Freehills

20 December 2004

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Mr Mark Pearson
General Manager
Adjudication
Australian Competition and Consumer Commission
470 Northbourne Avenue
DIXON ACT 2602

By courier

Dear Mr Pearson

Little Company of Mary Health Care Limited – application for authorisation

We act for Little Company of Mary Health Care Limited (**LCMHC**).

LCMHC applies to the Australian Competition and Consumer Commission (**Commission**) under section 88(9) of the *Trade Practices Act 1974* (Cth) (**Act**) for authorisation of its acquisition of St Vincent's Hospital Launceston.

The following documents are enclosed:

(a) completed Form F;

(b) a supporting submission regarding the acquisition of St Vincent's Hospital Launceston by LCMHC (**confidential submission**);

(c) a document containing a list of the parts of the confidential submission over which confidentiality is claimed and the reasons for claiming confidentiality;

(d) a copy of the supporting submission regarding the acquisition of St Vincent's Hospital Launceston by LCMHC, with confidential material removed (**public submission**);

(e) a cheque for $15,000.

Confidentiality

Pursuant to section 89(5) of the Act, we request that the Commission refrain from disclosing any information in the confidential submission which is not reproduced

in the public submission, and that only the public submission is placed on the Commission's public register.

Timing

In a facsimile to Freehills dated 25 November 2004, and in a number of subsequent telephone discussions, the Commission has indicated that it is likely to seek the applicant's agreement on an extension of the time period for its determination of the application. Our instructions are that the applicant is willing to agree to such an extension. However, while recognising that allowance should be made for the Christmas/New Year period, our client submits that the timeframe should reflect the fact that the parties provided the Commission with a very detailed submission on the proposed acquisition in August 2004 (in the context of the parties' application for informal merger clearance), and with contact details of relevant stakeholders and interested persons in October 2004.

Please do not hesitate to contact Michael Gray on (02) 9225 5286 or Lisa Emanuel on (02) 9225 5415 if you would like to discuss this further.

Yours faithfully
Freehills

Michael Gray/Lisa Emanuel
Partner

FORM F

Regulation 7

[Front of Form]

COMMONWEALTH OF AUSTRALIA

Trade Practices Act 1974 ---- Sub-section 88(9)

MERGERS:
APPLICATION FOR AUTHORISATION

To the Australian Competition and Consumer Commission:

Application is made under sub-section 88(9) of the *Trade Practices Act* 1974 for an authorisation under that sub-section to acquire shares in the capital of the body corporate, or to acquire assets of the person (including a body corporate), named in item 2.

(PLEASE READ DIRECTIONS AND NOTICES ON BACK OF FORM)

1. (a) Name of applicant

Little Company of Mary Health Care Limited

(b) Short description of business carried on by applicant

The provision of health and aged care services.

(c) Address in Australia for service of documents on the applicant

c/- Michael Gray/Lisa Emanuel
Freehills
Level 32, MLC Centre
19-29 Martin Place
SYDNEY NSW 2000
Facsimile (02) 9322 4000

(d) Name and address of any person for whose benefit the shares or assets will be held

Little Company of Mary Health Care Limited
Haydon Drive (cnr Belconnen Way)
Bruce ACT 2617

2. (a) In the case of a body corporate whose shares or assets are to be acquired

(i) Name of the body corporate

Sisters of Charity Health Service Limited

(ii) Place of incorporation of the body corporate

New South Wales

(iii) Registered office of the body corporate

Level 1, 75 Grafton Street
BONDI JUNCTION NSW 2022

(iv) Short description of the business carried on by the body corporate

The provision of health and aged care services.

(v) Number of shares or description of assets to be acquired

St Vincent's Hospital Launceston

(b) In the case of a person (other than a body corporate) whose assets are to be acquired

(i) Name and address of the person

N/A

(ii) Short description of the business carried on by the person

N/A

(iii) Description of assets to be acquired

N/A

3. Where a contract, arrangement, understanding or proposal for the acquisition has been made, brief description of the contract, arrangement, understanding or proposal and its date

The parties have reached an in-principle agreement in favour of the Acquisition. The in-principle agreement provides that LCMHC will acquire St Vincent's Hospital Launceston Limited as a going concern, inclusive of, but not limited to: land and buildings, plant and equipment, licences and permits, hospital records, relevant St Vincent's contractual interests, intellectual property, and goodwill.

Please refer to the "Supporting submission regarding the proposed acquisition of St Vincent's Hospital Launceston" for more information.

(*See* Direction 3 on the back of this Form)

4. (a) Grounds for grant of authorisation

Please refer to the "Supporting submission regarding the proposed acquisition of St Vincent's Hospital Launceston".

(b) Facts and contentions relied upon in support of those grounds

Please refer to the "Supporting submission regarding the proposed acquisition of St Vincent's Hospital Launceston".

(*See* Notice on the back of this Form)

5. (a) Does this application deal with a matter relating to a joint venture (see section 4J of the *Trade Practices Act* 1974)

No

(b) If so, are any other applications being made simultaneously with this application in relation to that joint venture

N/A

(c) If so, by whom or on whose behalf are those other applications being made

N/A

6. Name and address of person authorised by the applicant to provide additional information in relation to this application

Michael Gray/Lisa Emanuel
Freehills
Level 32, MLC Centre
19-29 Martin Place
SYDNEY NSW 2000
Facsimile (02) 9322 4000

Dated....., 20.....

Signed by/on behalf of the applicant

.....
(Signature)

.....
(Full Name)

.....
(Description)

RESTRICTION OF PUBLICATION
OF PART CLAIMED – and granted

SUPPORTING SUBMISSION REGARDING PROPOSED ACQUISITION OF ST VINCENT'S HOSPITAL LAUNCESTON

Little Company of Mary Health Care

Table of contents

1 Introduction

1.1 The transaction and the parties

This is an application to the Australian Competition and Consumer Commission (**Commission**) for authorisation of the acquisition of St Vincent's Hospital Launceston (**St Vincent's**) by Little Company of Mary Health Care (**LCMHC**) (**the Acquisition**). At this time, the parties have reached an in-principle agreement in favour of the Acquisition, which is conditional on authorisation being obtained for the Acquisition from the Commission.

Both parties to the Acquisition are Catholic, not-for-profit, health and aged care service providers, with services throughout Australia. St Vincent's is a private, 112-bed hospital located in Launceston, and is the only facility operated by SCHS in Tasmania. The other overnight private hospital in Launceston, St Luke's Campus of Calvary Health Care Tasmania (**St Luke's**), is owned by LCMHC.

1.2 Health sector trends

The public benefits likely to result from the Acquisition, and the Acquisition's competitive effects, are best considered in the context of the following trends in the Australian health care industry:

(a) a greater emphasis on community care, and an increasing distinction between hospitals that provide state-of-the-art technology and high cost specialist acute services, and those that provide less complex care services, including post-acute care;

(b) a dramatic rise in the rate of technological change, which requires health care providers continually to expend significant capital to ensure that their facilities are state-of-the-art;

(c) an ageing population, which is placing increasing pressures and demands on the Australia health care system;

(d) increasing hospital admission rates; and

(e) a national decline in the supply of public hospital beds, but with the Tasmanian market remaining 'over-bedded'.

1.3 Private health sector trends

The following trends in the private health care industry in Australia also need to be considered:

(a) an expansion in the number of private health care facilities;

(b) a dramatic rise in the number of day surgery facilities;

(c) consolidation in the ownership of private hospital facilities, and small groups of hospitals consolidating facilities into large hospital networks; and

(d) the consolidation of health funds, with an overall reduction in the number of health funds, and the grouping of health funds to create consolidated negotiating blocks.

Like the broader private health sector in Australia, the Catholic health sector has undergone significant changes in recent years, which have been driven by the need for professional expertise, economies of scale, greater purchasing power, new and increasingly expensive technology, and enhanced relationships with health funds.

1.4 The health sector in Tasmania

The public benefits likely to result from the Acquisition, and the Acquisition's competitive effects, should also be considered in the context of the following features of the health sector in Tasmania:

(a) an oversupply of hospital beds;

(b) a depressed economy and a declining/ageing population;

(c) a reduction in health services provided to the people of Northern Tasmania, both in the public and private sectors;

(d) very little investment in health care facilities in recent years;

(e) increasing numbers of private patients being treated in public hospitals; and

(f) the consolidation of health funds.

1.5 The rationale

Both parties strongly believe that the current and future sustainability of private health care services in Northern Tasmania is best served through the integration of their Tasmanian health care services.

LCMHC is seeking to acquire St Vincent's for the following reasons:

(a) The Acquisition will further LCMHC's strategy of creating regional strengths through integrated services providing a seamless continuity of care.

(b) The Acquisition will provide LCMHC with an opportunity to introduce new and expanded services in Launceston.

(c) The Acquisition is consistent with LCMHC's growth strategy, which seeks to address mission and business issues, and to position LCMHC as a distinctive, stand-alone, medium sized private health care provider.

SCHS's decision to enter into the Acquisition is driven by its concerns regarding the current delivery of health care services in Northern Tasmania, and its belief that the recent entry of LCMHC into Launceston presents a unique opportunity to ensure the sustainability and continued development of the Catholic health care ministry in Northern Tasmania.

The parties believe that the Acquisition presents the most desirable solution to the problems facing the provision of private health care in Northern Tasmania and will result in numerous public benefits.

1.6 Public benefits

(a) The future with the Acquisition

Numerous and significant public benefits are expected to result from the Acquisition, including:

(1) new, expanded and better services for patients;

(2) a synergistic approach to health care service delivery;

(3) a reduction in pressure to increase charges to patients;

(4) reduced waiting times;

(5) greater opportunities for comprehensive care in Launceston;

(6) better opportunities to recruit and retain skilled health care professionals, and thereby offset the current under-resourcing of doctors, and the loss of specialists from Northern Tasmania;

(7) the potential for new technology and specialist support services for doctors; and

(8) a more attractive private health care product to market to existing and prospective health fund members, resulting in a higher likelihood that members will retain their private health insurance, and that new members will join a health fund.

LCMHC is confident that the benefits it has achieved in Hobart as a result of its acquisition of St John's Hospital Hobart (**St John's**) are also achievable in Launceston as a result of the Acquisition.

A number of the above benefits will be achievable through the synergies that will result from the Acquisition. These synergies – including in the areas of clinical service rationalisation, capital equipment replacement, human resources, purchasing, and the rationalisation of operating suites – will result in greater efficiencies and the ability to contain costs.

(b) The future without the Acquisition

The benefits outlined above are unlikely to be achieved absent the Acquisition for the following reasons:

(1) the sustainability of two private hospitals in a city the size of Launceston is questionable; and

(2) significant service expansion by either hospital is unlikely in the current environment.

(c) What will the parties do absent the Acquisition?

If the Acquisition does not take place, then there is a strong likelihood that St Vincent's will eventually close. While, in the short term, St Vincent's and St Luke's will continue to operate, the presence of two hospitals in a city the size of Launceston will inevitably lead to more duplication and waste, at a high cost to the community. The Acquisition is therefore essential to ensure the ongoing viability of the private health care system in Northern Tasmania.

1.7 Competitive effects

The Acquisition primarily concerns the following markets:

(1) the market for the provision of hospital services to patients;

(2) the market for the provision of hospital facilities and services to doctors; and

(3) the market for the provision of private hospital services to health insurers.

The Acquisition will not result in a substantial lessening of competition in any of these markets for the following reasons:

(a) in the long term, St Vincent's is unlikely to continue operating as an independent facility, and, even in the short to medium term, St Vincent's will not be in a position to compete effectively with St Luke's;

(b) the reality on the ground in Northern Tasmania is that Launceston General Hospital provides effective competition to St Vincent's and St Luke's;

(c) new and existing day surgery facilities will continue to provide effective competition to the merged entity;

(d) even with the Acquisition, the health funds will continue their strong negotiating position because of their size and position relative to the merged entity. Of the four funds (including the Department of Veteran Affairs (**DVA**)) that currently contribute over 85 per cent of St Luke's and St Vincent's revenue, three (including DVA) are national entities, with Northern Tasmania making up only a very small component of their overall market (0.68 per cent of the Australian population); and

(e) rather than resulting in an increase in prices, and/or a reduction of services, the Acquisition provides the potential for a significant increase in the quality and nature of services provided to both patients and doctors.

1.8 Conclusion

The Acquisition will result in material public benefits and no substantial lessening of competition. Therefore, the Acquisition should be allowed to take place.

2 The transaction

2.1 Brief overview

The proposed transaction (**the Acquisition**) involves the acquisition of St Vincent's Hospital Launceston (**St Vincent's**), which is owned by Sisters of Charity Health Service Limited (**SCHS**), by Little Company of Mary Health Care Limited (**LCMHC**). LCMHC owns several health care facilities in Tasmania, including the St Luke's Campus of Calvary Health Care Tasmania (**St Luke's**), which is a private hospital located in Launceston.

2.2 Current status

At this time, the parties have reached an in-principle agreement (**Draft Agreement**) in favour of the Acquisition. The Draft Agreement, which has been approved by both parties at board level, and by LCMHC at Province Leadership Team Level and by Sisters of Charity at Congregational Leadership Team Level, is conditional on authorisation being obtained for the Acquisition from the Australian Competition and Consumer Commission (**Commission**). A copy of the Draft Agreement is attached to this submission as Appendix A.

(a) The Draft Agreement provides that LCMHC will acquire St Vincent's as a going concern, inclusive of, but not limited to: land and buildings, plant and equipment, licences and permits, hospital records, relevant St Vincent's contractual interests, intellectual property, and goodwill. It is the intention of the parties that the completion of the Acquisition will result in all SCHS's liabilities in relation to St Vincent's being met.

(b) The following entities are parties to the Acquisition:

(1) LCMHC, as the parent company, whose members are the Province Leader and the other members of the Province Leadership Team of the Province of the Holy Spirit of the Sisters of the Little Company of Mary;

(2) LCM Calvary Health Care Holdings Limited, as the property holding company for LCMHC;

(3) Calvary Health Care Tasmania Inc (**CHCT**), as the operator of LCMHC's Tasmanian health services;

(4) SCHS, whose members are the Congregational Leader, the Council of Sisters of Charity of Australia, and the Trustees of Sisters of Charity of Australia (**TSCA**); and

(5) Sisters of Charity Healthcare Australia Limited (**SCHA**), as the property holding company for SCHS.

As well as being conditional on Commission authorisation, the Acquisition is subject to the following conditions:

(a) a response satisfactory to both parties being received from the Holy See;

(b) determining the position of the Office of State Revenue, Tasmania, on the granting of an exemption from stamp duty in relation to the Acquisition; and

(c) agreement by the Catholic Development Fund to transfer current debt attaching to St Vincent's land and buildings, on terms acceptable to both parties.

2.3 Holy See approval of the Acquisition

In accordance with the New Code of Canon Law, which is the Catholic Church's fundamental legislative document, SCHS must obtain the permission of the Holy See for the alienation of St Vincent's. Canon 1293-1 requires that, in order to alienate goods whose value exceeds the determined minimum sum (which has been exceeded in the case of St Vincent's), there must be a just reason, such as urgent necessity, evident advantage, or a religious, charitable or other grave

pastoral reason. The alienation of St Vincent's to another Catholic, not-for-profit, health and aged carer service provider, with similar values to those of SCHS, is viewed more favourably and is more likely to be approved, than a transaction involving a non-Catholic and/or for-profit operator.

3 The parties

3.1 Little Company of Mary Health Care

(a) Background

The Little Company of Mary (**LCM**) was founded by the Venerable Mary Potter in England in 1877. The first Sisters of LCM came to Australia in 1885, and established hospitals, nurse training schools, outreach and other services.

LCMHC is a service of the Sisters of LCM, and is operated as a Catholic, not-for-profit organisation. It is a national Catholic health and aged care services provider with services in five States and Territories – New South Wales, Victoria, Tasmania, South Australia, and the Australian Capital Territory. Its services include public and private hospital care, acute and sub-acute care, and retirement and aged care services, in both rural and metropolitan areas. The organisation operates the Calvary Health Care and Retirement Community Group, which includes Calvary public and private hospitals, hospices, and aged care services in Sydney, Melbourne, Hobart, Launceston, Canberra, Adelaide, Wagga Wagga, and the Hunter Valley.

LCMHC's health care services include: specialist, sub-specialist and general medical and surgical services; maternity; rehabilitation; treatment for alcohol and other drug addiction; breast screening; outpatient medical and allied health services; emergency departments; inpatient and outpatient mental health services; community based palliative care and rehabilitation; respite care; artificial limbs services; and community nursing and other outreach services. Central to its mission, LCMHC is one of the largest palliative care service providers in Australia, with specialist palliative care services and facilities in five of its sites, providing inpatient and community outreach services to more than 5,000 people annually. Its aged care services accommodate approximately 620 people in three levels of care: self-care or independent living, low care or hostel accommodation, and high care or nursing home accommodation. There are approximately 3,600 full time and part time staff working in the LCMHC system, including more than 2,000 nurses. Some 200 employed doctors provide medical care in LCMHC facilities, with a further 1,000 specialists providing visiting services.

In recent years, the Sisters of LCM have undergone a transition process to a collaborative model of working with lay leadership within LCMHC facilities and services. This process, which responds to the decrease in the numbers of Sisters available within the LCM health care system, aims to preserve the heritage created by the LCM Sisters in Australia over the past century and to ensure the continuation of the Catholic health care ministry in accordance with the mission and vision of the Venerable Mary Potter, and in collaboration with the members of Catholic Health Australia. LCMHC's models of care emphasise a community focus; regionally integrated services; primary health care, community based

services and aged care; and holistic care, which involves a concern for the overall health and wellbeing of individuals, their families, and their communities.[1]

LCMHC is governed by a national board, which is appointed by the Province Leadership Team, and given responsibility for the governance of the health system. The Board appoints the National Chief Executive Officer, who is responsible for the leadership and management of LCMHC's services. LCMHC Group companies are accepted as charitable by the Australian Tax Office. As such, their constitutions require that their income and assets be applied wholly to their respective stated charitable purposes.

A diagram illustrating LCMHC's organisational structure, and accompanying information detailing the organisation's facilities and services, are provided in Appendix B.

(b) Calvary Health Care Tasmania (**CHCT**)

CHCT is one of nine services[2] owned by the Sisters of LCM in Australia, and is the largest Catholic health care provider in Tasmania. The original Lenah Valley Campus (known as Calvary Hospital, Hobart) was commenced in 1939, and received its first patients in 1941. In October 2000, the services provided by CHCT expanded through the purchase of St John's Hospital Hobart (**St John's**) from Medical Benefits Fund of Australia Limited (**MBF**), and the assumption of responsibility for the operation of the Outpatient Rehabilitation Service in New Town. To reflect the broadening of the company's referral base beyond acute hospital care, and the move to a national structure, the local service was renamed Calvary Health Care Tasmania.

(c) St Luke's Campus of Calvary Health Care Tasmania

St Luke's commenced as a homeopathic hospital approximately 100 years ago. It was taken over by the Anglican Church in the 1920s, sold to St Luke's Health in 1986, and acquired by LCMHC on 17 May 2004. Since its acquisition by LCMHC, the hospital's name has been changed from St Luke's Private Hospital to St Luke's Campus of Calvary Health Care Tasmania.

LCMHC's acquisition of St Luke's was part of LCMHC's strategy to expand into Northern Tasmania, and thereby grow the organisation's mission in Tasmania. Because the Australian private hospital market is extremely tight, with low profit margins, it is important for operators to increase their efficiencies each year to achieve economies of scale and scope both across and within facilities. LCMHC's proposal to acquire St Luke's was largely driven by potential synergies to be achieved through linking St Luke's with CHCT facilities in Hobart. The acquisition gave LCMHC a 20 percent expansion in turnover in Tasmania.

St Luke's is licensed for 120 inpatients and 11 same day beds, but currently operates only 81 inpatient and 7 same day beds. This comprises a 31 bed surgical unit, which includes a three-bed high dependency unit; a 32 bed medical unit; a nine bed post-natal unit; and a nine bed oncology unit. The service range of the hospital covers medical, surgical and postnatal services, with major specialties being urology, orthopaedics, gynaecology, ENT, ophthalmology, upper and lower

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1 Helen O'Kane, Chair of the National Board, 28 November 2002 in *Little Company of Mary Health Care, National Strategic Plan 2 2002-2005.*

2 The Sisters of LCM operate 15 facilities in Australia.

GI surgery, endoscopy, medical oncology, and general medicine. The operating suite, which includes four operating theatres and two procedure rooms, undertakes approximately 3,500 cases per year, 78 per cent of which are same day procedures. This proportion is higher than the national average of day procedures for private hospitals, and reflects a low level of acuity of surgical admissions. St Luke's employs approximately 260 people in 150 EFT positions. In the financial year ending 30 June 2004, it generated a total turnover of approximately $14 million.

The following table illustrates the proportion of St Luke's business in terms of surgical,[3] day surgery,[4] and medical:[5]

	2004 FY		2003 FY		2002 FY	
	Admissions %	**Bed days %**	**Admissions %**	**Bed days %**	**Admissions %**	**Bed days %**
Surgical	17	33	24	35	24	36
Day surgery	60	24	58	22	59	22
Medical	23	43	18	43	17	42

St Luke's patients primarily come from Northern Tasmania, which spans from Launceston to the east coast and to a boundary approximately half way between Launceston and Hobart. The hospital also receives some patients from North-Western Tasmania towards Devonport and, to a lesser extent, Burnie. Generally, these patients are either referred for services not readily available in their home communities (for example, hepato-biliary surgery), or have opted for alternative providers of service.

For a number of years prior to its acquisition by LCMHC, St Luke's suffered from poor financial performance, and failed to generate sufficient cash flows to invest adequately in capital equipment, particularly medical equipment. While St Luke's underwent a major rebuilding project to upgrade ward and administrative amenities in the mid 1990s, its inability to repay debts it generated during those years resulted in the curtailment of planned works to upgrade the theatre complex and basic safety infrastructure. The recent implementation of cost saving initiatives by management has resulted in modest improvements to the hospital's financial performance.

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3 "Surgical" refers to surgery involving an overnight patient stay.

4 "Day surgery" refers to surgery which does not involve the patient staying overnight at the facility.

5 "Medical" refers to a patient not requiring surgical intervention.

[Confidential material deleted]

CHCT estimates that it will need to spend a total of $2.8 million over the next five years simply to bring the hospital up to current industry standards, with initial expenditure planned on theatre sterilisation equipment, medical equipment and fire safety infrastructure (sprinklers and smoke compartmentalisation).

3.2 Sisters of Charity Health Service

(a) Background

The Congregation of Religious Sisters of Charity of Australia (**Sisters of Charity**) is a congregation of religious women formed within the Catholic Church, and governed by a Congregational Leader and her Council (**CL&C**).

The Sisters of Charity were founded in Ireland in 1815, and the first Sisters of Charity arrived in Sydney in 1838. Their earliest work was with convict women and children at the 'Female Factory' in Parramatta. The Sisters of Charity's work subsequently expanded to providing education and health and aged care facilities in the four eastern States. Their current activities include the provision of private

hospital services, health and aged care services, research and outreach programs. In Australia, the Sisters of Charity is a voluntary association.

The Trustees of the Sisters of Charity of Australia (**TSCA**) is a body corporate formed under the *Roman Catholic Church Communities' Land Act 1942* (NSW), whose members are the CL&C. Most of the property used to provide health and aged care facilities under the care of the Sisters of Charity throughout Australia is owned by TSCA.

(b) Organisational structure

Until the early 1990s, all of the health, aged care and educational facilities of the Sisters of Charity were conducted directly by the Sisters of Charity. Following an extensive review of the structure of the Sisters of Charity health and aged care facilities, the Sisters of Charity Health Service Limited (**SCHS**) was created in 1996. The underlying theme of the restructure was "national governance and regional management". SCHS is a company limited by guarantee. Its Corporation Law members are the CL&C and TSCA.

SCHS Group's current operating budget is $1 billion, and it employs approximately 10,000 staff. Its national office is located in Bondi Junction, New South Wales. Like LCMHC companies, SCHS companies are accepted as charitable by the Australian Tax Office. As such, their constitutions require that their income and assets be applied wholly to their respective stated charitable purposes.

SCHS is the sole owner and manager of some of the facilities with which it is involved, with ultimate responsibility being held by the CL&C. SCHS is also involved in partnerships with other Catholic health care providers for the provision of health care facilities; namely, the Congregation of the Missionary Servants of the Sisters of the Holy Spirit in Brisbane, and the Congregations of the Sisters of Mercy in North Sydney and in Melbourne.

SCHS has a complex organisational and reporting structure. Since 1996, it has developed a national framework, with a mix of centralised and decentralised decision making. Major decisions relating to most of the 32 facilities operated by SCHS require approval of the SCHS Board, and the Sisters of Charity must also approve specified acquisitions. Control of such matters as Board appointments to facilities and amendment of constitutions remains vested in the Sisters of Charity.

A diagram illustrating SCHS's organisational structure, and accompanying information regarding the organisation's governance reporting lines, are provided in Appendix C.

(c) St Vincent's Hospital Launceston

St Vincent's is the only hospital operated by SCHS in Tasmania. St Vincent's has 112 licensed inpatient beds, comprising 92 medical and surgical beds and 20 mental health beds, and an additional 20 day places. There are currently 74 inpatient beds available. St Vincent's operating budget is approximately $15 million, and there are 155 full time equivalent employees.

St Vincent's carries out a range of medical and surgical procedures. The hospital's major specialties are orthopaedics, urology, gastroenterology, plastic reconstructive surgery, colo-rectal surgery, and acute medicine. Other significant services performed by St Vincent's include palliative care, a sleep studies unit, a day surgery unit, and the home nursing service (which is partially supported by a

local services club). The patients attending St Vincent's are primarily drawn from Northern and North-Western Tasmania.

The following table illustrates the proportion of St Vincent's business in terms of surgical, day surgery, and medical:

	2004 FY		2003 FY		2002 FY	
	Admissions %	**Bed days %**	**Admissions %**	**Bed days %**	**Admissions %**	**Bed days %**
Surgical	25	32	23	31	23	31
Day surgery	53	20	53	18	53	17
Medical	22	48	24	50	24	52

[Confidential material deleted]

In the past two years, significant efforts have been made to improve the financial viability of St Vincent's. These efforts have included patient related improvements, such as the introduction of a pre-admission clinic and a mobile lithotripsy service, as well as the restructuring of various administrative departments. However, profitability for St Vincent's has come at the cost of a reduction in the services provided by the hospital to patients. It is expected that St Vincent's will continue to face significant financial challenges – including wage increases, tough health fund negotiations, increasing medical malpractice insurance premiums, and routine capital requirements – and these will constrain any significant capital or service expansion in relation to St Vincent's in the short to medium term. As illustrated above, the proportion of admissions and bed days of the hospital are constant, and no increase in overall activity levels has been budgeted for in the 2005 financial year, nor is any increase expected in the

ensuing years. In fact, if the Acquisition does not proceed, St Vincent's expects that its activity levels will decline as CHCT acts to upgrade St Luke's infrastructure, equipment and facilities.

[confidential material deleted]

3.3 Area of competitive overlap

St Vincent's and St Luke's are comparable facilities providing similar services to the people of Northern Tasmania. St Luke's is slightly stronger in the areas of urology and postnatal care, while St Vincent's is stronger in orthopaedics and plastic surgery. In most instances, however, the hospitals offer the same range of services. Most of the doctors who work at St Vincent's, also work at St Luke's, and vice versa.

4 The health sector in Australia

The health sector in Australia represents 8.5 per cent of GDP, and the percentage is rising. Australia's health system has significant strengths, including high clinical standards, universal access to care, and a mixed service delivery model including both public and private providers.

4.1 Health sector trends

The following are key trends in the health sector in Australia.

(a) Greater emphasis on community care

Over the past century, health care in Australia has centred on hospital care, and it is only in recent years that a greater emphasis on community care has developed. This trend has seen hospital stays in both public and private hospitals becoming shorter, more procedures being undertaken in short stay centres (both within and geographically separate from hospitals), a greater proportion of diagnostic and surgical activity being performed as day procedures, more hospital-in-the-home procedures, greater emphasis being placed on general practitioner links to hospitals, and greater support for older people to 'age in place'. The average length of stay in Australian hospitals in 2002-03 was 3.5 days, down from 4.6 days in 1993-94, a decline of 23.9 per cent. This decline is attributable to reductions in hospital-based nursing home type patient care, improved anaesthetics and antibiotics, the use of less invasive surgical techniques, an increase in the availability of post acute home-based care programs, and the increasing use of same day procedures.[6]

The implications of this trend include a greater focus on continuity of care for the patient, and a growing need for a coordinated and systematic view of patient management in a variety of health settings. It is predicted that future care settings will be smaller, and there will be an increasing distinction between those hospitals that provide state-of-the-art technology, high cost specialist acute services and

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[6] Final Report, *Strategic Services Planning for St Vincent's Hospital Launceston*, December 2002, p 11.

strategic placement, and those hospitals that provide less complex care services, including post-acute care. To an increasing extent, the former class of facilities will be supported by the latter. Within this context, it will be increasingly difficult for two, small, competing private hospitals, such as St Luke's and St Vincent's in a city the size of Launceston, to sustain the capital investment costs and human resources required to manage high acuity admissions. Further, if the Acquisition does not proceed, the two hospitals are unlikely to be in a position to meet growing demand in Northern Tasmania for a 'step-down care' facility to meet post-acute care needs.

(b) Technological change

The past decade has seen a dramatic rise in the rate of technological change, including the development of numerous new human pharmaceuticals. This trend is likely to continue, leading to improvements in disease management and patient outcomes, and a reduction in the amount of time patients spend in hospital. The increasing rate of technological change means that health care providers must continually expend significant capital to ensure that their facilities are state-of-the-art. The inability of some facilities to invest in such technology will contribute to the increasingly marked distinction in the Australian health care industry between state-of-the-art facilities, and those providing less complex services, as mentioned above in (a). The constant need for hospitals to invest capital in new technology is one of the primary drivers of the Acquisition, as the current operating margins of the two hospitals are insufficient to finance the technological investment required in the acute care setting.

The story of the harmonic scalpel provides an excellent example of how the Acquisition will enable the merged entity to respond better to technological change. The harmonic scalpel is a cutting instrument used on very soft tissues, such as kidneys and livers, to minimise bleeding. It works by vibrating the tissue cells apart, rather than cutting, thereby reducing trauma to the patient. Whereas a traditional disposable scalpel costs between $2 and $10, a harmonic scalpel costs $50,000, and can use between $200 and $300 of disposable accessories every time it is used. St Vincent's has recently purchased a harmonic scalpel, which is being used for up to eight hours per week. Up until the recent announcement of the Acquisition, St Luke's had been under pressure from doctors also to purchase a harmonic scalpel. However, the Acquisition will alleviate the need for St Luke's to purchase a second machine as the harmonic scalpel purchased by St Vincent's has the capacity to cover all the work of both facilities. This means that the money that would have been spent on a second harmonic scalpel can be used to update equipment and facilities in other important respects.

(c) Ageing population

A significant factor in health service planning for the future in Australia is the ageing of the Australian population. The Australian Bureau of Statistics (**ABS**) forecast is for the percentage of children under 14 years to decline from 21.3 per cent of the population in 1997 to 13.2 per cent by 2051, and the percentage of people aged over 65 years to increase from 13.1 per cent to 31.7 per cent of the population over the same period.[7]

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[7] ABS Population Projections 1997-2051, 1998 Series 2.

These changes will profoundly impact upon the community in general, and Australia's health services in particular. The implications of this trend in terms of health care include a rise in demand on emergency departments in public and private hospitals (the numbers of people over 80 years of age being seen in public hospital emergency departments is currently increasing by an average of 8 per cent per annum); and an increased need for effective multi-disciplinary hospital aged care units, which will focus on restoring older people's functioning and getting them home, with appropriate community support. While the number of patients requiring care by reason of ageing is increasing, these patients are spending fewer days in hospital on each occasion as a result of improved treatments and an emphasis on home-based care. Consequently, despite the ageing population, overall demand for bed numbers is stable or declining.

It is expected that the Acquisition will enable the parties better to respond to this trend by leading to an expansion in the home based nursing services currently provided by each hospital. By reducing the duplication of services between the two facilities, the Acquisition will create savings that can be invested in expanding home care services to support future demand for "ageing in place", a direction promoted by the Federal Government, which aims to maintain people in their homes as long as possible and to quickly return them to home nursing and support services after an episode of acute care. At present, St Vincent's has a part-time home based nursing service, partially supported through the efforts of a local service club. St Luke's has no regular home based service, and addresses this need on an ad hoc basis. The combined demand of the two hospitals would support a single, more comprehensive service.

(d) Increase in hospital admission rates

The admission rates of Australian hospitals, both public and private, are rising. In 2002-03, 6.65 million hospital admissions were recorded, an increase of 4.0 per cent over the previous year. Most of the growth in hospital activity occurred in the private sector. Between 1993-94 and 2002-03, admissions increased by 44.4 per cent overall, with public admissions increasing by approximately 23.6 per cent, and private admissions (including in relation to freestanding day hospital facilities) increasing by approximately 95 per cent.

The increase in admissions reflects a growing and ageing population, the introduction of new technologies, and an increase in private health insurance coverage in response to the Federal Government's private health insurance initiative in 2000.[8] Despite this trend, however, neither St Luke's nor St Vincent's has achieved enough activity growth to address its poor financial performance. While the activity levels of both hospitals have improved, the slowly declining rates of private health insurance coverage into the future are likely to reduce demand for private beds, and arrest any further improvements in activity if the hospitals continue to operate as independent facilities.

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[8] Final Report, *Strategic Services Planning for St Vincent's Hospital Launceston*, December 2002, p 10.

(e) A national decline in the supply of public hospital beds, but with significant variation between States and territories

Throughout Australia, licensed or available bed numbers[9] in the public health sector have decreased by an average of two per cent annually, from 55,737 in 1997-98 to 51,461 in 2001-02. Over the same period, the private sector grew by 2.9 per cent per year, from 24,439 beds in 1997-98 to 27,407 beds in 2001-02.

On a State by State basis, however, there are significant differences in available beds per 1,000 population. South Australia has the highest number of beds, with 4.8 beds per 1,000 population. Tasmania is second, with an estimated 4.7 beds per 1,000 population.[10] In comparison, New South Wales has 3.7 beds, Victoria has 3.8 beds, and the ACT has 3.4 beds per 1,000 population.[11]

As well as having a disproportionately high number of public hospital beds, Tasmania has the largest proportion of private hospital licensed beds per 1,000 population of all the Australian States. Consequently, even given the increase in demand for health care due to the ageing population, and a national decline in the supply of public hospital beds, Tasmania is an over-bedded market.

4.2 Private health sector trends

The private health sector in Australia has experienced significant change over the past 10 years, with evidence of new entrants and considerable growth. The total number of available private hospital beds in Australia in 2003 was 27,112, or 34.2 per cent of the total available beds nationally.[12]

The following are key trends in the private health sector:

(a) Expansion in the number of private hospital facilities

The number of private hospital facilities has expanded from 391 in 1991-92 to 560 in 2001-02.[13] This number includes 314 acute and psychiatric hospitals and 246 freestanding day hospital facilities, with most of the recent growth occurring in day hospitals. The number of available beds in private free standing day hospital facilities has increased by an average of 7.3 per cent annually between 1993-94 and 2002-03, from 917 to 1725. The number of available beds in other private hospitals has increased by two per cent for the same period.

(b) Rise of day surgeries

A particular feature of the expansion in the number of private hospital facilities discussed above at (a) is the dramatic rise in the number of day surgery facilities in Australia. This rise is largely due to an enormous growth in day surgery procedures, as more and more procedures are able to be carried out as day

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9 Statistics provided by the Australian Institute of Health and Welfare (**AIHW**) give the number of "available or licensed beds per 1,000 population". Whether or not the data refers to licensed or available beds depends on the definitions used in each State and Territory. Whenever possible, this submission specifies whether a reference to bed numbers is to licensed or available beds.

10 This is a conservative estimate, as private free-standing day hospital facilities were not included in estimates for Tasmania, whereas they were for other States.

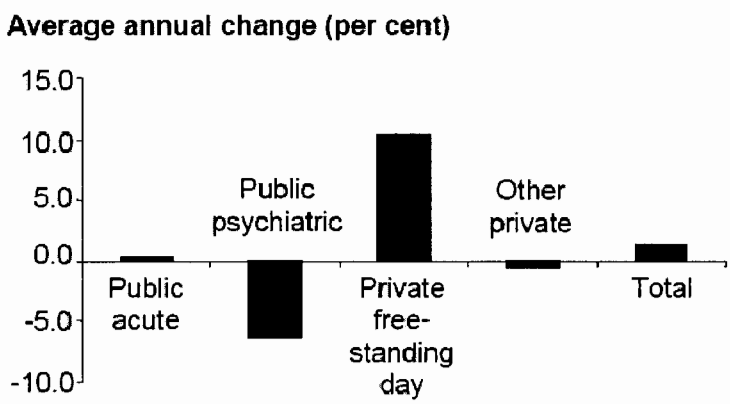
11 ABS Private Hospitals Australia, *Australian Hospital Statistics 2002-03*.

12 ABS Private Hospitals Australia, *Australian Hospital Statistics 2002-03*.

13 ABS Private Hospitals Australia, *Australian Hospital Statistics 2002-03*.

surgery. In 2001-02, approximately 50 per cent of surgery performed in Australia was day surgery, and this figure is expected to rise beyond 65 per cent within a decade. As stated above in (a), most of the growth in private hospital facilities since 1991-92 has been in day (as opposed to overnight) hospitals. Given that the entry costs for a day surgery facility are quite low, especially in comparison to the start-up costs of an acute overnight hospital, and that new technologies are expected to give rise to new day surgery treatment options, the growth in day surgery facilities is likely to continue, and accelerate, well into the future.

The following graph, developed by the Australian Institute of Health and Welfare (**AIHW**), illustrates the overall decline in the number of private hospitals and the dramatic rise of free-standing day surgery centres between 1993-94 and 2001-02:



(c) Consolidation in ownership of private hospital facilities, and small groups of hospitals consolidating facilities into large hospital networks

In the private hospital sector, there are overall trends (at both the national and regional level) towards both the consolidation in ownership of individual hospital facilities, and small groups of hospitals consolidating facilities into large hospital networks. A recent example of the trend towards consolidation in the ownership of private hospital facilities is the acquisition of the Benchmark Group of hospitals by Ramsay Health Care (**Ramsay**). As a result of the acquisition, there are now only three significant for-profit operators in private health care in Australia: Ramsay, Affinity Health (**Affinity**), and Healthscope. These three operators now dominate the Australian private hospital sector.

The consolidation trend is driven by a desire on the part of private health care providers to gain the efficiency advantages enjoyed by groups of hospitals. These efficiencies are available in relation to such management functions as accounting, payroll, human resources, risk management, marketing, negotiations with suppliers, and the provision of information technology services. Economies of scope also develop as a consequence of critical mass. When CHCT acquired St John's, for example, the intensive care unit (**ICU**) at CHCT's existing Hobart facility, Calvary Hospital Campus Lenah Valley (**Lenah Valley Campus**), was running at approximately 50 per cent occupancy, and St John's operated a mid-level high dependency unit (**HDU**). After the acquisition, CHCT was able to concentrate the high complexity patients from both campuses at the ICU. This resulted in the ICU having increased activity levels which, in turn, enabled it to attract additional staff, lift staff training levels, and expand services. Four years

later, the ICU is now running at 80 per cent occupancy. As the critical volume of patients required to lift capabilities has been reached, CHCT is expanding the unit to accept more complex cases. Demand for the ICU service is now far greater than that which existed when there were two separate services. Doctors now directly admit patients to CHCT for ICU services, whereas previously, the ICU catered only for existing patients experiencing sudden setbacks. Further efficiencies which have been generated through CHCT's acquisition of St John's, and how these can also be expected to result from LCMHC's acquisition of St Vincent's, are discussed below at 7.1.

The economies of scale and scope that are driving this trend towards consolidation mean that it is very unusual for a population centre the size of Launceston to be serviced by more than one private hospital, and helps to explain why both St Vincent's and St Luke's have struggled to survive over an extended period of time. The following comparable regional centres in Australia have only one private hospital:

Region	**Regional population base**	**Number of licensed/available private hospital beds**	**Population per licensed/available private hospital bed**
Launceston	130,000	232 licensed/162 available	560 licensed 802 available
Wagga Wagga	152,854	104 available	1,092
Bathurst	177,983	30 available	5,933
Bendigo	167,089	117 available	1,428
Ballarat	141,723	224 licensed	633
Cairns	228,154	141 licensed	1,618
Gladstone	181,583	30 available	6,053
Lismore	216,717	103 licensed	2,104
Armidale	62,746	32 licensed	1,961
Tamworth	80,562	77 licensed	1,046
Port Macquarie	280,067	84 licensed	3,334
Dubbo	139,989	60 licensed	2,333
Burnie	107,027	56 available	1,911

Other comparable population centres that support only one inpatient private hospital provider include Mildura, Mandurah, Coffs Harbour, Orange, Latrobe Valley (Victoria), Shepparton, Wangaratta, and Maryborough. The Acquisition is therefore consistent with the trend towards consolidation in the private health care industry.

Public hospitals have also recognised the need to obtain scale in both operations and service delivery, as evidenced by the move in the public sector towards amalgamation and integration of services at a regional level.

(d) Consolidation of health funds

Consolidation is also occurring in the private health insurance industry, with an overall reduction in the number of health funds, and the grouping of health funds to create consolidated negotiating blocks. Examples of negotiating blocks include the Australian Health Services Alliance and the Australian Regional Health Group (**ARHG**). Recent acquisitions in the private health insurance industry include MBF's acquisition of NRMA Health, NIB's acquisition of the health insurance business of IOOF Health Services Limited, and The Hospitals Contribution Fund of Australia Limited's (**HCF**) acquisition of the health insurance business of I.O.R Australia Pty Limited.

4.3 Participants in the private hospital sector

Affinity, Ramsay, and Healthscope are the three largest private health care providers in Australia. All three are for profit operators.

(a) Affinity

Affinity is the major new entrant into the Australian hospital sector, acquiring 41 hospitals from Mayne Health (**Mayne**) in 2003. Prior to its acquisition by Affinity, Mayne was the largest provider of private hospital services in Australia, with an estimated 6,451 beds or 24 per cent of the Australian private hospital market in 2002. The Mayne Group had evolved from the original merger of Hospitals of Australia and HCA, which became HCoA. It expanded throughout the 1990s, including through winning co-location (with public hospital) opportunities (for example, Prince of Wales Private in New South Wales).

Affinity was created for the purpose of acquiring Mayne's hospitals and is now Australia's largest private hospital group, operating 41 hospitals in metropolitan and regional Australia – in New South Wales, Victoria, Queensland and Western Australia. In December 2003, as part of the Mayne acquisition, Affinity entered into arrangements to acquire an additional nine co-located and privatised hospitals from Mayne, subject to obtaining assignment of the leases by the relevant State governments.

(b) Ramsay

In May 2004, Ramsay announced that it had reached agreement with Benchmark to acquire its 10 hospitals in Victoria and South Australia. This acquisition, which settled on 1 July 2004, increased the number of Ramsay operated hospitals to 35, and the number of licensed beds by an additional 1,119 to approximately 4,000.

Ramsay is a public company listed on the ASX. It expanded through the past decade by acquiring the Department of Veterans Affairs' (**DVA**) hospitals at Hollywood (Perth) and Greenslopes (Brisbane), acquiring the Alpha Group, purchasing Lake Macquarie Private from MBF, and by winning co-location (with public hospital) opportunities, such as North Shore Private in New South Wales and Flinders Private in South Australia.

(c) Healthscope

Healthscope is ranked as the third largest private for-profit health care provider in Australia. Listed on the ASX since 1994, Healthscope owns and operates medical/surgical, psychiatric, and rehabilitation hospitals throughout Australia,

and has approximately 2,400 beds.[14] Healthscope operates private hospitals in two of the four cities in Tasmania (Burnie and Hobart), and operates all private hospital facilities in North-Western Tasmania. In addition to private hospitals, Healthscope owns Modbury Public Hospital in South Australia.

Healthscope entered the Tasmanian market 13 years ago with the construction of North West Private Hospital in Burnie. In 2003, Healthscope purchased Mersey Community Hospital, Hobart Private Hospital and St Helen's Private Hospital from Mayne. In December 2004, Healthscope relinquished the Mersey Community Hospital, which is now operated as a public hospital by the State Government Health Department.

4.4 The Catholic health sector

Like the broader private health sector in Australia, the Catholic health sector has undergone significant changes in recent years. These developments are inextricably linked to the belief among sector participants that the survival of the Catholic health mission is dependent on closer integration between Catholic health care providers, particularly in light of substantial growth in the for-profit networks, such as Affinity and Ramsay. These changes have been driven by the need for professional expertise, economies of scale and scope, greater purchasing power, and enhanced relationships with health funds.

Integration 2000 is a structural reform process, overseen by Catholic Health Australia, to which both SCHS and LCMHC have been committed. Its aim has been to develop a Catholic health sector that upholds the Catholic mission to deliver person-centred, accessible, equitable, and compassionate health and aged care services. The reform process is driven by the diminishing and ageing nature of Catholic religious congregations in Australia. The congregations recognise that, within 10 years, congregational ownership and management of healthcare entities will no longer be sustainable.

In this context, various alliances between Catholic health care providers have been formed. Catholic Health Australia, an association of Catholic health care providers, was set up as part of the Integration 2000 process, and has since become a significant advocate for Catholic health. Within the SCHS Group, there have been mergers and partnerships with other congregations. In January 2001, for example, St Vincent's Private Hospital (Sydney) merged with Mater Misericordiae Hospital in North Sydney. In 1999, SCHS formed a partnership with Mercy Health & Aged Care in Melbourne, which has brought the St Vincent's Private Hospital (Melbourne) and the Mercy Private hospitals together as St Vincent's and Mercy Private Hospital Limited. Such arrangements have resulted in demonstrable public benefits in the form of efficiency improvements. These improvements result from economies of scale and scope, improved utilisation of infrastructure, synergies across the hospital campuses, and better continuity of care for patients.

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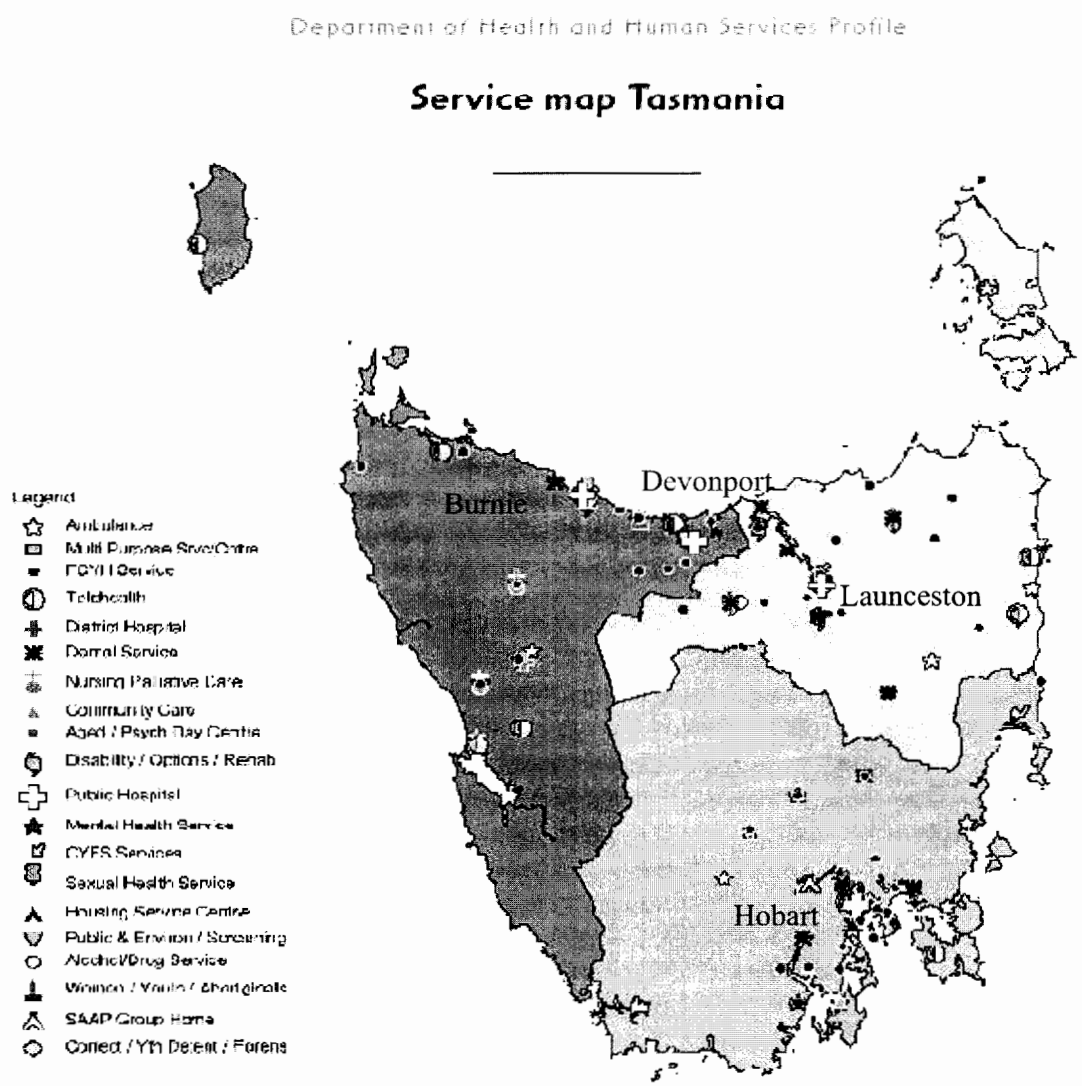
[14] Healthscope 2003 Annual Report. These figures do not take into account the transfer of Mersey Community Hospital by Healthscope back to the Tasmanian Government in December 2004.

5 The health sector in Tasmania

5.1 Geographic areas

Tasmania is divided into three regions:

- Southern Tasmania, centred on Hobart;
- Northern Tasmania, centred on Launceston;
- and North-Western Tasmania, centred on Burnie.



5.2 Features of the hospital sector in Tasmania

(a) Oversupply of hospital beds

Tasmania has an estimated 4.7 hospital beds per 1,000 population, the second highest bed per population ratio in Australia. As stated above at 4.1(e), only South Australia has a higher ratio, with 4.8 hospital beds per 1,000 population.[15] There are 36 hospitals (including 25 public hospitals and 11 private hospitals) operating in Tasmania. Many of these hospitals are small public facilities with less than 20 beds.

The 2002 Final Report of Australian Healthcare Associates into "Strategic Services Planning for St Vincent's Hospital Launceston" (**AHA Report**) found that St Vincent's was "operating in a market where there appears to be a saturation of private hospital services". The AHA Report found that there was a 21 per cent surplus of private hospital beds in Northern Tasmania,[16] and concluded that "[w]ithin the Northern region of Tasmania there appears to be an excess of private hospital beds exacerbated by an ongoing decline in bed demand".[17] Given that the proportion of the population with private health insurance cover had peaked at 44 per cent, the AHA Report's authors concluded that it was "unlikely this current situation [would] abate in the foreseeable future".[18] A copy of the AHA Report is attached to this submission at Appendix D.

(b) Depressed economy and declining/ageing population

Tasmania is well recognised as having a socio-economic status well below the national average, and the State regularly competes with the Northern Territory for last place.[19] Tasmania's unemployment rate is currently two per cent above the national average. At the time of the 2001 census, Tasmania had the lowest median weekly individual income of any State or Territory, and the lowest percentage of people with tertiary education.[20] Northern Tasmania, in particular, is economically depressed.

Tasmania is the least populated State in Australia, with only the two Territories having fewer people. In 2001, the Tasmanian population was 456,652, representing 2.4 per cent of Australia's total population. The Tasmanian population is expected to fall, and become increasingly elderly, over the next 10 years. In 2000, the Australian Bureau of Statistics (**ABS**) estimated that the

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15 Both Queensland and Western Australia have 4.3 beds per 1,000 population. Victoria has 3.8, New South Wales has 3.7, and the ACT and NT both have 3.4 beds per 1,000 population. ABS Private Hospitals Australia, *Australian Hospital Statistics 2002-03*.

16 Note, however, that this figure did not take into account beds required to meet demand for DVA, compensable and 'self-insured' cases.Similarly, Australian Healthcare Associates appears not to have allowed for privately insured patients being treated in the Launceston General Hospital as either private or public patients, a factor that decreases demand for private hospital beds. These two adjustments would tend to cancel each other out, leading to the conclusion that the statement is fairly accurate.

17 Final Report, *Strategic Services Planning for St Vincent's Hospital Launceston*, December 2002, p 130.

18 Final Report, *Strategic Services Planning for St Vincent's Hospital Launceston*, December 2002, p 17.

19 ABS, *Census 2001*.

20 Department of Health and Human Services (**DHHS**), *State of Public Health Report 2003*.

population would decline by approximately 32 per cent by 2051.[21] In addition, the proportion of Tasmania's population aged 65 years and over is expected to grow as a proportion of the total population from 13.5 per cent in 2001 to 31.7 per cent in 2051.[22] The ABS predicts that, by 2016, Tasmania will have the highest proportion of people over the age of 65 of all the Australian States and Territories. These factors will place increasing pressures on the Tasmanian hospital sector, and Tasmanian health care generally.

Perhaps surprisingly, prior to the Federal Government's health insurance initiatives in 2000, Tasmania had the highest participation rate in private health insurance. However, private health insurance participation rates did not increase as much as in other States as a consequence of the Federal Government's initiatives, and levels have been decreasing since 2001. The following table, which sets out health insurance participation rates as a percentage of population in all the States and Territories, illustrates this decline:

Date	NSW	Vic	Qld	SA&NT	NT	WA	TAS	AUST
09/01	45.5%	44.8%	42.3%	45.8%	34.0%	47.9%	44.7%	44.9%
12/01	45.5%	44.7%	42.3%	45.8%	33.9%	48.0%	44.7%	44.9%
03/02	45.4%	44.3%	42.2%	45.5%	33.5%	47.7%	44.6%	44.6%
06/02	45.2%	44.1%	41.8%	45.3%	33.3%	47.1%	44.2%	44.3%
09/02	45.2%	43.9%	41.6%	45.3%	33.0%	47.1%	44.1%	44.2%
12/02	45.1%	43.7%	41.4%	45.2%	32.8%	47.0%	44.2%	44.1%
03/03	45.0%	43.4%	41.2%	44.9%	32.5%	46.7%	43.7%	43.9%
06/03	44.6%	43.0%	40.7%	44.5%	32.4%	46.1%	43.2%	43.5%
09/03	44.6%	42.9%	40.7%	44.4%	32.2%	46.1%	42.9%	43.4%
12/03	44.7%	42.8%	40.6%	44.4%	32.1%	46.2%	42.8%	43.4%
03/04	44.5%	42.6%	40.4%	44.1%	31.8%	46.1%	42.5%	43.2%

The following graph illustrates variations in the percentage of Tasmanians with total hospital coverage between December 1976 and December 2003, and compares this with the percentage of coverage Australia-wide during the same period:

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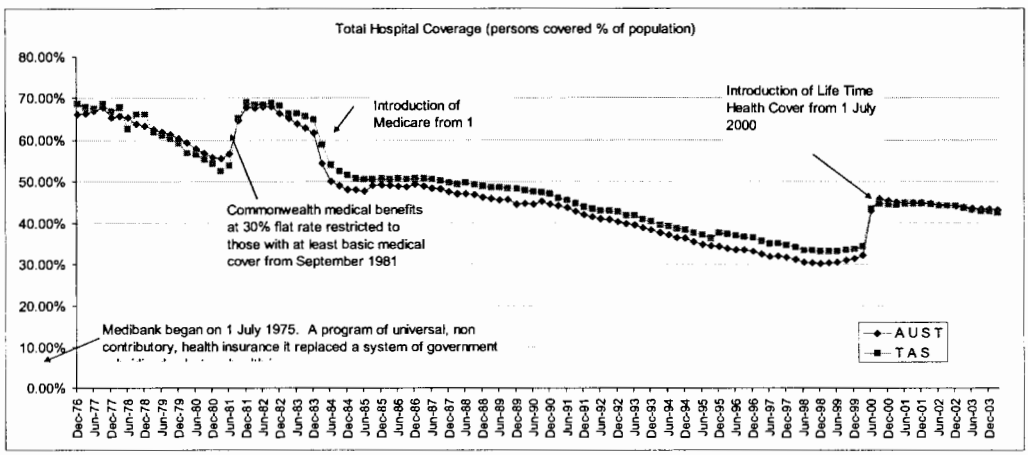
[21] Australian Bureau of Statistics (**ABS**), 2000, *Population Projections Australia 1999-2000*. The ABS projected that there would be an overall decrease in the population of Northern Tasmania of 30 per cent by the year 2051.

[22] ABS, *Population Projections 1997-2051*, 1998.



The current level of private health insurance coverage in Tasmania is considered by Australian Healthcare Associates and others to be unsustainable, due to inevitable increases in private health insurance premiums.[23]

(c) Reduction in health services

In recent times, there has been a reduction in health services provided to the people of Tasmania.

With respect to Northern Tasmania, in particular, the delivery of health care services has been affected by the following factors:

- an oversupply of private hospital beds;
- inefficiencies caused by the private hospital beds in Launceston being supplied by two independent operators;
- an overall loss of medical staff from Northern Tasmania;
- the centralisation of services in Hobart; and
- neither private hospital in Launceston being able to maintain profitability over the past five years or adequately service debt obligations. This has prevented further capital investment or service enhancement by either St Vincent's or St Luke's.

Consequently, a number of health services have closed over the past five years; in particular, accident and emergency and HDUs. With respect to St Vincent's, the emergency department, which was opened in March 1996, was closed in June 1999; a coronary ICU, which was also opened in March 1996, was closed in February 1998 (and since that time has been operated as an HDU); a 19 bed ward was closed in June 1999; and a primary care centre, which was opened in May 2000, was closed approximately 12 months later.

Launceston General Hospital recently lost its vascular surgical service and now relies on a visiting service from Hobart.. All three private obstetricians in Launceston have either ceased practice or will do so by June 2005.

In North-Western Tasmania, Mersey Community Hospital (owned by Healthscope until December 2004), recently ceased delivery of obstetric services

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[23] Final Report, *Strategic Services Planning for St Vincent's Hospital Launceston*, December 2002, p 16.

and reduced the operating hours of its emergency department to 9am to 5pm weekdays. The hospital's return to public operation in December 2004 brought a further reduction in services, with the loss of its sleep disorders unit.[24]

(d) Minimal investment in health care facilities

The over-bedded nature of the private health care market in Tasmania has meant that the State has seen very little investment in health care facilities in recent years. The most recent major capital expenditures in private health facilities in Tasmania involved the establishment of the Eye Hospital/Day Surgery Centre in Launceston (**Eye Hospital**) and LCMHC's acquisition of St Luke's. The only recently built private hospital in Tasmania is Hobart Private Hospital, which was completed in 2000 and involved an investment of approximately $40 million. Since its inception, Hobart Private Hospital has struggled financially, and has been sold twice, both times at the significantly reduced capital value of approximately $10 million. When Mayne sold out of Tasmania in 2003, only Healthscope and LCMHC expressed interest in its facilities. As a result of Mayne exiting Tasmania, Healthscope acquired Mersey Community Hospital in Latrobe, which was a privately operated facility with both public and private beds. This facility also struggled financially, and Healthscope relinquished ownership of the hospital back to the Tasmanian Government in December 2004. Given these recent experiences, it is highly unlikely that new overnight hospitals will be established in Tasmania, or that anything more than modest enhancements will be undertaken by existing hospitals.

A recent attempt by the Commonwealth Government to enhance private health services in Northern Tasmania is the Bush Nursing, Small Community and Regional Private Hospitals Programme, which was designed to assist struggling hospitals. St Vincent's has been a beneficiary of a capital grant under the programme, and used it to rebuild/expand its day surgery facilities (which are replicated at St Luke's, Launceston General Hospital, and the Eye Hospital).

(e) An increasing number of private patients are going to public hospitals

The Tasmanian public hospital system is increasingly competing for private patients to supplement public funding of its services. The parties believe that this trend reflects a deliberate change in policy by Tasmanian public hospitals actively to seek private patients as a source of non-government revenue. AIHW Australian Health Statistics for 2001-02 report that, between 1999-2000 and 2001-02, the number of private patients admitted to public hospitals in Tasmania increased by 3,893. Given that, over the same period, the total number of patients admitted to these hospitals increased by only 3,536, the number of public patients admitted to public hospitals in Tasmania actually declined.

The trend towards public hospitals providing services to private patients is also evident in health fund payments to Tasmanian public hospitals. In the year 1999-2000, public hospitals in Tasmania received $4.7 million in health fund benefits. This figure increased to $5.4 million in 2000-01 and to $7.1 million in 2001-02.[25] Recently published data from the Private Health Insurance Administration

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[24] See 4.3(c) above.

[25] AIHW, *Australian Hospital Statistics 1999-00 to 2002-03*.

Council (**PHIAC**) shows a sharp increase in private patient bed days and revenue in Tasmanian public hospitals in 2004.[26]

(f) Consolidation of health funds in Tasmania

The trend towards the consolidation of private health funds nationally, is particularly evident in Tasmania, where three private health funds – MBF, Medibank Private Limited (**Medibank Private**), and St Luke's Health Insurance (**St Luke's Health**) – account for 89.5 per cent of the private health insurance market.[27] In Northern Tasmania, the home of St Luke's Health, the same three participants account for 90 per cent of the market. Consequently, whether in respect of Tasmania as a whole, or Northern Tasmania specifically, no private hospital can afford to be out of contract with any one of the major health funds for any length of time, as this will alienate a significant proportion of the insured patient community.

The following table illustrates the market shares of private health insurance funds in Tasmania, based on hospital benefits paid:[28]

Rank	Name	% market share
1	MBF	40.5
2	Medibank Private	33.5
3	St Luke's Health	15.5
4	Others	10.5

Launceston is the headquarters and home base of St Luke's Health. Consequently, the private health insurance market is differently distributed in Northern Tasmania, as compared to the rest of the State. The following table sets out the market shares of private health insurance funds in Northern Tasmania, based on hospital benefits paid:[29]

Name	% market share
MBF	25
Medibank Private	25
St Luke's Health	25
Others	25

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[26] PHIAC, Tasmanian data for 2004; available at www.phiac.gov.au/statistics/trends/index.htm.

[27] PHIAC Tasmanian data for 2002/2003.

[28] PHIAC, data for 2002/2003.

[29] PHIAC, data for 2002/2003.

5.3 Participants in the private hospital sector in Tasmania

There are currently two main private hospital providers in Tasmania: Healthscope and CHCT. Both Healthscope and CHCT have facilities in Southern Tasmania, with Healthscope having additional facilities in North-Western Tasmania, and CHCT in Northern Tasmania. Healthscope has four hospitals and a total of 367 licensed private beds (37.26 per cent of the Tasmanian private hospital market).[30] CHCT has two hospitals on three sites, and a total of 448 licensed beds (45.48 per cent of the Tasmanian private hospital market). SCHS, the only other significant private health care provider, has a single facility in Tasmania, St Vincent's. This facility represents 12.99 per cent of the private hospital market in Tasmania.

The major private hospitals are located in Hobart, and are approximately double the size and complexity of those located in Launceston. In turn, the two Launceston private hospitals, St Vincent's and St Luke's are approximately double the size of the next largest private hospital in Burnie (the North West Private Hospital). These differentials essentially follow the population distribution in Tasmania, with an additional complexity factor in Hobart, which acts as the tertiary referral centre for the entire State.

(a) Hospital facilities in Northern Tasmania

The northern region of Tasmania is based around Launceston, with a population approaching 130,000. In addition to the usual general services, the facilities in this region provide limited specialist services (for example, interventional cardiology, orthopaedics, urology, ENT, ophthalmology and some oncology). Patients requiring open heart surgery, neurosurgery, neurology, treatment for major burns or trauma, elective angioplasty, major vascular surgery, paediatric surgery, or faciomaxiliary surgery must travel to Hobart for these services.

[30] These figures do not take into account Healthscope's recent transfer of Mersey Community Hospital back to the Tasmanian Government.

The following hospitals are located in Northern Tasmania:

Name of facility	Location	Ownership	Number of beds[31]	
			Licensed	Available
Launceston General Hospital	Launceston	Public	291	291
St Luke's	Launceston	Private – LCMHC	131	88
St Vincent's	Launceston	Private – SCHS	112[32]	74
Eye Hospital	Launceston	Private – doctors	2 theatres	2 theatres
Oakden House	Launceston	Private – Anglican Church in Australia	6 licensed (palliative care)	6 (with contracted access for public patients)
Deloraine	Deloraine	Public	20	20
North East Soldiers Memorial	Scottsdale	Public	23	23

All of the facilities in the above table, excluding Deloraine and Scottsdale Hospitals, are located in Launceston. St Vincent's, St Luke's, and the Eye Hospital all located within three kilometres of one another.

(1) Launceston General Hospital

Launceston General Hospital is a public hospital providing acute care facilities for the residents of Launceston and Northern Tasmania. With the exception of certain super specialty services (eg neurosurgery), Launceston General Hospital provides the full range of clinical services normally found in large provincial centre hospitals. Launceston General Hospital is a teaching hospital of the University of Tasmania for both undergraduate and postgraduate medical students. Each year, the hospital treats over 24,000 inpatients and over 225,000 outpatients and effectively competes with St Vincent's and St Luke's for privately insured patients.

(2) Eye Hospital

The Eye Hospital is a private day facility undertaking mainly ophthalmology day procedures and, recently, minor plastic day procedures. Since St Luke's acquisition by LCMHC, the Eye

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[31] Bed numbers are taken from data published by the Tasmanian Department of Health and Human Resources (**DHHS**) in *Healthy Hospitals Come From Healthy Debate: A Review into Key Issues for Public and Private Hospital Services in Tasmania*, 2004.

[32] The number of beds recorded by DHHS for St Vincent's is 128. The reason for this inconsistency may be that the higher figure includes day beds as well as inpatient beds (this is the case in respect of the DHHS bed figure for St Lukes). In fact, St Vincent's has 112 licensed inpatient beds and 20 day beds.

Hospital has also provided an IVF service. It is owned and managed by a group of ophthalmologists.

(3) Oakden House

Oakden House is an aged care complex operated by One Care[33] at Kingsmeadow in Launceston. The facility includes six licensed private hospital beds, which are used exclusively for palliative care. Launceston General Hospital admits some public patients to these beds under a service contract.

Deloraine and North East Soldiers Memorial Hospitals are small community hospitals serviced by general practitioners.

(b) Hospital facilities in North-Western Tasmania

Northern Tasmania is distinct from North-Western Tasmania, which includes the population centres of Devonport and Burnie, and encompasses a population of approximately 100,000. North-Western Tasmania's split population centres have created a demand for two public hospitals. However, both hospitals are "district" hospitals, with minimal specialist services.

Hospitals in North-Western Tasmania offer a range of general medical, surgical and obstetric services. Specialist services are limited to orthopaedics, ophthalmology and ENT surgery. There is significant movement of patients from North-Western Tasmania to Northern and Southern Tasmania (as well as interstate) to access specialist services. The following hospitals are located in North-Western Tasmania:

Name of facility	Public/private	Number of beds
North-West Regional Hospital Burnie	Public	131 licensed
North-West Private Hospital Burnie	Private/public – Healthscope	74 licensed (14 public/60 private)
Mersey Community Hospital Latrobe	Public[34]	130 licensed
Smithton	Public	16 licensed
King Island MPC	Public	6 licensed
West Coast	Public	23 licensed
Rosebery Community	Public	6 licensed

[33] One Care is a private not-for-profit company provided aged care services across Tasmania. It holds six acute hospital bed licences in Launceston, from which it provides palliative care services. LCMHC believes that four of these beds are under contract from Launceston General Hospital, and the other two beds are available for private admissions.

[34] Ownership of Mersey Community Hospital was transferred by Healthscope back to the Tasmanian Government in December 2004.

North West Private Hospital Burnie is situated 150 kilometres from Launceston. Mersey Community Hospital Latrobe is located at Devonport/Latrobe, 100 kilometres from Launceston.

(c) Hospital facilities in Southern Tasmania

Southern Tasmania accounts for approximately 230,000 people, or 50 per cent of the State's population. The region centres on Hobart, which is located two hours drive from Launceston, and provides the highest tertiary level services available in the State, in addition to a broad range of general services. Tasmanians requiring tertiary level care will be treated in Hobart or travel interstate. The following hospital facilities are located in Southern Tasmania:

Name of facility	Public/private	Number of beds
Royal Hobart	Public	499 licensed
Calvary Health Care Tasmania	Private – LCMHC	317 licensed
Hobart Private	Private – Healthscope	152 licensed
St Helen's Private	Private – Healthscope	115 licensed
Hobart Clinic	Private – independent	30 (acute psychiatric)
Hobart Day Surgery	Private - independent	2 theatres
New Norfolk	Public	10
Huon District	Public	6
Ouse	Public	5

6 The rationale

During 2004, discussions have taken place between LCMHC and SCHS regarding the future of private hospitals in Launceston. Both parties strongly believe that the current and future sustainability of private health care services in Launceston and Northern Tasmania is best served through the integration of their Tasmanian health care services.

LCMHC is seeking to acquire St Vincent's for the following reasons:

(a) The Acquisition will further LCMHC's strategy of creating regional strengths through integrated services providing a seamless continuity of care, including primary health care, community and home based care, acute care, sub-acute care, palliative care, and aged care; the establishment or expansion of outreach programs; and the establishment of GP relationship strategies, including improved communication, liaison, education, support and information sharing.

(b) The Acquisition will provide an opportunity for LCMHC to introduce new and expanded services (currently considered to be principally in the areas of cardiology, vascular surgery, rehabilitation, palliative care, and mental

health). The effect of the Acquisition on the provision of health and aged care services by the facilities is discussed in detail below.

(c) The Acquisition is consistent with LCMHC's growth strategy, which seeks to address mission and business issues, and position LCMHC as a distinctive, stand-alone, medium sized private health care provider. As part of this strategy, LCMHC seeks the formation of strategic alliances with others – including other Catholic health care organisations (such as SCHS) and non-Catholic organisations with similar values – which contribute to the development of integrated models of care. In Tasmania, LCMHC's local strategy is to develop stronger associations with other Catholic and not-for-profit providers of health and aged care services, and maintain or establish Catholic health care services outside Southern Tasmania.

SCHS's decision to enter into the Acquisition is driven by its concerns regarding the current delivery of health care services in Northern Tasmania. SCHS believes that the current delivery of health care services is less than optimal for the following reasons:

(a) the oversupply of hospital beds in Tasmania;

(b) the inefficiencies caused by private hospital services in Launceston being supplied by two independent operators; and

(c) the limited opportunities for capital investment or service enhancement in the current environment.

SCHS considers that the recent entry of LCMHC into Launceston, through its acquisition of St Luke's, presents a unique opportunity to ensure the sustainability and continued development of the Catholic health care ministry in Northern Tasmania, in circumstances in which SCHS is confident that the continuing entity will be aligned with its mission and values. SCHS believes that the streamlining of Catholic health services in Launceston under one overall management team is likely to be of great long term benefit to the community because it will result in:

(1) more efficient service delivery;

(2) less fragmentation and duplication of services;

(3) cost savings, which can be reinvested in new services and technology; and

(4) enhancements in the development and implementation of rational health planning, with public and private sector consultation, such as the Tasmanian Department of Health and Human Services' recently developed vascular surgery services plan.[35] This is because one service provider will be better able to negotiate effective service linkages.

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[35] This plan reviewed current and future demand for vascular surgical services across Tasmania and then attempted to develop the service delivery model most likely to attract and retain the required staff. This model involves a single team based in one physical location but visiting other locations on a rostered basis. A key to the plan is the development of a structure whereby surgeons are clustered, and therefore able to access peer support, and participate in a shared after-hours roster. Tasmanian Department of Health and Human Services (**DHHS**), *Statewide Review of Vascular Surgical Services*, 2003.

Further, St Vincent's is currently a stand-alone facility and lacks valuable back-up services because it has no clinical linkages with other SCHS hospitals, all of which are located on mainland Australia. LCMHC already has an established presence in Tasmania and could provide substantial backup to a merged St Vincent's/St Luke's from its Hobart based operations.

In pursuing the Acquisition, the parties are largely driven by the same motivating factors. Both LCMHC and SCHS want to improve the provision of private health care in Northern Tasmania and ensure its continued sustainability and growth. In this regard, the parties believe that the Acquisition will result in numerous and substantial public benefits, which could not be achieved absent the Acquisition. These public benefits are discussed in detail below at 7.

It is the parties' view that the Acquisition, when compared with any alternative options, presents the most desirable solution to the problems facing the provision of private health care in Northern Tasmania, for the following reasons:

(a) As Catholic health care providers, LCMHC and SCHS share a unique mission and approach. Consistent with this approach, the primary objective of both parties in relation to the Acquisition is to strengthen, nurture and promote the healing ministry.

(b) Largely because of the factors outlined in (a) (and 2.3 and 3 above), SCHS has considerable difficulties with the acquisition of St Vincent's by a for-profit organisation, and such an acquisition is unlikely to be contemplated by SCHS. Similarly, a partnership or other cooperative arrangement with a party other than LCMHC in relation to St Vincent's is problematic.

(c) While the parties have canvassed several options for the integration of their Tasmanian health care services – including the establishment of a joint venture or partnership between LCMHC and SCHS for the continued operation of St Vincent's and St Luke's (which would require authorisation) – the parties believe that the Acquisition is the best means through which to achieve the benefits they seek in terms of simplicity, potential, efficiency and effectiveness. Therefore, the Acquisition promises the most benefits for patients, doctors and other stakeholders; and the greatest potential for those benefits to be achieved within a reasonable time frame.

7 Public benefits

7.1 The future with the Acquisition

The parties believe that the Acquisition will result in numerous and substantial benefits to stakeholders. These benefits include the following:

(a) The introduction of new services

The Acquisition will provide an opportunity for LCMHC to introduce new and expanded services in Northern Tasmania (principally in the areas of cardiology, vascular surgery, rehabilitation, palliative care, and mental health). A single health care provider will be able to deliver its services more efficiently, with less duplication of resources (for example, equipment and professional skills), and with the opportunity to consolidate clinical and administrative services on one site

or the other. These cost savings, which the parties consider to be significant, will facilitate a higher quality service, and an expansion in clinical services offered. As a consequence, the provider will be in a stronger position to meet the future health care needs of Northern Tasmanians, thereby contributing to the sustainability and development of the Catholic healthcare ministry in Tasmania.

The Acquisition will provide LCMHC with the potential to upgrade and enhance the services it provides to Northern Tasmania. For example, a single service could ensure critical mass for an expanded, higher level HDU, and more on-site medical staff and diagnostic facilities, all of which are necessary to support new and more complex procedures (in specialties such as cardiology, vascular surgery, and obstetrics). Initial market analysis suggests that new services could be delivered in areas such as palliative care, psychiatry, and rehabilitation (both physical and chemical), and the support of urgent admissions after hours. St Luke's will also look at the potential to establish a private obstetric service, given that current demand is in excess of 400 deliveries a year.[36]

All of the above services require additional capital investment in order to meet specific building and equipment needs. Neither St Vincent's nor St Luke's is able to undertake such investment without the improved operating performance which can be gained through the Acquisition. The critical mass to be achieved through the Acquisition is therefore necessary in order to move to a higher level of service.

(b) The expansion of existing specialised services, consistent with need

The Acquisition will also enable the extension of existing specialised services, consistent with need. St Vincent's and St Luke's currently duplicate most service lines. This means that volumes of services provided at each hospital are small. Following the Acquisition, clinical service lines will be merged to gain efficiencies and to concentrate expertise. This will increase the hospitals' capacity to expand the scope and complexity of surgery offered. For example, in gastro-intestinal surgery, only minor and mid level complexity procedures are currently undertaken at each hospital. Insufficient volume exists separately in either St Vincent's or St Luke's to sustain the up-skilling of staff, or the upgrading of equipment, to undertake more complex work. Merging the two hospitals will allow a single HDU with higher throughput to maintain skills and financially justify new equipment.

Opportunities to expand existing services exist in areas such as cardiology, urology, orthopaedics and gynaecology. In fact, all specialties report the capacity to admit more seriously ill patients within their discipline, provided adequately trained staff and appropriate equipment are available. For example, urologists currently working at both hospitals will admit more complex patients if a holmium laser for treating prostate disease is purchased. Similarly, orthopaedic surgeons will admit more patients with co-morbidities (for example, heart disease), provided an upgraded HDU is available, as these patients carry a higher level of anaesthetic risk and require closer post-operative monitoring. Critical mass in terms of patient volumes is required to sustain more complex services, and this can be delivered only through combining the throughout of the two hospitals. The sort of service rationalisation required to support such clinical

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[36] This is contingent on the merged entity being able to recruit and support additional obstetricians.

expansion could not occur without one or other of the two hospital locations becoming non-viable as a stand-alone facility.

(c) Improvements in the quality of the services provided

Quality of service is driven by access to high level facilities, equipment and staff. The ongoing training and education of staff is essential. Neither St Vincent's nor St Luke's currently trades well, and therefore the hospitals have limited capacity to finance new equipment or enhance staff training.

Improvements in efficiency and profitability will allow for further investment in quality programs, quality measurement, the purchase of new equipment, and staff training. Among other things, this will result in lower infection and complication rates. The development of a single medical staffing structure will enhance the capacity of management to work with clinicians constantly to improve, review and refresh services, and to standardise approaches to clinical protocols. Patients will have access to a more efficient service through specialties being provided from a single location with a dedicated service unit.

If more intensive medical services are introduced, there will be increased availability of an on-site medical practitioner after hours and in emergencies. New technology will result in reduced morbidity and reduced lengths of stay, so that patients can be discharged earlier and more rapidly return to daily activities.

Such improvements in the quality of service provided by the facilities is unlikely absent the Acquisition because significant levels of capital are required to upgrade facilities, equipment and training. As operating margins are currently very low or non-existent, it is unlikely that any operator will invest in anything other than mandatory items unless efficiency can be dramatically improved. Using the orthopaedic example provided above at (b), St Luke's could admit patients in older age groups with more co-existing illnesses (for example, heart disease, diabetes, and kidney disease) if it installed better patient monitoring systems (at a cost of approximately $150,000), had on-site medical cover at night (at a cost of approximately $400,000 per annum), and up-skilled its nursing staff (at a cost of approximately $100,000 per annum). However, such expenditure would require an improvement in the hospital's bottom-line financial performance of at least $500,000 annually, and could not be sustained on St Luke's existing operating margins.

St Vincent's lower than expected performance against budget this year has forced a freeze on the facility's capital works expenditure.

[Confidential material deleted]

Another example is the inability of both facilities to fully equip their HDUs, which means that some high dependency cases are not able to be admitted to either St Vincent's or St Luke's, and instead are treated at Launceston General Hospital.

The Acquisition offers St Vincent's and St Luke's the maximum opportunity to harness economies of scale and clinical synergies, and will therefore lead to

significantly increased investment and consequent improvements in the quality of services provided.

CHCT's acquisition of St John's illustrates what the Acquisition can achieve

The opportunities that the Acquisition provides to improve the delivery of private health care services in Northern Tasmania are illustrated by the example of CHCT's acquisition of St John's in October 2000. LCMHC is not able to commit to taking any particular course of action in relation to the merged entity until after the Acquisition takes place and it has access to all the necessary information. However, LCMHC is confident that the same sort of benefits can be achieved in Launceston as a result of the Acquisition as those that were achieved in Hobart following its acquisition of St John's.

St John's was merged with CHCT's existing Hobart facility, Lenah Valley Campus, thus providing CHCT with an opportunity to review how clinical services were delivered across the two campuses. The aim was to match clinical services with the infrastructure already in place on each campus, and thereby achieve the best use of resources and enhance the delivery of health care to the community. Lenah Valley Campus was a high acuity facility with an accident and emergency department, ICU, and on-site radiology department with advanced diagnostics and imaging support for complex cases, including CT scan and MRI. When it was acquired by CHCT, St John's was a low acuity facility with minimal imaging support for more complex cases and an HDU, which was proving difficult to staff with sufficiently skilled employees because of low throughput. St John's did, however, have an excellent day surgery unit co-located with the theatre suite, with opportunities for the growth and expansion of day surgery services.

The benefits to the community brought about by the merger of St John's and Lenah Valley Campus are best illustrated using the examples of orthopaedics and ophthalmology. At the time of the acquisition, these specialties were delivered on both campuses, with the result that resources were duplicated, additional capital outlay was required to service the two sites, and there were difficulties in recruiting and training skilled staff.

Within three months of the acquisition, all orthopaedic surgery was based on the Lenah Valley Campus. Orthopaedic trained staff from St John's joined the staff at Lenah Valley Campus, and CHCT was able to provide highly skilled orthopaedic nurses for both elective and emergency surgery, 24 hours a day, 7 days a week. This led to an increase in the confidence of the visiting medical officers in the level of service and care being provided, establishing CHCT as a centre of excellence for orthopaedic surgery in Hobart. Over the ensuing 12 months, orthopaedic throughput increased by 30 per cent and three surgeons decided to work exclusively at CHCT. Having achieved critical mass, CHCT has been able to invest heavily in orthopaedics, and has purchased a state-of-the-art image intensifier and other technology for minimally invasive surgery, and the latest equipment for joint replacement. CHCT now offers a no-cost pre-admission service to all orthopaedic patients, which has streamlined the admission process and ensures that all relevant assessments and tests are performed pre-operatively. The establishment of a post-operative care unit in the orthopaedic ward means that patients are now provided with immediate post-operative care in a monitored bed in the ward, instead of an overnight stay in the ICU, which was previously the case. This provides patients with continuity of care, a more relaxed environment, and the attention of orthopaedic trained nurses.

All ophthalmology services were relocated to St John's within 12 months of the acquisition, as the vast majority of eye surgery is performed as day procedures, and the St John's day surgery unit was therefore considered to be the ideal location for the

specialty. A number of benefits have resulted from this strategy. First, the removal of service duplication between the two campuses has meant that capital outlay for ophthalmology is now channelled into a single site, and CHCT has invested significantly in the provision of the latest technology for eye surgery. In particular, CHCT has recently purchased a new phaecoe-mulsification machine for cataract surgery, which has improved patient outcomes by reducing the duration of surgery and anaesthesia. Second, CHCT now has a core team of expert ophthalmology nurses based on a single campus, which increases staff satisfaction, assists in the retention of highly skilled staff, and assures a high standard of patient care. Third, the establishment of a pre-admission clinic, incorporating an anaesthetic consultation, has led to a significant reduction in both pre-operative cancellations and unplanned overnight admissions. Further, patients are now oriented to the environment into which they will be admitted, which is of particular benefit to the elderly.

(d) The Acquisition will enable a synergistic approach to health care service delivery

LCMHC envisages that similar efficiencies and advantages to those achieved in relation to its acquisition of St John's can be generated in Launceston as a result of the Acquisition, through a synergistic approach to health care service delivery across St Vincent's and St Luke's. In the future, services can be differently distributed over the two sites, with, for example, high care services being provided at one site, and low care services provided at the other.

In the short term, the synergies sought between the two campuses will primarily be in the area of non-clinical services, such as:

- finance;
- payroll;
- health information services;
- accommodation services;
- risk management;
- administration and document management;
- catering;
- maintenance; and
- domiciliary care.

The estimated value of synergies that are relatively easily implemented is $300,000 per annum. This is a significant figure relative to the combined turnover of the facilities, and even more so relative to the facilities' operating surpluses. Further, this figure does not include the larger benefits that will result from improved clinical service planning and delivery, and further corporate services consolidation.

The most important changes over the medium to longer term derive from the potential to rationalise clinical services between the two campuses. This rationalisation will result in the following benefits:

- opportunities for higher-level services (as a result of the creation of a single, stronger service out of two smaller, vulnerable services);
- improvements in the continuity of patient care;
- improvements in theatre utilisation;
- enhanced differentiation between acute and low care needs, particularly in the management of older patients; and
- improvements in after hours patient management.

(e) Reduction in charges to patients

The Acquisition is unlikely to reduce direct charges to patients, as patients usually pay a pre-set excess or co-payment, which does not vary with the price of the total service. However, the operating efficiencies gained through the Acquisition will reduce demand for price increases by the hospital. This, in turn, will reduce the need for health funds to increase the premiums they charge to members

Further, any increase in negotiating power obtained by the hospitals as a result of the Acquisition will not result in increases in charges to patients, although this will partly depend upon whether health funds extend 'out of pocket' provisions as part of their restructure of benefits. The effect of the Acquisition on the hospitals' negotiations with health funds should not be overestimated, as the private health fund market in Northern Tasmania (which comprises just 0.68 per cent of the Australian population) is a very small component for national funds. The fund most likely to be impacted is St Luke's Health, which supports the Acquisition

[confidential material deleted].

(f) Reduced waiting times

Waiting times are presently short in the private sector, and will only get shorter if operational efficiencies eventuate as a result of the Acquisition. For example, surgeons currently operate on the same day in both hospitals. The consolidation of operating facilities on a single site will result in an improvement in medical time management and patient throughput and a reduction in costs. These outcomes will be beneficial to both patients and doctors

It is also likely that the acquisition will result in a reduction in waiting times at Launceston General Hospital. At the moment, there are three procedure lists, one for each of St Vincent's, St Luke's and Launceston General Hospital. Many Launceston doctors have patients on all three lists. If the three lists were reduced to two, greater efficiency will be achieved, with doctors working in the private hospital no longer needing to travel between sites. This increased efficiency in the private sector will open up more time for doctors to take on public patients.

(g) Less likelihood that patients will have to travel to Hobart or Melbourne for specialist care

To the extent that it will allow for additional services to be developed, the Acquisition will provide greater opportunities for patients to receive comprehensive care in Launceston. Consequently, there will be a reduction in the need for local people to travel elsewhere to access private facilities of a higher calibre than those currently offered in Launceston.

(h) Better opportunities to recruit and retain skilled health care professionals and thereby offset the current under-resourcing of doctors, and the loss of specialists from Northern Tasmania

Launceston has suffered from an under-supply of cardiologists, intensivists, vascular surgeons, anaesthetists and obstetricians for the past 12 months or more, as a result of retirements and relocations. These shortages have been recently exacerbated by a number of serious illnesses amongst orthopaedic, hepatobiliary surgery and urology specialists in Launceston. In light of national shortages of doctors, particularly in rural and regional areas, these people will be extremely difficult to replace. Launceston must compete with many other rural centres to recruit replacement doctors, and a strong, well-equipped private hospital sector will assist in this process, as almost all specialists generate a significant proportion of their income from private patients.

An underperforming private sector can act as a real deterrent to the recruitment and retention of specialist doctors. For example, Mr Peter Hewitt, a hepatobiliary surgeon, is a leading surgeon in his field in Australia, but has been limited in his capacity to practice in Launceston. Although Launceston General Hospital has been able to support Mr Hewitt's patients, it has long waiting lists due to the rationing of hospital resources. Mr Hewitt has not been able to operate to his full capabilities in the private sector because of the lack of high level HDU/ICU facilities and surgical equipment, such as the harmonic scalpel. Mr Hewitt is no longer able to work due to a serious illness. However, prior to his illness, he had questioned whether he could remain in Launceston if the private hospital sector could not enhance access for his patients.

A sustainable private health sector with the capacity to adjust and expand services according to patient needs is more conducive to the attraction and retention of highly skilled health care professionals. The concentration of patients with particular specialties on a single site will increase the facilities' capacity to build multi-disciplinary teams matched to a particular specialty. This will result in significant benefits to patients.

(i) Benefits to doctors

As well as the benefits mentioned above in (a)-(d) and (h), the Acquisition will result in the following benefits to doctors:

- the potential for new technology;
- specialised support services;
- less onerous on-call arrangements, as calls will be coordinated between the campuses;
- a single medical record for private hospital patients;
- a single booking system; and
- fewer committees.

There is a partnership between the facilities and the doctors, which is characterised by mutual dependence. The doctors are essentially independent contractors of St Vincent's and St Luke's. What doctors require is access to theatres and good facilities, and both of these factors will be significantly enhanced as a result of the Acquisition.

In recognition of the above, doctors have responded extremely positively to the announcement of the Acquisition. In particular, doctors are looking forward to the prospect of bringing medical records from the two hospitals together into a single file, and to the potential for rationalising services so that each discipline is concentrated on a single campus. A further benefit that has been articulated by doctors is that the merged facility will place less after-hours pressure on anaesthetists, as the single on-call private anaesthetist will no longer be required to cover two private hospitals.

LCMHC held an open evening for doctors on 1 December 2004, which was attended by approximately 18 specialists serving the two hospitals. Not one doctor spoke against the Acquisition at this forum, and most were very anxious that the proposed merger proceed as soon as possible. The doctors have commenced work on a clinical services plan, which will guide the restructuring process after the Acquisition takes place.

(j) Benefits to health funds

The Acquisition will result in the following benefits to health funds:

- the capacity to sustain a private health care market in Northern Tasmania in the long term;
- a more attractive product (better range of services) to market to existing and prospective new members, resulting in a higher likelihood that members will retain their private health insurance, and new members will join the fund; and
- greater efficiencies and the ability to contain costs.

(k) Continuation of Sisters of Charity outreach service

The parties have agreed that, if the Acquisition proceeds, LCMHC will continue the highly valued Devonport-based counselling service currently provided to the community of Northern Tasmania by the Sisters of Charity.[37] This service, which seeks to address a shortage in counselling services in Northern Tasmania, was established by the Sisters of Charity within its social accountability program, and is in addition to St Vincent's hospital services.

7.2 Cost savings

As discussed above, the parties believe that the Acquisition will enable the merged entity to adopt a synergistic approach to health care service delivery across St Vincent's and St Luke's. The resulting cost savings will make many of the public benefits discussed above achievable.

Modern private hospitals have very high fixed costs. Staff costs represent 70 per cent of total costs and it is difficult to adjust the majority of staffing levels to correspond with activity fluctuations. Economies of scale and efficient use of infrastructure (including high occupancy of all facilities) must be achieved by hospitals if they are to remain competitive. In this regard, the Acquisition will promote the efficient use of current infrastructure by the parties.

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[37] Funding of the outreach service by LCMHC is capped at $170,000 per annum for the three calendar years of 2005, 2006 and 2007.

There are long term and short term synergies achievable as a result of the Acquisition. The more significant benefits are long term and require structural change. Certain costs are involved in the realisation of potential synergies. For example, redundancies are required in order to achieve reductions in employment costs, and capital investment is required to meet the service requirements of new infrastructure.

The following major categories of synergies will be achieved as a result of the Acquisition:

- clinical service rationalisation;
- capital equipment replacement;
- human resources; and
- purchasing.

(1) Clinical service rationalisation

The most significant long term opportunity presented by the Acquisition is the removal of service duplication between the two sites. At present, the service profiles of the two hospitals have more similarities than differences. Both St Vincent's and St Luke's offer acute medical and surgical services of similar complexity, with an increasing tendency towards short stay or same day surgical admissions.

In many instances, subspecialties are replicated at both sites. This duplication leads to additional capital outlays to equip two hospitals to deliver the same services. In many instances, the equipment available at one site is sufficient to manage the entire case volume of two sites. This is the case, for example, in relation to operating theatres, orthopaedic equipment and general surgery equipment. High technology medical equipment, in particular, is rarely heavily utilised. Therefore, an opportunity exists to coalesce each service line into a single location.

Should the Acquisition proceed, it is expected that one campus will be developed as the location of acute services, including the HDU, while the alternative campus will specialise in the provision of short stay procedures, less acute admissions and, perhaps, post-natal care. Such a rationalisation is likely to enhance the facilities' capacity to provide on-site medical cover (full-time (24 hours)), or at night only (8pm-6am)).

Service rationalisation will generate significant savings in capital investment over time, as duplication of equipment and instruments will be minimised. There will be upfront costs required to move services from one campus to another, but a net saving overall.

The time frame for any changes is at least 12 months to three years, and involves further financial and business analysis, including consultation with stakeholders and determination of necessary capital outlays.

(2) Capital equipment replacement

Capital equipment purchasing does not benefit from corporate buying arrangements to the same extent as the purchase of supplies. This is because capital equipment purchases are sporadic, and are often dictated by service arrangements and doctor preferences. Nevertheless, the

Acquisition will allow greater standardisation of equipment in Launceston and, where appropriate, in CHCT Hobart/Launceston linkages.

A single capital equipment replacement contract for both St Vincent's and St Luke's will allow better capital planning and leveraged purchasing. For example, most anaesthetic monitors are modular and require hospitals to specify the range and quantity of modules supplied. Some modules are rarely used, but are required to be available for safety reasons. Under the Acquisition, one module can support both St Vincent's and St Luke's.

Benefits in this area will not be realised for between one to three years, and will largely depend upon the outcome of a clinical services rationalisation review.

(3) Human resources

A combined service will result in improved opportunities for staff specialisation, staff skill development, and the development of more comprehensive human resource policies and practices.

[confidential material deleted]

(4) Purchasing

Both St Vincent's and St Luke's are currently leveraging purchasing power from their parent organisations. While there is little doubt that the Acquisition will increase the purchasing power of LCMHC, this increase in power is most likely to be noticed in trade with local Tasmanian companies, where national buying power is irrelevant.

Items such as fresh foods, allied health, linen and laundry, service utilities, and maintenance are likely to benefit from increased purchasing power in the local market. These items, however, constitute only a small proportion of total operating expenses (approximately five per cent). A five per cent reduction in unit price across each of these items will result in an annual cost saving of approximately $30,000. However, there may be further savings in administrative costs, with similar procurement systems being installed across both sites.

The time frame for any savings may be 12 months, depending upon expiry/review dates of existing contracts.

[confidential material deleted]

The following potential synergies have also been identified:

- streamlining through a single switchboard and improved billings and admissions processes;
- reduction in the number of meetings;
- reduction in the use of agency staff;
- maximising doctor leave at Christmas and Easter;
- standardising stores, inventory, maintenance, and training;
- creating a single pharmacy;
- expanding community nursing; and
- enhancing education and training.

Following completion of the Acquisition, LCMHC intends rapidly to develop a clinical services plan to examine efficient and effective service distribution between the two campuses. The plan will be prepared in consultation with local medical professionals, health funds, and the local community.

7.3 The future without the Acquisition

The benefits discussed above are unlikely to be achieved absent the Acquisition for the following reasons:

- the sustainability of two private hospitals in a city the size of Launceston is questionable; and
- significant service expansion by either hospital is unlikely in the current environment.

(a) The sustainability of two private hospitals is questionable

Given Launceston's size, the parties believe that its population is best serviced by one private hospital. The growing need for scale in hospitals, and the trend towards consolidation, mean that both St Vincent's and St Luke's will continue to struggle to survive in the current environment. In particular, both hospitals suffer from the oversupply of hospital beds in Northern Tasmania, and from difficulties in attracting and retaining specialists for their facilities. Both hospitals also require significant capital expenditure in order to upgrade their facilities, and such expenditure is unlikely while the hospitals' long-term sustainability is questionable.

The over-bedded nature of private health care in Northern Tasmania leads to reduced financial performance and lower levels of activity for both hospitals, and makes it much more difficult for the hospitals to continue to invest in new technology and obtain a reasonable return on investment to fund future needs. Experience to date suggests that, even if St Vincent's or St Luke's obtains superior technology through investment, doctors working in Launceston will continue to support both hospitals, thereby limiting the growth of both facilities and the return they can get on new technology. Alternatively, if Launceston doctors support only the hospital that is the first to implement new technology, then the other hospital will be placed under considerable financial pressure. In such circumstances, the second hospital is likely to copy the first hospital's capital investment, and both hospitals will consequently receive a lower return. Therefore, while new capital investment will be implemented with both hospitals

operating in Launceston, there will be much more conservative levels of investment and wasteful duplication by both facilities.

Both St Luke's and St Vincent's are currently under-utilised relative to their physical capacity, with each site operating at approximately 65 per cent occupancy on reduced bed numbers. To gain maximum efficiency, private hospitals ideally operate at approximately 80 to 85 per cent occupancy. Actual bed numbers are also important; once a private hospital falls below approximately 100 beds, it is very difficult for it to manage the overhead costs associated with management, payroll, accounting, maintenance and human resources. Once bed numbers drop below 100, overhead expenses become a significant proportion of total costs, and a small hospital will struggle to survive unless private health funds support its existence through additional fee payments. While health funds may observe a need for this in certain remote and regional markets, such support is unlikely to be forthcoming in circumstances where there are two hospitals supplying services in a sector where demand could adequately be met by one.

While the financial position of St Vincent's has improved over the past two years, its forecast result is dependent on it maintaining its current level of activity. With strong competition for doctors between public and private hospitals in Northern Tasmania, St Vincent's activity and profitability can diminish rapidly if doctors move their practices away from the hospital.[38] Such volatility in activity and profitability is not strategically sustainable. To reduce the impact of financial volatility, St Vincent's strategic plan has, for several years, included the merger of St Vincent's and St Luke's. This strategy is supported by St Vincent's and St Luke's medical advisory committees and by the AHA Report referred to above at 5.2(a).

In a "consensus letter" to the chief executive officers of St Vincent's and St Luke's dated 13 March 2001, the members of the hospitals' medical advisory committees expressed their "serious concern about the future of private medicine in Launceston". The letter states:

> *"We note with much disquiet the difficulties that arise from the existence of two tightly competitive and duplicating private hospitals in this city. It is our belief that these hospitals continue to be financially under threat in spite of all best endeavours. As such they cannot accommodate the development of new services which would guarantee the future provision of quality private medicine and surgery to the Northern region. As representatives of the specialist fraternity that use both of the private hospitals of Launceston, we feel there is an urgent need to address this issue.*
>
> *We request that the Management Boards of both hospitals realistically consider this dilemma and how best it may be resolved. The options are indeed difficult and limited:*
>
> *1. Voluntary closure of one hospital.*

---

[38] **[confidential material deleted]**

2. Take-over of one hospital by the other.

3. Amalgamation of both hospitals in some form."

The letter listed the following as advantages of amalgamation:

(1) single administration/single operating systems/economies of scale supporting the survival of both institutions;

(2) avoidance of duplication of services, staff and equipment;

(3) rationalising of staff rostering, allowing movement between hospitals as needs arise;

(4) potential for alternating after-hours services with more cost effective rostering of on-call staff;

(5) improved training for nursing and ancillary staff who wish to specialise;

(6) potential for cost effective campus specialisation;

(7) more rational and economical funding of new and replacement equipment with confidence to invest in modern technology;

(8) improved negotiating power with health funds;

(9) realistic bargaining power with DVA;

(10) improved patient care through combined access to data by both hospitals;

(11) marketing of realistic rental facilities at both hospitals; and

(12) improved clinical confidence in both hospitals.

The letter also identifies the following as desirable developments which should be available in a city the size of Launceston, but which "are currently thwarted" by the existence of two private hospitals:

(A) ICU – without the backup of a dedicated ICU in addition to an HDU, leading edge surgery and other complex procedures cannot currently be offered by either facility. The doctors write that, "unless this situation is promptly addressed ... it will be impossible to retain ... skilled practitioners and encourage new specialists to Launceston".

(B) Department of Emergency Medicine with 24 hours medical cover within the hospitals.

(C) A first rate coronary care facility.

(D) Investigational and interventional angiography services, servicing cardiology and vascular surgery.

(E) Obstetric, neonatal and paediatric facilities.

(F) A dedicated psychiatric unit.

(G) A single room with ensuite facilities to all patients who request it.

A copy of this letter is provided at Appendix E.

The AHA Report aimed to assist St Vincent's to identify and implement its strategic needs for restructure and reform in order to maintain and improve health services in Northern Tasmania. As a regional private hospital, St Vincent's sought assistance to develop a strategic service plan that identified a strategic direction designed to enhance and maintain the long term viability of the facility whilst improving the community's access to health services. The AHA Report states that, as a result of the surplus in private hospital beds in Tasmania, St Vincent's and St Luke's

> *"compete for patients and medical specialists. The end result is that neither [h]ospital can achieve a profit and both have a significant deficit of net assets and are highly dependent upon the goodwill and ongoing financial support of their related 'parent' organisation."*[39]

The AHA Report's executive summary states:

> *"St. Vincent's Hospital Launceston's current financial problems arise from historical strategic decisions, including borrowing $7 million to redevelop sections of the Hospital including the establishment of an accident and emergency department and coronary intensive care unit, that subsequently proved to be non-viable.*
>
> *Recovering from the consequential ongoing financial burden will require long-term strategic initiatives rather than short-term service growth solutions which themselves may prove unsustainable in the current over-competitive operating environment."*[40]

Having canvassed a number of options, the AHA Report recommends that, in the short term, St Vincent's should improve its operational efficiency as a matter of some urgency to ensure its continued survival as a financially viable entity. In the longer-term, the AHA Report recommends that St Vincent's should pursue a merger with another hospital:

> *"One scenario would involve a closer association with other Catholic hospitals such as Calvary Healthcare Tasmania in Hobart or the St. Vincent's and Mercy Private Hospital in Melbourne. An alternative approach would be a merger, amalgamation or collaborative association with St. Luke's Private Hospital, in order to rationalise current service duplication and to prevent unnecessary competition for patients and medical specialists."*[41]

There are inherent difficulties in predicting the future of the health care industry in Northern Tasmania. However, the commercial volatility of the hospital industry, and the excess of private beds within the region, leads to the conclusion that the existence of two private hospitals in Launceston is not sustainable in the medium term if separate ownership is maintained. The Acquisition is therefore essential to avoid the deterioration and eventual closure of one or both of St Vincent's and St Luke's. While two hospitals with less than 100 beds are not sustainable, one hospital with more than 100 beds is sustainable in both the short and long term.

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[39] At p 4.

[40] At p 6.

[41] At pp 5-6.

(b) Significant service expansion by either hospital is unlikely in the current environment

For a private hospital to ensure its future sustainability, it must do more than simply maintain its existing level of services, which itself necessitates significant expenditure. In order to provide cutting edge care, hospitals need constantly to update their facilities and technology. Even if St Vincent's is able to continue operating in the short term, it is unlikely to be able to invest the resources necessary to enable it to keep up with developments in the industry. The changing nature of private hospitals, as discussed above, with their increasing emphasis on day procedures at the expense of traditional longer stay bed occupancy, will necessitate ongoing capital expenditure in order to maintain a relevant physical infrastructure. St Vincent's is currently not in the strong financial position required to ensure that it accumulates the resources necessary to maintain a contemporary hospital.[42]

[Confidential material deleted]

St Vincent's does not, on its own, have the capacity significantly to increase existing services or to introduce new services. Such measures require significant capital, which St Vincent's does not have, and the expenditure of which it could not justify. As stated in the AHA Report, given St Vincent's "precarious viability", it would be "financially imprudent [for it] to embark upon any potential service expansion initiatives that will require substantial capital or management resources".[43]

Medium to long term decisions, such as service expansion requiring major capital investment, will proceed with less difficulty under a single service provider. The Acquisition is therefore the best means through which to ensure that private health care in Tasmania is supported, sustained, and expanded.

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[42] Final Report, *Strategic Services Planning for St Vincent's Hospital Launceston*, December 2002, p 40.

[43] Final Report, *Strategic Services Planning for St Vincent's Hospital Launceston*, December 2002, p 45.

7.4 What will the parties do absent the Acquisition?

In the short term, St Vincent's and St Luke's will continue to operate, and this inevitably will lead to more duplication and waste, at a high cost to the community. LCMHC may look to force St Vincent's out of the market through increasing its investment in St Luke's to make St Luke's the more attractive hospital to stakeholders. CHCT could use its capital reserves and the administrative synergies available from its other facilities in Tasmania to support and expand St Luke's. However, St Vincent's could counter in a similar way, and attempt to minimise activity losses by drawing upon its national parent to purchase new equipment similar to that purchased by St Luke's. The end result would be that the two hospitals would continue to engage in wasteful duplication, to the detriment of the community. Even if this were to occur, the level of service provided by either hospital would not be increased to that possible if the Acquisition were to go ahead.

If the Acquisition does not take place, then there is a strong likelihood that St Vincent's will eventually close. St Vincent's is unlikely to be able to maintain its recent profit results, and will probably return to deficit in one to three years. This result is more likely if LCMHC pursues its current growth strategy in Northern Tasmania. It will then be up to the Sisters of Charity as to whether to keep cross-subsidising the hospital, sell it to another provider, or close it. Past experience suggests that the Sisters of Charity may be prepared to abandon St Vincent's in certain circumstances.[44]

It is highly unlikely that any other Catholic provider would wish to purchase St Vincent's, as no other such provider currently operates in Tasmania. While the option of sale to a non-Catholic provider exists, this would be inconsistent with the mission and values of SCHS, and is therefore highly unlikely. It would also be more difficult to gain approval from the Holy See for such a transaction, as discussed at 2.3 above. Further, the other major operator in private health care in Tasmania, Healthscope, is unlikely to be interested in purchasing St Vincent's. Service closure would therefore be the most likely outcome.[45]

8 Competition analysis

8.1 Substitutability between public hospitals and private hospitals

In Authorisation A90679, dated 21 December 1998, the Commission said that "while there is certainly substitutability between public and private hospitals there may well be differences in the degrees and directions in which such substitution occurs". The Commission noted that gaps in insurance cover for private hospitals, waiting lists in public hospitals, and the availability of highly specialised services were relevant factors. The overall impression was that "competition to private hospitals from public hospitals is in decline", and this decline is expected to accelerate with the growth in health fund membership.

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[44] For example, St Vincent's Riverina was recently abandoned back to government control.

[45] Another option is that St Vincent's is turned into an alternative model of service (for example, old aged care).

SCHS and LCMHC submit that, based on St Vincent's and St Luke's case mixes and other relevant factors, there is strong substitutability between themselves and Launceston General Hospital in the patient market in Northern Tasmania. In particular, almost all (if not all) of the doctors working at St Vincent's and/or St Luke's have visiting rights at Launceston General Hospital. All in-patient services provided by St Luke's and St Vincent's are duplicated by Launceston General Hospital. Further, Launceston General Hospital has the only emergency centre in Launceston, so private patients arriving via the emergency centre are likely to undergo their procedure at Launceston General Hospital rather than be transferred to either of the private facilities, especially given that most doctors work in all three facilities. We have also discussed the increasing number of private patients going to public hospitals in Tasmania at 5.2(e).

However, for an analysis of concentration ratios in the hospital/patient market, we have considered both a market including the public and private sector, and a market confined to private hospitals.

8.2 Market analysis

In recent authorisation decisions, the Commission has described the health sector as involving five principal groups: public hospitals, private hospitals, doctors, patients, and health funds. These groups are inter-related in one way or another and each depends on the others to varying degrees. The Commission has pointed out that "[d]efining the relevant market or markets in such circumstances is difficult as the boundaries between them are often unclear or overlap and there may be flow on effects from one market to another".[46]

In relation to the operation of private hospitals, the Commission has identified the following six main product markets:

(1) the market for the provision of hospital services to patients;

(2) the market for the provision of hospital facilities and services to doctors;

(3) the market for the provision of medical services to patients by doctors;

(4) the market for the provision of health insurance services to the general public;

(5) the market for the provision of private hospital services to health insurers (HPPAs); and

(6) the market for the provision of private medical services to health insurers (MPPAs).

The parties consider that the Acquisition affects markets (1), (2) and (5).

(a) The provision of hospital services to patients

The Commission has expressed the view that the hospital-patient market is relatively local due to the preference of patients to enter a hospital close to home where they can be near family, friends, known medical practitioners, and follow

[46] Authorisation No. A50019, 1 September 1999, p 30.

up care if needed.[47] However, where highly specialised medical care is not available locally, patients are likely to travel to receive the required services.

The parties consider that the relevant market is wider than the Launceston market. The catchment area from which St Vincent's and St Luke's draw the majority of their patients is Northern Tasmania, including Launceston and the areas north and north-west of the city. The total population of this catchment area is approximately 130,000 in seven local government areas. St Vincent's admission data for the two year period ended 30 June 2004 indicates that 72 per cent of the hospital's admitted patients came from this area.

Because Tasmania is not densely populated, patients often travel some distance to receive hospital care, and both hospitals treat patients travelling to Launceston from outside Northern Tasmania. Admission profiles indicate that patients to the east of Launceston will travel up to 100 kilometres from towns such as Perth, Evandale, Scottsdale, Bridport, St Helen's, St Mary's, Campbell Town and Bicheno to attend the facilities. To the west, the catchment only extends approximately 50 kilometres to cover areas such as George Town, Longford, Westbury and Deloraine. Beyond this, people in the west will tend to travel to Devonport (Latrobe) or Burnie, unless the service they require is unavailable in those locations. St Vincent's admission data indicates that 17 per cent of its admitted patients come from North-western Tasmania, 6 per cent from North-eastern Tasmania, and 5 per cent from elsewhere.

The major determinant of a patient's choice of hospital is the treating doctor. The reputation of the hospital, and a patient's prior experience of the hospital, are also relevant, but much less so. Most private hospital admissions occur under specialists, so the key determinant is the hospital at which the specialist prefers to work. Because a number of specialists work at both St Vincent's and St Luke's, patient preference becomes more important in Northern Tasmania, as does available dates for admission. For example, a specific surgeon may not have theatre time available for 10 days at hospital A, but has a space in hospital B in two days. The urgency of the admission and the personal circumstances of the patient are then likely to influence his or her final choice.

St Vincent's and St Luke's generally provide equivalent hospital and medical services to patients, with a few exceptions. The areas where there is no overlap are ophthalmology and post natal services, which are provided only at St Luke's, and lithotripsy and sleep study services, which are provided only at St Vincent's. Ophthalmology is also provided by the Eye Hospital. Launceston General Hospital provides a similar range of hospital and medical services to St Vincent's and St Luke's.

The following table illustrates the medical services provided by St Luke's, St Vincent's, Launceston General Hospital, and the Eye Hospital.

Specialty	St Luke's % revenue	St Vincent's % revenue	LGH	The Eye Hospital
Urology	[confidential material deleted]	[confidential material deleted]	Yes	No

[47] Authorisation No: A50019, 1 September 1999, p 33.

Obs & Gynae	[confidential material deleted]	[confidential material deleted]	Yes	Yes (IVF)
Gastroenterology	[confidential material deleted]	[confidential material deleted]	Yes	No
Oncology	[confidential material deleted]	[confidential material deleted]	Yes	No
Orthopaedics	[confidential material deleted]	[confidential material deleted]	Yes	No
General Surgery	[confidential material deleted]	[confidential material deleted]	Yes	No
ENT Surgery	[confidential material deleted]	[confidential material deleted]	Yes	No
General Medicine	[confidential material deleted]	[confidential material deleted]	Yes	No
Ophthalmology	[confidential material deleted]	[confidential material deleted]	Yes	Yes

(b) The provision of hospital facilities and services to doctors

The geographic extent of the market for the provision of hospital facilities and services to doctors is likely to be relatively local, for similar reasons to those expressed above in relation to the provision of hospital services to patients.

Generally, medical practitioners who refer work to St Vincent's, also refer work to St Luke's and Launceston General Hospital, and vice versa.

[confidential material deleted]

(c) The provision of private hospital services to health insurers (HPPAs)

As compared to the hospital–patient and hospital-doctor markets, the Commission considers the geographic extent of the private hospital–health insurer market to be less clear cut. On the one hand, health funds have the potential to operate on a national basis and some private hospital chains operate on a national basis; on the other hand, insurers need adequate coverage to provide an attractive product to members and must, therefore, have contracts with private hospitals within each local area.

[confidential material deleted]

The outputs of the hospitals are services delivered to patients (for example, nursing care, accommodation, and procedures). These services are generally paid for by health funds under a schedule of fees covering accommodation (including nursing care and hotel services) and operative procedures. While the fees charged are the responsibility of the patient, in most instances a third party funding agent is involved (for example, a health fund or DVA). Funding agents meet the proportion of the cost specified in the health insurance product sold to the patient, with an excess or co-payment being paid by the patient where applicable. These co-payments are either fixed (for example, $250 per admission), or pro-rata (for example, $50 per day), but in nearly all instances can be estimated prior to admission. Most funding agents enter into contracts to control the total fee being charged by the hospital, irrespective of what proportion the funding agent will actually meet, resulting in agreed fee schedules being in place between each health fund and the hospital.

In relation to private hospitals, the price negotiations between hospitals and health funds have little direct impact on individual patients, as their share of any treatment cost is usually set on a national basis by the health fund. The negotiations centre on the amount being paid by the funder. The indirect consequence is that increased payments to hospitals will place upward pressure on premiums to members.

Both St Vincent's and St Luke's have HPPAs with the following health insurance funds:

- Medibank Private;
- DVA;
- MBF;
- Australia Regional Health Group Limited, comprising:
  - (A) Cessnock District Health Benefits Fund,
  - (B) Federation Health,
  - (C) GMHBA,
  - (D) Latrobe Health Service,

(E) Mildura District Hospital Fund,

(F) St Luke's Health,

(G) United Ancient Order of Druids Friendly Society, and

(H) Westfund;

- Australia Health Services Alliance Limited, comprising:

(A) ACA Health Benefits Fund,

(B) AMA Health Funds Limited,

(C) Australian Health Management Group Limited,

(D) Australian Unity Health Limited,

(E) Credicare Health Fund,

(F) CBHS Friendly Society Limited,

(G) Defence Health Limited,

(H) Druids Friendly Society,

(I) GMF Health,

(J) Grand United Corporate Society,

(K) Grand United Friendly Society,

(L) Health Guard Health Benefits,

(M) Health Partners,

(N) IOOF Health,

(O) IOR Health Benefits,

(P) Lysaght Peoplecare,

(Q) Manchester Unity Friendly Society NSW Limited,

(R) Navy Health Limited,

(S) Police Health,

(T) Phoenix Health Fund Limited,

(U) Queensland Country Health Limited,

(V) Railway and Transport Employees Friendly Society Health Fund Limited,

(W) Reserve Bank Health Society Limited,

(X) SGIO Health/SGIC Health/NRMA Health,

(Y) Teachers Federation Health,

(Z) Teachers Union Health, and

(AA) Transport Friendly Society.

In addition, St Luke's and St Vincent's have service agreements in place with the Motor Accidents Insurance Board (**MAIB**)[48] and in relation to cases covered by workers' compensation insurance.[49]

The HPPAs cover all available services and follow a standard format for each health fund.

[confidential material deleted]

Negotiation of fee schedules with health funds is usually an annual event. Traditionally, this negotiation has centred on cost increases being borne by the hospital, which are balanced off against the desire of health funds to minimise any increases in premiums to members. While the health funds know that few hospitals can continue to operate without contracts being in place with major funders, they also risk losing members if a particular hospital is not covered, especially given the fact that patients (and their doctors) exercise significant control over where a patient is admitted.

[confidential material deleted]

In general, hospitals are currently unable to negotiate price increases with health funds that meet their cost increases. This is partly because of increased utilization of private health insurance, which is driven by the ageing of the population, and the availability of new, and more costly, technology. The view of health funds is that it will be necessary to limit the price increases of private health insurance products to maintain the health funds' membership base, and private funds have openly adopted a focus of "sustainable affordability".[50] The effect of health funds limiting private health insurance product price increases will be restrictions on the money available for price increases for the provision of health care services by private hospitals.

The mechanism for the negotiation of prices with the merged entity would remain the same under the Acquisition, with the merged entity taking the same factors into account in negotiations with health funds.

The reimbursement rates provided by health funds to St Vincent's and St Luke's are likely to remain low relative to the national average. This is a result of both the depressed nature of the Northern Tasmanian economy and the need for both the service provider and the health fund to maintain the affordability of the health fund product. While the Acquisition will improve the negotiating position

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[48] MAIB provides third party insurance through vehicle registrations to cover injuries. Motor accident victims can use this insurance to fund their care in the private hospital sector.

[49] Workers' compensation insurance is, in fact, a number of insurance companies licensed to offer insurance against work related illness or injury in Tasmania. Workers' compensation insurance can fund treatment within the private hospital sector.

[50] This term was used by the health funds at the Health Insurance Summit 2004 (BUPA/Medibank Private present). It was used in the context of health funds wanting to contain the prices of health insurance products by maintaining them as close as possible to CPI, for fear of membership fallout.

of St Vincent's and St Luke's in relation to the health funds, because the hospitals will no longer be 'played off against each other', in reality, this will only improve the hospital's negotiating position from a very weak position to a slightly stronger one.

[confidential material deleted]

One benefit of the Acquisition will be that the administrative burden and cost of negotiating HPPAs will be halved for both the hospital and the health funds.

St Luke's Health has expressed strong support for the merging of the two hospitals into one. The rationale, as expressed by St Luke's Health, is that a reduction in wasteful duplication of equipment and services at the two hospitals will allow funds to be spent recruiting new specialists and establishing an expanded service range. This, in turn, will provide St Luke's Health with the opportunity to market the benefits of private health to sustain and grow its membership based. At present, Launceston is losing specialist services, particularly in the private sector, and this threatens the desirability of private health insurance.

The DVA has also expressed support for the development of a single private hospital service provider in Northern Tasmania and has expressed concern that the current level of duplication may be reducing the range of services available.

8.3 Competitive effects of the Acquisition

(a) Introduction

The Acquisition will not lead to a lessening of competition in any of the markets in which St Luke's and St Vincent's operate for a number of reasons. First, in the long term, St Vincent's is unlikely to continue operating as an independent facility. Even in the short to medium term, St Vincent's will not be in a position to compete effectively with St Luke's. This is not surprising, considering the environment in which St Vincent's operates. As discussed above, Northern Tasmania is an over-bedded market, with a declining population and steadily decreasing rates of health insurance coverage. As a small, regional population centre, Launceston is not able to sustain two private hospitals, as illustrated by the number of comparable population centres with just one private facility. Consequently, both St Vincent's and St Luke's will struggle to attract highly skilled professionals and provide quality health care services while they continue to operate as independent facilities. If the Acquisition does not take place, the most likely outcome is that, in the medium term, St Vincent's will return to deficit, and will most likely close, or be converted into an alternative model of service. Even if the two hospitals were to continue operating independently, the level of service provided by either hospital would not be increased to that possible if the Acquisition were to go ahead.

Second, Launceston General Hospital provides effective competition to St Vincent's and St Luke's. The trend of public hospitals in Tasmania increasingly competing for private patients is discussed above at 5.2(e). Data suggests that the number of private patients being admitted to public

hospitals in Tasmania has increased significantly in recent years. Further, almost all of the doctors working at St Vincent's and/or St Luke's have visiting rights at Launceston General Hospital, and the public hospital duplicates all in-patient services provided by St Luke's and St Vincent's. In addition, because Launceston General Hospital has the only emergency centre in Launceston, private patients arriving via the emergency centre are likely to be treated at Launceston General Hospital. Whatever the case may be in relation to the broader Tasmanian or Australian health care market, the hospitals, doctors and community in Northern Tasmania see Launceston General Hospital as an alternative to the St Vincent's and St Luke's.

Third, new and existing day surgery facilities will continue to provide effective competition to the merged St Vincent's/St Luke's. The relatively low start-up costs for day surgery facilities, and the recent experience of the Eye Hospital, are discussed in further detail below at (c). Already, 60 per cent of the procedures performed at the hospitals are day surgery procedures, and this percentage is likely to increase significantly in the future. In relation to overnight surgery and other acute care services, the first two points above indicate that the Acquisition will not lead to a lessening of competition in the market.

Fourth, if one looks at the competitive dynamics of the market, it is evident that the Acquisition will not lead to a lessening of competition. Even with the Acquisition, the health funds will continue their strong negotiating position with the merged facility. The Acquisition will have no direct impact on the prices charged to patients, as these are determined by the health funds on a national basis. Rather than resulting in an increase in prices, and/or a reduction of services, the Acquisition will lead to a significant increase in the quality and nature of services provided to both patients and doctors.

(b) Market concentration

A table setting out the bed shares of hospitals in Tasmania (both public and private) is attached to this submission at Appendix F. A table setting out the bed shares of private hospitals in Tasmania is attached to this submission at Appendix G.[51]

The following table illustrates St Vincent's and St Luke's bed shares:

		St Vincent's %	**St Luke's %**	**St Luke's + CHCT (LCMHC) %**	**CR4 %**
Market includes private and public hospitals	Launceston	23.02	23.56	23.56	100.00
	Northern Tasmania	19.91	20.37	20.37	92.23
	Tasmania	5.89	6.03	20.62	84.52

[51] The data in Appendix F and Appendix G, and that in the table below, does not take into account the transfer of Mersey Community Hospital from private to public ownership in December 2004.

Market includes only private hospitals	Launceston	48.30	49.43	49.43	100.00
	Northern Tasmania	48.30	49.43	49.43	100.00
	Tasmania	12.99	13.30	45.50	99.39

Apart from CHCT and SCHS, the other major operator of private hospitals in Tasmania is Healthscope. It current holds 37.3 per cent of licensed or available private hospital beds in Tasmania.[52]

(c) Barriers to entry

Given the existing barriers to entry into the health care market, the Acquisition will not create new barriers to entry. If anything, by lowering the number of participants in an over-bedded market, the Acquisition will make it more conceivable for a new entrant to enter the market, or for an existing player to expand its services and facilities.

The capital intensive nature of the health care industry means that the entry of a new, general service hospital in Northern Tasmania, which would require substantial building or renovation, is unlikely. The capital cost of building a new hospital is $250,000 to $400,000 per bed, and much of this is sunk cost.[53] Few private hospital operators would consider construction of a new inpatient facility of less than 100 beds, as the infrastructure costs require this scale if they are to be recouped. At a minimum scale of 80 beds, the initial cost of entry into a market is therefore approximately $20 to $32 million. It would be difficult for a new provider to achieve an acceptable rate of return on capital investment given the current population-to-service ratios. With respect to a 100 bed facility, if occupancy levels of approximately 70 per cent are not achieved, capital depreciation and financing costs will exceed gross margin.[54]

Consequently, the most significant competitive threat to St Vincent's and St Luke's is the entry of a new day surgery, or the further expansion of the Eye Hospital or the existing gynaecological clinic, which is operated by Gynaecology Centres Australia.. As discussed earlier at 4.2(b), a major trend in private health care is the move to day surgery centres, as bed days decrease and the number of procedures being done as day procedures increases. The Eye Hospital has already expanded significantly since its inception as an ophthalmological practice, introducing first plastics services, and now IVF. It is currently operating at capacity, but there is no reason why it cannot acquire more land and expand its services further. The capital costs of a new free-standing day surgery centre are much lower than those involved in the establishment of a general service hospital, and will fluctuate widely depending on the service range offered. For example, a single discipline, single theatre day surgery specialising in endoscopy or

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[52] This figure does not take into account Healthscope's recent relinquishing of Mersey Community Hospital to the Tasmanian Government.

[53] Modern private hospitals are purpose built facilities with few alternative uses. Closure of a private hospital is likely to see the majority of the capital investment lost. The best outcome is sale to another operator or, possibly, conversion to a nursing home. Second hand private hospitals sell for somewhere between $50,000 to $200,000 per bed if a market exists. Losses of up to 50 per cent of establishment costs are not uncommon.

[54] St Luke's is currently averaging 65 per cent occupancy.

ophthalmology or plastic surgery would involve capital costs of $1.5 to $3 million. A same day cancer chemotherapy centre could be established for less than $1 million.

The Gynaecological Clinic was recently opened to provide a limited range of same day procedures related to fertility. It has been established in premises previously housing the Queen Victoria Medical Centre and Hospital, a publicly operated women's hospital for obstetrics and gynaecology, whose services were centralised to Launceston General Hospital when it was rebuilt. The buildings in which the Gynaecological Clinic is located are capable of being refurbished to expand the clinic's capabilities, which further lowers the capital cost involved in it establishing new day procedure facilities. The owners are currently canvassing this option amongst surgeons/proceduralists in Launceston.

9 Conclusion

Northern Tasmania is a region suffering from an oversupply of hospital beds, a depressed economy, and a declining and ageing population. These factors are placing increasing pressure on the region's health care facilities.

In Launceston, the presence of two private hospitals is causing wasteful duplication, at a high cost to the community. While the current situation exists, significant improvements in services provided by either hospital are unlikely.

Considered in this context, the Acquisition plainly offers material public benefits. Most importantly, it will result in new, expanded and better services for both patients and doctors, all delivered at a lower cost. Moreover, the Acquisition will help to ensure the long-term sustainability and continued development of private health care in Northern Tasmania.

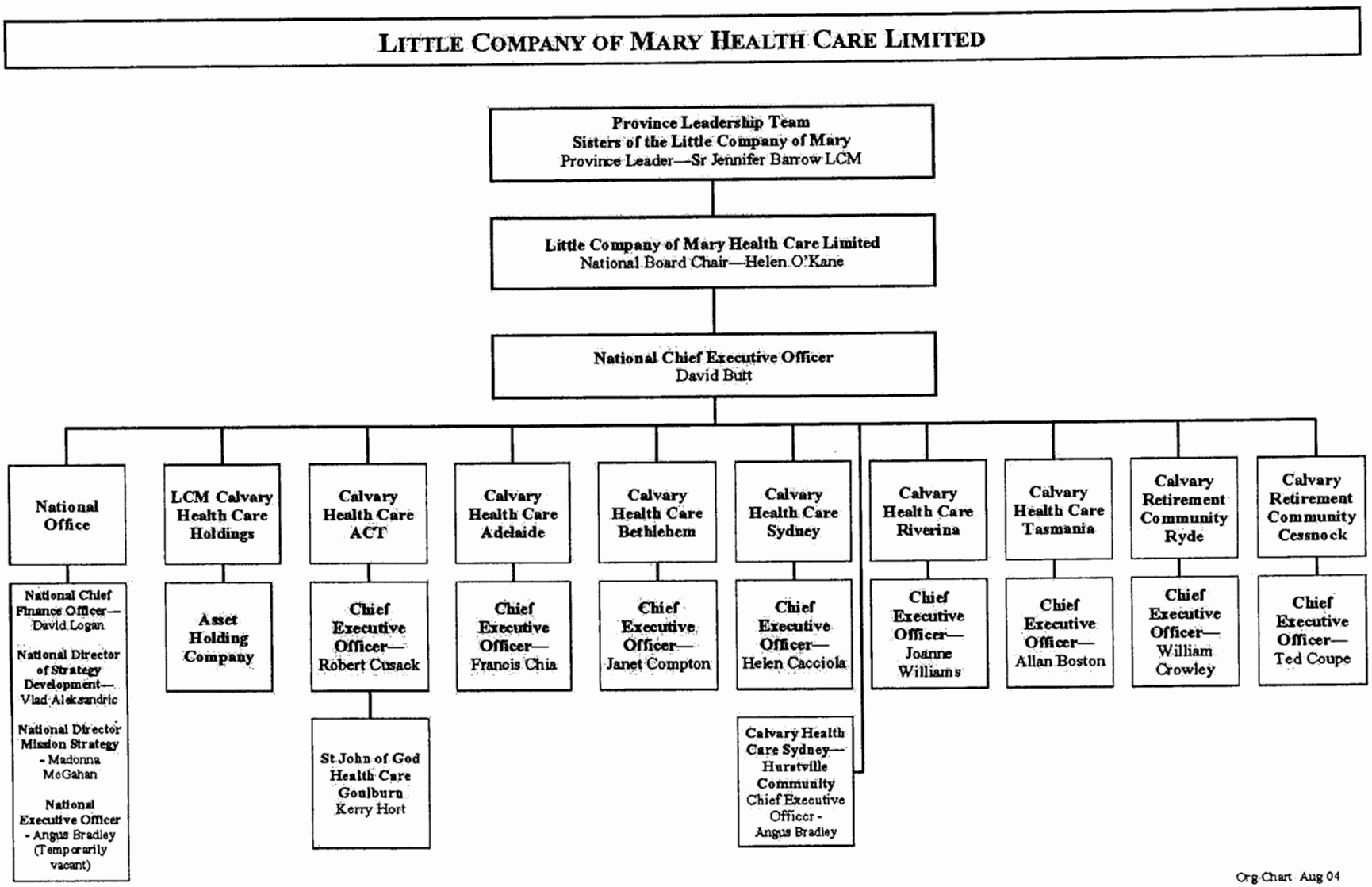
Further, when the competitive landscape is examined, it is obvious that the Acquisition will not result in a substantial lessening of competition in any market. Most significantly in this regard, new and existing day surgery facilities will continue to provide effective competition to the merged entity, and health funds will continue to exercise significant countervailing power. Rather than resulting in an increase in prices and/or a reduction of services, the Acquisition will lead to a significant increase in the quality and nature of the services provided to both patients and doctors.

Given the above, it is not surprising that all relevant stakeholders – from representatives of the Tasmanian Government through to Launceston community representatives and hospital staff – have expressed support for the Acquisition. The question these stakeholders have been asking is not *if* but *when* the Acquisition will take place.

This is a merger that should be allowed to take place.

Appendix A removed by reason of confidentiality

Appendix B: LCMHC organisational structure



LCMHC companies

LCMHC operates the following health and aged care services:

(a) Calvary Health Care ACT

- Calvary Public Hospital (established 2 March 1979), a 159-bed, acute hospital providing general medical and surgical services, material services, emergency, and outpatients services.
- Calvary Private Hospital (established 18 June 1987), a 109-bed, acute private hospital providing general medical and surgical services, and maternity services.
- Hyson Green, a private psychiatric service.
- Clare Holland House, providing public hospice and community-based palliative care services.

(b) Calvary Health Care Adelaide

- An acute private hospital (founded on 24 March 1900) providing general medical and surgical services, and maternity services.
- Mary Potter Hospice, providing both public and private palliative care services.

(c) Calvary Health Care Bethlehem (Melbourne)

- A sub-acute public hospital, which was opened in 1982, and provides specialist inpatient and domiciliary palliative and neurological services, geriatric evaluation and management services, home respite care, bereavement services, and day centre programs.
- Calvary Health Care Bethlehem operated a private hospital between 1941 and 1982.

(d) Calvary Health Care Riverina (Wagga Wagga)

- Calvary Hospital Wagga Wagga (established 30 August 1926), a 104-bed, acute private hospital providing general medical and surgical services including cardiac catheterisation, and maternity services.
- Alcohol and other drug services, including O'Connor House (established 3 September 1978), the Peppers Drug Service (established 12 June 2001), and the Home Detoxification Service.
- Calvary Day Procedures Centre (acquired by Calvary on 22 April 2002), a free standing day procedures centre in Wagga Wagga with three procedure rooms, 13 stage one recovery places, and 15 stage two places.

(e) Calvary Health Care Sydney

- Calvary Hospital Kogarah (established 7 March 1965), a 100-bed, sub-acute public hospital providing palliative care and rehabilitation services, the State-wide Artificial Limbs Scheme, community based palliative care, rehabilitation, and home nursing.

- Hurstville Community, acquired by LCMHC on 16 February 2004.

(f) Calvary Health Care Tasmania

- Calvary Hospital Campus Lenah Valley (commenced on 18 October 1938), an acute private hospital providing general medical and surgical services, maternity, neurosurgery, cardiac catheterisation, and emergency services.
- St John's Hospital Campus (acquired in October 2000), an acute and sub-acute private hospital providing general medical and surgical services, and palliative care services.
- Rehabilitation Services Campus, New Town (acquired in 2001), providing a broad range of outpatient rehabilitation services to adults and children.
- St Luke's Campus of CHCT (SLPH), acquired in May 2004.

(g) Calvary Retirement Community Cessnock

- A 336 place aged care and retirement community in the Hunter Valley, NSW, acquired by Calvary Health Care on 2 January 2003.

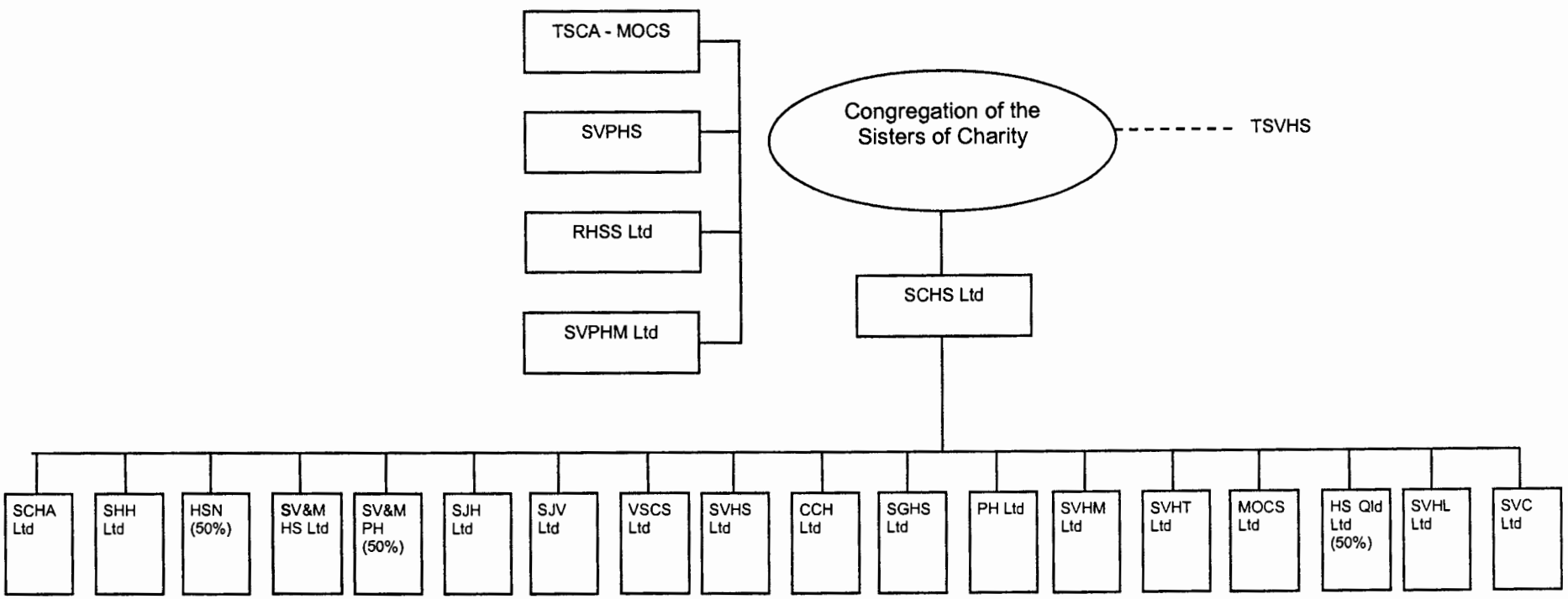
(h) Calvary Retirement Community Ryde

- The Mary Potter Nursing Home (including a 20 bed dementia unit), established in the 1890s.
- The Marian Hostel, established on 2 June 1993.
- The Dalton Gardens Retirement Village, which was opened on 14 April 1997, and has independent living units.
- The Mt St Margaret's Hospital was operated between 1891 and 1991.

(i) St John of God Health Care Goulburn

A third schedule public hospital and health service provider located in the NSW Southern Tablelands, which provides a range of sub-acute and non-acute inpatient and outpatient services. In December 2002, St John of God Health Care invited LCMHC to assume strategic and operational management responsibility for St John of God Goulburn, through Calvary Health Care ACT.

Appendix C: SCHS organisational structure



- Research Facilities have been excluded (Garvan Institute, VCCRI, SVIMR, BOIM)

SCHS governance reporting lines

The following are the main boards that report to the SCHS National Board:

(a) St Vincent's and Mater Health Sydney Board

Established in 2001, St Vincent's and Mater Health Sydney (SV & MHS) comprises the following legal entities:

- St Vincent's Private Hospital Sydney – conducted by the Sisters of Charity Congregation;
- St Vincent's and Mater Health Sydney Limited – operates the Mater Hospital North Sydney and is the vehicle for group wide operations;
- Sacred Heart Hospice Limited – a public hospital; and
- St Vincent's Hospital Sydney Limited – a public hospital.

(b) St Joseph's Hospital Auburn and St Joseph's Village Auburn Boards

- St Joseph's Hospital Limited – an affiliated organisation under the Health Service Act 1997 (NSW); reports to the Western Sydney Area Health Service;
- St Joseph's Hospital Auburn – a public hospital;
- St Joseph's Village Limited – an aged care facility.

(c) St Vincent's Health Melbourne Board

The Board of St Vincent's Health Melbourne (SVH Melbourne) comprises the following reporting facilities:

- St Vincent's Hospital Melbourne Limited – a public hospital;
- Caritas Christi Hospice Limited – a public palliative care facility;
- Prague House Limited – a residential facility for homeless men;
- St George's Health Service Limited – aged care facilities; and
- Eastern Palliative Care – an incorporated association with four sponsoring bodies.

(d) St Vincent's and Mercy Private Hospital Limited Board (Melbourne)

SCHS and Mercy Health and Aged Care Inc (MH & AC), through its partnership with SCHS, are the members of St Vincent's and Mercy Private Hospital Limited (SV&MPH) in Melbourne.

(e) Sisters of Charity and Holy Spirit Health Service Queensland Board

SCHS and Holy Spirit Care Services Limited (HSCS) are the Corporations Law members of Sisters of Charity and Holy Spirit Health Service Queensland (SC & HS HS Queensland). The directors of SC & HS HS Queensland are also the directors of the three facility boards reporting to SC & HS HS Queensland, namely:

- St Vincent's Hospital Toowoomba Limited – a private hospital;
- Mount Olivet Community Services Limited – aged care facilities; and

- Holy Spirit Northside Private Hospital Limited – a private hospital.

(f) St Vincent's Hospital Launceston Limited Board

The SVHL Board reports directly to the SCHS National Board. It also retains an advisory council linked to the local community.

Appendix D removed by reason of confidentiality

Appendix E: Letter from Medical Advisory Committees

Mr Mike Monsour,
Chairman,
Medical Advisory Board,
St Luke's Private Hospital,
C/- 38 Elphin Road,
LAUNCESTON, 7250

Mr John Batten,
Chairman,
Medical Advisory Board,
St Vincent's Hospital Launceston,
C/- 152 St John Street,
LAUNCESTON, 7250

Dear Messrs Monsour, Batten and Representatives of Medical Advisory Committees,

We acknowledge receipt of your letter of 13 March 2001 regarding St Luke's Private Hospital and St Vincent's Hospital Launceston. We note your concern for the future of Private Health Services in Launceston.

We look forward to discussing these issues further following consultation with our Hospital Boards and will be in contact with you again as soon as possible.

Yours sincerely,

Kaye Gillespie,
Executive Director/Director of Nursing
St Vincent's Hospital Launceston

Colleen McGann,
Chief Executive Officer,
St Luke's Private Hospital

16 March 2001

doc. 4

13th March 2001

Ms Colleen McGann
The Chief Executive Officer
St Luke's Private Hospital
Lyttleton Street
LAUNCESTON 7250

Ms Kaye Gillespie
The Chief Executive Officer
St Vincent's Private Hospital
Frederick Street
LAUNCESTON 7250

Dear Ms McGann and Ms Gillespie,

This is a consensus letter to the executives of both Launceston private hospitals from representatives of the Medical Advisory Committees of both hospitals. It is written to express serious concern about the future of private medicine in Launceston and to suggest one possible solution to the current problem.

We note with much disquiet the difficulties that arise from the existence of two tightly competitive and duplicating private hospitals in this city. It is our belief that these hospitals continue to be financially under threat in spite of all best endeavours. As such they cannot accommodate the development of new services which would guarantee the future provision of quality private medicine and surgery to the Northern region. As representatives of the specialist fraternity that use both of the private hospitals of Launceston, we feel there is an urgent need to address this issue.

We request that the Management Boards of both hospitals realistically consider this dilemma and how best it may be resolved. The options are indeed difficult and limited:

1. Voluntary closure of one hospital.
2. Take-over of one hospital by the other.
3. Amalgamation of both hospitals in some form.

We do acknowledge with gratitude the help provided by our private hospitals over many years. As a group we recognize that from time to time one or other of the hospitals may have had particular features that have attracted our individual disciplines. We have supported both as best we can, sometimes with liaisons of convenience or with the obligation to sit on various committees, occasionally with duplication of time and effort. Nevertheless, our loyalty must in the end lie with the development of a sustainable private hospital service rather than with supporting any individual hospital.

.../2.

Having said this, **it is our view that an administrative amalgamation would allow each hospital to retain its unique identity in the public eye** and we see the following as potential advantages to both hospitals, the medical fraternity and the private patient population:

- Single administration / single operating systems / economy of scale supporting the survival of both institutions.
- Avoidance of duplication of services, staff and equipment.
- Rationalizing of staff rostering, allowing movement between hospitals as needs arise.
- Potential for alternating after-hours services with more cost effective rostering of on-call staff.
- Improved training for nursing and ancillary staff who wish to specialize.
- Potential for cost effective campus specialization, without fear of competition.
- More rational and economical funding of new and replacement equipment with confidence to invest in modern technology.
- Planned refurbishment and equipment maintenance made possible by negotiated ward closures between hospitals during quiet periods.
- Improved negotiating power with the Health Funds.
- Realistic bargaining with DVA.
- Improved patient care through combined access to data by both hospitals.
- Marketing of realistic rental facilities at both hospitals.
- Improved clinical confidence in both hospitals.

We also identify the following desirable developments which should be available in a city of this size and which are currently thwarted by the existing two hospital competitive system:

.../3.

- Intensive care unit. Launceston is fortunate to have secured a level of medical and surgical specialization and excellence that would be the envy of many a larger centre; for example: a statewide hepatobiliary service and minimally invasive endovascular services. However, without the backup of a dedicated ICU in addition to a High Dependency Unit, such leading edge surgery and other complex procedures cannot currently be offered by either private facility. Unless this situation is promptly addressed, we feel it will be impossible to retain these skilled practitioners or encourage new specialists to Launceston.
- Department of Emergency Medicine with 24 hour medical cover within the hospital(s).
- A first rate coronary care facility.
- Investigational and interventional angiography services, servicing cardiology and vascular surgery.
- Obstetric, neonatal and paediatric facilities.
- Dedicated psychiatric unit.
- A single room with ensuite facilities to all patients who request this.

We acknowledge that there are obstacles to be addressed by both hospital administrations and we do not presume to have the answers to matters best negotiated by senior hospital executives. We appreciate that each hospital may have definite views regarding autonomy but would hope that both are willing to adopt a philosophy of dialogue and change.

Should there be an absence of any co-operative endeavour it is entirely possible that a third player may in time enter the arena and indeed it may well be that the medical community would support them if they were seen to be more responsive to the needs of the wider community. This would not be the preferred outcome from our perspective.

We request that you consider this issue as a matter of urgency so that Launceston can acquire the private hospital facilities that are needed to operate effectively in the 21st Century. The undersigned would welcome an opportunity for discussion with representatives from both Hospitals and we look forward to your early acknowledgement of this correspondence.

.../4.

Yours sincerely,

MR M MONSOUR and MR J BATTEN. (Chairmen, Medical Advisory Committees.)

MR R BUTORAC.

DR B MITCHELL.

MR D STARY.

DR J SANDS.

MISS A YOUNG.

DR P OGDEN.

DR C MIDDLETON.

Appendix F: Bed shares of hospitals (private and public)[1]

Name of hospital	Location	Public/private	Number of licensed acute beds[2]	Launceston %	Northern Tasmania %	Tasmania %
Launceston						
St Vincent's	Launceston	Private (SCHS)	128[3]	23.02	19.91	5.89
St Luke's	Launceston	Private (CHCT)	131	23.56	20.37	6.03
Launceston General Hospital	Launceston	Public	291	52.34	45.26	13.39
Oakden House	Launceston	Private (One Care)	6	1.08	0.93	0.28
Eye Hospital	Launceston	Private (doctors)	2 theatres[4]			
Total (Launceston)			**556**	**100.00**	**86.47**	**25.59**
rest of Northern Tasmania						
North East Soldiers Memorial	Scottsdale	Public	23		3.58	1.06
Deloraine	Deloraine	Public	20		3.11	0.92
George Town	George Town	Public	15		2.33	0.69
St Helen's	St Helen's	Public	10		1.56	0.46

[1] The data in this table does not take into account the transfer of Mersey Community Hospital from Healthscope to the Tasmanian Government in December 2004.

[2] The bed numbers are based on data published by the Tasmanian Department of Health and Human Services (**DHHS**), most recently in *Healthy Hospitals Come From Healthy Debate: A Review into Key Issues for Public and Private Hospital Services in Tasmania*, 2004. At least in respect of St Vincent's and St Luke's, the bed numbers published by DHHS include day beds as well as inpatient beds. This may create a misleading impression in terms of bed shares because licensed beds in day surgery facilities (which do not provide overnight accommodation) are not included in the calculation.

[3] In the case of St Vincent's, the number of licensed beds recorded by DHHS (128 beds) is incorrect. In fact, St Vincent's has 112 licensed overnight beds and 20 day surgery beds.

[4] These beds are not included in the calculation of bed shares.

Name of hospital	Location	Public/private	Number of licensed acute beds[2]	Launceston %	Northern Tasmania %	Tasmania %
Campbell Town	Campbell Town	Public	6		0.93	0.28
Beaconsfield	Beaconsfield	Public	4		0.62	0.18
St Mary's	St Mary's	Public	4		0.62	0.18
Flinders Island MPC	Whitemark	Public	3		0.47	0.14
Toosey Memorial	Longford	Public	2		0.31	0.09
Total (Northern Tasmania)			**643**		**100.00**	**29.59**
North-Western Tasmania						
North West Regional	Burnie	Public	131			6.03
Mersey Community	Latrobe	Public (Healthscope under govt contract)	90			4.14
Mersey Community	Latrobe	Private (Healthscope)	40			1.84
North West Private	Burnie	Private (Healthscope)	60			2.76
North West Private	Burnie	Public (Healthscope under govt contract)	14			0.64
Smithton	Smithton	Public	16			0.74
King Island MPC	King Island	Public	6			0.28
West Coast	Queenstown	Public	23			1.06
Roseberry Community	Zeehan	Private (community)	6			0.28

Name of hospital	Location	Public/private	Number of licensed acute beds[2]	Launceston %	Northern Tasmania %	Tasmania %
Southern Tasmania						
Royal Hobart	Hobart	Public	499			22.96
Calvary Health Care Tasmania	Hobart	Private (CHCT)	317			14.59
Hobart Private	Hobart	Private (Healthscope)	152			6.99
St Helen's Private	Hobart	Private (Healthscope)	115			5.29
Hobart Clinic	Hobart	Private (Private Trust)	30			1.38
New Norfolk	New Norfolk	Public	10			0.46
Huon District	Franklin	Public	6			0.28
Ouse	Ouse	Public	5			0.23
Repatriation Centre	Hobart	Public	10[5]			0.46
Hobart Day Surgery	Hobart	Private (National Day Surgeries)	2 theatres[6]			
Total (Tasmania)			**2,173**			**100.00**

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5 Palliative care beds.

6 These beds are not included in the calculation of bed shares.

Appendix G: Bed shares of participants in the private hospital sector (Tasmania)[1]

Name of hospital	Location	Operator	Number of licensed acute beds[2]	Launceston %	Northern Tasmania %	Tasmania %
Northern Tasmania						
St Vincent's	Launceston	SCHS	128[3]	48.30	48.30	12.99
St Luke's	Launceston	CHCT	131	49.43	49.43	13.30
Oakden House	Launceston	One Care	6[4]	2.26	2.26	0.61
Eye Hospital	Launceston	Doctors	2 theatres[5]			
Total (Northern Tasmania)			**265**	**100.00**	**100.00**	**26.9**
North-Western Tasmania						
North-West Private	Burnie	Healthscope	60			6.09
Mersey Community	Latrobe	Healthscope	40			4.06
Roseberry	Zeehan	Community	6			0.61

1 The data in this table does not take into account the transfer of Mersey Community Hospital from Healthscope to the Tasmanian Government in December 2004.

2 The bed numbers are based on data published by the Tasmanian Department of Health and Human Services (**DHHS**), most recently in *Healthy Hospitals Come From Healthy Debate: A Review into Key Issues for Public and Private Hospital Services in Tasmania*, 2004. At least in respect of St Vincent's and St Luke's, the bed numbers published by DHHS include day beds as well as inpatient beds. This may create a misleading impression in terms of bed shares because licensed beds in day surgery facilities (which do not provide overnight accommodation) are not included in the calculation.

3 In the case of St Vincent's, the number of licensed beds recorded by DHHS (128 beds) is incorrect. In fact, St Vincent's has 112 licensed inpatient beds and 20 day surgery beds.

4 Palliative care beds.

5 These beds are not included in the calculation of bed shares.

Name of hospital	Location	Operator	Number of licensed acute beds[2]	Launceston %	Northern Tasmania %	Tasmania %
Community		ownership				
Southern Tasmania						
Hobart Private	Hobart	Healthscope	152			15.43
Calvary Health Care Tasmania	Hobart	CHCT	317			32.18
St Helen's Private	Hobart	Healthscope	115			11.68
Hobart Clinic	Hobart	Private Trust	30			3.05
Hobart Day Surgery	Hobart	National Day Surgeries	2 theatres[6]			
Total (Tasmania)			**985**			**100.00**

[6] These beds are not included in the calculation of bed shares.