has to be both material, and ordinarily able to be sustained for a period of at least two years or such other time frame as may be appropriate in any given case.

9. Similarly, when the impact of market power is felt in terms of the non-price dimensions of competition such as reduced services, quality or innovation, for there to be a substantial lessening, or likely substantial lessening of competition, these also have to be both material and ordinarily sustainable for at least two years or such other time frame as may be appropriate.

ANALYTICAL FRAMEWORK

10. The Commission applies a consistent analytical framework to all its clearance decisions. The first step the Commission takes is to determine the relevant market or markets. As acquisitions considered under s 66 are prospective, the Commission uses a forward-looking type of analysis to assess whether a lessening of competition is likely in the defined market(s). Hence, an important subsequent step is to establish the appropriate hypothetical future with and without scenarios, defined as the situations expected:

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

11. The impact of the acquisition on competition is then viewed as the prospective difference in the extent of competition in the market between those two scenarios. As stated above, the issue is whether there is a substantial difference between the two (ie a considerable and sustainable change). The Commission analyses the extent of competition in each relevant market for both the factual and the counterfactual scenarios, in terms of:

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

THE PARTIES

Sonic

12. Sonic is a subsidiary of Sonic Healthcare Limited, an Australian-based medical diagnostics company, providing pathology and radiology services to medical practitioners, hospitals, community medical services and their patients. Sonic Healthcare has an annual turnover of approximately A$1.3 billion, and is listed on the Australian Stock Exchange.

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[5] *Fisher & Paykel Limited v Commerce Commission* (1996) 2 NZLR 731, 758 and also *Port Nelson Limited v Commerce Commission* (1996) 3 NZLR 554.

13. In New Zealand, Sonic provides pathology services in 15 different DHB (District Health Board) districts.[6] Sonic has four subsidiary pathology businesses in New Zealand. These are Medlab South Ltd, Valley Diagnostics Ltd, Medlab Central Ltd and Diagnostic Medlab Ltd. A diagram of the Sonic group of companies in New Zealand is attached at Appendix A.

NZDG

14. New Zealand Diagnostic Group Limited (NZDG) is a privately-owned group of companies providing pathology services throughout New Zealand. NZDG's annual turnover is approximately [ ]. A diagram of the NZDG group of companies is attached at Appendix B.

15. NZDG operates pathology services in eight DHB districts.[7] It has four subsidiary pathology businesses in New Zealand. These are: Southern Community Laboratories Ltd (SCL), SCL Hawke's Bay Ltd, Medlab Hamilton Ltd, and Medlab Gisborne Ltd.

OTHER PARTIES

Abano Healthcare Group Ltd (Abano)

16. Abano Healthcare is a publicly-listed company, and currently has full or part ownership of a range of businesses in three key healthcare and medical service sectors – dental, diagnostics and rehabilitation. In September 2005, it also announced a move into orthotics, with the proposed acquisition of orthotic specialists, Orthotic Centre (NZ) Limited. Abano's total annual turnover is approximately $66 million. The diagnostics sector (pathology and radiology) makes up approximately $18 million of this total.

17. Abano's pathology business comprises operations in the Capital & Coast and Nelson/Marlborough DHB districts – Medical Laboratory Wellington and Nelson Diagnostic Laboratories, respectively.

Medlab Taranaki Ltd (Medlab Taranaki)

18. Medlab Taranaki is a pathologist-owned business, which has operated in New Plymouth since 1962. In the 1990s it expanded to provide community testing to the entire Taranaki region. Medlab Taranaki has one laboratory located in New Plymouth, and collection points in Hawera and Stratford. Medlab Taranaki is the sole provider of community testing for the Taranaki DHB region. It has an annual turnover of approximately [ ].

Northland Pathology Laboratory Ltd (NPL)

19. NPL performs pathology testing in the Northland DHB region. NPL was acquired by the Gribbles Group Ltd from a private pathologist (Dr. Desmond Reddy) in June 2004. Gribbles was subsequently acquired by Australian company Healthscope Limited (Healthscope) in November 2004. NPL's annual turnover is presently [ ], approximately.

Pathology Associates Ltd (PAL)

20. PAL is pathologist-owned and run, and predominantly operates in the middle of the North Island. PAL operates the Tauranga hospital laboratory, performing all the hospital and community-referred testing in the Bay of Plenty DHB region.

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[6] See Appendices D and E.
[7] See Appendices D and E.

21. PAL has 100% ownership of Pathlab Waikato Ltd, and performs around [ ] of the community testing for the Waikato DHB. It also has a 50% shareholding in Rotorua Diagnostic Laboratory, with Sonic holding the remaining 50%. Rotorua Diagnostic Laboratory undertakes community testing in the Lakes DHB region.

Mayne Pathology Ltd (Mayne)

22. Mayne Pathology (a subsidiary of Mayne Group Ltd) is the second-largest pathology provider in Australia (behind Sonic Healthcare). It has an annual turnover of approximately $600 million and operates in Victoria, New South Wales, Queensland, Western Australia and the Northern Territory. Its core businesses include pathology, diagnostic imaging, pharmaceuticals, and a chain of pharmacies across Australia. Mayne is presently in the process of restructuring its business lines. Mayne is in the process of demerging its pharmaceutical operations, which is expected to be completed by the end of the 2005. Following this restructure, pathology will represent approximately [ ]% of its total business.

St John of God Pathology Ltd (SJGP)

23. SJGP is a division of St John of God Healthcare, a large healthcare provider in Australia. SJGP is presently Australia's fourth largest private pathology provider, serving a population of over 500,000 in Western Australia and Victoria. It has 18 laboratories throughout these two regions, and employs over 400 staff, including 15 pathologists. St John of God Healthcare has an annual turnover of approximately [ ], of which SJGP represents approximately [ ] of this total.

Canterbury Health Laboratories Ltd (CHL)

24. CHL is the public hospital laboratory owned by Canterbury DHB. CHL is the largest medical laboratory in the South Island. It undertakes all the hospital testing for Christchurch Hospital, and, as a reference laboratory (see definition below in Industry Background section), also performs the majority of specialist send-away testing, and cervical screening testing, for the South Island and the lower North Island.

LabPLUS Ltd (LabPLUS)

25. LabPLUS is the public hospital laboratory owned by Auckland DHB. It is the tertiary medical laboratory attached to Auckland City Hospital. It also operates as a specialist service centre, undertaking all send-away testing for the Auckland region, and performs specialist work for other regions from its base in Auckland. LabPLUS is the largest DHB-owned laboratory in the country.

INDUSTRY BACKGROUND

Types of Tests and Laboratories

26. The core services provided by the parties are pathology services (also called diagnostic laboratory services). These services involve examining clinical specimens to provide information for the diagnosis, prevention and treatment of disease, and reporting the diagnosis to the referring health professional. Ancillary to the analysis itself is the collection and transportation of the samples.

27. Diagnostic testing covers a number of speciality areas including :

- Haematology – the quantification and assessment of blood cells and clotting factors;
- Clinical biochemistry – the quantification of enzymes, other proteins and biological chemical components of the fluid fraction of the blood;

- Endocrinology – quantification of hormone agents in the blood or body secretions;
- Microbiology – the culture and identification of bacteria and fungi from samples of biological material;
- Serology – using body fluids, mostly blood, to quantify and identify immune responses indicative of the state of disease or immunity;
- Anatomical pathology – the branch of pathology concerned with the diagnosis of disease based on the gross and microscopic examination of cells and tissues. It includes;
  - cytopathology, the study and diagnosis of diseases at the cellular level (for example the reading of a Pap smear, used to detect cervical cancer), and
  - histopathology, the microscopic examination of diseased tissue (for example examination of an excised tumour).

28. There are approximately 1200 different pathology tests, ranging from the more routine (and, consequently, high volume) to the highly specialised and extremely rare. Most laboratories do not conduct the full range of tests. Some of the non-routine and/or more specialised tests requiring highly skilled clinical input are sent to a small number of "reference laboratories", recognised for their particular specialisation/expertise, and where an aggregated "critical mass" of such tests can be analysed.

29. Two main forms of pathology testing exist in New Zealand: community testing and hospital testing. Community testing is, in the main, carried out by private providers such as NZDG and Sonic, and prices were historically fixed according to a schedule of approximately 180 commonly-performed tests. Hospital testing is generally performed by public providers (ie DHB provider arms), although there are instances where private providers hold contracts to carry out both community and hospital testing[8].

30. Laboratories (community and hospital) that do not perform some of the non-routine tests will refer the samples to the reference laboratories; these tests are called "sendaways". The reference laboratories where such tests are aggregated into appropriate volumes are LabPLUS, Waikato Hospital Laboratories, the Institute of Environmental Science and Research (ESR) in Wellington and CHL.

Funding of Pathology Services

31. Currently the New Zealand government, through the Ministry of Health (MoH) and the DHBs' funder arms, meets the full cost of most diagnostic tests for New Zealand citizens and permanent residents. Even where diagnostic testing is carried out in relation to a medical incident covered by the patient's medical insurance or by the Accident Compensation Corporation (ACC), the DHBs fund the diagnostic testing. Neither the patient nor ACC is billed for the service. Part-charges to patients are not permitted. As exclusive funders, DHBs are monopsony purchasers of pathology services. Community laboratories are dependent on this public funding. Over 96% of their revenues by value and volume comes from publicly funded testing paid for by the DHBs.

32. The DHBs fund third party service providers from their budgets, which are set in funding agreements with the MoH. Funding is distributed by MoH among the DHBs according to a population-based allocation system. Most DHBs are vertically integrated

[8] For example, MedLab Central performs all hospital testing for Palmerston North Hospital, MedLab South conducts all hospital testing for Timaru hospital, and MedLab Bay of Plenty carries out all hospital testing for Tauranga hospital.

in that they fund their provider arms which provide laboratory services – predominantly hospital based services.

33. Historically, there has been a clear distinction between community and hospital laboratories, in terms of both the environment from which testing was referred and the funding of those services by the DHBs. Community laboratories have historically provided testing of samples referred from community or primary care sector health professionals, such as General Practitioners, specialists and midwives. These community laboratories have traditionally been funded on a fee-for-service basis and could claim reimbursement from the DHBs (and their predecessors) for tests listed on "the Schedule" (so-called "Schedule tests").[9]

34. The Schedule contains the tests that GPs and specialists may readily require and which are generally carried out by community laboratories.[10] It is currently national in application in terms of both content and prices, although there are some relatively minor and largely historic variations that arose under the former Regional Health Authority (RHA) and Health Funding Authority (HFA) structures (these bodies are among the predecessors to the DHBs).

35. The community laboratories also perform a limited amount of testing that is not paid for by the DHBs and the public health system. Such "privately-funded" tests are generally paid for by the patient or the patient's insurer. Examples include tests required for immigration and/or visa applications, life insurance, superannuation and similar benefits, health and safety in employment, or tests prior to travel abroad. This work accounts for less than 4% of the business by value and volume.

36. In contrast, the hospital laboratories largely provide testing for the hospital or secondary care sector by testing in-patient and out-patient samples. The hospital laboratories are generally funded on a bulk basis from DHB hospital budgets rather than on a fee-for-service basis. The hospital laboratories are not limited by the content of the Schedule. Through use of the reference laboratories, hospital laboratories can offer the full range of diagnostic testing.[11] In many cases the tests routinely provided for hospital in-patients and out-patients are, of course, the same as those tests listed on the Schedule. The hospital laboratories also carry out non-schedule testing referred from the community.

Industry Change

37. Due to a requirement of the MoH that DHBs seek more cost effective service provision, many DHBs are presently seeking to reduce the cost of pathology services. In most cases, the DHBs are seeking to change the way pathology services are funded, from a fee-for-service payment towards bulk funding arrangements.

38. The New Zealand Health Strategy published by the MoH in 2000 states:

> <u>Improved co-ordination</u>
>
> For health services to address the needs of local communities and individuals more co-ordinated and complementary ways of working across the sector need to be established. Competition

[9] Tests that might be requested by a community referrer but which are not covered by the Schedule are, by definition, "non-Schedule" tests. Where a health professional requests a non-Schedule test, a community laboratory that is not funded to carry out non-Schedule testing sends the sample to a laboratory with a contract to perform non-Schedule tests. Generally, this would be a hospital laboratory. Smaller hospital laboratories would refer these samples to the reference laboratories.

[10] Commerce Commission Staff Report, *SGS/Diagnostic*, 14 April 1999, para 8.

[11] Some hospital laboratories in smaller regional centres have limited facilities and therefore a limited range of testing. Hospital laboratories in the larger urban centres have a greater range.

> between providers or professional groups has inhibited the development of services oriented to the needs of individuals and communities.
>
> The Government expects District Health Boards to ensure service providers in their districts work with each other to maintain and develop well co-ordinated programmes to improve the health of communities and individuals (across public health, primary care, community-based care and secondary/tertiary service sectors).
>
> District Health Boards will need to work with each other to ensure access for their populations to regional and national services. This is particularly important for public health and mental health services, where regional planning and networking is imperative.[12]

39. Many DHBs have commissioned independent reviews and economic analyses to assist them in identifying the cost drivers and potential options for the future provision of pathology services. Consolidation is a common theme of these reports and analyses, although there are differing views between the districts as to how results can be achieved.[13]

40. The approaches taken by DHBs to contracting for pathology services varies by region, and some DHBs have not yet reached final positions. Some strategies being considered (and in some instances, adopted) by DHBs to achieve this include:

    - moving from fee-per-service to bulk funding for community testing (to incentivise more efficient levels of testing);
    - awarding exclusive regional provision contracts (channelling all testing through a single provider to generate economies of scale and lower costs of provision);
    - the merging of regional community and hospital testing, such as in South Canterbury, and anticipated in Otago and Southland (to capture operational synergies, and generate economies of scale);
    - greater cooperation between DHBs when purchasing pathology services (eg Otago/Southland and Capital & Coast/Hutt Valley DHBs); and
    - increased integration of IT systems and data repositories between primary, secondary, and tertiary health providers (to minimise the unnecessary duplication of testing).

41. Some DHBs have identified (and quantified) the short-term savings that may be achieved by the adoption of these new funding models. The Otago DHB stated that its proposed bulk-funded single provider contract for all pathology services will achieve savings of over $50 million over a ten-year period. The Commission notes that the savings being claimed by the DHBs involved in the current proposal are being measured against what they have paid under the previous fee-for-service approach, and derive from moves to sole supplier contracts rather than from the proposed joint venture arrangements.

42. It appears likely that all 21 DHBs will be carrying out some form of review of the provision of pathology services in their districts, although not all have commenced this

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[12] Ministry of Health The New Zealand Health Strategy, , December 2000, p 27-28

[13] See *Options for Reform of Diagnostic Laboratory Services Markets*, Simon Terry Associates Ltd (Reinhard Pauls) August 2002; *DHBNZ discussion paper and related matters*, EW Consulting P/L, 26 May 2003; *A Response to Reinhard Pauls' Paper*, Brown, Copeland & Company Ltd, Prepared for the Association of Community Laboratories 16 June 2003; *Discussion Document – The future of laboratory services delivery in the central region* , LECG, 16 September 2004; *Laboratory services in the Auckland region - A Review of Future Options for Supply-side Configuration*, Final report to the DHB Chief Executives, December 2004; *Central Region Laboratory Project – Report from the Central Region Laboratory Working Party*, LECG, February 2005; *Waikato DHB Laboratory Service Strategy* Waikato DHB March 2005, under cover of a memorandum to the Community and Public Health Advisory Committee dated 27 April 2005.

process, and a number of DHBs are yet to express clear views on their preferred contracting approach (for example, Canterbury DHB).

Applicants response

43. The Applicants contend that the joint venture proposals are a response to the MoH and DHB initiatives towards greater integration, greater consolidation, and towards fundamental change in the manner and nature of funding of pathology services described above.

44. The Applicants stated that the key driver for the proposed joint ventures is to respond to the desire of DHBs to control costs for such testing and to drive down costs through demand management. They contend that the only way these savings may be generated is through the achievement of economies of scale and potential business synergies, which would flow from the proposed joint ventures.

THE NEWCOS

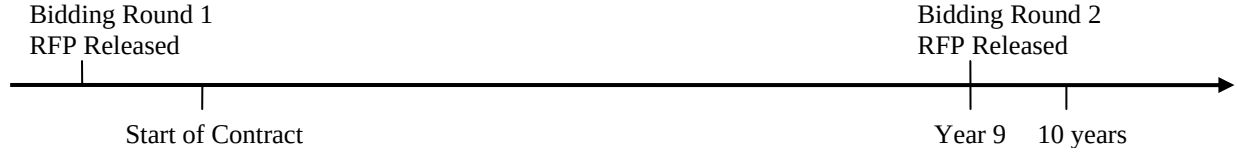
Otago / Southland (O&S Newco)

45. The Otago and Southland DHBs advised the Commission that they saw an opportunity for collaboration for the future provision of laboratory services. They are both relatively small DHBs, serving geographically large but sparsely populated regions. The populations of Otago and Southland are 180,000 and 110,000 respectively. The DHBs believed that they could gain economies of scale through joining together to provide services such as pathology.

46. The total annual value of laboratory services (hospital and community) in Otago and Southland has been approximately [ ] to date. The main providers of community testing in the two regions are Sonic and NZDG, with market shares of approximately [ ]% and [ ]% respectively[14], while the main providers of hospital testing are the Dunedin and Invercargill hospital laboratories.

47. In Otago/Southland a 'Request for Proposal' (RFP) was issued to the market in February 2005, seeking bids for the provision of all hospital and community testing for a period of ten years. The value of this contract is approximately [ ] over ten years. As a result, the Otago/Southland market will change from a contracted fee-per-service market, where competition occurs for volume on a day by day basis, to a bidding market. This will operate as outlined in Diagram 1:

Diagram 1: The Otago / Southland Bidding Cycle



[14] The markets shares stated here are based on figures submitted by the Applicants. The Application submitted market shares based on a market for pathology testing (hospital and community combined), rather than just community testing, but noted that the Applicants understand that the split in funding between hospital and community testing is approximately 50:50. The Commission calculated market shares for community testing on this basis. They are approximate figures.

48. At bidding round one (B1) the Otago and Southland DHBs put their RFP to the market. The South Island Shared Services Agency Ltd (SISSAL) was commissioned by the two DHBs to co-ordinate the RFP process, and to evaluate the respective proposals.

49. Initially (in a draft RFP), the Otago and Southland DHBs encouraged both the two hospital laboratories and the two community laboratories to come together and present a joint bid (ie all four providers together). However, the four providers were unable to agree on various matters and so they submitted separate responses, one from a joint venture of the Southland and Otago hospital laboratories, and the other from the proposed joint venture partners, LabCo (O&S Newco).

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51. [ ]:

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52. LabCo [ ] was duly granted "preferred bidder" status by the DHBs (any proposed contract between the provider and the DHBs would require MoH approval).

53. The DHBs stated that it would achieve savings of $50 million over ten years, as a result of the proposed contract with O&S Newco. These savings claimed by the DHBs are being measured against what the DHBs have paid under the previous fee-per-test approach. The Commission considers that any savings made purely by way of the joint venture should be measured against the sole supplier competitive counterfactual.

54. The Otago/Southland contract is for ten years which means competition for the provision of hospital and community testing would next occur at bidding round two (B2).

Hawke's Bay (HB Newco)

55. The Hawke's Bay DHB (HBDHB) region services a population of around 148,000. The total annual cost of community laboratory services in the region is currently approximately [ ]. The main providers of community testing in the region are Sonic and NZDG, with market shares of approximately [ ] and [ ] respectively[16].

56. Recognising that the cost of and demand for community laboratory services was increasing, the HBDHB sought to control the cost of those services. In September 2004, the HBDHB put consultation documents regarding the future provision of laboratory services in the Hawke's Bay region to interested parties and to the public for comment.

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[15] [ ].

[16] The markets shares stated here are based on figures submitted by the Applicants. The Application submitted market shares based on a market for pathology testing (hospital and community combined), rather than just community testing, but noted that the Applicants understand that the split in funding between hospital and community testing is approximately 50:50. The Commission calculated market shares for community testing on this basis. They are approximate figures.

57. In late November 2004, the Applicants approached the DHB with a view to forming a joint venture in the Hawke's Bay region (HB Newco) for the provision of laboratory services. After a number of discussions and meetings, the HBDHB and the Applicants signed a Heads of Agreement in respect of the provision of community testing in the HBDHB regions for the next five years.

58. The Agreement involves the formation of a contract whereby Hawke's Bay Newco would provide community testing [

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59. In essence, the agreement provides that:

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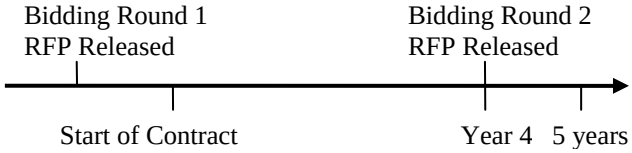
60. When the DHB recently decided on the future provision of services in this region, pathology services were not tendered, and there was no RFP issued. However, although the HBDHB did not undertake a contestable process before awarding the contract to HB Newco, the Commission considers that at the end of a five year period with a single provider, it is likely that the DHB would issue an RFP or re-tender community testing. The HBDHB advised the Commission that at the end of the contract period it may elicit bids from the joint venture as well as any other interested providers and potentially its provider arm. As a result, the Commission considers it likely that Hawke's Bay community testing market would change to a bidding market and would operate as outlined in Diagram 2 below:

Diagram 2: The Hawke's Bay Bidding Cycle



61. The Commission notes that the HBDHB [

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62. The Hawke's Bay DHB advised the Commission that it would save a minimum of [ ] per annum as a result of the proposed new contract. These savings claimed by the DHBs are being measured against what the DHBs have previously paid. The Commission considers that any savings made purely by way of the joint venture should be measured against the sole supplier competitive counterfactual.

South Canterbury, Canterbury and West Coast (Canterbury Newco)

South Canterbury

63. South Canterbury is a small DHB region, servicing a population of 55,000. The total annual value of laboratory services in the region is approximately [ ] (this is the annual value of the bulk-fund contract to provide all services, currently held by Medlab South (Sonic)).

64. In 1997, the South Canterbury DHB reviewed its hospital laboratory services. These services were tendered and Medlab South was successful in winning that contract.

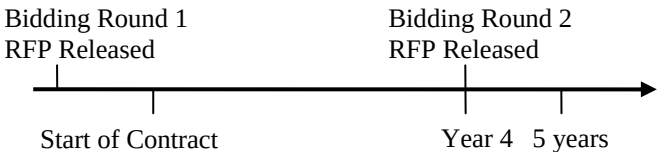
65. In October 2003, the South Canterbury DHB issued an RFP for the provision of community testing in the region. The DHB received two bids: one from Medlab South (Sonic), and the other from SCL (NZDG). The contract was awarded in March 2004 to Medlab South for a period of five years [ ].

66. Prior to the RFP process Medlab South provided the majority of community testing for the region. SCL had a very small presence in the region, providing approximately [ ] of testing (primarily in the Mackenzie region).

67. [ ] The South Canterbury DHB was one of the first DHBs to move towards a single provider bulk-funded contract for community testing. The DHB believed that it could achieve savings through the use of a competitive bidding process. As a result of this process, the DHB reduced its laboratory expenditure by [ ].

68. The contract to provide all services has been in operation since March 2004, and expires in 2009. At that time, it is likely that the services will be tendered again. In the factual, Canterbury Newco would acquire this contract to provide all hospital and community testing in the South Canterbury DHB district. The Commission considers that the South Canterbury community testing market will operate as outlined in Diagram 3:

Diagram 3: The South Canterbury Bidding Cycle



Canterbury

69. The Canterbury DHB services a population of approximately 430,000. There are currently three pathology providers in the Canterbury DHB region - Medlab South (Sonic), SCL (NZDG) and CHL. Medlab South and SCL perform the majority of community testing, while CHL undertakes all hospital testing as well as a small amount of community testing.

70. The Canterbury DHB is currently reviewing its laboratory services. It has not decided on the future model for laboratory services in the region, and is waiting to see what other DHBs decide. The DHB has not decided whether it will move towards a single provider model, or whether it will tender out hospital testing, community testing or both. The current community contracts expired at the end of September, but have been rolled over while the laboratory review is being undertaken.

71. The parties are uncertain of the future plans of the Canterbury DHB with regards to laboratory testing. However, in the factual, Canterbury Newco would likely contest

future contracts in the region. In a summary of a paper to Colin Goldschmidt, Managing Director, Sonic Healthcare, from Brian Willcox, CEO of Medlab South, Mr Willcox stated:

[

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West Coast

72. The West Coast DHB services the isolated area of the West Coast, with a catchment area of 30,000 people. There are currently two main providers of pathology services in the West Coast – Medlab South (Sonic) and the DHB-owned hospital laboratory (Grey Hospital Laboratory).

73. The DHB-owned hospital laboratory is the main provider in the region, providing all hospital testing for Grey Base Hospital, as well as [ ]% of community testing for the region. It subcontracts some specialist testing to CHL. Medlab South undertakes the remainder of community testing in the region, although it does not have a laboratory in the region. It provides testing services from its Christchurch base, and has a courier network that collects samples from GPs on the West Coast. A very small amount of testing (value of less than [ ] is performed by SCL (NZDG).

74. The West Coast DHB currently has a discussion document out amongst stakeholders (GPs, hospital doctors, and primary care providers) that proposes moving to a sole supplier of (community and/or hospital) laboratory services on the West Coast. The deadline for comments and submissions has not yet been reached. The DHB stated that if the feedback received is broadly positive, it would be looking to issue an RFP for a sole supplier of laboratory services. The form of this RFP has not yet been decided, and it is uncertain whether it would involve hospital testing, community testing or both.

75. Under the factual, Canterbury Newco would assume the pathology testing currently performed by Medlab South (Sonic) and SCL (NZDG) in the West Coast region. If an RFP seeking a sole supplier were issued in the future, Canterbury Newco could submit a bid for the sole supplier contract.

PREVIOUS COMMISSION DECISIONS

76. The Commission has previously considered mergers involving pathology services.

77. The *Tairawhiti Healthcare Limited / Gisborne Laboratories Ltd* Application[17] sought clearance for an acquisition by Tairawhiti Healthcare Ltd of the goodwill and some assets of Gisborne Laboratories Limited. The acquisition involved aggregation in the markets for the provision of pathology and medical laboratory testing services for the carrying out of scheduled tests for medical practitioners in the Poverty Bay/East Coast region. The clearance was assessed under the (now repealed) dominance test. The Commission was satisfied that the proposal would not result, or would not be likely to result, in any person acquiring or strengthening a dominant position in a market.

THE APPLICATION

78. As outlined in paragraph 1, the Application relates to the proposed merger of the diagnostic laboratory (pathology) services businesses of NZDG and Sonic or their subsidiaries, in six DHB districts. The merger would be effected by the establishment of

[17] Tairawhiti Healthcare Limited / Gisborne Laboratories Limited, 8 December 1995.

three joint venture companies that would acquire the relevant businesses of the parties in those six DHB regions. The Application stated that the proposals were a direct response to fundamental industry change being driven by the DHBs, in particular the move to a single provider environment based on fixed price, bulk funded, exclusive contracts.

79. In considering the Application the Commission has not questioned the appropriateness of DHBs moving to a single provider environment. On the information before it the Commission has assumed that this is the likely outcome. Similarly, the Commission understands that there may be substantial variations in approach between regions. For instance, DHBs may be looking to outsource only community pathology testing, or they may outsource both community and hospital testing; services may be awarded by way of a competitive tender process, a request for proposal process or by negotiation; and contractual details such as the length of the contract may differ. For the purposes of considering the Application, the Commission has assumed that the majority of DHBs may be moving to a single provider (and bulk-funded) environment.

80. The Application suggested that if the Commission takes as given the move by the DHBs to a single provider, then there is little difference between the factual (the joint venture providing services) and the counterfactual (NZDG or Sonic or another entity providing services). For example, paragraph 15.25 of the Application states:

> Given the Hawke's Bay DHB's clear preference for one community service provider to the district, a reduction in the number of competitors in the district could reasonably be anticipated whether or not the proposal proceeds. The merger of the parties' businesses does not result in a substantial lessening of competition in comparison to a counterfactual tender scenario. In either case there would be only one community service provider to the district, and in either case the DHB's ability to integrate the hospital and community laboratories (ie to self-supply through the hospital laboratories) exerts a significant competitive constraint.

81. The Commission departs from the analytical approach implicitly suggested in the Application, in that it considers whether the transaction is likely to affect competition at the point where competition occurs (ie when the parties bid for contracts). In this case, competition occurs *for* the market rather than *in* the market. As a result, the Commission must make a comparative judgment between the dynamics in the factual, where Sonic and NZDG jointly submit a bid and alternatively, the dynamics in the counterfactual, of a bidding market where both Sonic and NZDG may compete against each other for the market.

MARKET DEFINITION

82. 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.

83. For competition purposes, a market is defined to include all those suppliers, and all those buyers, between whom there is close competition, and to exclude all other suppliers and buyers. The focus is upon those goods or services that are close substitutes in the eyes of buyers, and upon those suppliers who produce, or could easily switch to produce, those goods or services. Within that broad approach, the Commission defines relevant markets in a way that best assists the analysis of the competitive impact of the acquisition under consideration, bearing in mind the need for a commonsense, pragmatic approach to market definition.[18]

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[18] Australian Trade Practices Tribunal, *Re Queensland Co-operative Milling Association* (1976) 25 FLR 169; *Telecom Corporation of NZ Ltd v Commerce Commission & Ors* (1991) 3 NZBLC 102,340 (reversed on other grounds).

84. For the purpose of competition analysis, the internationally accepted approach is to assume the relevant market is the smallest space within which a hypothetical, profit-maximising, sole supplier of a good or service, not constrained by the threat of expansion and entry, would be able to impose at least a small yet significant and non-transitory increase in price, assuming all other terms of sale remain constant (the SSNIP test). The smallest space in which such market power may be exercised is defined in terms of the five dimensions of a market, two of which are relevant to this case and are discussed below. The Commission generally considers a SSNIP to involve a five to ten percent increase in price that is sustained for a period of one year.

85. The Applicants submitted that the relevant markets in which there will likely be an aggregation of business activity as a result of the proposed acquisition are the markets for the provision of pathology services (or diagnostic laboratory services), both hospital and community testing, including the collection and transport of samples, in the following DHB regions:

- Otago and Southland (aggregated for pathology services, but remain two separate DHB regions);
- South Canterbury
- Hawke's Bay;
- Canterbury; and
- West Coast.

Market Mechanism

86. In the past, any private provider that could demonstrate to a contracting DHB that they were capable of supplying pathology services was awarded a contract to perform schedule-based community testing in that DHB area on a fee-for-service basis. Potentially, therefore, multiple providers of community testing could have existed in any given region.

87. In recent times, in line with the National Health Strategy, many DHBs have indicated a preference to contract exclusively with a single provider for at least some portion of pathology services in their respective regions. This is reflected in the Requests for Proposals (RFPs) issued by the Otago/Southland (two DHBs aggregated for future pathology contracts) and the South Canterbury DHBs, and the invitation for a single provider of community testing by the Hawke's Bay DHB. The duration of these proposed contracts varies from three to ten years. There appears to be a trend towards bulk-funded contracts rather than the traditional fee-per-test contracts, although some DHBs such as [ ] are continuing with fee-per-test contracts.

88. Most DHBs have employed, or have indicated that they intend to employ, a tender process in imminent contracting rounds. Here, providers tender against one another for contracts guaranteeing exclusive provision. In contrast, at least one DHB (Hawke's Bay) has elected to negotiate directly a contract for services with a provider, rather than run a competitive tender (the DHB relied on its own bargaining position to arrive at a contractual outcome instead of competitive market forces). However, this approach appears to be the exception rather than the norm.

89. Current changes in the way DHBs purchase pathology services, ie the move towards a single-provider bulk-funded model, represent a significant shift in the nature of service provision in this industry. It is important to emphasise that the Commission has assumed that this change applies in both the factual and counterfactual scenarios.

90. The present move towards contests for single-provider contracts means that competition will be for the market, rather than in the market. In a sense, all of the competition 'in' the market is being compressed into a winner-takes-all 'for' the market each time there is a contracting round.

91. It has often been argued in auction theory literature, and before various competition authorities, that in bidding markets (that is, markets when competition is for the market), market share does not correlate to market power, as tends to happen in 'normal' markets. Rather, the existence of just two competing players may be enough to ensure competitive outcomes, or even that one firm is enough.[19]

92. However, critics of this view, such as Klemperer, argue that the competitive outcome result flows directly from the adoption of strict assumptions that describe an 'idealized' bidding market, and that violation of these assumptions leads to the familiar problems of unilateral and co-ordinated effects.[20] Klemperer argues that in practice many bidding markets fail to satisfy these "extreme" assumptions, in which case it is appropriate to analyse them as conventional antitrust markets, where the extent of competition is a function of the number of competitors and firm-specific factors, such as size.

93. Taking into account the preceding discussion, any market definition used to aid competition analysis in the present case should recognise that:

- competition for supply will occur not continuously as in the past, but rather at discrete and infrequent intervals;
- competition results in the winning provider securing exclusive rights to provide services to a region for the duration of the contract period; and
- the use of a bidding mechanism to determine the supplier does not obviate the need to conduct a full competition analysis.

94. The issue for the Commission is to determine the difference in competition for the markets in the factual and in the counterfactual, and to determine the extent of any lessening at the end of the contract period.

Product Markets

95. Initially, markets are defined for each product supplied by two or more of the parties to an acquisition. The Commission usually employs the SSNIP test to assess the scope for demand- and supply-side substitution. That is, the Commission asks, would a five to ten percent price rise, by a hypothetical monopolist, sustained over a year, induce substitution by buyers or near competitors? The point at which the SSNIP becomes profitable for the hypothetical monopolist defines the boundary of the relevant market since no potential substitute beyond this point is sufficiently close to constrain the SSNIP.

96. Practical application of the SSNIP test in this case is problematic given that competition will occur through bidding markets in future. Tenders in response to an RFP are typically sealed bids placed simultaneously (by a specified date) to the issuing DHB. Hence, in theory, in any given bidding round, players do not have the opportunity to

[19] See, for example, S. Bishop, and M. Walker, (2002) *The Economics of EC Competition Law: Concepts, Application, and Measurement*, Chapter 14, Sweet & Maxwell: London; and P. Klemperer, "Bidding Markets", *Working Paper*, UK Competition Commission, (2005), p.4.

[20] The extreme assumptions include, in particular: competition is winner take all so there is no smooth trade-off between price and quantity; competition is 'lumpy' so that in each contest, there is an element of 'bet your company'; competition begins afresh in each contracting round so there is no 'lock-in' or significant advantages from incumbency; entry of new suppliers to the market is easy; and a bidding system is involved. See Klemperer (2005) for a more detailed discussion.

observe each others' prices and respond accordingly. The difficulty with applying the SSNIP test in such instances is that there is no obvious price on which to add the SSNIP. Even if the hypothetical monopolist in the region were assumed to add 5% to 10% to its full costs, it is difficult to predict whether a provider elsewhere would bid.[21]

97. Notwithstanding the difficulties in applying the SSNIP test in this particular case, the notion of substitutability is useful when considering the appropriate definition of the market. There are several non-price factors that can help inform the extent of product substitutability on both the demand- and supply-side. These may include, among other factors: distinct product characteristics and uses; unique production facilities or processes; distinct purchasers; specialisation of sellers; and recognition and views of industry participants of market boundaries.

98. In instances where the SSNIP test cannot readily be applied because buyers and sellers cannot easily observe and respond to relative prices, the Commission may give more weight to such non-price considerations when assessing the scope for substitutability.

99. 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.

100. Close substitute products on the supply-side are those between which suppliers can shift production easily and in the short-run, using largely unchanged production facilities and little or no additional investment (including investment that would be sunk), when they are given a profit incentive to do so.

101. In terms of the relevant product dimension, the Applicants argued that the relevant market is a single market for all pathology services, both hospital and community testing, including the collection and transport of samples.

Community Testing and Hospital Testing

102. Two main forms of pathology testing exist in New Zealand: community testing and hospital testing. Community testing is, in the main, carried out by private providers such as NZDG and Sonic, and prices for these tests were historically fixed according to a schedule of approximately 180 commonly-performed tests. Non-schedule tests are generally referred to hospital providers, who hold contracts to perform this work.

103. Community testing may be performed either at a private facility in the community, or at a public hospital laboratory (for instance, where a provider has been contracted to perform both community and hospital testing), whereas hospital testing is always performed onsite at a public hospital laboratory. This is because hospital tests are usually referred from within the hospital (ie through inpatient or outpatient clinics) rather than from community sources (eg General Practitioners), and these referrers often require results to be processed urgently. To ensure fast turnaround times, the hospital provider must be located in close proximity to where the sample is drawn. Additionally, it is advantageous for hospital clinicians and surgeons to be able to confer with the

[21] It may be possible for players to glean some information about competitors' bidding strategies from experiences with tenders in other regions, or from previous contracting rounds. However, such information would be useful only to a limited extent: there are significant regional variations in terms of demographics, testing needs, relationships with DHBs, etc. Also, tender rounds will likely occur infrequently (ie every three to ten years), so market conditions may evolve significantly in the intervening years, potentially rendering past information obsolete.

pathologists and scientists over test results, which is assisted by having these staff onsite.[22]

104. Some DHBs informed the Commission that there are strong synergies between hospital and community laboratories, and there are efficiencies, economies of scale and savings to be made by combining hospital and community testing. So, although hospital testing is generally performed by public providers (ie DHB provider arms), there are a few instances where private providers hold contracts to carry out both community and hospital testing. MedLab Central performs all hospital testing for Palmerston North Hospital (MidCentral DHB), MedLab South conducts all hospital testing for Timaru hospital (South Canterbury DHB), and MedLab Bay of Plenty carries out all hospital testing for Tauranga hospital (Bay of Plenty DHB). If clearance were granted, the proposed joint venture in Otago and Southland would be an example of such an arrangement. To date, however, such arrangements have been the exception rather than the norm.

105. There are a number of similarities between community and hospital testing. First, both are funded by a common purchaser – the DHB - although, as discussed earlier, the funding mechanism used may vary on a contract by contract basis.[23] Second, all tests carried out by community providers (ie schedule tests) are generally also performed by hospital providers. Third, since hospital providers can, and do, perform the same tests as community providers, they typically employ similar equipment. Some DHBs, such as the ones stated above, have opted to contract hospital and community testing to one provider, due to the potential efficiencies and increased utilisation of capacity achieved from combining the two types of testing.

106. However, there are also a number of key differences, both on the demand- and supply-side, which suggest the two forms of testing types are non-substitutable and should be defined in separate markets.

107. First, on the demand-side, as discussed above, the testing needs of public hospitals are often very time-critical (with respect to the urgent tests). So, even though community and hospital providers do both perform schedule tests, hospital providers must generally achieve much faster turnaround times (within minutes, in some cases) for the same tests. The 24-hour turnaround times typically offered by community providers would not be a close-enough substitute for hospital-based referrers.

108. On the supply-side, community providers wanting to switch into the provision of hospital work must be capable of meeting these urgent testing needs. Achieving this is likely to entail a reasonably significant re-configuration of operational systems (in particular, the location of the laboratory and proximity to hospital facilities, the way in which work is scheduled, staff are rostered, and equipment is utilised). This suggests that switching between the provision of community and hospital testing may have some costs.

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[22] For instance, a histopathologist may perform immediate diagnostic testing on a tissue biopsy in the operating theatre while a patient is still under anaesthetic to determine if a tumour is cancerous and should therefore be removed.

[23] For instance, community testing may be entirely schedule-based, as has been the case thus far. In contrast, hospital testing may be funded via the schedule (for instance, Hawke's Bay hospital performs all after-hours community testing in the region, and is funded at schedule rates), and through non-schedule capped-rate arrangements. In the new contracting environment, these mechanisms will depend on the specific contracts negotiated between the provider and the DHB. In Otago/Southland for instance, both hospital and community testing will be bulk-funded so the schedule will not apply to that contract. However, in Hawke's Bay, it is proposed that all community testing be [ ].

109. Hospital providers, in addition to providing the common schedule work that community providers perform, typically also offer a range of more advanced testing. This is because public hospitals offer tertiary-level healthcare, which, by nature, is comprehensive and complex. With this added complexity comes the need for tertiary hospitals to have access to advanced diagnostic tools. In pathology, as with most medical fields, complex work is labour intensive and demands a high level of skill and training to perform. The upshot is that hospital providers require a greater proportion of technical staff, such as pathologists and scientists, than do community providers, given their need to meet the advanced testing requirements of tertiary hospitals.

110. Given that community providers would need to incur the time and cost associated with altering staffing mix (ie hiring specialist staff) in order to perform hospital testing, there appears little scope for immediate supply-side switching to take place.

111. The demands for community and hospital testing also tend to differ greatly. Hospital providers must operate 24 hours a day, everyday, to meet the round-the-clock testing needs of the associated hospital. Demand for hospital testing is driven by the incidence rate of acute referrals, and the work routines of clinicians (daily demand for hospital testing typically peaks around 10am when specialists and consultants finish morning ward rounds and begin ordering tests). Hence, demand for hospital testing can be quite lumpy. In contrast, community providers tend to only operate during normal working hours, and due to the non-urgent nature of most community referrals, are able to smooth workloads throughout the day.

112. Schedule-based tests, which represent all community testing, are the most routine and commonly-ordered kind. Hence, community providers tend to deal in high-volume throughput, whereas most hospital testing is low-volume work.[24] This means that hospital providers contemplating a switch or expansion into the provision of community testing must build up enough capacity to cope with volume demands.

113. As mentioned earlier, most hospital testing in New Zealand has generally been conducted by DHB provider arms, and whenever this has been the case, hospital providers have been subject to policy direction from their DHB. Historically, most DHBs have not permitted their provider arms to conduct community testing, except to meet overflows in demand (eg after-hours community testing). Instead, their focus has generally been directed by DHBs towards meeting the testing needs of referrers from within the attached hospital.

114. In recent times, some hospital providers have been allowed, and in some cases encouraged, by their DHBs to compete for community testing, although this practice has not become commonplace. Nor is it clear that it will become the norm. If past DHB policies are any indicator of future behaviour, then it may be difficult on the supply-side for some hospital providers to compete for community testing. The future strategic direction of DHBs is uncertain at this time, especially given the present shift in approach to contracting for pathology services. Nevertheless, the potential for policy restrictions to remain a barrier to supply-side switching is recognised by the Commission.

115. Hospital providers receive all referrals from within the attached hospital[25] so have no need to offer ancillary services, such as facilities and staff for sample collection and transportation of samples. In contrast, referrals (and therefore, samples) for community testing typically derives from a wide geographic area (usually the DHB district), so

[24] In general, schedule-tests are also the most easily automated and so community testing tends to be capital-intensive, while, as discussed earlier, hospital testing is generally more complex and tends to be more labour-intensive.

[25] The exception to this is samples for so-called 'send-away' tests, which are discussed in fuller detail further on.

provision of such ancillary services to ensure access to referrals is essential. Hence, hospital providers wanting to expand or switch into community testing would likely need to invest in at least some collection facilities and a transport system.

116. The discussion above shows that whilst there are some similarities between community- and hospital testing, there are also a number of significant differences. These differences suggest that the scope for substitution between community and hospital testing, both on the demand- and supply-side, may be limited. On this basis, and for the purposes of this Application, the Commission considered that community- and hospital testing should be defined in separate product markets.

Send-away Testing

117. Within what is broadly referred to by industry participants as 'hospital testing' lies a category of complex or rare tests that are performed by only a few specialised laboratories ('reference laboratories') around the country. The Applicants identify four reference laboratories in New Zealand: LabPLUS, Waikato Hospital Lab, ESR, and CHL. Samples for these tests are collected, either by community or hospital providers, and are sent away to a reference laboratory "where an aggregated 'critical mass' of such tests can meaningfully be analysed".[26] Such tests are therefore termed 'send-away tests'.

118. Send-away tests are very labour-intensive and require highly qualified and specialised staff, such as pathologists and scientists, to be able to perform them. Given the global shortage of such specialised staff, the Commission considers that it is unlikely that supply-side switching into send-away testing could readily occur.

119. On this basis, the Commission, for the purposes of the present application, defines a discrete market for send-away tests.

120. Sonic and NZDG do not currently perform send-away testing. In order to do so, a pathology provider would need to pool a critical mass of specimens to support the investment in the specialist equipment. Neither Sonic nor NZDG indicated plans to expand to perform this specialised testing in the future. As the proposal did not give rise to any aggregation with respect to send-away testing, and no competition issues relating to this market were identified, send-away testing was not analysed further as a relevant market.

Cervical Screening Tests

121. Cervical screening tests are contracted for by the National Screening Unit (NSU) – a business unit of the Ministry of Health – rather than by DHBs. This work is carried out presently on a contract basis by both private and public providers.

122. These services are funded on a fee-per-test basis, and the NSU advised the Commission that this is unlikely to change in the foreseeable future. Hence, there is a difference in the funding mechanism for cervical screening tests and other pathology services (although some DHBs still operate fee-per-test contracts for other pathology services).

123. Referrals for these tests come from a variety of sources, including GPs, gynaecologists, family planning centres, and Well Women's Nursing Services, etc.

124. On the demand-side, these tests have a specific purpose so obviously cannot be substituted for other testing procedures. On the supply-side, the NSU enforces very strict accreditation standards (for instance, a provider must perform a minimum of 15,000 tests annually in order to qualify for a cervical screening contract).

[26] The Application, p 8, paragraph 10.5.

125. Whereas DHBs who fund community and hospital testing were concerned about reducing the volume of tests, given the belief that there is presently over-testing occurring in these areas, the NSU is actively trying to promote an increase in the volume of cervical screening tests. Hence, there appears to be a fundamental difference in the nature of demand for these different categories of pathology work.

126. Industry participants viewed cervical screening work as a distinct category of testing that is both funded differently to other pathology services and has special accreditation standards that determine who can perform such testing.

127. On this basis, the Commission considered that cervical screening tests should be defined, for the purposes of the present Application, in a discrete product market.

128. Competition between providers of cervical screening tests occurs on a day-by-day basis, rather than through infrequent bidding for exclusive rights to provision. The Commission was not aware of any future policy changes that may alter the way competition would occur for this work.

Conclusion on Product Markets

129. For the purposes of the present application, the Commission concludes that the relevant product markets are:

- the provision of community testing pathology services (excluding send-away and cervical screening tests) – 'community testing';
- the provision of hospital testing pathology services (excluding send-away and cervical screening tests) – 'hospital testing'; and
- the provision of cervical screening tests – 'cervical testing'.

Geographic Markets

130. The Commission defines the geographic dimension of a market to include all of the relevant spatially dispersed sources of supply to which buyers would turn, whenever competition occurs.

131. The Applicants submitted that the geographical markets should be defined by DHB district, except where two or more DHBs are collaborating together (eg Otago and Southland), in which case the geographic area of the market should be the broader region comprising the relevant DHB districts. They state that while referring practitioners currently make some consumption decisions, the DHBs are the funders of the services consumed (and the party setting price, demand and quality requirements). The DHBs are now positioning themselves very much as the "customer" on the demand-side and each DHB should be viewed as the customer in its market for the purposes of the competition analysis.

Community Testing

132. As discussed later, some community tests require relatively swift turnaround times, and so necessitate the provider to be located within the region in order to perform them.[27] In the case of such tests, there may be no substitute for within-region supply. Non-urgent community testing though may be provided from outside the region, and there is evidence that some providers, such as NZDG and Sonic, have in the past been able to transport samples for such procedures between regions to centralised testing facilities.

[27] In this section these tests are referred to as 'urgent' community tests. However, these tests are in practice less urgent than what the Commission has referred to as 'urgent' hospital tests; results from urgent hospital tests are often returned within a matter of hours, whereas urgent community tests are reported usually within a few days. Results for non-urgent community tests sometimes take weeks to be returned.

133. Previously, providers had the ability to choose either to perform both urgent and non-urgent community testing for a region, or alternatively, to specialise in one or the other. By specialising in non-urgent testing, providers could still supply a region without necessarily establishing facilities there.

134. For instance, all NZDG and Sonic community testing presently performed for the West Coast is carried out at their respective facilities in Canterbury, and NZDG collects samples from the Kapiti region (for the Mid Central and Capital & Coast DHBs), which are then sent to Canterbury for testing.

135. In the present single-provider environment however, this flexibility is largely removed. As noted earlier, most DHBs are seeking a single provider for all community testing (both urgent and non-urgent). At contract renewal time, suppliers outside the region may bid for the work, but if one is successful it must set up a laboratory within the region in order to provide the required urgent community testing. By virtue of the single-provider requirement, DHBs will only consider those providers who can locate within the region when awarding contracts; supply of the service from outside the region would not be considered an acceptable substitute by the buyer.

136. Of course, once awarded the contract, a provider may decide to shift non-urgent testing to other regions, perhaps to centralise testing and thereby generate economies of scale. (The actual arrangements that a single provider may put in place, with respect to the location of non-urgent testing, are not obvious at this point. Furthermore, the extent of out-of-region testing may vary with and without the proposed joint ventures. Without the joint ventures, NZDG and Sonic can only utilise their respective out-of-region testing facilities to perform non-urgent testing. Were the joint ventures to proceed, the Newcos could likely call on both NZDG's and Sonic's out-of-region testing facilities to perform non-urgent testing. Centralising (at least some proportion of) non-urgent community testing is one option that providers may have at their disposal. Nevertheless, this fails to alter the fact that in the current environment, DHBs require successful providers to set up operations within its region, which makes the demand-side considerations strongly regional.

137. On the supply side, even if it were economically and technically feasible for providers to supply community testing from outside the region,[28] the single-provider criterion (for all community testing) specified by DHBs means that the provider must always locate within the region in order to perform at least the urgent community testing. This indicates that the market is regional in extent, both from a demand- and supply-side perspective.

138. Given that within-region supply is an absolute requirement (for all urgent testing, which cannot be unbundled from non-urgent testing, by virtue of DHBs' sole-supplier criterion), and that all community-testing could be within-region in some cases (eg large urban regions), the Commission defined regional markets delineated by DHB district for the purposes of the present Application as it considered that this best exposed the relevant competition issues. The Commission's market definition is consistent with that of the Applicants', which argued for regional DHB markets.

139. Historically, the Otago and Southland DHB regions have contracted separately for the provision of pathology services. However, the two DHBs have recently decided to

[28] For the purposes of assessing the extent of a geographic market, the Commission typically evaluates the economic and technical feasibility of supplying across geographic space by considering the following factors (among others): transport costs, the time required to expand supply, the availability of capacity to increase supply using existing plant and equipment (or at least, to be able to expand easily without incurring sunk costs) etc.

collaborate in order to purchase pathology services. Therefore, the Commission treated Otago/Southland as one single regional market.

140. The Commission concludes that, for the purposes of the present Application, it is appropriate to assess competition on the basis of regional markets for community testing.

141. Thus, the Commission has assessed competition in each of the regional markets where the parties are proposing joint ventures:

- Otago/Southland;
- South Canterbury;
- Hawke's Bay;
- Canterbury; and
- West Coast.

142. The Commission has also explored potential effects of the proposed mergers on competition in other regions that are not the subject of the Application. The Commission has assessed the potential for co-ordinated behaviour in respect of those other regions.

Hospital Testing

143. The majority of hospital testing has to date been incontestable in the sense that, for policy reasons, most DHBs have permitted only their provider arms to perform this work. However, in some regions hospital testing has been put to competitive tender, thus allowing private providers to contest for this work.

144. Whenever hospital testing is made contestable, the geographic considerations are very similar to those discussed above in relation to community. As noted earlier, hospital testing is typically performed onsite at public hospital given the general urgency of such tests. This urgency implies that providers of hospital testing must be located within the region to which services are delivered. Hence, on the demand-side, there is no substitute to within-region supply of hospital testing.

145. On this basis, the Commission concludes that, for the purposes of the present Application, it is appropriate to assess competition on the basis of regional markets for hospital testing.

146. The Commission considered the markets for hospital testing only in the regions where hospital testing is, or is likely to become, contestable. Historically, hospital testing has been performed only by public hospital laboratories, and this work has been incontestable. In recent years, a few DHBs have opted to outsource their hospital testing (eg, MidCentral DHB, South Canterbury DHB, Bay of Plenty DHB, Otago/Southland DHBs), but this practice is still the exception rather than the norm.

147. With respect to the regions relevant to the proposed joint ventures, three of the six DHB regions are combining hospital and community testing. The Canterbury DHB has not yet indicated its plans for the future provision of laboratory services, and the Commission has no reason to assume it would be likely to outsource its hospital testing. The Commission is also unsure of the plans of the West Coast DHB and the Commission has no reason to assume it would be likely to outsource its hospital testing. The Hawke's Bay DHB has chosen to retain hospital testing within its DHB provider arm.

148. Therefore, the Commission has considered the competition effects in the following regions where the parties are proposing joint ventures:

- Otago/Southland; and
- South Canterbury.

Cervical Screening Tests

149. All cervical screening work in New Zealand is currently concentrated in 11 testing centres around the country. Cervical cytology requires a reasonable degree of judgment, so it is important that the screening pathologist sees a large number of cases to build up the necessary experience to maintain their expertise. To this end, the NSU introduced accreditation and minimum-volume standards for cervical cytology.[29] These regulatory restrictions effectively limit the number of providers by imposing qualifying criteria on laboratories.

150. With few providers of cervical screening around the country, referrers must send samples further afield for analysis than if these testing centres were more numerous. Karen Mitchell, Group Manager, National Screening Unit (NSU), advised that there is evidence that accredited cervical screening laboratories regularly receive referrals from all over the country – in some instances from Northland to Dunedin.

151. On this basis, the Commission considered it appropriate to define a national market for the provision of cervical screening tests.

Temporal Dimension

152. The Commission typically adopts a two year time horizon over which to analyse the likely future competition effects of a proposed merger. However, where a market is characterised by infrequent transactions, the Commission may define a time dimension for the market that deviates from this two year horizon. Time considerations are important where there are long-term contracts, as in the markets considered for this application, where the exclusive right to provide community and/or hospital testing is conferred for between three and ten years.

153. As discussed in the Market Mechanism section above, there has been a shift in the way the majority of DHBs purchase pathology services. Many DHBs are moving towards a single-provider, bulk-funded model, via tender. Under such winner-takes-all contracting arrangements, competition for the market only occurs at infrequent contracting rounds, not day-to-day.

154. The Commission therefore considered the impact of the proposed mergers at the point in time at which they would have effect, which is when pathology contracts are next awarded. The proposed term of each contract varies by region, and in some regions the term is uncertain. The proposed contract durations are show in Table 1:

[29] Presently, the minimum-volume criterion for cervical cytology is 15,000 tests per year. The NCSU expects this number to increase to 30,000 – 50,000 tests, annually, with the more widespread uptake of a relatively new technology called liquid-based cytology.

Table 1: Proposed Contract Terms

Region	Proposed term of future contract	Status of plans for future provision
Otago/ Southland	10 years	Proposed contract subject to Commerce Commission and Ministry of Health approval
South Canterbury	5 years	Contract already in operation, expires in 2009
Hawke's Bay	5 years	Proposed contract subject to Commerce Commission and Ministry of Health approval
Canterbury	likely to be 3 to 5 years	Plans uncertain, undertaking pathology services review
West Coast	likely to be 3 to 5 years	Plans uncertain, undertaking pathology services review

155. Thus, the Commission considers the competitive effects of the proposed acquisition over ten years for Otago/Southland, five years for South Canterbury and the Hawke's Bay, and three to five years for Canterbury and the West Coast.

Conclusion on Market Definition

156. On balance, the Commission concluded that the relevant markets for the purpose of analysing the proposed acquisition are:

- regional markets for each of the Otago/Southland, South Canterbury, Canterbury, West-Coast, and Hawke's Bay DHB districts for the provision of community testing pathology services;
- regional markets for each of the Otago/Southland and South Canterbury DHB districts for the provision of hospital testing pathology services; and
- the national market for the provision of cervical screening tests.

OTAGO / SOUTHLAND – COMMUNITY TESTING AND HOSPITAL TESTING

Counterfactual and Factual

157. In reaching a conclusion about whether an acquisition is likely to lead to a substantial lessening of competition, the Commission makes a comparative judgment considering the likely outcomes between two hypothetical situations, one with the acquisition (the factual) and one without (the counterfactual).[30] The difference in competition between these two scenarios is then able to be attributed to the impact of the acquisition.

Factual

158. In the present proposal, Sonic and NZDG would form a joint venture in the Otago and Southland DHB districts (O&S Newco). The Otago and Southland DHBs have advised O&S Newco that it is the preferred bidder for the provision of all of the hospital and community testing in the Otago and Southland regions for a 10 year term, expiring in 2015. The contract is worth approximately [ ] over that time. The shareholdings

[30] *Air New Zealand & Qantas Airways Ltd v Commerce Commission (No 6),* unreported HC Auckland, CIV 2003 404 6590, Hansen J and K M Vautier, Para 42.

of NZDG and Sonic in O&S Newco are expected to be around [ ]% and [ ]% respectively.

159. In this scenario, the DHB hospital laboratories would cease to exist and all of their assets (except the building in which the laboratory is situated) including equipment and staff would be transferred to O&S Newco. Accordingly, there would be a single provider of hospital and community testing in the Otago and Southland DHB regions.

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Counterfactual

164. As discussed, various DHBs are presently deciding how they will obtain pathology services in the future: whether they will contract with one or several providers, whether they will contract community referred services only or all of the pathology services in their district, or whether they will contract with a private provider or with their own provider arms.

165. The Otago DHB advised the Commission that if the proposal did not proceed, the Otago and Southland DHBs would have two options:

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The Commission notes that both of these options represent a shift from a fee-per-test to a single provider, bulk-funded model.

166. The Otago DHB also advised the Commission that it believed the first of these alternatives [ ] was the correct counterfactual scenario for the Commission to use.

167. However, a report submitted to the DHBs by the SISSAL Evaluation Group on 5 April 2005, stated that the following were the risks of greatest concern in respect of the hospital laboratories' bid: [31]

[31] South Island Shared Service Agency Limited, Memo from Philip Pigou, on behalf of the Laboratory Service RFP Evaluation Group, to Brian Rousseau, Otago DHB and Dr Gershu Paul, Southland DHB, 5 April 2005.

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170. Therefore, the Commission considers that if the current application were declined, [

]. The Commission considers it is more likely that the DHBs would reconsider their options and might opt to put out a further RFP, to which Sonic and NZDG would likely respond with separate proposals.

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175. Given all these factors, the Commission considers that the appropriate counterfactual scenario is that a single provider, either Sonic or NZDG, would be awarded an exclusive contract by the aggregated Otago and Southland DHBs to provide all hospital and community testing to the DHBs for a ten year period. The Commission considers that the counterfactual scenario in ten years time (at the end of the contract period) is that Sonic and NZDG could bid for a future contract to provide community and hospital testing.

Competition Analysis

176. In a typical market, where transactions occur (effectively) on a continuous basis, ideas like "entry" and "existing competitors" have conventional meanings. In this case, the Commission has analysed the state of competition at the point at which competition occurs – ie at the end of a contract period when the DHBs request bids for the future provision of pathology services. At this point, all providers become "potential competitors" bidding for the provision of community and hospital testing. Accordingly, in this case the Commission has modified its standard analysis of "existing competition" and "potential competition" and has instead analysed the nature of competition by identifying the likely potential bidders for future contracts, and the extent of competition these bidders would provide in the factual and the counterfactual.

177. The DHBs' preference in Otago/Southland is for a single provider for all services – hospital and community testing. Thus, provided the Otago/Southland DHBs maintain this funding model in the future, any potential bidder for a pathology contract would need to bid for the provision of all services. The likelihood of a potential bidder winning a contract for hospital testing would be constrained by its ability to provide community testing, and vice versa. Accordingly, the competition analysis for hospital testing and community testing in the Otago/Southland region is the same, as in this instance, they are being rolled into one contract.

178. The Commission has identified the likely potential bidders in the Otago/Southland region both today and in ten years time, under the factual and the counterfactual.

179. The potential bidders identified under the factual were:

- Previous provider to the region: at the next contracting round O&S Newco would have been the incumbent provider for a period of ten years;
- New domestic bidders – pathology providers presently operating in other DHB regions throughout New Zealand: Abano, Medlab Taranaki, NPL, and PAL;
- International bidders: Mayne, SJGP and Healthscope;
- DHB-owned laboratories outside the region: CHL and LabPLUS; and
- The local DHB-owned hospital laboratory: the OSRL joint venture.

180. The potential future bidders identified under the counterfactual were:

- Previous providers to the region: NZDG and Sonic (at the end of the ten year period, both providers would still have a history of provision, given that they are currently the main providers of community testing in the region);
- New domestic bidders: Abano, Medlab Taranaki, NPL, and PAL;
- International bidders: Mayne, SJGP and Healthscope;
- DHB-owned hospital laboratories outside the region: CHL and LabPLUS; and
- The local DHB-owned hospital laboratory: the OSRL joint venture.

181. The key difference is these two scenarios is the aggregation of NZDG and Sonic in the factual.

Barriers to Entry

182. The Commission assessed the likelihood and extent to which each player would likely provide competition in future bidding rounds within the time dimension of the market (ie ten years), both with and without the proposed joint ventures. In doing so, the Commission consulted widely amongst industry participants and, in the process, identified a number of entry conditions that providers would likely face when attempting to enter a new region by tender. These entry conditions included:

- access to scarce technical labour, eg pathologists, scientists, and highly specialised technicians;
- capital: land, purpose-specific buildings, equipment;
- scale of operations;
- incumbent knowledge; and
- reputation and prior relationships with the purchasing DHB(s).

183. The Commission considers that these entry conditions in aggregate amount to an entry barrier. They represent conditions that are sunk for an incumbent firm – the provider currently holding the contract – when contesting for work in the region in which it presently operates. The incumbent would have already faced these costs when it first set up in the region. As the following discussion demonstrates, the Commission found that these entry barriers would be more readily overcome by some providers than others, and that the level of the barriers varied between different classes of bidders.

184. Industry participants such as [ ] advised that tendering for work in a new region is a significant undertaking, and is an additional entry condition. It involves:

- conducting essential research about an unknown region (eg forecasting volumes, demographics, expected cost of provision etc.) and months of bid preparation;
- non-trivial legal and accounting fees; and
- significant effort in lobbying the purchasing DHB.

185. Industry participants advised that these would represent significant costs for small competitors in particular, and unless there was a reasonably high chance of success in winning the contract, it would not be worthwhile for small providers to bid, and thereby incur these costs, in the first instance.

186. The discussion that follows provides an elaboration on each of the identified barriers, which are discussed later in the context of each potential bidder.

Technical Labour

187. Access to technical staff, such as pathologists, qualified scientists, and specialised laboratory technicians are essential to the provision of pathology services.

188. The Commission understands that there is a global shortage of pathologists. [

]. A number of providers have advised that the unavailability of pathologists has been the key factor in limiting their expansion to date.

189. Industry participants such as NPL and CHL, have suggested that some pathologists may be particularly mobile (given their scarcity), and that regular re-contracting would create uncertainty for staff, leading to difficulties in retaining key technical personnel.

190. Potential bidders, with the exception of NZDG and Sonic, considered that this would create significant uncertainty for them when contesting for new work: competitors would be forced to bid for contracts without certainty that all the required staff could be secured.

191. Competitors considered that this would create significant uncertainty for DHBs in supporting a new provider, whereas an existing incumbent would represent a safe supply option.

192. Furthermore, although pathologists have an option of signing on with the new provider, some parties have suggested that an unsuccessful incumbent may attempt to shift essential personnel to other regions, either to supplement a shortage elsewhere, or to frustrate competitors' expansion plans. This may be possible if the incumbent operated in a number of other regions, and if technical staff have strong employment relationships with the unsuccessful incumbent. An incumbent operating in several regions might also have an incentive to disrupt a successful firm's entry plans, in order to discourage the entrant from bidding against it in other markets (ie it would wear any cost involved in order to protect its other markets).

193. As indicated in the factual section above, [

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194. However, [ ], the Commission considers that a potential entrant would have to factor in the possibility that the incumbent could hinder the [ ] so as to frustrate new entry.

195. Competitors argued that all these uncertainties may deter them from bidding for work in a new region. At the very least, they may need to pay a premium (eg offer higher salaries or more favourable employment terms) to secure key staff.[32]

Capital

196. As pathology is an essential health service, contracting DHBs must take steps to ensure continuity of service when awarding contracts for provision. In particular, a DHB must have a fair degree of certainty that a contracted provider has the necessary facilities and equipment to meet the testing needs of the region. This is especially true in an exclusive-provider environment since the DHB has no second provider to revert to in the event that the contracted provider fails to deliver the service.

197. A competitor expanding into a new region would require access to a fully operational laboratory (land, building, and equipment) and have the ability to support upgrades (which could be significant over ten years), to provide immediate service delivery (there is no option to build up over time since continuity of service provision is a key requisite for any contracting DHB). These assets may potentially be acquired from an outgoing incumbent (either through purchase or lease), or from elsewhere.

198. A potential entrant would need to factor in the risk of an outgoing incumbent deciding not to sell (or lease) existing assets to a competitor, either because it has use for those assets in another region, or in order to hinder entry. However, as discussed above, [

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[32] However, the unsuccessful incumbent may also have to offer a premium to get staff to stay with it, especially as this may involve a move to a new region.

199. If the outgoing incumbent did retain its existing assets, competitors would be forced to purchase new assets rather than existing, depreciated assets, paying a premium for capital as a result. At least some of this capital expenditure is likely to represent a sunk cost.

200. However, some industry participants did not consider access to capital to be a significant barrier to entry. They argued that most regional contracts would be sufficiently large to justify the capital expenditure. In addition, the Applicants submitted that access to capital does not represent a significant barrier to entry.

201. Industry participants also raised the possibility of transporting some samples to other regions where their main testing facilities are based to perform non-urgent work, in lieu of establishing large laboratories in every region. However, the Commission considers this would depend on the needs of the specific region, and the feasibility of transporting samples and achieving required turn-around times. As discussed in market definition above, there are some tests which must be done within the region.

Scale of Operations

202. Industry participants advised the Commission that operational scale offers many advantages in the provision of pathology services. Some testing procedures are highly automated, meaning that high volumes can lead to significant economies of scale.

203. Firstly, large players may feasibly move samples between regions for non-urgent, routinely performed tests, in order to take advantage of economies of scale. There is evidence of this already occurring, such as samples from the West Coast presently being transported to Christchurch for testing by both Sonic and NZDG.

204. Secondly, large operators have access to a larger pool of technical expertise via a network of pathologists and scientists throughout the country than small fringe players. This allows them to offer specialist opinions over a wide range of services and testing procedures (economies of scope).

205. Thirdly, greater size provides greater buying power with respect to equipment, reagents (substances used in the chemical reactions undertaken to detect substances/levels of substances for the purposes of specimen analysis), and other raw materials.

206. Finally, competitors argued that firms that are large enough to operate in many regions across the country enjoy the ability to share information and benchmark volumes/costs when tendering for new contracts. This would reduce their research and bid preparation costs. By contrast, small players operating in geographic isolation have limited ability to pool information.

207. With respect to scale of operations, the incumbent may not have an advantage when it comes to bidding for future contracts. A large entrant might be lower cost than a small incumbent, so the incumbent may not be protected by this barrier.

Incumbent Knowledge

208. The move towards a capped-funding, single provider regime in many regions imposes significant uncertainties for firms contesting such contracts. Providers are required to submit a fixed price to perform testing over the period of the contract, which in the Otago/Southland region is a ten year term [ ]. However, there are a number of variables that could change over the contract period, such as changes in testing needs, volume growth and volatility, costs, technology changes, the structure of the health sector, and so on.

209. [

]. Hence, it is imperative for bidding firms that they gain as much knowledge about expected future market conditions as possible; research at the bid-preparation stage is crucial.

210. Industry participants submitted that an incumbent firm would have a significant advantage over its competitors by way of its specific knowledge of its region, gained over the term of the contract. The longer an incumbent operates in a particular region, the deeper its specific knowledge, and the greater its learning-by-doing advantage over other potential bidders. An incumbent is likely to have learning-by-doing advantages relating to more information about demand trends, costs, and operational logistics relating to provision in that region.

211. [ ] advised that:

> Once {an incumbent firm} has been operating in an area {it would} know everything about volumes and {costs}… and we would be coming in with no understanding of that at all.

212. This asymmetry of information imposes significant costs, such as time and money, on competitors relative to the incumbent, in terms of carrying out additional research. But even conducting thorough research is unlikely to completely mitigate the risk of competitors incorrectly forecasting conditions.

213. To understand these costs it is useful to understand the mechanics of the DHB tender processes. The Commission's understanding of the process for a typical bidding round is described in Appendix C to this Decision. The diagram shows that firms incur entry costs at two stages.

214. The first is at Stage 2 when firms are evaluating the business case for entering a new region. The Commission terms these 'bid preparation costs', which are the costs associated with predicting post-entry conditions such as the level of demand for services, the expected cost of provision, setup costs, etc.[33,34] Bid preparation costs are largely sunk – once paid for, they are irretrievable, regardless of whether or not the firm lodges a bid.

215. The second incidence of costs is at Stage 6 when entry actually occurs and the successful bidder begins provision. The Commission terms these 'setup costs'.

216. Although a successful firm only incurs setup costs at Stage 6, it must form expectations about these costs at Stage 2 to decide, in the first instance, whether or not it is economically feasible to bid for the work. Setup costs also matter at Stage 3 when the firm is deciding on an appropriate price to tender, as this price must be high enough to cover expected future entry costs.

217. With regards to the asymmetry of information, potential competitors considered that one of three outcomes may occur:

- uncertainty remains so high for a competitor that it considers it too risky to bid for the contract;

[33] Bid preparation costs may extend to Stage 3 where, for instance, the firm incurs costs specific to the placement of bids, eg legal fees.

[34] Ex ante evaluation of post-entry conditions are particularly important for potential bidders as these capped-rate contracts are designed to transfer volume risk from the purchaser to the provider, ie the firm must meet all demand at the set bid. This would seem to make for considerable uncertainty as to the appropriate price to bid, as the first rule of bidding is never bid below costs. This might lead us to expect a significant risk premium to be built into the price.

- the contracting DHB recognises the information asymmetry and considers it safer to allocate the work to the existing incumbent; or
- the contracting DHB could attempt to make some of this information available, by factoring it into an RFP. Some DHBs may be in a position to provide information, but in other cases, the DHBs are themselves not aware of the volumes and costs of provision of services.

218. The first two of these outcomes raises the probability that the incumbent will win the contract over other competitors, even at a higher price.

Reputation and Relationships

219. A related issue concerns the reputation of the provider, and the nature of prior relationships with contracting DHBs.

220. Some private pathology providers in New Zealand are significantly less well-resourced than other providers, and smaller in terms of turnover and operational scale. Furthermore, because some providers operate in very few regions around the country (mostly in the North Island), most DHBs have had little past experience or contact with them.

221. Competitors have argued that for this reason, purchasing DHBs are far less likely to contract with these providers because of the risk associated with contracting with a relative unknown.

222. The Applicants submitted that entry may need not be by an existing player. In Otago/Southland, [

]. However, DHBs advised the Commission that a non-industry provider would create an increased degree of uncertainty for the DHB, and it would be unlikely to pursue this option.

223. As likely incumbents in most regions, the joint venture parties would have the opportunity to develop existing relationships with purchasing DHBs. For example, having contracted with a single provider for ten years, in the case of Otago/Southland, it may be difficult for the DHBs to switch to another provider, particularly if that provider does not have a proven prior history of provision in the region. This would be the case for the incumbent in the factual and counterfactual scenarios.

Assessment of Potential Competitors

224. The Commission assessed the effect of the barriers outlined above, amongst others, in relation to each of the potential competitors identified. Whilst the barriers discussed exist under both the factual and counterfactual scenarios, they impact on market participants to a greater or lesser extent. Some players may find these barriers insurmountable when attempting to enter a new region, whereas others may overcome them more readily.

225. As outlined earlier, the identity of the potential bidders under the factual and counterfactual differs. Under the counterfactual, the Commission considers that NZDG and Sonic would be in direct competition with one another for the market. Under the factual, this competitive tension would be removed in Otago/Southland as the two would combine their operations into O&S Newco.

226. It would then fall on the remaining potential competitors (new domestic bidders, international bidders, and local and other regional DHB hospital laboratories) to provide a constraint on O&S Newco in the factual. If those players faced such high barriers to entry that they would be unlikely to provide sufficient competitive constraint in the

factual or the counterfactual, then a substantial lessening of competition may be found. This issue is explored below.

Previous Providers

227. Under the counterfactual, NZDG and Sonic would be the only likely potential bidders at the next contracting round with prior experience of operating in Otago/Southland, even though this provision may have been ten years' prior. In the factual, NZDG and Sonic would cease to exist separately in this region, but would instead be combined into O&S Newco, who, at the next contracting round, would be the only potential bidder to have prior experience operating in the region.

228. Hence, for the purposes of the competition analysis, the Commission classified NZDG and Sonic (in the counterfactual) and O&S Newco (in the factual) as 'previous providers'.

NZDG and Sonic

229. NZDG and Sonic are the two largest private providers of pathology services in New Zealand. Although Sonic, as a subsidiary of Sonic Healthcare Ltd, is a larger organisation than NZDG, NZDG is a larger provider by financial size and market penetration relative to the other small providers. The Commission considers that Sonic and NZDG would face a similar level of entry barriers, as discussed below.

230. Under the counterfactual, it is likely that both NZDG and Sonic would compete for the provision of community testing in Otago/Southland, and as discussed earlier, the Commission considers that one or other of the two would secure this contract. Given their previous history of provision in the region, the unsuccessful party in a tender round could contest for provision in subsequent contracting periods.

231. At that time, the firm that was successful (eg Sonic, for the sake of illustration) would likely enjoy some advantage from incumbency over its main rival (ie NZDG). These advantages would potentially reflect the five barriers outlined earlier. These are discussed in greater detail below, in relation to Sonic and NZDG.

Technical Labour

232. As outlined earlier, in any given contracting round, the incumbent firm has the advantage of access to existing personnel. In contrast, an outside competitor is forced to bid for the contract without the certainty of knowing that it could absorb all technical staff from the outgoing incumbent. Given the global shortage of such highly-skilled workers, this may be problematic for outside competitors.

233. The Applicants submitted that although some bidders may not be prepared to simply make an assumption that key staff will come across to a new employer, this is a risk faced by any bidder for a sole supply contract in the counterfactual. They state that the mergers do not change that. However, the Commission considers that access to technical labour may be less of an issue for NZDG or Sonic than it would be for smaller players.

234. Given their scale and access to funds, the Commission considers it likely that both NZDG and Sonic would have the financial resources to offer sufficiently attractive employment terms to secure most of the required technical staff when re-entering Otago/Southland in future rounds.

235. Contracting DHBs are also likely to view Sonic and NZDG's ability to secure key staff more credibly (relative to smaller, less well-known operators), so the chances of the DHBs accepting an outside bid over either of these two players would likely be low.

236. Furthermore, the Commission notes that both Sonic and NZDG have a significant pool of technical staff in regions outside Otago/Southland presently, and the Commission was advised by both the parties, and other industry participants, that the two operators regularly move pathologists between regions to meet short-term staffing needs.

237. For instance, in their joint response to the Otago/Southland RFP, the parties stated:

> [ ].[35]

238. [ ]:

> [ ][36]

239. Given evidence of the parties' ability to shift personnel between regions, their expressed confidence in being able to fill temporary staffing shortfalls while recruiting from overseas, and the other reasons discussed above, the Commission concludes that access to technical staff would not be a significant barrier to entry for either Sonic or NZDG in the counterfactual.

Capital

240. An entrant to a region may be able to purchase equipment from an outgoing incumbent. There may be a risk that the incumbent may refuse to sell plant and equipment to its competitors (either to frustrate its expansion, or because it has use for equipment in other regions where it operates).

241. However, this is unlikely to limit either NZDG's or Sonic's re-entry into Otago/Southland. NZDG operates from an asset base of [ ]. In addition, it has, through its seven subsidiary companies in New Zealand, the ability to shift under-utilised equipment between regions. Sonic Healthcare is one of the world's largest medical diagnostics companies, with an annual turnover of approximately A$1.3 billion. Through its four pathology subsidiary companies in New Zealand, it may be able to source excess equipment to aid re-entry into Otago/Southland.

242. Industry participants advised the Commission that even if spare equipment could not be sourced from other regions, potential bidders could either purchase, or as is more commonly done, lease equipment from reagent suppliers such as Roche and Bayer. Leasing allows providers to annualise the capital expenditure, and mitigate the risk of technical obsolescence, associated with outright purchase of equipment, making it a common practice in this industry.

243. Similarly, the Commission understands that in general, laboratory sites may be purchased or leased (although some refurbishment would typically be required to convert generic sites into purpose-specific ones). However, in the specific case of Otago/Southland, the contract is for both community and hospital testing, with the view towards establishing *in situ* hospital laboratories in each of the two regions to perform both types of testing. These laboratories would likely become available at the next contracting round for the successful provider to occupy. In the event that, at that time, the DHB separates the provision of community and hospital testing, all providers of community testing would have to establish an off-site facility.

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[35] Proposal: Laboratory Diagnostic Services for the Southland and Otago District Health Board regions (Medlab South and Southern Community Laboratories), p 4

[36] [ ].

244. Nevertheless, some industry participants did not consider access to capital to be a significant barrier to expansion. Competitors considered that most regional contracts would be sufficiently large to justify the capital expenditure required to enter those regions. The incumbent may not necessarily have a distinct advantage with respect to capital, as it would probably have to replace its equipment for the ten year period of the contract, just as the entrant would have to buy to start up.

245. In addition, the scale of both Sonic's and NZDG's operations may offer them significant purchasing power with respect to equipment (as well as inputs, such as reagents and laboratory supplies), in contrast to smaller players such as Abano, Medlab Taranaki, PAL, and NPL. This would give them an advantage over other smaller providers.

246. Finally, industry participants raised the possibility of NZDG and Sonic shifting samples for processing to other regions where these providers already have established laboratories. The Commission recognises that some community testing is of an urgent nature and therefore cannot be performed outside the region of origin due to the delays that that would entail. However, the Commission considers that it is possible that for non-urgent testing, which represents the bulk of community work, inter-regional testing is possible. This would reduce the size (and therefore, the cost) of any new testing facility that may need to be established when re-entering Otago/Southland.

247. This may be particularly feasible for NZDG and Sonic, given that they operate in several regions throughout New Zealand already. For example, Sonic could choose to send non-urgent work to its large laboratory in Auckland, and NZDG may send work to its Waikato laboratory. There is evidence of this already occurring; for example, samples from the West Coast (a remote and small DHB region) are presently transported to Christchurch for testing by both Sonic and NZDG.

248. On the basis of these arguments, the Commission considers that although access to capital may be a barrier for some potential bidders (as discussed below), it is unlikely to represent a significant barrier to entry to NZDG or Sonic, under the counterfactual.

Scale of Operations

249. Whilst it is difficult to assess the commercial landscape ten years hence, the Commission considers it is likely that NZDG and Sonic would, absent the proposal, remain large national operators. Therefore, scale is unlikely to represent a barrier to either of these providers.

250. The Applicants submitted that large contracts for major metropolitan areas have their own economies of scale.

251. However, the Commission considers it likely that Sonic and NZDG would both have operations in a number of other regions, and industry participants advised the Commission that operational scale offers many advantages in the provision of pathology services. NZDG or Sonic may be able to shift samples between regions for non-urgent tests, in order that the tests can be done at the lowest possible cost. [ ] considered that it would be difficult to compete on price because of the economies of scale realised by large companies such as Sonic and NZDG (given that both Sonic and NZDG each have the ability to centralise a substantial portion of test volumes).

252. In addition, as stated above, Sonic and NZDG would have access to a larger pool of technical expertise via a network of pathologists and scientists throughout the country than small fringe players. This allows them to offer specialist opinions over a wide range of services and testing procedures (economies of scope).

253. Furthermore, greater size provides greater buying power with respect to equipment, reagents, and other raw materials. [

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254. On the basis of these arguments, the Commission considers that although scale of operations may be an issue for some potential bidders (as discussed below), it is unlikely to represent a significant barrier to entry to NZDG or Sonic, under the counterfactual.

Incumbent Knowledge

255. The incumbent is likely to have an advantage when forecasting the cost of provision over the term of the future contract, which in turn informs the appropriate level at which to bid for work. Contracting DHBs recognise this fact. Given their apparent (and legitimate) concerns over bidders miscalculating the cost of provision under a capped funding scheme,[37] DHBs are likely to favour bids that they consider to be the most credible when awarding contracts.

256. However, NZDG and Sonic, unlike other potential competitors, have both operated in Otago/Southland for a number of years, and in most other regions at some point. Although particular aspects of service provision (eg testing needs) in an area may change over the course of a contract, prior experience in Otago and Southland is likely to aid NZDG and Sonic in estimating the cost of provision and the testing needs of the population in the region, even after ten years.

257. Also, since both providers operate in several regions throughout New Zealand, they enjoy the ability to pool information and benchmark volumes/costs when tendering for new contracts. This would reduce their research and bid preparation costs and likely reduce the disadvantage they face when bidding against one another to re-enter Otago/Southland.

258. The Commission concludes that under the counterfactual, advantages from incumbent knowledge would not represent a significant barrier to entry for Sonic or NZDG in Otago/Southland in future rounds. The Commission considers that incumbent knowledge may be an issue for some potential bidders who do not have a history of provision in the region (as discussed below). However, given both providers have prior experience operating in the region and a continuing significant presence in other regions, the purchasing DHBs are likely to view bids from both NZDG and Sonic as credible, under the counterfactual.

Reputation and Prior Relationships with Purchasing DHB

259. Industry participants have argued that DHBs are less likely to contract with a relatively unknown provider due to difficulties in assessing that provider's capabilities. Therefore, a lack of reputation and/or prior relationship with a contracting DHB may represent a barrier to entry to some players.

260. Under its previous national contract (a legacy of the CHE era), NZDG could enter any region to provide community testing. These tests were charged to the Otago DHB, who then billed the relevant DHB. This contract was recently devolved, but the result remains that NZDG has provided community testing, at one time or another, to 13 of the 21 DHB regions.[38] Were NZDG to bid for a contract in any of these regions in the future, it would likely be recognised by most DHBs as a capable and strong service

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[38] Northland, Auckland, Waitemata, Counties Manukau, Waikato, Tairawhiti, Hawke's Bay, Capital & Coast, West Coast, Canterbury, South Canterbury, Otago, Southland

provider, with a proven track record in that region. Its previous nationwide coverage would also give other DHBs comfort that NZDG would have the resources and the expertise to adequately service a contract.

261. Sonic also enjoys an excellent reputation with DHB funders. It is strong in most parts of New Zealand, having operated at some point in at least 15 of the 21 DHB regions.[39] Sonic has four subsidiaries in New Zealand: Diagnostic Medlab (DML); Medlab Central; Valley Diagnostics; and Medlab South. Diagnostic Medlab is the largest community laboratory in New Zealand and serves the geographical area in New Zealand with the highest population (Auckland, with approximately 1.5 million people in the catchment area). It employs 750 staff, including 32 pathologists, and according to DML's website, this is the largest pool of pathologists and laboratory scientists of any laboratory in New Zealand. Medlab Central and Medlab South have a history of successful provision in a number of regions, both in the community and hospital testing markets. Medlab Central has an exclusive contract for all testing (hospital and community) for the MidCentral DHB, and Medlab South has an exclusive contract for all pathology services in South Canterbury.

262. The Applicants submit that DHBs may place little value on the past reputation of providers when making a decision on a preferred provider. [

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263. The Commission was advised by various DHBs that price is only one consideration when choosing a provider, and that their primary focus is to ensure the provision of a sustainable, high quality pathology service to their region. During the Otago/Southland DHBs' consultation with key stakeholders during the RFP process, many submissions (from general practioner referrers in particular) addressed the issue of potential quality of services. Many of these submissions were in favour of Sonic or NZDG, given their long history of service provision. The reputation of these providers appears to have been a contributing factor in the awarding of the contract to these two private providers.

264. The Commission therefore concludes that a lack of reputation and/or prior relationships with DHBs may put other smaller providers at a disadvantage when bidding, compared with Sonic and NZDG under the counterfactual.

<u>O&S Newco</u>

265. Under the factual, in ten years time, O&S Newco would be the incumbent provider to the Otago/Southland region, and would enjoy all the benefits of incumbency that follow. Having been the sole employer of pathology staff in the region over the preceding contract term (ten years), it is likely to be able to retain most, if not all, requisite key personnel in subsequent periods. O&S Newco might enjoy the combined scale of both Sonic and NZDG, as well as specific operational knowledge about the region gained over the preceding ten years (which it could use to estimate future demand and costs).

266. The Commission concludes that O&S Newco, as the incumbent, would not face barriers to recapturing Otago/Southland community testing in future contract rounds. The

[39] Auckland, Waitemata, Counties Manukau, Tairawhiti, Hawke's Bay, Lakes West Coast, Canterbury, South Canterbury, Otago, Southland

Commission has gone on to assess the extent to which other providers would face barriers relative to O&S Newco as the incumbent.

Conclusion on Previous Providers

267. The Commission considers that, whilst NZDG or Sonic may face some barriers to unseating the other in the Otago/Southland community testing market under the counterfactual, these barriers are likely to be low, so able to be overcome by either provider. Hence, the Commission concludes that under the counterfactual, the parties would provide a strong competitive constraint on one another.

268. Under the factual, this strong competitive constraint is eliminated by virtue of the proposed joint venture in O&S Newco.

269. As discussed below, the same barriers apply to other operators, but with greater force.

New Domestic Bidders

270. Other potential domestic competitors (apart from NZDG and Sonic) include Abano, Medlab Taranaki, NPL (international parent, Healthscope), and PAL. None of these providers have operated in Otago/Southland in the past. Were they to contest for work in the future, they would all be new bidders.

271. It is useful, for the purposes of the competition analysis, to classify these new domestic bidders separately from NZDG and Sonic, given their distinct characteristics. Specifically, they are all small operators (in terms of operational scale and access to resources), relative to NZDG or Sonic, and each presently operate in only a few regions throughout New Zealand.

Abano

272. Abano's diagnostics business comprises of operations in the Capital & Coast and Nelson/Marlborough DHB districts – Medical Laboratory Wellington and Nelson Diagnostic Laboratories, respectively.

273. The Applicants submitted that Abano could present a credible alternative to the merged entity in the markets of relevance.

274. Medical Laboratory Wellington was originally formed from a medical partnership established in 1932. It was one of the first private medical testing services established in New Zealand to support community-based healthcare, and since that time it has continued to provide community testing with various partners and under various company names.

275. Medical Laboratory's contract with Capital & Coast DHB was due to expire in September 2005, but was extended a further year until September 2006. The DHB has been in discussions with industry participants over future provision of services and an RFP for community testing within the Capital & Coast and the Hutt Valley DHB regions has recently been issued.

276. [ ]. In June 2005, Abano made an announcement to the stock exchange that it had entered into discussions with Valley Diagnostics Limited (Valley Diagnostics) – a Sonic subsidiary – to merge their pathology businesses in the Wellington and Hutt Valley regions. Abano and Valley Diagnostics are presently considering submitting a joint tender for the community testing to both the Hutt Valley and Capital & Coast DHBs later this year. [ ]

277. Abano's Nelson laboratory has been operating for 30 years. Alan Clarke, Managing Director, Abano, advised the Commission that the future of laboratory services in Nelson/Marlborough is presently uncertain as the DHB is currently assessing a number of purchasing options. [

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278. [ ]. Mr. Clarke stated that, when entering a new region:

> …you have to find pathologists, who are very expensive and like hen's teeth, who would work for you.

And, generally, on the shortage of pathologists in New Zealand:

> Sourcing pathologists is a significant issue for New Zealand … Pathologists, if they go to Australia, could probably earn 30 to 40 % more than if they came to New Zealand … attracting and retaining pathologists is a major issue for both DHBs and the private sector.

279. When asked about the possibility of absorbing pathologists from an outgoing incumbent in an exclusive-provider scenario, Mr. Clarke responded:

> It's possible … there may be pathologists there who may like working in the Hutt Valley, like working in the Wellington region, don't want to move to another city. {In a single-provider environment} their alternatives are gone. They might then say 'yes, we would consider coming and working for you', and then you could offer them a job. Or, Sonic could say 'come and work in Brisbane; come and work in Sydney; come and work in Canada; come and work in the U.K.', where they have operations. Or, those pathologists may elect to move to Auckland to work in the public system… it's not a given that you can pick them {the pathologists} up. The issue there is, can you offer them an attractive salary; and conditions that they would accept; and can you offer them the right kind of work that would meet their clinical needs?

280. Abano considered that there would be a significant amount of uncertainty associated with bidding for a contract without having first secured all the technical staff to perform the work.

281. [ ]:

> It is almost an impossibility to greenfields start … you would have to establish a complete laboratory from scratch, and it's very difficult unless you have the infrastructure capability in that region to establish a brand new start-up laboratory

282. Reputation and a lack of prior relationship with the Otago/Southland DHBs is likely to represent a substantial barrier to expansion to Abano. It has never operated outside the Capital & Coast and Nelson Marlborough DHB regions before, so is a relative unknown when compared to either NZDG or Sonic. It may however, be able to obtain references from these DHBs.

283. Abano's experience of operating in only two out of 21 DHB regions in New Zealand is also likely to create difficulties for it when forecasting demand volumes, and operating costs, in a new region, such as Otago/Southland. [

] The Commission considers that Abano may not be well-placed to forecast conditions in a completely new region, where it has no prior experience to draw upon.

284. For these reasons, the Commission considers that the Otago/Southland DHBs, who advised that they were themselves "risk-averse", are likely to favour experienced, established national providers, such as NZDG and Sonic, over minor providers such as Abano, when contracting for all pathology services.

285. Furthermore, Abano's expressed position that it [

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288. Given the uncertainties involved, the Commission cannot be satisfied that Abano would be willing to compete for new work a decade from now. Nor can it be satisfied that Abano would be able to overcome the barriers to entry it would face. On this basis, the Commission considers that Abano would be unlikely to bid for future contracts under either the factual or the counterfactual.

Medlab Taranaki

289. Medlab Taranaki currently has a contract with the DHB to provide all histology testing (a subset of pathology testing) for Taranaki hospital. It also has a management contract with the DHB to provide a form of clinical governance over the hospital laboratory, as the DHB does not employ any pathologists. Medlab Taranaki employs four pathologists.

290. The Taranaki DHB is exploring options for the future of pathology services in that region, and although a form for the new contract is yet to be finalised, Medlab Taranaki and the Taranaki DHB advised the Commission that it is likely that Medlab Taranaki would continue to provide community testing, as well as support to the hospital laboratory in Taranaki.

291. John Shuker, Laboratory Manager, Medlab Taranaki, stated that [

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292. Specifically, he advised the Commission that Medlab Taranaki [
], unlike NZDG or Sonic, and that, historically, the company has had trouble attracting well-qualified and experienced staff.

293. When questioned on the likelihood of absorbing technical staff from an outgoing incumbent (in the event that Medlab Taranaki won an exclusive-provider contract in a new region), Mr. Shuker acknowledged that this was a possibility. However, he considered that there would be a real risk that some pathologists "may just walk away": pathologists are very mobile, and it is likely that the unsuccessful incumbent would attempt to shift staff to other regions.

> … there would be no guarantee, if we moved into {a new} area that the paths {pathologists} would stay.

294. Mr. Shuker also submitted that pathologists' salaries in New Zealand are considerably lower than in other countries, such as Australia, so a change of employer may be enough to induce pathologists to shift overseas.

295. Mr. Shuker believed that [

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296. Medlab Taranaki views itself as a very small player in New Zealand. [

]. Given its size, the Commission considers that Medlab Taranaki lacks the scale economies, the scope of medical expertise, the financial resources, and the purchasing power for equipment and other inputs enjoyed by Sonic and NZDG. Medlab Taranaki submitted that the likelihood and scope for its expansion would be significantly greater, were it the size of a company such as Sonic.

297. Furthermore, Medlab Taranaki has no experience operating in any region outside Taranaki. This suggests that, for the same reasons as outlined above for Abano, incumbent knowledge, reputation, and lack of prior relationships with the Otago/Southland DHBs are likely to represent significant barriers to Medlab Taranaki's entry into those regions.

298. When pressed about the possibility of Medlab Taranaki entering a new region at the request of a DHB, Mr. Shuker responded by saying he considered it unlikely that Medlab Taranaki's owners would be interested in significant future expansion, even with DHB support. [

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299. [ ], the Commission concludes that it cannot be satisfied that Medlab Taranaki would be willing to compete for new work, ten years hence. Nor can it be satisfied that Medlab Taranaki would be able to overcome the barriers to entry it faces. On these grounds, the Commission considers that Medlab Taranaki would be unlikely to bid for future contracts under either the factual or the counterfactual, and is likely to remain a small operator in future contracting rounds.

<u>NPL</u>

300. NPL estimates that it performs approximately [ ]% of the testing in the Northland DHB region. It shares the region with the four regional hospitals, which carry out [ ]% of the work between them, and until recently, NZDG, who performed approximately [ ]% of the work.[40]

301. The Commission was advised that any NPL expansion plans would be directed by the parent company, Healthscope, in Australia. [

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[40] Since the recent devolvement of NZDG's contract, it has been unable to operate in Northland. Northland DHB advised the Commission that NZDG would have an opportunity to bid for community testing in that region in early 2006.

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303. [ ]. On the prospect of expanding in New Zealand, Neil Henderson, Business Development, Healthscope, stated:

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304. Brian Watson, the Managing Director of NPL [

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305. Mr. Watson considered that it would be difficult for NPL to expand further south due to its geographic isolation. He also considered that the risk of bidding for a contract in another region, without first having secured the necessary pathologists, would be significant. [

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306. NPL believes it would also be disadvantaged when bidding for contracts against the large providers, due to its small size. It considered that it would [ ] because of the economies of scale realised by large companies such as Sonic and NZDG (given that both Sonic and NZDG have the ability to centralise a substantial portion of test volumes). Mr Watson stated that in an industry such as pathology services, it is very difficult to compete with large conglomerate companies that have major portions of market share around New Zealand.

307. As with Abano and Medlab Taranaki previously, NPL has no prior experience outside Northland. The Commission therefore considers that incumbent knowledge, reputation, and lack of prior relationships with the Otago/Southland DHBs are likely to represent significant barriers to NPL's expansion into that region.

308. The Commission concludes that, given the significance of the barriers to entry NPL is likely to face, NPL would be unlikely to bid for future contracts in the Otago/Southland community or hospital testing market, either under the factual or the counterfactual.

<u>PAL</u>

309. The Applicant submitted that PAL could present a credible alternative to the merged entity in the markets of relevance.

310. PAL has a history of expansion. Its business started with a contract in Tauranga (1996). It branched out to secure a contract in Rotorua (a joint venture with Sonic), and then moved on to the Waikato. However, [

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314. The Commission asked PAL whether it would bid for contracts in areas where Sonic or NZDG are the incumbent. PAL stated that:

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315. PAL added:

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316. In respect of the proposed consolidation of pathology laboratories, PAL commented:

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317. Given the different business model that PAL operates, the Commission cannot be satisfied that PAL would be willing to compete for new work ten years from now. Nor can it be satisfied that PAL would be able to overcome the barriers to entry it faces. On this basis, the Commission is of the view that PAL would be unlikely to bid for future contracts under either the factual or the counterfactual.

Conclusion on New Domestic Bidders

318. The Commission considers that new domestic bidders would face a number of barriers to entering another region, both in the factual and the counterfactual. The Commission

cannot be satisfied that Abano, Medlab Taranaki, NPL and PAL would overcome the barriers they face.

319. In conclusion, the Commission considers that both in the factual and counterfactual, Abano, Medlab Taranaki, NPL and PAL would be unlikely to bid for future community and hospital testing contracts in the Otago/Southland DHB regions.

International Bidders

320. The Applicants submitted that there are several pathology providers in Australia with the requisite expertise and resources to set up operations in New Zealand, if they perceived an opportunity. These are:

- Healthscope Limited (Healthscope);
- Mayne Pathology (Mayne); and
- St John of God Pathology (SJGP).

321. The Commission assessed the possibility of these parties as potential 'international bidders'.

322. In addition to the potential barriers discussed above, international bidders would face barriers to entry relating to knowledge of pathology needs in New Zealand (at a regional level, especially demographics, testing needs, size of regions etc) and the New Zealand health sector in general. A discussion of each of these international bidders follows.

Healthscope

323. The Commission assessed the likelihood and extent of competition provided by Healthscope earlier when considering the possibility of expansion of its New Zealand subsidiary, NPL. The Commission concluded that it could not be satisfied that NPL, and therefore Healthscope, would offer sufficient competitive constraint, either in the factual, or the counterfactual.

Mayne

324. The Applicants argued that Mayne is one of Australia's largest pathology providers, and that entering New Zealand would be a logical strategic extension of its operations. However, Mayne advised the Commission that [

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325. The Commission questioned Mayne on the likelihood of entry into any of the various regional markets in New Zealand in future contracting rounds (ten years from now, in the case of Otago/Southland). In response, Neil Rodaway, Group Manager, Head of Diagnostics, Mayne, submitted that if a DHB approached Mayne today and offered it assistance in entering a region, it would look at the offer with some seriousness (depending on the size of the market, and the availability of pathologists). However, Mr Rodaway also stated [

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326. Mayne considered that forecasting five years ahead was extremely difficult, let alone ten years. Mr. Rodaway stated that

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329. Mayne echoed the views of other industry participants by advising the Commission that one of its most significant barriers to entry into New Zealand was access to scarce pathologists and other skilled laboratory staff.

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330. Mayne considered that an incumbent (O&S Newco in Otago/Southland) could make entry very difficult for new players by frustrating the transition of existing staff to any successful entrant. Mr. Rodaway stated:

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331. In particular, Mayne considered it both feasible and strategically desirable from the perspective of an unsuccessful incumbent to frustrate new entry by maintaining a laboratory in the region to perform testing for subsidiaries in other regions, retaining key staff, instead of allowing them to transfer to the DHB or new entrant.

332. For instance, O&S Newco may attempt to recruit staff back from the DHB or new entrant by offering sufficiently attractive employment terms (most likely when the incumbent wants to discourage further entry). The incumbent in the counterfactual could also attempt to do this. On the other hand, it may also be possible that at that time some staff may be willing to transition to a new employer for any number of reasons, ignoring any potential offers from O&S Newco. However, these arguments are entirely speculative at this time. It does seem an entirely sensible response, from both a commercial and strategic perspective. It is conceivable that by behaving in this fashion, the former incumbent might be able to defeat the entrant and still secure the contract for want of anyone else being able to do the work.

333. The Commission is of the view that this uncertainty is likely to deter many potential competitors from contesting for work in regions such as Otago/Southland. [

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[ ].

334. The Commission questioned Mayne about the feasibility of transferring pathologists and other technical staff from Australian operations to discharge a regional contract in New Zealand. Mayne responded that it was [

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335. Another barrier that Mayne is likely to face is its lack of specific knowledge of regional markets, such as Otago/Southland. This is similar to the informational barriers faced by new domestic bidders discussed earlier, but is likely to be compounded by [

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336. Finally, when asked about its views on the proposed joint ventures, Mayne responded that there were some real competition risks to contracting DHBs in the two largest private pathology providers in New Zealand amalgamating in some markets. In particular, Mr. Rodaway stated:

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337. [

], the Commission cannot be satisfied that Mayne would likely bid for the Otago/Southland community and hospital testing markets. The Commission therefore concludes that Mayne would be unlikely to bid for future contracts in future contracting rounds in the factual and counterfactual.

SJGP

338. SJGP has not previously operated a pathology practice in New Zealand, although it did hold a contract to provide management and IT consultancy services to Taranaki DHB laboratory at New Plymouth Hospital between 2000 and 2003.[41] George Thomas, CFO, Taranaki DHB advised the Commission that after a period of managing the laboratory services at Taranaki Base Hospital, SJGP made a [

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339. [

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340. [

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341. Mr. Taylor considered that one of the biggest barriers to entry would be access to technical staff. In particular, it would be a big business risk to bid for an exclusive regional contract without first having secured the required pathologists to perform the work:

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[41] Both SJGP and Taranaki DHB advised the Commission that the extent of SJGP's involvement in Taranaki was purely for management services and did not involve SJGP taking over the hospital laboratory (as proposed in Otago/Southland), or provision of pathologists or other laboratory personnel.

[42] [

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342. An additional entry barrier raised by SJGP, related to incompatibilities between various Laboratory Information Systems (LIS).[43] Robust LIS are essential in pathology provision to ensure effective follow-up care, and also because of "medico-legal requirements" to retain patient documentation for a given period of time.

343. Mr. Taylor advised that there are a number of different IT platforms, and typically, pathology providers each have their own unique systems. The uniqueness of the various IT platforms makes them difficult to integrate with one another. He was unaware of any system that was readily compatible with another so as to allow easy transition of stored data. Mr. Taylor considered that this would represent a major barrier to competitors entering new regions.

344. When entry occurs, the new provider would need to either transition all data from the incumbent's system onto its own, or adopt the system utilised by the incumbent. Mr. Taylor indicated that both options would have significant costs attached: transitioning data between systems is costly and time-consuming. In addition, once transition costs are incurred, they are sunk. In general, the larger the sunk costs, the less attractive is entry. Operating multiple platforms (both the incumbent's system, and the entrant's system) can be inefficient and lead to diseconomies of scale.

345. Mr. Taylor stated that:

> Wherever there's been a takeover of one pathology practice {by} another, one of the biggest problems relates to the transfer of IT information and … continuity.

346. To illustrate this point, he provided the example of the difficulties [

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347. Like Mayne, SJGP is a well-known international provider of pathology services, so reputation is unlikely to represent a barrier to its entry into Otago/Southland.[44] However, the Commission considers that a lack of region-specific knowledge and prior relationships with contracting DHBs (both of which the incumbent would enjoy), would represent barriers to entry for SJGP. SJGP has little experience of pathology in New Zealand, and no experience in Otago/Southland. Given the requirement (and pressure) to provide continuity of an essential health service to their regions, this may encourage DHBs to favour the tried-and-tested incumbent over SJGP.

348. [

]. The Commission also recognises that SJGP is likely to face a number of barriers to entry that are likely to be significant enough to hinder, or altogether deter, entry. Given all these factors, the Commission therefore concludes that SJGP would be unlikely to bid for future contracts in future contracting rounds in the factual and counterfactual.

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[43] All pathology providers operate LIS – Software-based data repositories for storing patient biodata, test results, and maintaining records.

[44] The fact that the Capital & Coast/Hutt Valley DHBs invited SJGP to respond to its recent RFP suggests that SJGP is well-recognised by (at least some) DHBs.

Conclusion on International Bidders

349. The Commission considers that international bidders would face substantial barriers to entering another region, both in the factual and the counterfactual. The Commission cannot be satisfied that Healthscope, Mayne or SJGP would overcome the barriers they face.

350. In conclusion, the Commission considers that both in the factual and counterfactual, Healthscope, Mayne and SJGP would be unlikely to bid for future contracts in the Otago/Southland region.

Other regional DHB-owned Laboratories

351. The Applicants submitted that either of the two largest DHB-owned laboratories in New Zealand – CHL and LabPLUS – could tender for community testing outside their traditional areas of operation. As discussed earlier, CHL and LabPLUS are two of the four specialist reference laboratories in New Zealand. Between them, they provide the majority of specialised send-away testing in New Zealand. They receive referrals for this work from other DHB-owned laboratories as well as private community providers, who do not have the contracts, or the resources, to undertake send-away testing.

352. The volume of routine community testing currently undertaken by these laboratories is minimal, and incidental to their core operations.

353. This section discusses the possibility of DHB-owned hospital laboratories based in regions other than Otago or Southland entering the Otago/Southland regional market in future contract rounds. The Commission analysed CHL and LabPLUS as potential competitors because, as the largest DHB laboratories in New Zealand, they are the most likely to have the resources and capacity to contest for work in regions outside their own. The Commission has assessed the possibility of CHL and LabPLUS expanding by bidding for community testing in Otago/Southland.

354. The Applicants submitted that there are several examples of DHB laboratories tendering for, or participating in, contracts outside their region. The Applicants cited examples such as the support offered by CHL to the OSRL joint venture in Otago/Southland, and support that may be offered in future to hospital laboratory bids for community testing in regions such as the West Coast; Whanganui; Nelson/Marlborough; and Tairawhiti.[45]

355. However, the Commission was advised by Otago DHB that [

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356. CHL advised the Commission that its rationale for supporting the OSRL bid was based on reciprocity: CHL would offer short-term assistance to OSRL over the transition phase, and OSRL would ensure the flow of send-away testing work from Otago/Southland to CHL. It was never CHL's intention to assume all community testing in Otago/Southland, either in the short-term, or the long-term. This is true of the other examples of CHL offers of support and participation in contracts outside its own region presented by the Applicants.

357. Both CHL and LabPLUS stated that the key reasons they would not tender for full service contracts outside their traditional regions are:

[45] Letter from Chapman Tripp (acting for Sonic) to the Commission, dated 9 September 2005, para 19; and letter from Minter Ellison (acting for NZDG) to the Commission, dated 12 September 2005, para 20(d)(i).

- [ ][46]; and
- expansion into other regions (to carry out all community testing, for example) is outside the terms of reference set by DHBs for their own hospital laboratories, and would be unlikely to receive DHB approval.[47]

358. In addition, the Commission considers that CHL and LabPLUS would be likely to face similar barriers to some private pathology providers, such as: access to technical labour, access to capital and incumbent knowledge (especially given that neither provider currently operates in community testing markets).

CHL

359. CHL is the Canterbury DHB hospital laboratory. Approximately [ ] of the testing that CHL performs outside its standard hospital testing, consists of send-away and cervical screening referrals.[48] Given its size, CHL also supports a number of small hospital laboratories around New Zealand by providing clinical expertise (to help maintain accreditation in those hospitals) and additional capacity on a short-term basis.

360. [

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361. [

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362. In addition, CHL submitted that its core business and primary responsibility is to the Canterbury DHB region. CHL did not consider that it would be able to persuade the Canterbury DHB to allow it to bid for new work elsewhere. It considered that the DHB would instruct it to utilise any excess resources or capacity it had to better the level of service in its own region, rather than undertake entrepreneurial expansion into new districts. Canterbury DHB advised the Commission that it would be unlikely to allow CHL to bid for community or hospital testing work in other regions.

363. CHL advised the Commission that if it was interested in expanding into new regions, as suggested by the Applicants, it [

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364. For the reasons outlined above, the Commission considers it unlikely that CHL would bid for community testing outside the Canterbury region, and would therefore be unlikely to pose a competitive constraint on O&S Newco in future contracting rounds.

LabPLUS

365. LabPLUS is the largest DHB-owned laboratory in the country. LabPLUS stated that it does not currently compete for community testing in the Auckland region [

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[46] [

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[47] This policy appears to be consistent across DHBs. However, in ten years time, the funding for health services may have changed, and the new funding body may be open to wider collaboration between regions. However, the Commission is uncertain about this possibility.

[48] The bulk of the remaining [ ] consists of schedule and non-schedule work from Christchurch hospital.

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366. [

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367. Accordingly, the Commission considers it unlikely that LabPLUS would bid for community testing outside the Auckland region, and would therefore be unlikely to pose a competitive constraint on O&S Newco in future contracting rounds.

Conclusion on regional DHB-owned laboratories

368. The Commission considers that DHB-owned laboratories outside Otago and Southland would face a number of barriers to entering another region, both in the factual and the counterfactual. The Commission cannot be satisfied that DHB-owned laboratories such as CHL and LabPLUS would overcome the barriers they face.

369. In conclusion, the Commission considers that both in the factual and counterfactual, CHL and LabPLUS would be unlikely to bid for future contracts in the Otago/Southland region.

DHB Provider Arm Laboratories in the Region (Self-Provision)

370. The fifth category of potential competitors is local DHB-owned laboratories in the region (the prospect of self-provision).

371. In Otago/Southland the proposed contract is for all services (hospital and community) for a ten year period. Therefore, the DHB would not own or operate a hospital laboratory at the end of this period in the factual [

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372. The Commission has assessed the extent to which the ability of the Otago and Southland DHBs to self-provide would provide a constraint on the combined entity post-merger.

373. The Otago DHB submitted that it believes it has substantial countervailing power, and that its DHB provider arm bid in ten years time would be a credible competitive constraint on the merged entity, should the DHB not receive bids from any other parties.

374. [
], identified the key risks of the two proposals. The risks of the LabCo proposal (proposed joint venture partners - O&S Newco)[49] noted the difficulties of bringing all services back in-house after ten years of outsourcing:

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375. [ ]:

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[49] Cross-reference: O&S Newco section

376. The above statements indicate that the Otago and Southland DHBs [
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377. Further, [ ] listed the key risks of the hospital labs proposals:

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378. The report of the SISSAL evaluation group to the Otago and Southland DHBs concluded that:

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379. These risks were identified even though the DHBs currently operate hospital laboratories. The Commission considers that these risks are likely to be present, and potentially exacerbated, at the end of the contract period when the DHBs have not been involved in running a hospital laboratory for ten years. In addition, many industry participants advised the Commission of the difficulties of bringing all services back in-house after a period of outsourcing. [

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380. [ ] stated that the Otago and Southland DHBs were "naive in the extreme" in respect of the ability of the DHBs to bring all services back in-house. Other parties stated that they thought DHBs were looking for short-term cost savings with no consideration for loss of competition and bargaining position in the long-run. [
] stated that the Otago/Southland proposal seemed to be "horrendously risky, and may have the effect of increasing prices in the long-term."

381. The [ ] DHBs stated if all services were outsourced, the DHB could become "locked in" at the end of the contract if it did not have another choice of provider, and would face many difficulties with bringing all services back in-house.

382. David Moore's LECG discussion document prepared for Capital & Coast, Hawke's Bay and Hutt Valley DHBs, states that outsourcing hospital testing can be problematic, as it creates significant lock-in with the preferred private provider, and there would be significant costs to unlock the arrangement in the future. The final report states:

> Once contracted out, there is significant lock-in from the private sector to an essential hospital service. From experience, the extent of this lock-in appears to be highly problematic. DHBs are likely to find themselves short of both information and negotiating leverage. Private sector provision is the least preferred option of the working party.

383. A laboratory services review paper for the Auckland region[50] identifies a number of options for the future structure of laboratory services in the region, one of which was the tendering of all services. Risks of this option were identified as: DHBs' loss of control,

[50] *Laboratory Services in the Auckland region – A Review of Future Options for Supply-Side Configuration,* A project for the Northern Region DHB CEOs facilitated by the Northern DHB Support Agency (NDSA), Final Report to the DHB Chief Executives, December 2004.

considerable risk of service disruption, poor cost transparency, and the DHBs being very exposed at the end of the contract period.

384. The Applicants submitted that there are examples in other regions of formerly outsourced contracts being successfully brought back in-house. For example, Whangarei Hospital (Northland DHB), North Shore Hospital (North Shore DHB), Thames Hospital (Waikato DHB), Princess Margaret Hospital (Christchurch DHB), and Taranaki Hospital (Taranaki DHB).

385. The Commission notes that these examples differ in size and extent from the proposal in Otago/Southland, which would involve bringing back in-house the provision of all community testing as well as hospital testing.

386. The small hospital laboratories at Whangarei hospital, North Shore hospital laboratory and Thames hospital were all outsourced in the 1990s, and subsequently brought back in-house (in all three cases, the period of outsourcing was less than six years). In Whangarei, the laboratory assets were jointly owned by the DHB and the private provider, and at the end of the contract period when the services were brought back in-house, the assets were taken over by the DHB. [ ], stated that such a transition is never easy, but as all work was being done on-site, the transition from private to public operation of the laboratory was not overly problematic. He stated that if some work had been done off-site, bringing the service in-house would have been a major issue. [ ] DHB stated, with respect to bringing hospital laboratory services back in-house, that "it can be done, but takes time, energy and money".

387. Princess Margaret Hospital laboratory was outsourced to SCL (NZDG) in the 1990s but brought back in-house in 2003, at which point CHL took over the operation of the hospital laboratory. During the period of outsourcing, SCL did not have any pathologists working in the laboratory, and CHL performed all of the more complex tests and after-hours work for the laboratory. There was a very limited amount of on-site testing, and thus it was a relatively easy transition for CHL to take over the running of the on-site laboratory. CHL currently has only four staff on-site at Princess Margaret Hospital.

388. Taranaki Hospital laboratory was outsourced to SJGP in 2000. The outsourcing was limited to a management contract and IT consultancy. SJGP did not supply any pathologists but sent a manager from Australia to run the laboratory, and provided management support from its Australian operations. In 2003, SJGP withdrew back to Australia and Medlab Taranaki (the local community provider) took over a management contract to run the hospital laboratory. The function of this contract is to provide loose governance over clinical matters, as the hospital laboratory does not employ any pathologists.

389. In none of the examples above, did the outsourced services include any community testing or involve the transfer of pathologists back to the DHB provider arm. In the Otago/Southland situation, the services to be brought back in-house would include all community testing for the two regions and the transfer of a number of pathologists. Therefore, past examples of services being brought back in-house are of limited relevance to the proposition in the Otago/Southland region.

390. Although some DHBs around New Zealand provide a small amount of community testing as well as hospital testing, the Commission notes that there are no examples of a DHB providing all community testing for a region. As such, the prospect of bringing all services (including community testing) back in-house at the end of a ten year period is untested. In the absence of appropriate examples of similar past behaviour by DHBs

against which to assess the possibility, the Commission has assessed the potential risks and barriers associated with a return to self-provision.

391. The Commission identified the following as the major potential issues with self-provision:

- the ability of the DHB to benchmark and appropriately cost services after the length of the contract period;
- access to the capital necessary to set up an integrated laboratory services business;
- the uncertainty of securing critical technical labour such as pathologists;
- the absence of managerial laboratory services knowledge within the DHB at the end of the contract period; and
- the transfer of volume and cost risk back to the DHB.

Each issue is detailed below.

Benchmarking

392. At the end of the ten year contract period, in both the factual and the counterfactual, and in the absence of a DHB-operated hospital laboratory, it is possible that the Otago DHB would have no direct comparison against which to evaluate the price the private provider is offering the DHB to perform pathology services. Although DHBs would typically have access to information regarding testing types and volumes when testing is being provided by a private provider, it is unlikely that a DHB would have access to the costing information and margins of the private provider.

393. The Otago DHB stated that at the end of the ten year period, if its provider arm were required to bid, it would use domestic and international experts for advice. It stated that DHBs are part of an inter-related network providing hospital services and that detailed benchmarking information is freely available from other DHBs.

394. The Applicants also submitted that the Otago and Southland DHBs could seek assistance from DHBs in other regions. They submitted that although there a number of demographic factors that would contribute to the likely cost of providing pathology services to a particular DHB region (population size, age, ethnicity, and geography), the existence of these variables does not represent an impediment to a particular DHB's ability to obtain useful benchmarking information.

395. The recent Dunedin and Invercargill hospital laboratories bid for all services was based on cost estimates of its hospital operations. However, industry participants advised the Commission that there are major differences between hospital and community provision of pathology services.

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397. [

]. In ten years time, the Commission is not satisfied that the

DHB provider arms would accurately estimate the costs of the provision of all services in the absence of DHB-operated hospital laboratory.

398. [ ]:

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399. Industry participants and other DHBs expressed doubt over the ability of a DHB to appropriately benchmark in the absence of a DHB-operated hospital laboratory.

400. The [ ] DHB stated that in situations where the hospital laboratory testing is also contracted to a private provider, the DHB:

> Would not be able to provide a benchmark against the pricing it is being offered, and it would have got out of touch with technology and other advances occurring in laboratory testing. Within the ten-year period, there would have been a significant reduction in the costs of laboratory testing because of changes in technology.

401. In relation to [ ] DHB also stated that

> Having the hospital laboratory sitting there at the end of the five years, able to be used as a benchmark, understanding what is happening with technology, is a key part of the [ ] recommendation.

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402. [ ]:

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403. In a report produced by the [ ] DHB, the DHB noted that it does not have a clear understanding of the costs involved in operating a community pathology laboratory. It stated that as the DHBs currently pay on the basis of historical schedules, the reasonable costs of individual community tests are uncertain. In addition the [ ] DHB told the Commission that it is currently unaware of the true costs of its own hospital laboratory and that it anticipated it would be two years before it would have an accurate assessment of its laboratory costs.

404. The Commission considers that there is significant uncertainty over the ability of the Otago and Southland DHBs to estimate the competitive price of services after pathology testing has been contracted out for ten years. The DHBs may not be able to recognise a 'bad deal' as they would not have been involved in the provision of services for ten years.

<u>Access to Capital</u>

405. The Applicants submitted that the capital cost of returning to self-provision would be relatively modest. The Applicants stated that the cost of financing the purchase of the assets of the business at the end of the contract period is insignificant in the context of the overall budget of the DHBs, particularly when the total capital cost is amortised over time. The Applicants were of the view that even if the DHB budget had been fully

allocated to other uses, a request for further funding could be expected to be approved, given the modest level of capital expenditure required. [

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406. However, various DHBs advised the Commission that in comparison to private providers, DHBs are capital constrained and any large capital expenditure needs to be planned well in advance and approved by the Board. The [ ] DHB stated that accessing the capital needed to self-provide would be an issue, but one which could be overcome. The [ ] DHB stated that the capital required to bring services back in-house would be "prohibitive". The [ ] DHB stated that if capital is needed for a service, it can always be accessed somehow, but will come at the cost of other health services.

407. The proposal from the Otago and Southland DHB hospital laboratories in the recent RFP round estimated start-up costs of [ ] which would be necessary for the hospital laboratories to expand into community testing. [

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[ ].

408. At the end of the ten year contract period, it is likely that these start-up costs would be larger than [ ] as the DHB would no longer operate a hospital laboratory. The DHB would need to buy back the equipment for the hospital laboratory (although it may be possible to lease some equipment rather than purchase it outright), as well as set up the infrastructure to expand into community testing.

409. [

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410. Some DHBs suggested that in three to five years, let alone ten years, as technology evolved, some of the equipment would be outdated and it would be necessary for the DHB to invest in new technology. This may increase the capital expenditure necessary to bring all service back in-house, but on the other hand, the joint venture would be likely to have a capital replacement plan, which may offset this concern. O&S Newco could however, defer new investment towards the end of the contract to make it less attractive for the DHBs to bring the laboratories back in-house.

411. The Commission understands that the DHB may be able to access the necessary capital if laboratory services are prioritised for capital expenditure. However, DHBs have advised the Commission that such capital expenditure would come at the expense of other health services and the DHB may be unwilling to make this sacrifice. The Commission considers that although the barrier relating to access to capital may be overcome by the DHB, it is an issue that may deter the DHB from making the decision to self-provide.

<u>Access to technical labour</u>

412. The NZDG/Sonic joint proposal included [

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413. The Otago DHB stated that although specialists such as pathologists are in short supply, it competes internationally for staff. The Applicants submit that staff choose to live in a region for particular lifestyle reasons and would not exit the region simply because their employer changes.

414. The Commission considers that while this may be the case for some staff, there still exists a significant risk to the DHB that some pathologists might not be recruited by the DHB provider arm. Some industry participants told the Commission that some staff may be reluctant to work for a public rather than a private provider. [ ] DHB, stated:

> It takes an average of about 5 years to recruit a pathologist, 12 years to train one…there are philosophical and cultural differences between specialists in the public and private sector. They can always get paid more in the private sector, but public sector specialists choose to work there because they enjoy the teaching and research, and the variety.

415. [ ] DHB, stated that if the DHB were to bring all services back in-house after a period of outsourcing, "recruiting would be incredibly difficult". The Otago DHB argued that the "public vs private" ideology is only one of the many reasons why staff choose to work in the public or private sector.

416. It is uncertain whether all [ ] pathologists and other specialists would choose to be employed by the provider arm of the Otago/Southland DHBs at the end of the contract period. It is possible that NZDG and Sonic could offer pathologists positions within their operations in other regions. As discussed earlier, industry participants advised the Commission that pathologists are in very short supply and providers will be eager to retain their specialists. Pathologists are also perceived to be particularly mobile. John Shuker of Medlab Taranaki stated that pathologists are in a unique situation - due to the shortage, there is a demand for their skills in any area they move to. He also stated that pathologists' salaries in New Zealand are low compared to Australia and other countries, and a change of employer may be enough to induce pathologists to shift overseas.

417. The [ ] DHB advised the Commission that attracting back all staff and specialists would be the main difficulty with self-provision. Historically, public providers have not been able to offer the same terms of employment as a private provider. The [ ] DHB stated that it would be very difficult for its DHB-owned hospital laboratory to enter the market at the end of a contract period with a private provider. The difficulties would arise primarily from the inability to recruit and employ specialists and pathologists.

418. The Otago and Southland DHB provider arms are currently unable to employ appropriate specialists to undertake all the necessary hospital testing. The hospital laboratories currently subcontract with private providers for the provision of some specialist services. For instance, [

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419. In evaluating the risks of the two proposals (O&S Newco proposal and joint hospital laboratories proposal)[51], [ ]:

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[51] Cross reference – O&S Newco section.
[52][ ].

420. The SISSAL report to the DHBs stated that one risk associated with the hospital laboratories' proposal was:

[

].[53]

421. For the reasons listed above, the Commission considers that access to technical labour would present a significant barrier to the DHB, should it decide to bring all services back in-house at the end of the ten-year contract period, in the factual and the counterfactual.

Corporate Knowledge / Institutional History

422. Industry participants suggested that, in areas where both the hospital laboratory work and the community work is out-sourced, while pathologists and laboratory technicians may transfer to the combined entity, there would be a loss of corporate memory. After a period of 5-10 years, the DHB may have lost the management staff within the DHB provider arm, which has the requisite skills and knowledge of laboratory services.

423. The Applicants contended that in Otago/Southland, [

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424. However, various DHBs have expressed concern over the potential loss of the requisite knowledge of laboratory services *within* the DHB after a ten-year period of outsourcing all services. [ ] DHB stated that if the DHB was to self-provide, he would have difficulty getting the skilled people to manage the service. [ ] questioned how the public provider could compel the management staff of a private provider to transfer over to a public operation.

425. Some industry participants suggested that some management employees of the outgoing provider may be unwilling to work for a public sector organisation. In a discussion document prepared for the Capital & Coast, Hawke's Bay and Hutt Valley DHBs, [ ], offered observations from his experience of bringing together hospital and community testing volumes. He noted the following as an issue with the merger of hospital and community laboratories in the MidCentral DHB region:

> Cultural differences in staff from the community and hospital laboratories. It was very difficult to manage the combined workforce. Years were required before complete unity was achieved.

426. The Commission considers that access to the corporate knowledge or institutional history required by the Otago/Southland DHBs may be a barrier to the DHBs when they are assessing the merits of self-provision.

Transfer of Risk

427. The DHBs are seeking to generate reductions in the cost of pathology services. In Otago/Southland, the DHBs are seeking to change the way pathology services are funded, away from a fee-for-service towards a bulk funding arrangement. DHBs stated that a major rationale for the move from a fee-per-test funding model to a single provider bulk-funded model was the shift of volume and cost risk from the DHB to the pathology provider. Escalating costs for pathology services have been largely due to

[53] South Island Shared Service Agency Limited, Memo from Philip Pigou, on behalf of the Laboratory Service RFP Evaluation Group, to Brian Rousseau, Otago DHB and Dr Gershu Paul, Southland DHB, 5 April 2005.

volume growth of over [ ]% per annum. The DHBs stated that the proposed contract with Newco would include [ ].

428. In their joint response to the Otago / Southland RFP, Sonic and NZDG state:

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]. [54]

429. [ ], noted one of the key risks of the hospital laboratories proposal to be that:

[ ].

430. In addition to the other barriers listed above, transfer of risk presents another reason why the DHBs may not re-enter, whether under the factual or the counterfactual. The private provider may be able to increase its price at the end of the contract period, in the knowledge that the DHB would be unwilling to take back this volume and cost risk.

Conclusion on Self-provision

431. It is possible that the Otago and Southland DHBs could bring all services back in-house if necessary at the end of the proposed contract period of ten years. However, the Commission considers that this may be an option which would only be exercised in extreme circumstances, both in the factual and the counterfactual. The Commission considers that the transition to bring all services back in-house would not be completely seamless, and there are significant risks to the DHBs in exercising this option. In the face of a price rise, the DHB may have a strong incentive to bring all services back in-house, but the Commission considers that the DHB would not be able to reinstate the services after ten years without significant cost and difficulty.

432. Therefore, the Commission cannot be satisfied that the Otago and Southland DHBs' ability to self-provide pathology services would provide competitive constraint in the factual or the counterfactual. In ten years' time, under either the factual or the counterfactual, it is unlikely that the DHBs would revert to self-provision, without significant delay and increase in cost.

Conclusion on Potential Competition

433. The Commission assessed the likelihood of entry, and ability to exert constraint, by various players, both with and without the proposed joint venture in Otago/Southland.

434. The first category of potential competitors – previous providers – included Sonic and NZDG (under the counterfactual), and O&S Newco (under the factual). The Commission found that whilst the incumbent firm in these regions in the counterfactual would enjoy several benefits from incumbency, either NZDG or Sonic, as the next closest competitor, would likely be able to overcome any barriers in future contracting rounds. Hence, under the counterfactual, the ability of either NZDG or Sonic to usurp each others' incumbency would result in a substantial degree of competitive tension in future contracting rounds. Under the factual, this strong competitive tension is lost as NZDG and Sonic consolidate their operations into O&S Newco.

435. It therefore falls on the remaining potential competitors to provide constraint by virtue of their ability, or perceived ability, to enter the market. Their ability to enter is conditional on the extent of the barriers they would face when doing so.

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[54] Medlab South and SCL 'Proposal: Laboratory Diagnostic Services for the Southland and Otago District Health Board regions', submitted to Otago and Southland DHBs March 2005, p5, para 3.8

436. The second category of potential competitors – new domestic bidders – included Abano, Medlab Taranaki, PAL, and NPL. The Commission found that all these firms would likely face five common barriers to entry, and considered that these may be sufficient in extent to prevent entry from occurring. A number of these providers also submitted that they had no intention of expanding beyond their immediate regions in the foreseeable future. The Commission concludes that it could not be satisfied that these new domestic bidders would provide competitive constraint in the future under the counterfactual or the factual.

437. Next, the Commission examined potential international bidders, such as Healthscope, Mayne, and SJGP. [

]. None were contemplating entry into New Zealand, even though most DHBs are currently seeking to contract for community-testing in their regions for significant periods of time. The Commission cannot know where these potential international bidders will be placed in future contract rounds, given the distance of those rounds in the future; however, sufficient uncertainty has been raised that the Commission cannot be satisfied that entry would occur from overseas. The Commission also found that overseas bidders would likely face barriers relating to access to technical labour, and information, and that these barriers may deter entry. The Commission therefore concludes that it could not be satisfied that international bidders would exert competitive constraint in future contracting rounds in the factual or the counterfactual.

438. The fourth category – extra-regional DHB-owned laboratories – included CHL and LabPlus. These providers were constrained in competing in new regions for two main reasons. [

]. Second, they considered they would not be permitted by their DHBs, for policy reasons, to assume all community or hospital testing in other regions: their primary responsibility is to provide quality service to their respective regions, and entry into other districts would be viewed by their DHBs as a digression from this goal. Hence, the Commission concludes that DHB-owned hospital laboratories outside Otago/Southland would not provide competitive constraint in the factual or the counterfactual.

439. The fifth category of potential bidders involved the DHB provider arm bringing pathology services back in-house at the end of the ten-year period. The Commission considers that the transition to bring all services back in-house would not be completely seamless, and there are significant risks to the DHBs in exercising this option. Therefore, the Commission cannot be satisfied that the Otago and Southland DHBs' ability to self-provide pathology services would be a sufficient competitive constraint in the factual or the counterfactual.

440. In summary, the Commission assessed the likely competitors for future contracts in Otago/Southland, at the next bidding round in ten years time. The Commission concludes that both in the factual and counterfactual, new domestic bidders, international bidders, DHB-owned laboratories and the Otago/Southland DHB provider arm would be unlikely to provide competitive bids in Otago/Southland. However, under the counterfactual, NZDG and Sonic are likely to be vigorous competitors for future contracts in Otago/Southland, whereas in the factual, this competition would be lost.

441. Therefore, the Commission assessed the likelihood of several potential competitors providing competitive constraint in the counterfactual and the factual scenarios, and concludes it could not be satisfied that potential competition would be likely, or

significant enough in extent, to prevent a substantial lessening of competition in the Otago/Southland community and hospital testing markets.

Countervailing Power

442. In some circumstances the potential for the combined entity to exercise market power may be sufficiently constrained by a buyer or supplier to eliminate concerns that an acquisition may lead to a substantial lessening of competition. All DHBs fund approximately 96% of all pathology services for their regions. As such, they are effectively the sole purchaser of pathology services in their region. The Commission has assessed the extent to which the countervailing power of the Otago/Southland DHB as the sole purchaser of pathology services would provide a constraint on O&S Newco in the factual.

443. Ordinarily, the Commission considers that the countervailing power of a monopsonist purchaser relies on the necessity of having a choice of providers. As concluded above, in the factual it is unlikely that DHBs would receive more than one bid from a private provider for a contract at the end of the ten year period. In contrast, at least two bids seem likely under the counterfactual.

444. The Commission considers that although the DHBs may currently have a degree of countervailing power in their role as the sole purchasers of pathology services and provider of hospital testing, this countervailing power is likely to be substantially lessened by the DHBs' move to a single provider contract for all services.

445. In addition, recent behaviour indicates that the DHBs have failed to exercise their countervailing power. During an interview with the Commission, Brian Rousseau, CEO of the Otago DHB, advised the Commission [

]. Chris Fraser, Chief Planning and Funding Officer, Otago DHB, also told the Commission [

]. It was "extremely surprised to receive a joint bid", but it simply "took the bids as they came". In a letter to the Commission, [

].[55] The DHB made the assumption that it was necessary for the parties to come together in order to be able to bid for the contract for all services.

446. In this case, the Applicants submit that the countervailing power of the DHB does not rely on having a choice of private provider. The DHB is a vertically integrated monopsonist purchaser. It has a provider arm as well as a funder arm, and would always have a "make or buy" option for the provision of pathology services. The Applicants submit that the countervailing power of the DHBs in Otago and Southland would provide a constraint on the combined entity post-merger, and that this constraint would come from the ability of the DHB to self-provide pathology services by bringing all services back in-house.

447. However, the integrated monopsonist argument is unlikely to be credible unless re-entry in ten years is likely. As discussed above, the Commission considers that there would be significant issues faced by the DHB if it were to attempt to bring all services back in-house, and as such, the threat of self-provision would not provide a sufficient constraint on the merged entity in the factual or the counterfactual. Thus, in the factual, the DHB

[55] Letter to Commerce Commission (Sinead Sinnott, Tania Pringle, Sonia Wansbrough) from Minter Ellison (Oliver Meech and Andrew Matthews), 24 August, P 6, Para 37

would have its countervailing power significantly reduced by its inability to threaten a "locked in" NewCo with re-entry of the DHB provider arm, for the reasons discussed above.

448. In the past, the DHBs (through the MoH) have been price-setters, as the MoH has set national prices for the list of schedule tests against which DHBs purchase community testing. However, in the move to a bulk-funded single-provider model, the DHB would no longer be a 'price setter', and would instead rely on competitive market forces (eg through competitive bidding) to determine the competitive price. Under this new framework, and provided they have choice between providers, DHBs will have the ability to influence this (competitive) price by playing various competitors off against one another. That is, the market's price discovery mechanism is strengthened by the countervailing buyer power wielded by DHBs where there is more than one bidder. This is what could be expected to occur under the counterfactual.

449. However, without choice between providers (the situation of a monopoly provider versus a monopsony buyer) the countervailing power of DHBs, and therefore ability to influence prices, is significantly weakened. In this situation the purchaser has no alternative supplier to turn to. This is likely to be the scenario under the factual.

450. In conclusion, due to the reduction in the choice of providers in the Otago/Southland region, the Commission considers that the countervailing power of the DHBs is significantly weakened in the factual compared to the counterfactual. The prospect of self-provision is unlikely in the Otago/Southland DHB regions. This further weakens the countervailing power of the DHBs. The Commission concludes that the countervailing power of the DHBs is unlikely to provide a level of constraint on O&S Newco under the factual compared with the constraints under the counterfactual.

Conclusion on Competition in the Otago/Southland regions

451. In the Otago/Southland regional market, the Commission considers that the barriers faced by each of NZDG and Sonic are more easily overcome than those faced by smaller pathology providers such as Abano, Medlab Taranaki, NPL and PAL. The Commission considers that both in the factual and counterfactual, Abano, Medlab Taranaki, NPL and PAL are unlikely to bid for future contracts in the Otago/Southland regions. The Commission also considers it unlikely that international bidders and DHB-owned laboratories, such as CHL and LabPLUS, would bid for future contracts in the region. The Commission considers that in the counterfactual, the likely bidders in the next contract round in Otago/Southland would be Sonic and NZDG. In the factual, the joint venture would likely be the only bidder.

452. Thus, the Commission considers that in the factual there is likely to be only one bidder for the contract to provide pathology services at the end of the ten-year period, while in the counterfactual, it is likely that there would be two private providers bidding, and competing vigorously for the contract.

453. The Commission has considered the ability of the DHBs to self-supply pathology services to provide a constraint on the merged entity in the factual. The Commission is of the view that the DHBs would face significant costs, risks and difficulties if they were to consider bringing all services back in-house, and as such, the threat of self-provision would not provide a level of constraint on the merged entity in the factual, compared with the constraints in the counterfactual.

454. The Commission considers that due to the reduction in the choice of providers in the Otago/Southland region, and given that the prospect of self-provision in unlikely, the

countervailing power of the DHBs is significantly weakened in the factual compared to the counterfactual.

455. Accordingly, as the proposal would reduce the number of likely potential bidders in the Otago/Southland region from two to one, and as the DHB provider arm is unlikely to provide sufficient constraint on the joint venture, the Commission cannot be satisfied that the proposed merger would not have, or would not be likely to have[56], the effect of substantially lessening competition in the Otago/Southland region community testing and hospital testing markets.

SOUTH CANTERBURY – COMMUNITY TESTING AND HOSPITAL TESTING

Counterfactual and Factual

Factual

456. In the present proposal, Sonic and NZDG would form a joint venture in the Canterbury, South Canterbury and West Coast DHB regions (Canterbury Newco). Canterbury Newco would acquire an exclusive contract to provide all hospital and community testing in the South Canterbury DHB district until 2009.

Counterfactual

457. The Commission considers that the appropriate counterfactual scenario is a single provider of all services in South Canterbury. Medlab South (Sonic) currently has a contract to provide all services in the region, which has been in operation since March 2004. Under the counterfactual scenario, both NZDG and Sonic would exist to bid for future contracts in the region.

Competition Analysis

458. The South Canterbury DHB has outsourced all pathology services (hospital and community) to a single provider since March 2004. The DHB stated that a single provider of all services is the most efficient method of providing pathology services for a small region such as South Canterbury. The DHB has no intention of altering this current model. Thus, any potential bidder for a pathology contract in the future would need to bid for the provision of all services. The likelihood of a potential bidder winning a contract for hospital testing would be constrained by its ability to provide community testing, and vice versa. Accordingly, the competition analysis for hospital testing and community testing in the South Canterbury region is the same, as in this instance, they are being rolled into one contract.

Potential Bidders

459. In the South Canterbury DHB region, the Commission identified the following potential future bidders:

- Previous provider to the region: NZDG and Sonic in the counterfactual[57], Canterbury Newco in the factual;
- New domestic bidders: Abano, Medlab Taranaki, NPL, and PAL;
- International bidders: Mayne, SJGP and Healthscope;
- DHB-owned laboratories outside the region: CHL and LabPLUS; and

[56] *Brambles New Zealand Ltd v Commerce Commission* (2003) 10TCLR868, 877

[57] In the counterfactual, both now and in five years time, NZDG and Sonic would be "previous providers". NZDG provided a small amount of testing in the region up until 2004, when Sonic was offered the single provider contract. Sonic currently provides all testing.

- The local DHB-owned hospital laboratory (self-provision).

460. Under the counterfactual, NZDG and Sonic would be the only potential bidders at the next contracting round with prior experience operating in South Canterbury. In the factual, NZDG and Sonic would cease to exist separately in this region, but would instead be combined into Canterbury Newco, who, at the next contracting round, would be the only potential bidder to have prior experience of operating in the region.

461. The Commission considers that the barriers faced by new domestic bidders, new international bidders, DHB-owned laboratories and Sonic and NZDG in South Canterbury, would be similar to those faced by these bidders in Otago/Southland.

462. Accordingly, the Commission considers it is unlikely that new domestic bidders or international bidders would provide a constraint on Canterbury Newco in the South Canterbury DHB region in the factual or the counterfactual.

NZDG and Sonic

463. In 2003, both Sonic and NZDG responded to the RFP for the provision of all laboratory testing services in the South Canterbury DHB region. At the time, the hospital laboratory was outsourced to Medlab South (Sonic). Medlab South also undertook the majority of the community testing in the area. However, NZDG submitted a bid for all services and the Commission was advised by the South Canterbury DHB that [
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464. Ross MacDonald, Manager Support Services, South Canterbury DHB, advised the Commission that at the end of the contract period, he was expecting to get bids from Sonic and NZDG. He was of the view that the parties had sufficient business in other areas of the country, such that they would both exist in five years time to bid for the next pathology contract in the South Canterbury region. He expressed concern about the proposed joint venture as he felt that the South Canterbury DHB would not have a viable alternative option at the end of the contract period.

465. The 2003 South Canterbury DHB tender is a clear example of how competition from NZDG and Sonic resulted in a satisfactory price for the DHB. This competition would be absent in the factual. In a summary of a paper to Colin Goldschmidt, Managing Director, Sonic Healthcare, from Brian Willcox, CEO of Medlab South, Mr Willcox expressed the rationale for the proposed joint ventures in the South Island:

[

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466. In the counterfactual, the Commission considers it likely that both NZDG and Sonic would bid for the contract to provide all testing in South Canterbury at the end of the five year period, whereas in the factual this competitive tension would be lost.

CHL

467. [

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[58] Attachment to email from Brian Willcox to Nick Thornton, 24 February 2005, "Abridged summary of Brian Willcox paper to Colin Goldschmidt".

468. CHL stated that it is beyond its capabilities to bid for a contract such as the South Canterbury contract, unless the Canterbury DHB instructed it to do so. The South Canterbury DHB stated that at the end of the contract period, it could not rely on CHL bidding for the provision of services in the South Canterbury DHB.

469. Jock Muir, General Manager – Hospital and Specialist Services, Canterbury DHB, stated that [

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470. Accordingly, the Commission considers that it is unlikely that DHB-owned laboratories outside the region, such as CHL, would bid for future contracts in the South Canterbury region under the factual or the counterfactual.

DHB-owned laboratory (Self-provision)

471. The South Canterbury DHB has contracted out all services (hospital and community testing) for the last eight years, and thus no longer operates its own hospital laboratory. In 1997, the DHB reviewed its hospital services and decided to outsource its hospital laboratory. Medlab South won this contract, and has been operating the hospital laboratory at Timaru hospital since 1997. The DHB owns the onsite facility for the laboratory, but all equipment is owned by Medlab South.

472. The Commission considers that the South Canterbury DHB would face similar issues as Otago/Southland DHB in bringing all services back in-house, namely:

- the ability of the DHB to benchmark and appropriately cost services after the length of the contract period;
- access to the capital necessary to set up an integrated laboratory services business;
- the uncertainty of securing technical labour such as pathologists;
- the absence of managerial laboratory services knowledge within the DHB at the end of the contract period; and
- the transfer of volume and cost risk back to the DHB.

473. A small DHB such as South Canterbury is likely to be hindered by each of these issues to a greater extent than the Otago/Southland DHBs. South Canterbury DHB stated that self-provision of all pathology services was "not an option" for them. The DHB is too small to be able to employ the specialist staff and management with laboratory knowledge. It stated that it is a much better option to "latch onto a large organisation such as a private laboratory provider".

474. The DHB stated that it may be possible to access the capital needed to purchase the equipment from the outgoing incumbent operator, but such capital expenditure would be at the expense of other health services in the region, and the DHB would be reluctant to compromise these other services.

475. Ross MacDonald, Manager Support Services, South Canterbury DHB stated that the DHB would have trouble obtaining skilled people to manage the service. The laboratory would need to have a pathologist on-site in South Canterbury, and it would be hard to attract one to the region on a full-time basis. He also stated that in the absence of a competitive process, the DHB would have no idea what a competitive price is. This South Canterbury case illustrates that after even five years of full out-sourcing, the DHB would struggle to bring services back in-house, and is averse to trying to do so.

476. The Commission considers that the prospect of self-provision is unlikely in the South Canterbury DHB region, and therefore would be unlikely to provide a sufficient constraint on Canterbury Newco under the factual.

Countervailing Power

477. Countervailing power ordinarily relies on the prospect of having a choice of providers. The South Canterbury DHB was of the view that even though it had moved to a single provider of all services, it still had bargaining power as the sole purchaser of pathology services in the region. This bargaining power was evidenced in the 2003 tender, when the DHB was able to play one private provider off against the other, in order to obtain what it considered to be the most competitive price. Mr MacDonald stated:

> A joint bid from the providers would have taken the competitive nature out of the process….wouldn't have known if we had got a competitive price or not. The only way I know I've got a competitive price is that I had two bids to play off against each other. Need two providers to bid…the process of combining NZDG and Sonic for most of the South Island takes that opportunity away from me, as these are the only two possible providers.
>
> If I got a joint bid in the next round, I would feel at considerable risk that I was not getting the sharpest price.

478. The Commission considers that the countervailing power of the South Canterbury DHB would be significantly lessened in the factual, due to the DHB's loss of bargaining power.

479. Mr MacDonald did not agree with the Applicant's submission that the DHBs are price setters. He stated that "the market sets the price." In the past, the DHBs have indirectly been price-setters, as the MoH has set national prices for the list of schedule tests against which DHBs purchase community testing. However, in the move to a bulk-funded single-provider model, the South Canterbury DHB is no longer a 'price setter', and instead relies on market forces (eg through competitive bidding) to determine the price. Under this new framework, the South Canterbury DHB had the ability to influence this (competitive) price by playing Sonic and NZDG off against one another in the 2003 tender round. The Commission considers that this would continue under the counterfactual. However, in the factual there would likely not be choice between providers, and the countervailing power of the DHB, and therefore ability to influence prices, is significantly weakened. In this situation the DHB has no alternative supplier to turn to.

480. Due to the reduction in the choice of providers in the South Canterbury region, the Commission considers that the countervailing power of the DHB would be significantly weakened in the factual compared to the counterfactual. As discussed above, the prospect of self-provision is unlikely in the South Canterbury DHB region. This further weakens the countervailing power of the DHB. The Commission concludes that the countervailing power of the DHB is unlikely to provide a sufficient constraint on Canterbury Newco in the factual.

Conclusion on Competition in South Canterbury DHB

481. In the South Canterbury region, the Commission considers that the barriers faced by each of NZDG and Sonic are more easily overcome by those faced by smaller pathology providers such as Abano, Medlab Taranaki, NPL and PAL. The Commission considers that both in the factual and counterfactual, Abano, Medlab Taranaki, NPL and PAL are unlikely to bid for future contracts in the South Canterbury region. The Commission also considers it unlikely that international bidders and DHB-owned laboratories, such as CHL and LabPLUS, would bid for future contracts in the region. Therefore, the Commission considers that in the counterfactual, the likely bidders in the next contract

round in South Canterbury would be Sonic and NZDG. In the factual, the joint venture would likely be the only bidder.

482. Thus, the Commission considers that in the factual there is likely to be only one bidder for the contract to provide pathology services at the end of the five year period, while in the counterfactual, it is likely that there would be two bidders.

483. The Commission considers that due to the reduction in the choice of providers in the South Canterbury region, and given that the prospect of self-provision in unlikely, the countervailing power of the DHBs is significantly weakened in the factual compared to the counterfactual.

484. As the proposal would reduce the number of likely potential bidders in the South Canterbury region from two to one, and as the DHB provider arm is unlikely to provide an effective constraint on the joint venture, the Commission cannot be satisfied that the proposed merger would not have, or would not be likely to have, the effect of substantially lessening competition in the South Canterbury community testing and hospital testing markets.

HAWKE'S BAY – COMMUNITY TESTING

Counterfactual and Factual

Factual

485. Were clearance granted, Sonic and NZDG would form a joint venture in the Hawke's Bay region (HB Newco). HB Newco has been offered a five year contract by the HBDHB for the provision of community testing only in the Hawke's Bay district. [

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486. [

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Counterfactual

487. The HBDHB advised the Commission that if the proposal did not proceed, it does not have a clear idea of what its plans would be. It would have a number of alternatives to explore, including:

- roll over the current contracts for two years, to allow for the hospital laboratory so as to be able to expand to provide community testing;
- collaborating with other DHBs for the provision of services; and
- putting out an RFP for community-referred services.

The DHB is unsure which of these options it would pursue.

488. Given that the DHB has indicated its preference for a single provider of all services, the Commission considers that the appropriate counterfactual scenario is a single provider of community-referred services in the Hawke's Bay. It is uncertain who this provider would be, but it is likely to be either Sonic, NZDG or the hospital laboratories. Under the counterfactual scenario, both NZDG and Sonic would exist to bid for future contracts in the region.

Competition Analysis

Potential Bidders

489. In the HBDHB region, the Commission has identified the following potential future competitors:

- Previous provider to the region: NZDG and Sonic in the counterfactual[59], Hawke's Bay Newco in the factual;
- New domestic bidders: Abano, Medlab Taranaki, NPL, and PAL;
- International bidders: Mayne, SJGP and Healthscope;
- DHB-owned laboratories outside the region: CHL and LabPLUS; and
- The local DHB-owned hospital laboratory.

490. The Commission considers that the barriers faced by new domestic bidders, new international bidders, DHB-owned laboratories and Sonic and NZDG, in Hawke's Bay would be similar to those faced by these bidders in Otago/Southland and South Canterbury.

491. Accordingly, the Commission considers it unlikely that new bidders, international bidders or DHB-owned laboratories outside the region would provide a constraint in the Hawke's Bay DHB region in the factual or the counterfactual.

492. In the counterfactual, the Commission considers it likely that both NZDG and Sonic would bid for the contract to provide community testing in Hawke's Bay at the end of the five year period. This competitive tension would be lost in the factual.

Self-provision

493. In the Hawke's Bay, the proposed contract is for the provision of community testing only (unlike Otago/Southland and South Canterbury), and the hospital laboratory in the region would continue to be owned and operated by the DHB and would continue to undertake all hospital testing. The possibility exists for Hawke's Bay Hospital laboratory to expand into community testing by bidding for the contract at the end of the five year period. The Commission assessed the likely extent of any constraint provided by such entry.

494. The HBDHB stated that if it was not happy with the private pathology joint venture at some point in the future, Hawke's Bay hospital laboratory would still exist as a viable competitor at the end of the five year contract period. However, the DHB also advised the Commission that there would be a number of difficulties and risks to overcome, if this option were to be pursued.

495. In the Hawke's Bay region, the Commission has identified the following as the major potential issues with self-provision of community testing:

- access to the capital necessary to set up an integrated laboratory services business;
- the uncertainty of securing critical technical labour such as pathologists; and
- the transfer of volume and cost risk back to the DHB.

496. Various DHBs and industry participants around the country considered that there would be major risks in a DHB undertaking community testing at the end of a single-provider contract period, even in the situation where a hospital laboratory is retained by the DHB

[59] In the counterfactual, both now and in five years time, NZDG and Sonic would be "previous providers". NZDG currently provides [ ]% of community testing , while Sonic currently provides [ ]% of community testing.

for the duration of the contract. A review of laboratory services in the Auckland region identified the following as risks associated with the DHB laboratory taking over community testing[60]: no existing DHB infrastructure for community collections, transport or testing; likely opposition from staff, management, and unions; considerable risk of service disruption; and significant transitional cost and risk.

497. The HBDHB submitted to the Commission that if the HB Newco were unwilling to accept the new contract in five years under the price structure that the DHB would be satisfied with, the DHB would attempt to negotiate with HB Newco. The HBDHB considered that it would know whether or not it is getting a good price, [ ]. If it could not successfully negotiate an appropriate price, it would look at the option of self-provision.

498. Kevin Atkinson, Chair of the HBDHB, stated that [ ].

499. [ ].

500. [ ].

501. The DHB considered that the human resource assets (pathologists and other specialist staff) are the most important inputs for the provision of pathology services. It stated that each of NZDG and Sonic in the region had pathologist strengths in different areas of pathology, and that it was necessary for the two firms to come together in order to retain these strengths.

502. When considering the possibility of the HBDHB providing all services, the DHB identified the risk of the inability to retain or hire the required pathologists – particularly if those pathologists in the region that currently work in community laboratories are unwilling to work for the hospital provider, and others cannot be brought into the region. The HBDHB stated that this would impact on the ability to retain IANZ accreditation of the laboratory.

503. The HBDHB advised the Commission that it could not guarantee being able to recruit all the pathologists from HB Newco if it decided to self-provide all services. It currently receives pathologist support from the private providers in the region in order for the laboratory to retain its IANZ accreditation. Medlab South (Sonic) currently provides haematology support and SCL (NZDG) provides anatomical and cytology support to the HBDHB.

504. The DHB stated that if it were to self-provide it would firstly attempt to recruit pathologists from the outgoing incumbent. [

[60] Laboratory Services in the Auckland region – A Review of Future Options for Supply-Side Configuration, Final Report to the DHB Chief Executives December 2004

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[ ].

505. The HBDHB advised that if it could not recruit all pathologists from HB Newco, it would try to recruit pathologists from other regions. It stated that it does not know how long this would take. The DHB stated that it might have to rely on partnering with other DHBs, in order to retain appropriate pathologist expertise, but is unsure which DHB this support would come from, in five years' time.

506. [

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507. The Commission considers that access to technical labour and capital are likely to represent significant barriers to the HBDHB, should it explore the option of self-provision of community testing in five years' time. The DHB seemed confident that it would not have to pursue this option.

508. The Commission considers that the possibility of self-provision from the Hawke's Bay DHB would not provide a level of constraint under the factual or the counterfactual.

Countervailing Power

509. The HBDHB believed that in the factual, it would maintain its bargaining position because it intended to retain its hospital laboratory. However, as demonstrated above, self-provision is likely to be a difficult and risky prospect for the HBDHB, and would be therefore unlikely to represent a credible threat against HB Newco. The DHB believes it has negotiated a favourable arrangement with the private providers, which will ensure the DHB is offered the best price possible by the providers.

510. [

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511. The Commission considers that while the HBDHB may have more countervailing power than a DHB that contracted out all services and no longer operates pathology services in the region, it appears unwilling to exercise this countervailing power. The DHB was open to an approach from the two private providers to jointly provide pathology services for an agreed price. In fact, it actively encouraged the private providers to amalgamate. It could have undertaken a competitive process but chose not to. [

]. Minutes of a June Board Meeting discuss the laboratory services negotiations and state that:

[

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512. Although the prospect of self-provision is a possibility, especially given that the hospital laboratory is to be retained by the DHB, the Commission considers that this option is likely to pose significant costs and risks on the HBDHB, and is therefore unlikely to be pursued except as a last resort (at which point a substantial lessening of competition may have already occurred). The DHB seemed confident that it could negotiate a satisfactory arrangement with HB Newco in the future, and would have no need to expand its laboratory to undertake community testing.

513. The DHB stated that if the contract resulted in higher prices or unsatisfactory quality of service, the DHB would simply require NZDG and Sonic to tender separately for the provision of services. However, the DHB seemed unaware that there were likely to be restraint of trade provisions that would restrict each of Sonic and NZDG from competing with HB Newco in areas where Newco would operate. Even in the event that no restraint of trade conditions were applied, the Commission considers that the likelihood of real competition between the two providers is unlikely after they have been in a joint venture for a period of five years. Sonic and NZDG would have full information about each other's business and the cost structure of the business.

514. The Commission considers that the countervailing power of the HBDHB would be significantly lessened in the factual, due to the DHB's loss of bargaining power. In the counterfactual, the DHB could play one private provider off against the other, in order to obtain the best price. The DHB did not undertake a competitive process, and although the price for services it would receive from HB Newco was an improvement on what it had been paying, the DHB has no way of knowing whether it has attained a competitive price for the provision of services.

515. Consequently, the Commission considers that the countervailing power of the HBDHB would be substantially lessened in the factual, when compared with the counterfactual, and would be unlikely to provide a constraint in the factual or the counterfactual.

Conclusion on Competition in the Hawke's Bay region

516. In the HBDHB region, the Commission considers that the barriers faced by each of NZDG and Sonic are more easily overcome than those faced by smaller pathology providers such as Abano, Medlab Taranaki, NPL and PAL. The Commission considers that both in the factual and counterfactual, Abano, Medlab Taranaki, NPL and PAL are unlikely to bid for future contracts in the Hawke's Bay region. The Commission also considers it unlikely that international bidders and DHB-owned laboratories, such as CHL and LabPLUS, would bid for future contracts in the region under both the factual and the counterfactual. Therefore, the Commission considers that in the counterfactual, the likely bidders in the next contract round in the Hawke's Bay would be Sonic and NZDG. In the factual, the joint venture would likely be the only bidder.

517. Thus, the Commission considers that in the factual there is likely to be only one bidder for the contract to provide pathology services at the end of the five year period, while in the counterfactual, it is likely that there would be two bidders.

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[61] Draft Minutes of the Meeting of the Hawke's Bay District Health Board Held in the DHB Board Room, Wednesday 8 June 2005 at 10.30am, p 87.

518. The Commission considers that there would be significant barriers faced by the DHB if it were to consider expanding to provide community testing, and the DHB has expressed reluctance to exercise this option. Consequently, the Commission considers the threat of self-provision would not provide a level of constraint on the combined entity in the factual.

519. The Commission considers that due to the reduction in the choice of providers in the Hawke's Bay region, and given that the prospect of self-provision in unlikely, the countervailing power of the DHBs is significantly weakened in the factual compared to the counterfactual.

520. Accordingly, as the proposal would reduce the number of likely potential bidders in the Hawke's Bay region from two to one in the factual compared to the counterfactual, and as the DHB provider arm would be unlikely to provide constraint on the joint venture, the Commission cannot be satisfied that the proposed merger would not have, or would not be likely to have, the effect of substantially lessening competition in the market for the provision of community testing in the Hawke's Bay region.

CANTERBURY – COMMUNITY TESTING

Counterfactual and Factual

Factual

521. In the factual scenario, Canterbury Newco would acquire Sonic and NZDG's current businesses in the Canterbury region. It would then be likely to bid for any future pathology contracts offered by the Canterbury DHB for community testing.

522. The DHB has indicated that it is currently undertaking a review of its pathology services, but has given no indication at this stage, as to which funding model it is likely to adopt in the Canterbury region.

Counterfactual

523. The Canterbury DHB advised the Commission that it is unlikely to outsource all pathology services (hospital and community). However, the DHB may look for a single provider of community testing.

524. In the counterfactual scenario, NZDG and Sonic would exist to bid for future contracts for community testing in the Canterbury DHB region.

Competition Analysis

Potential Bidders

525. The Commission is uncertain whether the DHB would tender out all pathology services, community testing only, or whether it may maintain the status quo in the future. Regardless of the model the DHB adopts for future provision, the Commission has identified likely bidders for future pathology services contracts in the Canterbury DHB region. In the absence of information regarding the nature of any future contracts, the Commission has identified likely bidders for community testing only (however, as indicated in the Otago/Southland and South Canterbury sections above, if community and hospital testing were rolled into one contract, the analysis should essentially be the same).

526. In the Canterbury DHB region, the Commission identified the following potential future competitors:

- Previous providers to the region: NZDG and Sonic in the counterfactual[62]; Canterbury Newco in the factual;
- New domestic bidders: Abano, Medlab Taranaki, NPL, and PAL;
- International bidders: Mayne, SJGP and Healthscope;
- DHB-owned laboratory outside the region: LabPLUS; and
- The local DHB-owned hospital laboratory: CHL.

527. The Commission considers that the barriers faced by new domestic bidders, new international bidders, LabPLUS, and Sonic and NZDG, in Canterbury would be similar to those faced by these bidders in Otago/Southland and the other regions discussed above.

528. Accordingly, the Commission considers it is unlikely that new bidders, international bidders or LabPLUS would provide a constraint in the factual or the counterfactual in the Canterbury DHB region.

529. Whichever contracting model the DHB chooses to pursue, the Commission considers that the likely bidders for future contracts in the counterfactual would be Sonic and NZDG (the two current community providers in the region), as well as (potentially) CHL, the DHB-owned hospital laboratory in Canterbury. In the factual, likely bidders would be Canterbury Newco and CHL.

CHL

530. The Applicants submitted that CHL could be expected to compete vigorously for community work if an RFP were issued in the Canterbury region. It stated that CHL presently does some community testing, and has indicated the intention to gain market share from the community laboratories. However, CHL advised the Commission that it does not currently seek community work, and the small percentage of community testing it undertakes comes from the occasional 'walk-in' patient.

531. CHL informed the Commission that if the community work were tendered in the Canterbury region, [ ]. However, it also identified a number of issues that would either deter it from submitting a bid, or would present a barrier to its expansion if it were to submit a bid (which might affect the level at which it would bid). These are:

- community testing is not CHL's core business;
- capital constraints of a publicly-owned laboratory (and the expansion necessary to undertake community testing such as setting up a courier network service etc);
- potential issues employing specialist staff, particularly in the areas of anatomical pathology and histopathology; and
- [ ].

Each of these issues is discussed below.

[62] In the counterfactual, both now and in the future, NZDG and Sonic would be "previous providers". NZDG currently provides [ ]% of community testing, while Sonic currently provides approximately [ ]% of community testing in the Canterbury region.

Core Business

532. The Commission notes that no DHB-owned laboratories provide all community testing for a DHB region, and so this possibility is untested. In the counterfactual, the Commission considers that CHL may not be as vigorous a competitor as NZDG and Sonic in an RFP process for community testing in Canterbury, as it is not focused on the provision of community testing.

533. Its primary responsibilities are the provision of hospital testing and the provision of send-away testing. CHL provides all hospital testing for the Canterbury DHB, and clinical support to various other DHB laboratories around the country. CHL also receives referrals for specialist tests from pathology providers all around the country. Approximately [ ]% of CHL's non-schedule tests come from outside the Canterbury DHB region. CHL is also a key teaching and research institution for pathology in New Zealand.

534. Jock Muir, General Manager – Hospital & Specialist Services, Canterbury DHB, stated that bidding for community testing, even in its own DHB, would represent a diversion from CHL's core business.

Access to Capital

535. Peter George, Clinical Director, CHL, stated that potential expansion into community testing would require the setting up of courier systems, collection points, the purchasing of additional equipment, and the hiring of staff. [

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Technical Labour

538. Although CHL's core business is specialist testing, it stated that it has analysers with excess capacity in some areas, and it would make sense for these analysers to be utilised. In the haematology and biochemistry area, CHL's equipment has spare capacity in the afternoon and at night.

539. However, Peter George advised the Commission that if it were to expand into community testing, it would need to employ more pathologists in the areas of microbiology and anatomical pathology, as these branches are highly labour intensive. CHL considered that it would face significant difficulties recruiting pathologists and specialists in these areas of pathology.

540. As discussed above, there is a nationwide and global shortage of pathologists. The Commission considers that due to their scale and size, NZDG and Sonic would be less likely to face barriers to recruiting extra pathologists, and may be able to transfer pathologists from their other areas of operations. On the other hand, DHB-owned laboratories such as CHL may experience significant issues recruiting pathologists. Some industry participants told the Commission that some staff may be reluctant to work for a public rather than a private provider. [ ] DHB, stated:

> It takes an average of about 5 years to recruit a pathologist, 12 years to train one…there are philosophical and cultural differences between specialists in the public and private sector. They can always get paid more in the private sector, but public sector specialists choose to work there because they enjoy the teaching and research, and the variety.

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NZDG and Sonic

545. In a summary of a paper to Colin Goldschmidt, Managing Director, Sonic Healthcare, from Brian Willcox, CEO of Medlab South, Mr Willcox stated:

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546. The Commission considers that there is likely to be a substantial difference in the competitive dynamics of the bidding process in the factual compared to the counterfactual in Canterbury. In the factual, the likely bidders for future contracts would be the merged entity and CHL, while in the counterfactual the likely bidders would be Sonic, NZDG and CHL. The Commission considers that while CHL would probably submit a bid for community testing in the region, it is likely to be a "bidder of last resort" or a back-stop option, compared to either of the private providers, Sonic and NZDG.

547. Therefore, the Commission considers that the reduction of likely bidders in the factual, and the nature of those bidders, would be likely to give rise to a substantial lessening of competition when compared with a counterfactual scenario of two vigorous competitors, NZDG and Sonic.

Countervailing power

548. The Commission notes that it is difficult to assess the countervailing power of the Canterbury DHB in the future, as it has not indicated its future plans for the provision of pathology services. The particular funding model adopted by each DHB can affect the degree of the countervailing power it possesses. For instance, a DHB outsourcing all

pathology services to Newco in any of the relevant regions, may have a lesser degree of countervailing power than a DHB that decides to retain some pathology services in-house.

549. Regardless of which model the Canterbury DHB decides to adopt, the Commission considers that the countervailing power of the Canterbury DHB would be significantly lessened in the factual, due to the DHB's loss of bargaining power, as it would only have one choice of private provider. In the counterfactual, it would maintain the choice of two private providers, NZDG and Sonic, and would be able to play these providers off against each other.

550. The Commission concludes that there is likely to be a substantial difference between the countervailing power of the DHB in the counterfactual, where it would maintain the choice of two private providers, and the factual, where it could only rely on its provider arm hospital laboratory to provide constraint on Canterbury Newco.

Conclusion on Competition in the Canterbury DHB region

551. The Commission considers that in the Canterbury DHB region, there is likely to be a substantial difference in the competitive dynamics of the bidding process in the factual compared to the counterfactual. In the factual, the likely bidders for future contracts would be the merged entity and CHL, while in the counterfactual the likely bidders would be Sonic, NZDG and CHL. The Commission considers that while CHL would probably submit a bid for community work in the region, it is likely to be a "bidder of last resort" and would be unlikely to provide as substantial a constraint as vigorous competitors (Sonic and NZDG) bidding against each other for the market. The Commission considers that the proposed joint venture has the effect of eliminating the strongest source of competitive tension (between Sonic and NZDG) that would otherwise exist in the counterfactual.

552. The Commission considers that the countervailing power of the DHB would be lessened in the factual, compared to the counterfactual, due to the reduction in the number of likely bidders. The Commission considers that the countervailing power of the DHB would be unlikely to provide constraint on the combined entity in the factual.

553. In conclusion, the Commission cannot be satisfied that the proposed merger would not have, or would not be likely to have, the effect of substantially lessening competition in the market for the provision of community testing in the Canterbury region.

WEST COAST – COMMUNITY TESTING

Counterfactual and Factual

Factual

554. In the factual scenario, Canterbury Newco would take over Sonic and NZDG's current provision of pathology services in the West Coast, and would be likely to bid for any future single provider contract for community testing, should pathology services be re-tendered.

555. The Commission notes that the future provision of services is uncertain in the West Coast, as the DHB has not yet decided on a model for the future provision of community and hospital testing.

Counterfactual

556. As stated above, the funding and contracting arrangements for the future provision of services is uncertain on the West Coast. However, in the counterfactual scenario, both

NZDG and Sonic would exist separately to be able to bid for any future contracts for community testing in that region.

Competition Analysis

Potential Bidders

557. The West Coast DHB recently released a discussion document on the various provision options, inviting comment from various stakeholders. [

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558. Therefore, the Commission is uncertain whether the DHB would tender out all pathology services, or community testing only, or whether it might maintain the status quo, in the future. Regardless of the model the DHB adopts for future provision, the Commission has identified likely bidders for future pathology services contracts in the West Coast DHB region. In the absence of information regarding the nature of any future contracts, the Commission has identified likely bidders for community testing only (however, as indicated in the Otago/Southland and South Canterbury sections above, if community and hospital testing were rolled into one contract, the analysis would essentially be the same).

559. In the West Coast DHB region, the Commission has identified the following potential future competitors:

- previous providers to the region: in the counterfactual, NZDG and Sonic[63]; in the factual, Canterbury Newco.
- new domestic bidders: Abano, Medlab Taranaki, NPL, and PAL;
- international bidders: Mayne, SJGP and Healthscope;
- DHB-owned laboratories outside the region: CHL, LabPlus; and
- the local DHB-owned hospital laboratory: Grey Hospital Laboratory.

560. The Commission considers that the barriers faced by new domestic bidders, new international bidders, DHB-owned laboratories and Sonic and NZDG, in the West Coast would be similar to those faced by these bidders in the other regions discussed above.

561. Accordingly, the Commission considers it unlikely that new bidders, international bidders or DHB-owned laboratories outside the region would provide a constraint under the factual or counterfactual scenarios in the West Coast DHB region.

562. The Commission considers that NZDG and Sonic would likely bid for contracts in the West Coast region in the counterfactual, whereas in the factual this competitive tension would be lost by way of the proposed joint venture. [

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563. The Grey Hospital Laboratory provides all hospital testing for Grey Base Hospital. It also provides approximately [ ]% of the community testing for the region.

564. The Grey Hospital Laboratory does not currently employ any pathologists. It receives pathologist support from CHL so it can retain its IANZ accreditation. It also subcontracts the majority of all specialist testing to CHL. Given that the Grey hospital

[63] In the counterfactual, both now and in the future, NZDG and Sonic would be "previous providers". NZDG currently provides a very limited amount of community testing, while Sonic currently provides approximately [ ]% of community testing in the West Coast region. Grey Hospital provides the remaining [ ]% of testing.

does not employ any pathologists, the Commission has concerns over the ability of the hospital laboratory to consistently deliver the required level of service for both hospital and community testing.

565. The DHB stated that if an RFP were issued for the provision of pathology services in the West Coast region, [

]. It informed the Commission that it was looking to reduce the cost of laboratory services, and if a private provider could offer the best deal, the DHB would be open to contracting with that provider.

566. There are currently three providers of community testing in the West Coast region. Although some community testing is undertaken by Grey Hospital Laboratory, the DHB stated that some GPs prefer to deal with one of the private providers (NZDG or Sonic). In addition, due to the small population of the region, some patients' tests are sent to NZDG or Sonic for privacy reasons (patients may not want their tests performed by somebody who may know them at the hospital laboratory).

567. The factual scenario would result in a loss of competition as there would likely be only one private provider bidding (Canterbury Newco), as opposed to two in the counterfactual. The Commission considers that Grey Hospital Laboratory - a small publicly-owned hospital laboratory with no pathologists, and reliant on the DHB for any expansion - is unlikely to provide a level of constraint on Canterbury Newco in the factual.

568. Kevin Hage stated:

> We would have a concern if we only got one bid from an RFP, it would suggest that we would not be in a position to test that bid against someone else. It would be in the DHBs interest to have the maximum number of bidders for the contract…. have to balance how big the risk is of becoming a price-taker at the end of the contract period, versus the gains one expects to achieve during the term of the period.

569. The Commission considers that although Grey Hospital has stated an intention to bid for community testing if it were put up for tender, it is likely to be a "bidder of last resort" or a back-stop option, rather than a vigorous competitor such as either of the private providers, Sonic and NZDG.

Countervailing Power

570. The Commission notes that it is difficult to assess the countervailing power of the West Coast DHB in the future, as it has not indicated its future plans for the provision of pathology services. The particular funding model adopted by each DHB can affect the degree of any countervailing power it possesses. For instance, a DHB outsourcing all pathology services to Newco in any of the relevant regions may have a lesser degree of countervailing power than a DHB that decides to retain some pathology services in-house.

571. However, regardless of which model the DHB decides to adopt, the Commission considers that the countervailing power of the West Coast DHB would be significantly lessened in the factual, due to the DHB's loss of bargaining power (as mentioned above), as it would only have one choice of private provider to contract with, whereas in the counterfactual, it would maintain the choice of two private providers, NZDG and Sonic, and would be able to play these providers off against each other.

572. Kevin Hage of the West Coast DHB stated:

> I can see the concern with the two players coming together - the number of players is already small…if you had a monopolistic provider in the future, you would need to identify the barriers to entry that exist for new providers.

573. The Commission concludes that there is likely to be a substantial difference between the countervailing power of the DHB in the counterfactual, where it maintains the choice of two private providers, and the factual, where it can only rely on its provider arm hospital laboratory to provide constraint on Canterbury Newco.

Conclusion on Competition in the West Coast DHB region

574. The Commission considers that in the West Coast DHB region, there is likely to be a substantial difference in the competitive dynamics of the bidding process in the factual compared to the counterfactual. In the factual, the likely bidders for future contracts are the merged entity and the Grey Hospital laboratory, while in the counterfactual the likely bidders would be Sonic, NZDG and the Grey Hospital Laboratory. The Commission considers that while the Grey Hospital Laboratory would probably submit a bid for community work in the region, it is likely to be a "bidder of last resort" rather than a vigorous competitor such as either of the private providers, Sonic and NZDG, who would be seeking to increase market share, or in a bidding market, win that market. The Commission considers that the proposed joint venture has the effect of eliminating the strongest source of competitive tension (between Sonic and NZDG) that would otherwise exist in the counterfactual.

575. The Commission also considers that the countervailing power of the DHB is likely to be lessened in the factual, compared to the counterfactual, due to the reduction in the number of likely bidders.

576. The Commission cannot be satisfied that the proposed merger would not have, or would not be likely to have, the effect of substantially lessening competition in the market for the provision of community testing in the West Coast region.

CO-ORDINATED EFFECTS

577. The preceding competition analysis disposes of the relevant issues in assessing whether the Commission can be satisfied that the proposed joint venture arrangements would not result, or would not be likely to result, in a substantial lessening of competition in each of the proposed joint venture regions.

578. The Commission also identified the potential for NZDG and Sonic to engage in co-ordinated behaviour in regions outside the scope of the Application, by virtue of the relationships arising from the proposed joint ventures. Accordingly, the Commission has considered the scope for exercise of co-ordinated market power in regions outside the Application ('other regional markets') for the provision of community testing.

579. An acquisition may lead to a change in market circumstances such that co-ordination between the remaining businesses is made more likely, or the effectiveness of pre-acquisition co-ordination is enhanced.[64]

580. The issue is whether the Application, if approved, would materially increase the prospects of co-ordination between the Applicants in other regional markets, and whether that co-ordination is such that the Commission can be satisfied that the mergers would not have, or would not be likely to have, the effect of substantially lessening competition in those other markets.

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[64] Commerce Commission, *Mergers and Acquisitions Guidelines*, p33.

581. Rather than separately analysing each regional market outside the scope of the Application, the Commission has analysed other regional markets generally, on the grounds that the potential for co-ordination is sufficiently similar in all those other regional markets.

582. It may be the case that co-ordination is more likely in some regions than others. The Commission is particularly concerned with the potential for co-ordination in the regions in which either Sonic or NZDG is the main provider. However, even in those regions where there is an additional incumbent provider (eg PAL or Abano), or regions in which Sonic and NZDG do not currently operate (eg Northland), the Commission considers there may be muted competition between Sonic and NZDG in future bidding rounds. Thus, the Commission considers that the increased potential for co-ordination may have the effect of dampening competition in all other regional markets.

583. The main providers for community testing in each regional market are set out below (and in Appendices D and E):

Table 2: Community testing by DHB region

DHB region	**Current community testing provider(s)**
Northland	NPL
Waitemata	Sonic
Auckland	Sonic
Counties Manukau	Sonic
Waikato	PAL, NZDG
Bay of Plenty	PAL
Tairawhiti	NZDG
Lakes	Sonic, PAL
Taranaki	Medlab Taranaki
Hawke's Bay	Sonic, NZDG
Whanganui	Sonic
Mid Central	Sonic
Wairarapa	Sonic
Hutt Valley	Sonic
Capital & Coast	Abano
Nelson Marlborough	Abano, Sonic
West Coast	Sonic, NZDG, Grey Hospital
Canterbury	Sonic, NZDG
South Canterbury	Sonic
Otago	Sonic, NZDG
Southland	Sonic, NZDG

584. The Applicants submitted that the proposals do not involve the merger of NZDG's and Sonic's respective businesses on a national basis. They argued that neither the joint venture proposals, nor the commercial relationships between NZDG and Sonic arising from the proposals, extend beyond the regions specific to those proposals, and therefore that the Commission should analyse each proposed joint venture individually.

585. The Applicants submitted that the proposals would not lessen the likelihood that NZDG and Sonic would continue to compete head-to-head in other regions outside those specific to the proposed joint ventures. Sonic contended that it has independent businesses in other regions where it has no commercial incentive to engage with NZDG, and where there is no rationale for joint ventures. As an example of independent behaviour, [

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Factual

586. The Application seeks clearance for establishing three joint ventures, O&S Newco, HB Newco and Canterbury Newco, which would operate in six DHB districts (Hawke's Bay, Canterbury, South Canterbury, the West Coast, Otago and Southland).

587. Under the factual scenario, NZDG and Sonic would enter into joint ventures in every region in which they both currently operate and actually compete, but would remain as separate legal entities in all other DHB regions of New Zealand where one or the other party is operating but the other is not.

Counterfactual

588. Under the counterfactual scenario, NZDG and Sonic would remain separate entities in all 21 DHB regions.

589. In the majority of the other DHB regions, one or the other of NZDG and Sonic would be the incumbent provider if/when pathology services are tendered and the other would be the principle competitor.

Likely relationship between the parties in the Factual

590. Although the Applicants submitted that there are three separate joint venture proposals and that they should be analysed separately by the Commission, the Commission considers that the commercial arrangements entered into by the Applicants in the factual would likely establish a strong commercial relationship such that they may no longer have the incentive to compete when contracts come up for tender or on a fee-per-test basis in regions where only one party to the joint venture arrangement operates.

591. Table 3 below compares the current market shares of the parties in the joint venture regional markets prior to a change to single provider contracts. The table shows the link between current market shares and how those shares appear to determine the allocation of equity interest in the joint ventures.

Table 3: Sonic and NZDG Joint venture arrangements

	Community Testing Current Market Shares[65]		Equity Interest in the joint ventures	
	NZDG	Sonic	NZDG	Sonic
Otago/ Southland	[ ]% ($[ ] million p.a.)	[ ]% ($[ ] million p.a.)	[ ]%	[ ]%
Hawke's Bay	[ ]-[ ]% ($[ ] million p.a.)	[ ]-[ ]% ($[ ] million p.a.)	[ ]%	[ ]%
Canterbury	[ ]% ($[ ] million p.a.)	[ ]% ($[ ] million p.a.)	[ ]%	[ ]%
South Canterbury		[ ]% (Contract for community and hospital testing [ ])		
West Coast	[ ]% ($[ ] p.a.)	[ ]%[66] ($[ ] million p.a.)		

592. Further details and observations about these joint ventures are set out below:

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- In Hawke's Bay, [

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[65] The markets shares stated here are based on figures submitted by the Applicants. The Application submitted market shares based on a market for pathology testing (hospital and community combined), rather than just community testing, but noted that the Applicants understand that the split in funding between hospital and community testing is approximately 50:50. The Commission calculated market shares for community testing on this basis. They are approximate figures.

[66] Grey Hospital undertakes the remaining [ ]% of community testing.

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- The proposed joint ventures involve every DHB region in which NZDG and Sonic both currently compete with one another for volume on a fee-per-test basis. This suggests that the joint ventures are structured in an inter-related way that encompasses several markets.

593. The Commission considers the joint venture arrangements will inevitably establish strong relationships between NZDG and Sonic in the Otago/Southland, Hawke's Bay, Canterbury, South Canterbury and West Coast DHB regions. Establishing the relationship changes the market circumstances in other regions such that co-ordination, between the parties, whether tacit or explicit, is made more likely, or the effectiveness of pre-merger co-ordination is enhanced.

Market characteristics in the counterfactual

594. The competitive dynamics in the other regional markets in the factual would likely differ significantly to that likely in the counterfactual. In the counterfactual, NZDG and Sonic, apart from competing head-to-head for contracts in each of the six proposed joint venture regions in which they currently operate, would also have the incentive to compete and/or bid for contracts in other regions in which one or other is not the incumbent. Both NZDG and Sonic would have an incentive to vigorously compete to make-up for any contracts lost in regions where they previously had operations.

595. When assessing the scope for co-ordination the Commission evaluates the likely post-acquisition structural and behavioural characteristics of the relevant market or markets to test whether the potential for co-ordination would be materially enhanced by the acquisition. The intention is to assess the likelihood that certain types of behaviour will occur, and whether these would be likely to lead to a substantial lessening of competition. In broad terms, effective co-ordination can be thought of as requiring three ingredients: collusion, detection and retaliation.[67]

Collusion

596. There are several features of market structure and behaviour that the Commission considers in assessing the likelihood of collusive behaviour, such as: high seller concentration; undifferentiated products; static production technology; slow speed of new entry; characteristics of buyers; and a lack of fringe competitors. Some of these factors may not be strictly relevant in the context of the markets analysed here (ie markets that include a bidding process).

- High seller concentration – NZDG and Sonic are the primary providers of pathology services in New Zealand, and therefore are easily visible to one another. All other providers are small providers, half of whom presently operate in only one region (see Appendices D and E). Typically, the fewer the firms whose actions need to be co-ordinated, the easier it is to communicate and monitor each other's activities. This is particularly so when the primary providers will also be in close commercial relationships with significant joint ventures providing the same services.
- Undifferentiated products – although there are many different pathology tests and some of these tests are complex, the majority of pathology tests performed are the 180 standard tests set out in the national schedule, so there is limited scope for product differentiation to occur. The less differentiated are products, the easier it is to reach

[67] Commerce Commission, *Mergers and Acquisitions Guidelines*, p33

agreement on price and to avoid the problems associated with variations in quality, etc. Again due to the Applicants operating joint ventures providing these services, each will know the pricing approach of the other in the joint venture regions, which should facilitate the sharing of pricing information.

- Static production technology – pathology services are characterised by frequent technological change, which makes co-ordination more difficult as dynamic technology may augment the differences between the co-ordinating firms over time. However, with the establishment of joint ventures as presently proposed there is a likelihood that production developments will be shared more readily than if the parties were operating independently in competition with each other. Although technological developments could be frequent, the ability to share such developments diminishes the impact.
- Slow speed of new entry – under the new contracting regime presently being implemented by some DHBs, and which the Commission understands is likely to be adopted in many regions in the future,[68] entry can only occur at infrequent discrete points in time (contracting rounds), separated by long contract periods (three to ten years). Generally, the longer the time needed for entry to take place, the longer the co-ordinating businesses can enjoy higher profits before those profits are threatened by potential entry.
- Lack of fringe competitors – there are a number of fringe competitors (Abano, Medlab Taranaki, NPL, PAL). However, as discussed earlier, the Commission concluded that these competitors would be unlikely to exert much competitive constraint outside their own regions of incumbency.
- Characteristics of buyers – DHBs are the sole purchasers of pathology services. However, DHBs would likely have inadequate information regarding the costs of the private providers, as past prices paid for pathology services would have been larger than providers' costs. The Commission is not satisfied that the countervailing power of the DHBs would provide a sufficient constraint.

597. The above analysis suggests that the regional markets for community testing have the market characteristics required for successful co-ordination.

Detection

598. To successfully collude, parties to the arrangement must be able to detect defection and respond swiftly. The Commission considers that the ability of competitors to detect deviation is likely to be enhanced where the following market conditions, amongst others, apply: high seller concentration; frequent sales; cost similarities between businesses; multi-market contact; and price transparency. These are considered below:

- High seller concentration – as before. The fewer the number of firms that need to be monitored, the more easily detection can occur.
- Frequency and size of sales – trade in the majority of regional markets is likely to occur infrequently, should all DHBs move to the single provider model as seems likely. The single provider model involves contracts of substantial worth. Large, one-off contracts may provide greater incentive to cheat. However, the less frequent the trade, and the more substantial the sums involved, the greater the incentive (and the easier it is) for co-ordinating parties to monitor one another. Detection of deviations from tacit or explicit agreements is therefore more straightforward here. This is even

[68] Of the 21 DHB regions, the Commission is aware of 19 DHB regions that either currently have a single provider of community testing, or have indicated intentions to move towards a single provider funding model (ie have issued or are contemplating issuing an RFP for a single provider).

more so where the competing parties operate in significant joint ventures providing the same services.

- Multi-market contact – NZDG and Sonic would be in constant contact through the joint ventures. They would confront each other in the tendering of contracts in a number of regional markets, and could readily find ways of co-existing and of avoiding vigorous competition.
- Price transparency – it may be difficult for co-ordinating parties to discern relative prices in sealed-bid tenders, such as those typically run by the DHBs. However, detection is straightforward since industry participants can readily observe the winner of such tenders. This is discussed in further detail below.

599. In any potential co-ordination, defection would most likely involve NZDG bidding for a contract in a region where Sonic was the incumbent, or vice versa, rather than any tacit or explicit agreement to stay out of a region. The agreed 'loser' winning the contract signals that defection has occurred; therefore detection could occur readily. Alternatively, it might be that both would bid in order to preserve the appearance of competition, but on the understanding that the nominated party would tender the lower bid and win the contract. Given the incumbent advantage identified above, it would seem that this would be relatively easy to organise, allowing the existing incumbent to win the contract. Here too, detection would be straightforward.

600. Although DHBs may attempt to run closed tender processes, the RFP process typically undertaken may expose the identity (and potentially the bid price) of the other bidders. [

] Thus, even if one did not win the contract, the other would be likely to find out who it was bidding against. A further factor is that NZDG and Sonic are the main operators, such that it is reasonable to assume that both would be involved. Given the joint venture businesses, each would have good knowledge of the other's operations.

601. Therefore, the Commission considers that detection of deviation from a tacit or explicit market sharing arrangement would likely be relatively easy.

Retaliation

602. Deviations from the terms of co-ordination need not only to be quickly detected by the other suppliers, but also the deviating firm needs to be faced with a credible threat of being punished by the other firm. The threat of retaliation increases the cost of deviating, thereby reducing the short-term profit to be gained by the business from deviating, and helping to preserve the co-ordination.

603. If Sonic or NZDG were to "cheat" on an understanding by bidding for a pathology contract in a region where it does not currently operate, or at a price that allows it to win the contract, retaliation by the other party would be straightforward. For instance, if Sonic bid against NZDG in a region where NZDG was the incumbent, NZDG could easily retaliate by bidding against Sonic in a region in which Sonic was the incumbent.

604. The retaliator need not win the contract in the other provider's region in order to punish the defector. Simply by submitting a credible bid, the retaliator forces the defector to bid more competitively, and therefore less profitably than it otherwise would, had it been the only credible bidder. Thus, by "cheating", both parties risk facing potentially vigorous competition in regions of incumbency, and may even risk losing their business in those regions altogether.

605. Co-ordination may be made easier by the fact that regional contracts will tend to expire at different points in time. This allows each provider to assess whether or not defection

has occurred, and if so, prepare to retaliate in another regional market. This is especially so with the three and five year joint ventures. Each party has the ability to punish the other at the expiry of the contracts. Importantly for the Commission, the correspondence the Commission has seen makes it clear that the parties are already thinking along these lines.

Evidence

606. The Commission concludes that under the factual, the characteristics and structure of the markets are likely to increase the likelihood of co-ordinated behaviour. In addition to the market analysis discussed above, the Commission takes into account evidence of how parties are acting or intend to act. The Commission has evidence that suggests that the parties, anticipating Commission approval, are already co-ordinating their behaviour. As discussed above, the way in which the joint venture arrangements have been organised by the parties has allowed them to co-ordinate across regional markets. In addition, the Commission has some evidence that suggests that the proposed joint ventures would be likely to result in increased co-ordination. This evidence is now summarised.

607. Co-ordination could take a number of forms. The parties could attempt to avoid competition by agreeing not to "enter each other's patch", ie by market allocations. NZDG and Sonic could agree not to bid for contracts in regions in which one is the incumbent. By doing this, NZDG and Sonic could effectively divide up between them all community testing in New Zealand by DHB region. Alternatively, it might be that both would bid in order to preserve the appearance of competition, but on the understanding that the nominated party would tender the lower bid and win the contract, ie "bid-rigging". As noted earlier, the constraints provided by other competitors is not strong, and would be unlikely to hinder such behaviour.

608. The parties have already indicated their reluctance to compete head-to-head for contracts in any region. For example, [

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609. It appears that NZDG and Sonic have already contemplated sharing resources such as pathologists should the joint venture proceed. [

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610. [

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[69] [ ].
[70] [ ].

611. [

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612. [

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613. It is possible to infer from this correspondence that the behaviour of each firm is already co-operative rather than competitive – that each is already considering the potential negative impact of antagonising the other by aggressively competing in other regions. This would risk the benefits they see from co-ordinating their activities. The Commission considers that there is a real risk that this behaviour could increase in the factual. In the counterfactual there is a greater likelihood of greater competition leading to reduced prices for services as appears to have occurred in 2003 in South Canterbury.

Conclusion on Co-ordinated Effects

614. The Commission considers that under the factual, there will be a strong relationship established between the joint venture parties through the commonality of interests in Otago/Southland, Hawke's Bay, Canterbury, South Canterbury and West Coast DHB regions. The parties would no longer have the incentive they would otherwise have in the counterfactual to compete either on a fee-per-test basis, or when contracts come up for tender in regions where only one party operates. As a result, it is likely that the joint venture arrangements will affect the competitive dynamic in regions that are not the subject of the present Application.

615. The Commission cannot be satisfied that this increased likelihood for co-ordinated effects would not have, or would not be likely to have, the effect of substantially lessening competition in other regional markets (those not involved with the joint venture proposals) for the provision of community testing.

NATIONAL CERVICAL SCREENING MARKET

616. The National Screening Unit (NSU) is a separate business unit within the MoH. It is responsible for the funding and operation of the Cervical Screening Programme, which governs the provision of cervical cytology testing in New Zealand. The NSU also contracts for histology services. Approximately 410,000 cervical smears are taken each year.

617. When the unit was established in 2001, new quality and policy standards were set up for services. There were originally 21 laboratories holding contracts to provide cervical cytology testing, but with the initiation of the new standards, this number immediately reduced to ten, as many laboratories did not meet the new requirements.

618. There are now minimum volumes that must be maintained by each laboratory. If the laboratory does not maintain these volumes, the NSU will not renew their contract. At present, the minimum annual volume is 15,000 tests. However, a new liquid-based cytology test is in the process of being introduced, [

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619. Cervical cytology is funded on a fee-per-test basis. The cost per test is set nationally across all providers in New Zealand [ ]. The duration of the contracts varies between one and three years, with annual review clauses.

620. There are currently 12 pathology laboratories that hold contracts with NSU to provide cytology testing services. These providers are:

- Diagnostic Medlab (Sonic)
- Valley Diagnostic (Sonic)
- Medlab Central (Sonic)
- Medlab South (Sonic)
- Medlab Hamilton (NZDG)
- SCL Christchurch (NZDG)
- SCL Dunedin (NZDG)
- Medlab Bay of Plenty (PAL)
- Pathlab Waikato (PAL)
- Abano (through it subsidiary laboratory Medical Laboratory Wellington)
- LabPLUS – Auckland hospital laboratory
- CHL – Christchurch hospital laboratory.

621. Post-merger, the cervical screening tests of Medlab Central, Medlab South, and SCL (Christchurch and Dunedin), would be provided by the proposed joint ventures. In the factual, there would continue to be four other (non-Sonic / NZDG subsidiary) providers in the national market for the provision of cervical screening tests: Abano, PAL, CHL and LabPLUS.

622. The NSU did not have concerns regarding the proposed merger with respect to cervical testing, primarily due to the fact that there would be four current providers unaffected by the proposal, from which it could choose. It stated that it would always have the option of cancelling contracts with private providers, in which case all cervical testing volumes would be sent to the DHB-owned laboratories, LabPLUS and CHL. The NSU appears eager to maintain its contracts with the DHB-owned hospital laboratories, particularly as CHL and LabPLUS train the majority of the cervical cytology workforce. [

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623. The NSU considered that it has a substantial degree of countervailing power as it always has a choice of providers to contract with. Karen Mitchell, Group Manager, National Screening Unit, stated:

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[ ].

624. The NSU believed it was a price-setter. When questioned about the extreme hypothetical situation of only one private provider of cervical cytology, Karen Mitchell stated:

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625. The Commission considers that post-merger, there would continue to be considerable existing competition in the national market for the provision of cervical screening tests. In the factual, there would continue to be four providers of cervical cytology, other than Sonic or NZDG subsidiaries: Abano, PAL, CHL and LabPLUS.

626. In addition, the Commission considers that the NSU has a substantial degree of countervailing power. It decides who to contract with, and can cancel any providers' contract if it is not satisfied with the level of service provided. The Commission considers that the NSU is a price-setter. The fee per test is set across all providers. The NSU seemed particularly willing to maintain contracts with the two hospital laboratories and stated that it would be possible for these laboratories to undertake all cervical screening testing in New Zealand.

627. In conclusion, the Commission is satisfied that the proposed acquisition would not have, or would not be likely to have, the effect of substantially lessening competition in the national market for the provision of cervical screening tests.

OVERALL CONCLUSION

628. The Commission understands the rationale for a single provider funding model and does not challenge the DHBs' decision to adopt this contracting model. However, the Commission considers that there are options that are consistent with a single provider model which could potentially achieve even greater savings to DHBs with respect to spending on pathology services than those envisaged by DHBs supporting the present proposals. These savings derive, in part, from maintaining competition in the long-run. The Commission considers that, although the DHBs have indicated that they would achieve short-term savings as a result of the proposal, the loss of competition in the factual compared to the counterfactual may result in an increase in the costs of pathology services for DHBs in the long-run.

629. The Commission concludes that the proposed acquisition would reduce the number of likely potential private provider bidders in each region from two vigorous competitors in the counterfactual, to one in the factual. In addition, the Commission considers that the DHB provider arm in each region is unlikely to provide constraint on the proposed joint ventures.

630. For these reasons, the Commission cannot be satisfied that the proposed acquisition would not have, or would not be likely to have, the effect of substantially lessening competition in the Otago/Southland, South Canterbury, Hawke's Bay, Canterbury, and West Coast community testing markets, and the Otago/Southland and South Canterbury hospital testing markets.

631. In addition, the Commission cannot be satisfied that the proposals would not enhance the likelihood of co-ordinated behaviour occurring in other regional markets, such that the proposals would not have, or would not be likely to have, the effect of substantially lessening competition in other regional markets for the provision of community testing.

632. The Commission is therefore not satisfied that the proposed acquisition would not have, or would not be likely to have, the effect of substantially lessening competition in any market.

DETERMINATION ON NOTICE OF CLEARANCE

633. Pursuant to section 66(3)(b) of the Commerce Act 1986, the Commission determines to decline clearance for the proposed merger of the diagnostic laboratory (pathology) services businesses of New Zealand Diagnostic Group Limited and Sonic Healthcare (New Zealand) Limited or their subsidiaries in six District Health Board districts through the establishment of three joint venture companies that would operate in the following DHB regions:

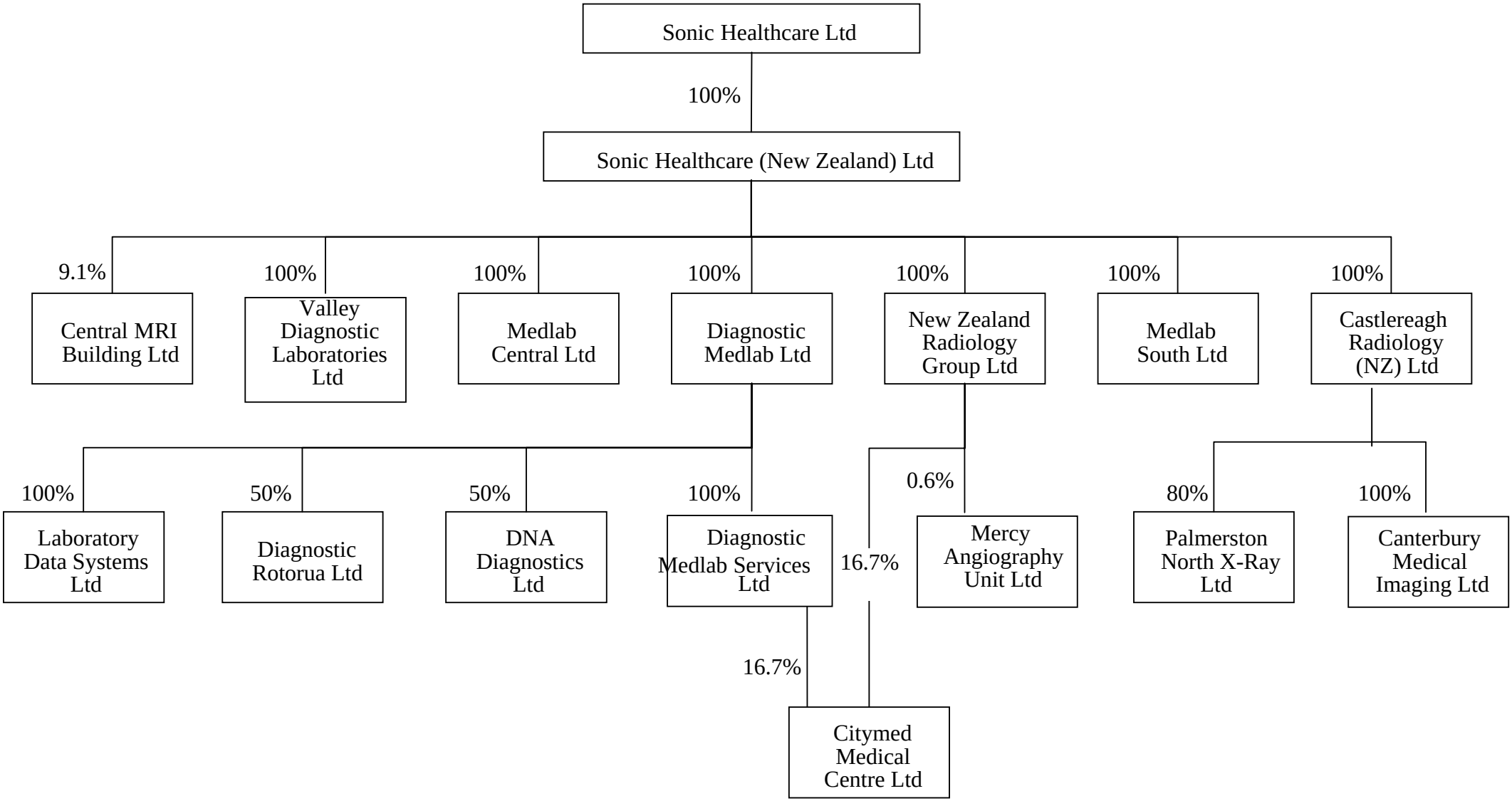
- Otago;
- Southland;
- Hawke's Bay;
- South Canterbury;
- West Coast; and
- Canterbury.

Dated this 29th day of September 2005

Paula Rebstock
Chair
Commerce Commission

APPENDIX A

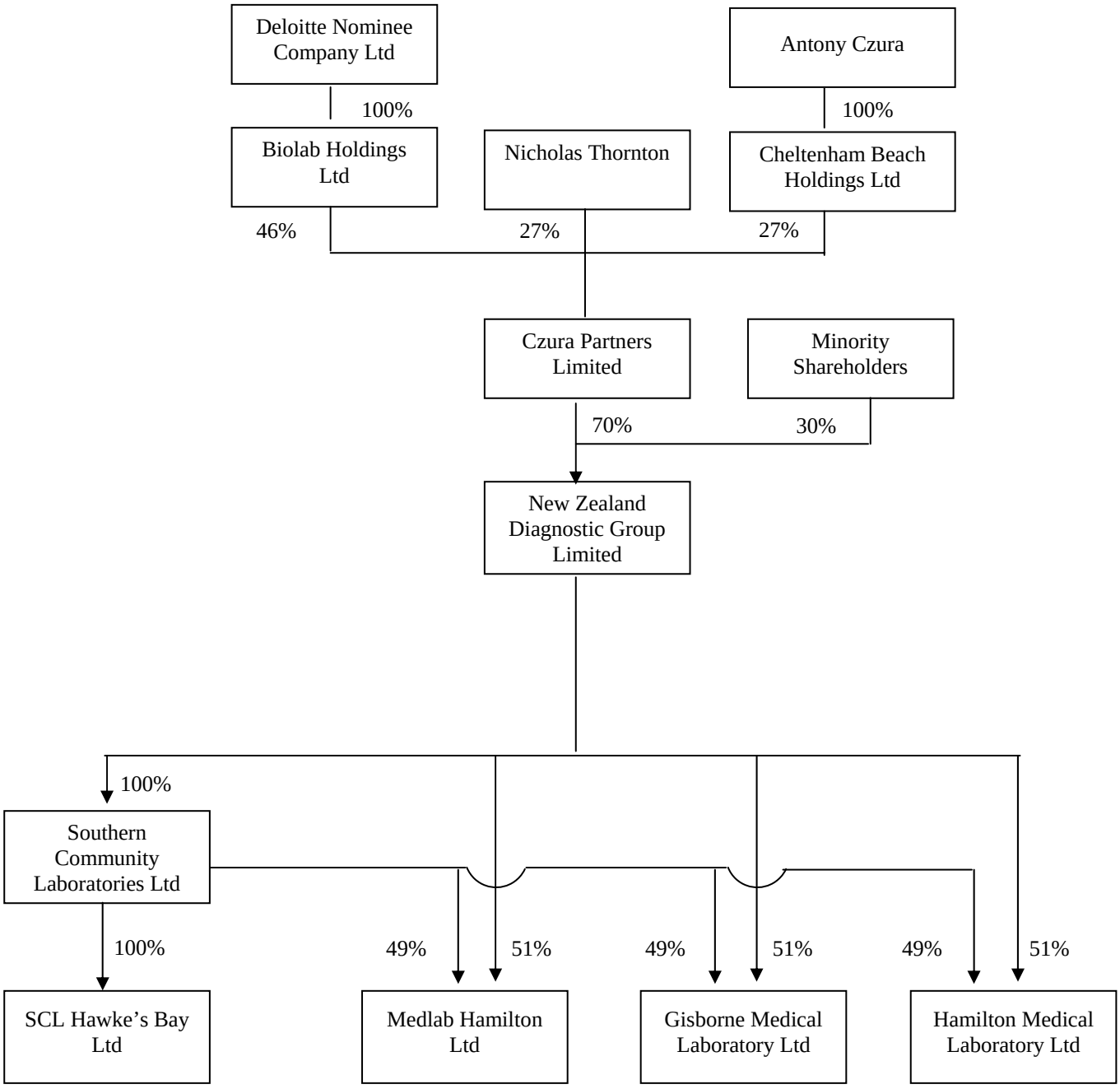
Sonic Corporate Structure (significant shareholdings) in New Zealand



APPENDIX B

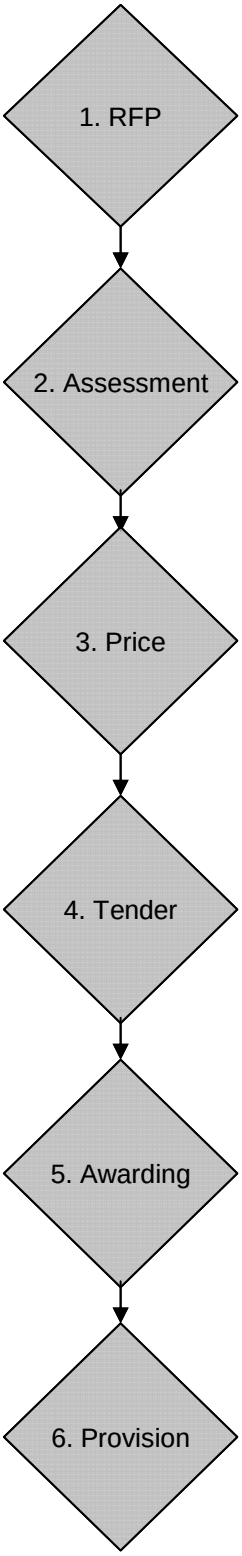
New Zealand Diagnostic Group Limited

Group Structure Chart



APPENDIX C

Process for a typical bidding round



DHB issues RFP.

Firms evaluates possibility of entry by examining the business case for doing so (i.e. conditions of RFP; likely cost of entry and operation; scope for recovery of sunk costs; likelihood of subsequent contract renewal; etc.). Firms incur bid preparation costs.

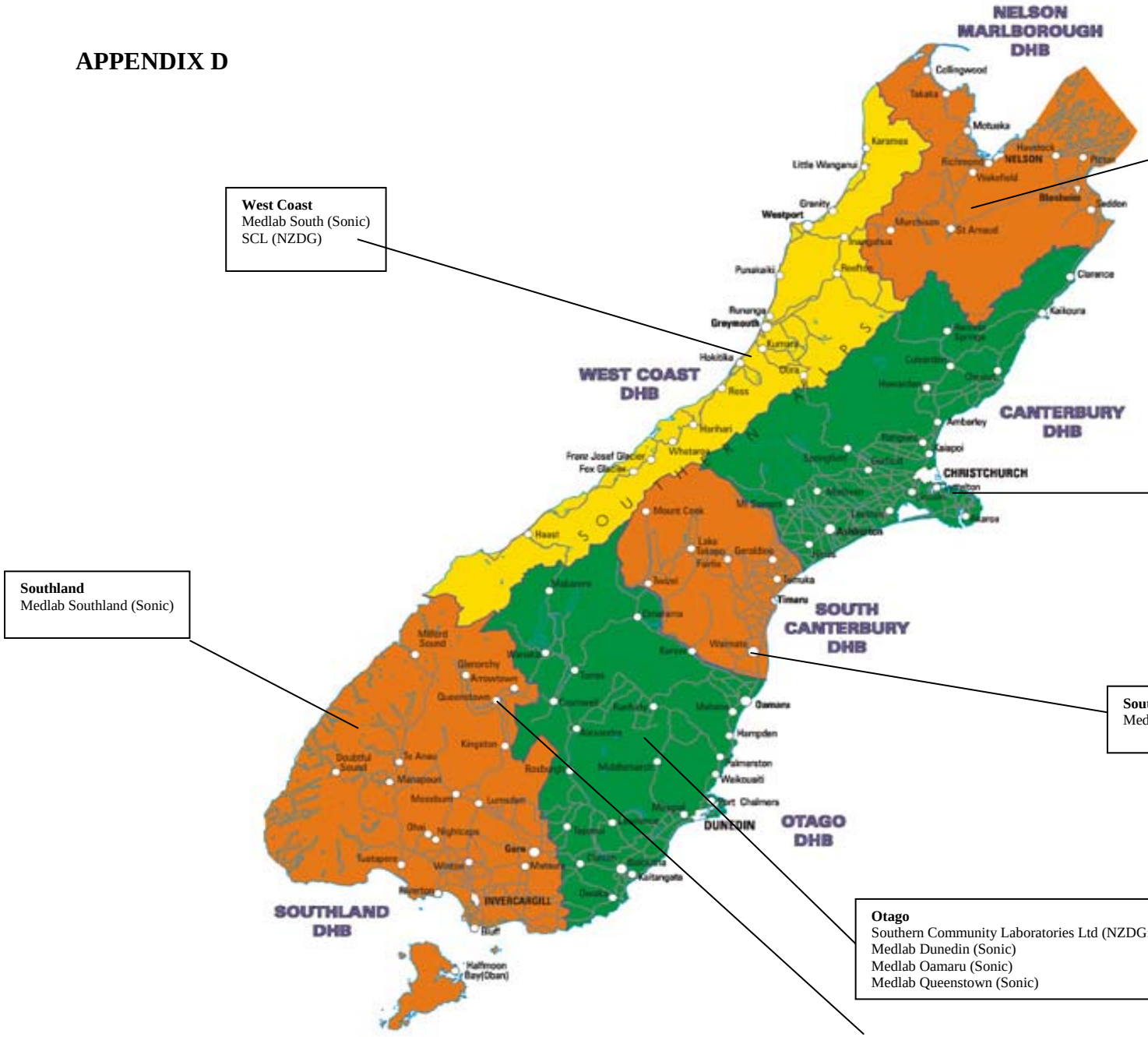
If firms decide to bid, they must determine a tender price such that expected costs can be covered and a suitable return made. Ex ante, firms incorporate expectations of future costs when bidding.

Firms respond to RFP.

DHB evaluates all proposals and awards a contract.

Winning firm enters (and the incumbent, if different from successful firm, is displaced). Winning firm incurs all necessary setup costs.

APPENDIX D



Nelson Marlborough
Medlab Marlborough (Sonic)
Medlab Nelson (Sonic)
Nelson Diagnostic Lab Ltd (Abano)

West Coast
Medlab South (Sonic)
SCL (NZDG)

Canterbury
Southern Community Laboratories Ltd (NZDG:Christchurch, Ashburton)
Medlab South Ltd (Sonic)

Southland
Medlab Southland (Sonic)

South Canterbury
Medlab Timaru (Sonic)

Otago
Southern Community Laboratories Ltd (NZDG: Dunedin, Clyde, Queenstown)
Medlab Dunedin (Sonic)
Medlab Oamaru (Sonic)
Medlab Queenstown (Sonic)

APPENDIX E

Northland
Northland Pathology Lab (Healthscope)

Auckland
Diagnostic Medlab Ltd (Sonic)
DNA Diagnostics Ltd (Sonic JV with Auckland University)

Waitemata
Diagnostic Medlab (Sonic)

Lakes
Diagnostic Rotorua (Diagnostic Medlab JV between Sonic and PAL)

Counties Manukau
Diagnostic Medlab (Sonic)

Bay of Plenty
Medlab Bay of Plenty (PAL)

Waikato
Medlab Hamilton (NZDG)
Pathlab Waikato (PAL)

Tairawhiti
Medlab Gisborne (NZDG)

Taranaki
Medlab Taranaki

Hawke's Bay
SCL Hawke's Bay Ltd (NZDG)
Medlab Hawke's Bay (Sonic)

Whanganui
Wanganui Diagnostic Laboratory (Sonic)

Mid Central
Medlab Central (Sonic)

Capital & Coast
Medical Laboratory Wellington (Abano)

Wairarapa
Valley Diagnostics (Sonic)
Medlab Central (Sonic)

Hutt
Valley Diagnostic Laboratories Ltd (Sonic)