Application for Authorisation

Lodged by

Little Company of Mary Health Care

In respect of

Proposed acquisition of St Vincent's Hospital (Launceston) Pty Ltd

Date: **11 March 2005**

Commissioners: Samuel
Sylvan
King
Martin
Smith
Willett

Authorisation no. A90947

Public Register no. C2004/1958

Executive Summary

Background

On 21 December 2004, Little Company of Mary Health Care (LCMHC) lodged an application for authorisation A90947 for the proposed acquisition of St Vincent's Hospital, Launceston. Both parties to the acquisition are Catholic, not-for-profit, health and aged care service providers, with services throughout Australia.

St Luke's Hospital is a general overnight private hospital in Launceston, and is owned by LCMHC. It currently operates 81 inpatient and seven same-day beds. The services range of the hospital cover medical, surgical and postnatal services, with major specialties being urology, orthopaedics, gynaecology, ENT, ophthalmology, upper and lower GI surgery, endoscopy, medical oncology, and general medicine. St Luke's has approximately 150 EFT positions. In the financial year ending 30 June 2004, it generated a total turnover of approximately $14 million.

St Vincent's is the other general overnight private hospital in Launceston, and is owned by Sisters of Charity Health Service. It currently has 74 inpatient beds available. Its operating budget is approximately $15 million, and there are 155 EFT positions. The hospital's major specialties are orthopaedics, urology, gastroenterology, plastic reconstructive surgery, colo-rectal surgery, and acute medicine.

Counterfactual

While it is not possible to predict the precise time at which one hospital might close, the information available to the Commission suggests that either St Luke's or St Vincent's is likely to close within approximately two-to-five years.

Market definition

The relevant markets are:

- the supply of general overnight private hospital services to hospital services purchasers – in particular, health funds and the Repatriation Commission. The Commission is not satisfied that hospital services purchasers would view arrangements with Launceston General Hospital or day surgeries as alternatives to one with the proposed merged hospital. The Commission was also satisfied that a price rise by the merged hospital would be likely to result in few private patients leaving health funds and switching to the public system. The geographic region is likely to be regional, in this case no broader than northern Tasmania (as described at paragraph 5.45); and

- the supply of private hospital services to self-funded patients. Self-funded patients constitute less than 10 per cent of private patients. The Commission is satisfied that self-funded private patients would be likely to switch to day surgeries in response to a price rise by the merged hospital for day surgery. The geographic region is regional – that is, the same as that for the market for the supply of general overnight private hospital services to hospital service purchasers.

Public benefit

The Commission accepts that the proposed acquisition is likely to generate cost savings, in particular by substantially reducing duplication between St Luke's and St Vincent's.

The Commission is also satisfied that LCMHC is likely to use the cost savings to improve the range and quality of services available to private patients in Northern Tasmania. It has particularly relied on information about the management of LCMHC hospitals in other regional areas of Australia in reaching this conclusion. The Commission also notes that LCMHC, as a charitable organization for taxation purposes, is required to apply all its income and assets to its charitable purposes.

However, the Commission was concerned that the public benefit might be significantly reduced particularly if the merged hospital was sold to a for-profit hospital operator.

Public detriment

Overall, the Commission's conclusion on the counterfactual is an important limit on the public detriment flowing from the proposed merger. Effectively, public detriment could only be generated for between two and five years.

The proposed merger would reduce the number of general overnight private hospitals in Launceston from two to one. Further, it is highly unlikely that a new private overnight hospital provider would enter the hospital-hospital service purchaser market given the investment required and the size of the market.

Given this, the Commission concludes that the merged hospital would be likely to be able to negotiate higher reimbursement rates from hospital service purchasers. However, it considers that the increase would be likely to be limited, particularly given that:

- confidential information available to the Commission suggests that 'monopoly' private hospitals in regional areas have not usually been able to negotiate higher rates than private hospitals in regional areas where there is more than one private hospital; and

- LCMHC would risk losing contracts for its private hospitals in Sydney, Canberra and Adelaide.

The Commission is satisfied that the possibility of new entry of a day surgery is likely to constrain the merged hospital from raising prices for day procedures for self-funded patients. It understands that self-funded patients mostly require day procedures.

Balance of public benefit and detriment

The ACCC considers that the proposed merger would generate limited public detriment. The public benefit is also limited given the possibility of the merged hospital being sold to a for-profit hospital operator.

However, LCMHC has offered a court-enforceable undertaking to the following effect: that it will not sell the merged facilities to a for-profit operator for a period of three years.

Given this undertaking, the Commission is satisfied that the public benefit outweighs the public detriment, and grants authorisation to application A90947.

List of Abbreviations

AMA	The Tasmanian Branch of the Australian Medical Association
AHSA	Australian Health Service Alliance
ARHG	Australian Regional Health Group Limited
CHCT	Calvary Health Care Tasmania
CL&C	Congregational Leader and her Council
DHHS	Department of Health and Human Services Tasmania
DVA	Department of Veterans Affairs Tasmanian Office
EFT	Full Time Equivalent
HPPAs	Hospital Purchaser Provider Agreements
LCM	Little Company of Mary
LCMHC	Little Company of Mary Health Care Limited
LGH	Launceston General Hospital
MBF	MBF Australia Limited
Medibank	Medibank Private Limited
RC	Repatriation Commission
SCHS	Sisters of Charity Health Service Limited
Sisters of Charity	The Congregation of Religious Sisters of Charity of Australia
St Luke's	St Luke's Campus of Calvary Health Care Tasmania
St Luke's MAC	Medical Advisory Committee, St Luke's
St Vincent's	St Vincent's Hospital (Launceston) Pty Ltd
St Vincent's MAC	Medical Advisory Committee, St Vincent's

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1. INTRODUCTION

Authorisations

1.1 The Australian Competition and Consumer Commission (the ACCC) is the Australian agency responsible for administering the *Trade Practices Act 1974* (the TPA). A key objective of the TPA is to prevent anti-competitive conduct, thereby encouraging competition and efficiency in business, resulting in a greater choice for consumers in price, quality and service.

1.2 The TPA, however, allows the ACCC to grant immunity from legal action for anti-competitive conduct in certain circumstances. One way in which parties may obtain immunity is to apply to the ACCC for what is known as an 'authorisation'.

1.3 Broadly, the ACCC may 'authorise' businesses to engage in anti-competitive conduct – including a proposed merger that might substantially lessen competition – where it is satisfied that the public benefit from the conduct outweighs any public detriment.

1.4 The ACCC conducts a public consultation process before making a decision to grant or deny authorisation.

1.5 Upon receiving an application for authorisation, the ACCC invites interested parties to lodge submissions outlining whether they support the application or not, and their reasons for this.

1.6 For merger authorisations,[1] the ACCC then considers the application taking into account submissions received and issues a written final determination. Should the public benefit outweigh the public detriment, the ACCC may grant authorisation. If not, authorisation may be denied.

Application by Little Company of Mary Health Care

1.7 On 21 December 2004, Little Company of Mary Health Care (LCMHC) lodged an application for authorisation A90947 with the ACCC.

1.8 Application A90947 was lodged under section 88(9) to allow LCMHC to acquire St Vincent's Hospital, Launceston (St Vincent's). St Vincent's is the only facility operated by the Sisters of Charity Health Service Limited (SCHS) in Tasmania.

1.9 An authorisation granted under subsection 88(9) provides immunity from court action for breaching section 50 of the TPA. Broadly, section 50 prohibits businesses from acquiring shares in, or assets of, a corporation if this would be likely to substantially lessen competition in a market.

[1] The TPA requires the ACCC to undertake a shorter consultation process for merger authorisations than for non-merger authorisations. For the latter, the ACCC is required to issue a draft determination and, if requested, hold a conference to hear oral submissions from interested parties about that draft.

Time limits

1.10 The ACCC has 30 days to consider an application for authorisation under subsection 88(9) unless (before the 30 day period expires):

- the ACCC requests further information from the applicant. In this case, the period is extended by the number of days taken by the applicant to provide this information;
- the ACCC notifies the applicant that it considers the application is complex. In this case, the period is extended to 45 days; or
- the applicant agrees to a longer period.[2]

1.11 On 21 December 2004, LCMHC informed the ACCC that it agreed to a time period expiring on 18 February 2005. On 28 January 2005, LCMHC agreed to a further extension of the time period to 4 March 2005. On 28 February 2005, LCMHC agreed to extend the time period until 11 March 2005.

1.12 If the Commission does not issue a determination on LCMHC's application by 11 March 2005, the application is deemed to be granted.[3]

Chronology

1.13 The following table is a chronology of significant dates in the consideration of the application.

DATE	ACTION
21 December 2004	Application received
23 December 2004	Letters seeking comment on the application for authorisation sent to interested parties
14 January 2005	Interested party submissions due
28 January 2005	LCMHC agreed to a further extension of the time period to 4 March 2005
2 February 2005	Final interested party response received
11 February 2005	LCMHC response to interested party submissions received
28 February 2005	LCMHC agreed to a further extension of the time period to 11 March 2005
11 March 2005	Final determination issued

[2] Subsections 90(11), (11A) and (12).
[3] Subsection 90(11).

2. THE MERGER PARTIES

Little Company of Mary Health Care Ltd (LCMHC)

2.1 LCMHC, a not-for-profit service of the Sisters of the Little Company of Mary, 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.[4]

2.2 LCMHC companies are accepted by the Australian Taxation Office as being charitable, and all their income and assets are required to be applied wholly to their respective charitable purposes.[5]

2.3 Calvary Health Care Tasmania (CHCT) is one of nine services owned by LCMHC in Australia, and is the largest Catholic health care provider in Tasmania.

St Luke's Hospital

2.4 St Luke's Hospital was acquired by LCMHC on 17 May 2004. It is licensed for 120 inpatient and 11 same day beds, but currently operates 81 inpatient and seven same-day beds. The service range of the hospital covers medical, surgical and postnatal services, with major specialties being urology, orthopaedics, gynaecology, ENT, ophthalmology, upper and lower GI surgery, endoscopy, medical oncology, and general medicine. St Luke's employs approximately 260 people in 150 full time equivalent (EFT) positions. In the financial year ending 30 June 2004, it generated a total turnover of approximately $14 million.[6]

Sisters of Charity Health Services

2.5 The Sisters of Charity Health Service (SCHS) operates (either by itself or in partnership with other Catholic healthcare providers) several health facilities in Queensland, New South Wales, Victoria and Tasmania. Its current operating budget is $1 billion and it employs approximately 10,000 staff. SCHS companies are accepted by the Australian Taxation Office as being charitable, and all their income and assets are required to be applied wholly to their respective charitable purposes.[7]

St Vincent's Hospital

2.6 St Vincent's is the only hospital operated by SCHS in Tasmania. It 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 EFT employees. The hospital's major specialties are orthopaedics, urology, gastroenterology, plastic reconstructive surgery, colo-rectal surgery, and acute medicine. Other significant

[4] LCMHC submission, 21 December 2004, p6.
[5] LCMHC submission, 21 December 2004, p10.
[6] LCMHC submission, 21 December 2004, p7-8.
[7] LCMHC submission, 21 December 2004, p10.

services performed by St Vincent's include palliative care, sleep studies unit, a day surgery unit, and the home nursing service.[8]

Rationale for the merger[9]

2.7 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 submits that the acquisition:

- will further its strategy of creating rural strengths through integrated services;
- provide it with an opportunity to introduce new and expanded services in Launceston; and
- is consistent with its growth strategy, which seeks to address mission and business issues, and to position it as a distinctive, stand-alone, medium sized health care provider.

2.8 LCMHC submits that SCHS's decision to enter into the acquisition is driven by its concerns regarding the current delivery of health 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.

[8] LCMHC submission, 21 December 2004, p9-10.
[9] LCMHC submission, 21 December 2004, p2.

3. SUBMISSIONS

3.1 LCMHC provided a supporting submission with its application for authorisation on 21 December 2004.

3.2 The ACCC also sought submissions from 15 interested parties. The ACCC received written submissions from the following parties:

Party	**Date lodged**
Australian Health Service Alliance	06 January 2005
Australian Regional Health Group	10 January 2005
St Vincent's Medical Advisory Committee	10 January 2005
St Luke's Medical Advisory Committee	13 January 2005
Australian Medical Association	14 January 2005
MBF Australia Limited	20 January 2005
Launceston General Hospital	24 January 2005
Department of Veterans' Affairs	25 January 2005
Medibank Private Limited	25 January 2005
Department of Health and Human Services Tasmania	02 February 2005
Department of Veterans' Affairs	15 February 2005
Launceston General Hospital	21 February 2005

3.3 Most interested party submissions broadly accept the need for the proposed merger, although MBF, the DVA and the AHSA raise concerns about the merged hospital's ability to increase prices.

3.4 LCMHC lodged a public submission responding to interested party submission on 15 February 2005.

3.5 The views of LCMHC and interested parties on particular issues are outlined in the Commission's evaluation of the proposed merger in Chapter 5.

4. THE PUBLIC BENEFIT TEST

4.1 The ACCC may only grant LCMHC's application for authorisation if it is satisfied in all the circumstances that the proposed acquisition would result, or be likely to result, in such a benefit to the public that the acquisition should be allowed to take place.[10]

4.2 The Tribunal has interpreted this test as requiring that the public benefit from the proposed acquisition outweigh the public detriment.[11]

4.3 The TPA largely does not define public benefit. However, the Tribunal has stated that it includes:

> …anything of value to the community generally, any contribution to the aims pursued by society including as one of its principle elements … the achievement of the economic goals of efficiency and progress.[12]

4.4 For merger authorisation applications, the ACCC must regard the following as public benefits (in addition to any other public benefits):

- a significant increase in the real value of exports; and
- a significant substitution of domestic products for imported goods.[13]

4.5 The ACCC must also take into account all other relevant matters that relate to the international competitiveness of any Australian industry.[14]

4.6 The TPA not does define public detriment. However, the Tribunal has stated that it includes:

> …any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency.[15]

Future with-and-without test

4.7 The ACCC applies the 'future with-and-without test' to identify and measure the public benefit and public detriment generated by conduct proposed for authorisation.[16]

4.8 Under this test, the ACCC compares the public benefit and anti-competitive detriment generated by arrangements in the future if the authorisation is granted with those

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[10] Subsection 90(9). This subsection specifies the public benefit test for authorisation applications made under section 88(9).

[11] See *Re Queensland Co-operative Milling Association Ltd* (1976) ATPR 40-012 at 17,243; *Re Queensland Independent Wholesalers Ltd* (1995) ATPR 41-438 at 40,927; *Re Rural Traders Co-operative (WA) Ltd* (1979) ATPR 40-110 at 18,123.

[12] *Re 7-Eleven Stores; Australian Association of Convenience Stores Incorporated and Queensland Newsagents Federation* (1994) ATPR ¶ 41-357 at 42677.

[13] Subsection 90(9A)(a).

[14] Subsection 90(9A)(b).

[15] *Re 7-Eleven Stores; Australian Association of Convenience Stores Incorporated and Queensland Newsagents Federation* (1994) ATPR ¶ 41-357 at 42683.

[16] *Australian Association of Pathology Practices Incorporated* (2004) ATPR 41-985 at 48,556. See also, for example: *Australian Performing Rights Association* (1999) ATPR 41-701 at 42,936; *Re Media Council of Australia (No2)* (1987) ATPR 40-774 at 48,419.

generated if the authorisation is not granted. This requires the ACCC to predict how the relevant markets will react if authorisation is denied. This prediction is known as the counterfactual.

Term of authorisation

4.9 The ACCC may grant authorisation for a specific period of time.[17] However, once an authorised acquisition of shares in the capital of a body corporate has occurred, the authorisation is, in practice, spent – that is, there is no ongoing conduct.[18] Consequently, unless, for example, there is a reason for requiring a merger to be completed within a specified period of time, the ACCC will usually not impose a time limit on a merger authorisation.

Conditions

4.10 The ACCC may grant authorisation subject to conditions.[19] However, the primary sanction against breach of a condition is revocation of an authorisation. As noted above, a merger authorisation is, in practice, spent once the merger is completed. Consequently, revoking an authorisation if a condition is not complied with after the completion of the merger would have no effect.

4.11 However, the ACCC may accept a written undertaking given by the applicants under section 87B of the TPA.

[17] Subsection 91(1).
[18] See *Broken Hill Pty Co. Ltd v Trade Practices Tribunal & Ors*, (1980) ATPR 40-173.
[19] Subsection 91(3).

5. EVALUATION

Counterfactual

LCMHC submission

5.1 LCMHC submits that 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.[20]

5.2 Generally, LCMHC highlighted that the following comparable regional centres in Australia have only one private hospital:

Table One: Regional centres with one private hospital[21]

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
Ballarat	141,723	224 licensed	633
Tamworth	80,562	77 licensed	1,046
Wagga Wagga	152,854	104 available	1,092
Bendigo	167,089	117 available	1,428
Cairns	228,154	141 licensed	1,618
Burnie	107,027	56 available	1,911
Armidale	62,746	32 licensed	1,961
Lismore	216,717	103 licensed	2,104
Dubbo	139,989	60 licensed	2,333
Port Macquarie	280,067	84 licensed	3,334
Bathurst	177,983	30 available	5,933
Gladstone	181,583	30 available	6,053

5.3 LCMHC also submits that:

> 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.[22]

[20] LCMHC submission, 21 December 2004, p.42.
[21] LCMHC submission, 21 December 2004, p.17.
[22] LCMHC submission, 21 December 2004, p.17.

5.4 With regard to Launceston in particular, LCMHC submits that:

> 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.[23]

5.5 LCMHC further submits that:

> Both St Luke's and St Vincent's are currently… operating at approximately 65 per cent occupancy... 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…[24]

5.6 Finally, LCMHC submits that:

> 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.
>
> 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 a sale to a non-Catholic provider exists, this would be inconsistent with the mission and values of SCHS, and therefore highly unlikely.[25]

Interested party submissions and LCMHC response

5.7 Most interested parties consider it unlikely that both St Vincent's and St Luke's can survive.[26] The DVA considers that one hospital is likely to close 'within a few years'.[27] The DHHS submits that:

> St Vincents, being a stand-alone facility, is the most likely to close in the foreseeable future. The last major capital investment in the hospital infrastructure at St Vincents was in the mid 90s and so a capital upgrade is likely to be required in the next five years. If St Vincents is unable to achieve the required capital investment then closure would be likely.[28]

5.8 The ARHG considers that St Vincent's is more likely to close 'as St Luke's is the larger and more modern facility'.[29] Other interested parties did not express a view on which hospital would close.

5.9 The Chairman of the Medical Advisory Committee at St Vincent's adds that:

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[23] LCMHC submission, 21 December 2004, p.42.
[24] LCMHC submission, 21 December 2004, p.43.
[25] LCMHC submission, 21 December 2004, p47.
[26] LGH submission, 24 January 2005, p2; DVA submission, 25 January 2005, pp5-6; AMA submission, 14 January 2005, p2; AHSA submission, 6 January 2005, p2; ARHG submission, 10 January 2005, p2; St Vincent's MAC submission, 10 January 2005, p1; and DHHS submission, 2 February 2005, p2.
[27] DVA submission, 25 January 2005, p6.
[28] DHHS submission, 2 February 2005, p2.
[29] ARHG submission, 10 January 2005, p2.

> If one hospital closed, the other would struggle to provide the necessary volume of service in the short to medium term (insufficient theatres and beds, insufficient physical room for expansion).[30]

5.10 However, the Chairman of the Medical Advisory Committee at St Luke's submits that:

> Both are sustainable but without this merger neither private hospital will be able to offer a growth of comprehensive services that are available in similar regional cities where there is only one private hospital…
>
> It is likely that both operators would maintain the quality of services (without growth) in the short term but my medical colleagues are anxious about inevitable deterioration in the medium to long term with spiralling costs in maintaining a facility.[31]

5.11 Finally, while acknowledging that the viability of two substantial private hospitals in Launceston has been questionable for some time, MBF highlights:

- the increase in the number of Tasmanians with private health cover since September 1999; and
- current and future demand for private hospital services in Launceston. It submits that, assuming it has 20 per cent of the market:

  > … we extrapolate that there would have been approximately 44,700 bed days across both facilities in FY04. At 100% occupancy this level of activity requires an allocation of 122 beds. Currently, there are only 88 utilised beds at St Luke's and 74 at St Vincent's. This is not to mention the current trend of increasing utilization through technological advances and ageing of the population. Even if private health insurance membership remains stable, we would expect demand to increase beyond current levels… we submit that one private hospital facility in Launceston would be insufficient to cater for the needs of our members in this market.[32]

5.12 In response, LCMHC submits, in particular, that:

- MBF's market-share is 25, not 20, per cent. Consequently, there are only 35,700 bed days requiring 98 beds at 100 per cent occupancy (or 122 at 80 per cent occupancy – the minimum LCMHC submit is required to sustain a hospital). At present, 162 beds exist;
- health insurance participation rates as a percentage of the population in Tasmania have decreased from 44.7 per cent in September 2001 to 42.5 per cent in March 2004. Further, the 2002 Final Report of Australian Healthcare Associates into 'Strategic Services Planning for St Vincent's Hospital Launceston' found, among other things, that the current level of private health insurance coverage in Tasmania is unsustainable because of inevitable increases in private health insurance premiums. Finally, the Australian Bureau of Statistics has estimated that the northern Tasmanian population will decline by approximately 30 per cent between 2000 and 2051;
- while the number of patients requiring care is increasing as the Tasmanian population ages, patients are spending less time in hospital (because of, for example, technological advances) meaning that overall demand for bed numbers is stable or declining; and

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[30] St Vincent's MAC submission, 10 January 2005, p1.
[31] St Luke's MAC submission, 13 January 2005, p1.
[32] MBF submission, 20 January 2005, pp3-4.

- while Launceston may require the continued operation of St Vincents and St Lukes to meet current and future demand, the proposed merger is essential 'so that activity on the two sites can be consolidated and duplication minimised to correct low utilisation rates'.[33]

Conclusion

5.13 The Commission accepts the view expressed by almost all interested parties that Launceston can only sustain one comprehensive, overnight private hospital. The current occupancy levels at St Vincent's and St Luke's (around 65 per cent) suggest that Launceston is currently over-bedded. Further, MBF's contention that demand is likely to increase in the future seems unlikely to be correct. In particular, its reliance on an increase in the number of Tasmanians with private health insurance since September 1999 ignores the impact of the introduction of Lifetime Health Cover by the Australian Government in July 2000, which was preceded by a one-off increase in the number of Tasmanians with private health insurance of over 40,000 people (around 10 per cent of the population). Since then, coverage has slowly declined, albeit with a slight increase in the September and December quarters of 2004.[34]

5.14 More generally, most other regional areas seem only to be able to sustain one private hospital.[35]

5.15 While it is not possible to predict the precise time at which one hospital might close, the evidence provided by LCMHC, DVA and DHHS (paragraphs 5.6-5.7) suggests that a closure is likely within approximately two-to-five years.

The relevant markets

5.16 A key first step in assessing the effect on competition of the conduct for which authorisation is sought is to consider the relevant market(s) in which that conduct occurs. However, depending on the circumstances, the ACCC may not need to comprehensively define the relevant markets as it may be apparent that a net public benefit will or will not arise regardless of the scope of the defined market.

5.17 The relevant markets are:

- the supply of hospital services to, in particular, health funds and the Repatriation Commission. Bodies of this type are referred to as **hospital service purchasers** in this determination; and

- the supply of hospital services to self-funded patients.

5.18 The Commission defines a market by determining the smallest market in which a notional profit-maximising monopolist could impose a small but significant non-transitory price increase.[36]

5.19 In this case, the notional monopolist would be a general overnight private hospital in Launceston. Unusually, this would actually be the hospital formed by the merger of St

[33] LCMHC submission, 15 February 2005, pp8-11.
[34] See: www.phiac.gov.au; accessed on 3 March 2005.
[35] Exceptions include Toowoomba and Townsville in Queensland.
[36] ACCC Merger Guidelines, June 1999, paragraph 5.44.

Luke's and St Vincent's. The merged hospital would offer a bundle of services including operating theatres, procedure rooms, accommodation, medical supplies and equipment, nursing and ancillary services. These services would underpin the availability of a broad range of medical and surgical procedures to patients (although not all services available at LGH – for example, the merged hospital would not treat emergency patients).

Hospital-hospital service purchasers market

5.20 Hospital service purchasers negotiate hospital prices on behalf of the patients they cover – that is, these patients are essentially collectively negotiating with hospitals, with their hospital service purchaser as their agent.[37]

5.21 Hospital service purchasers also fully or partially pay the price they negotiate with hospitals and, at least as regards health funds, receive premiums from patients in return.

5.22 In practice, health funds negotiate Hospital Purchaser Provider Agreements (HPPAs) with hospitals to set these rates. The Repatriation Commission is able to enter into similar arrangements with hospitals (public and private) for the provision of hospital care to veterans and entitled persons under the *Veterans' Entitlement Act 1986* (Cth) and the *Military Rehabilitation & Compensation Act 2004* (Cth). For convenience, all arrangements between hospital services purchasers and private hospitals are called HPPAs in this determination.

5.23 Negotiations between private hospitals and hospital service purchasers generally take place annually, and the resulting HPPA covers all medical and surgical procedures provided by the hospital.

5.24 Currently, the following hospital service purchasers have HPPAs with St Vincent's and St Luke's:

- two health funds (MBF and Medibank Private) each with around a 25 per cent market share;[38]
- the Australian Regional Health Group (ARHG), comprising several smaller health funds). One member of the ARHG, St Luke's Health, which is based in Launceston, has a 25 per cent market share;[39]
- the Repatriation Commission (represented by the DVA) with around a 10-15 per cent market share;[40]
- the Australian Health Services Alliance (comprising several smaller health funds) with a five per cent market share;[41] and
- third party and workers compensation insurances agencies, with a very small market share.[42]

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[37] Technically, hospital service purchasers acquire the right for the persons they cover to be charged at specific rates for hospital services.
[38] LCMHC submission, 21 December 2004, p25.
[39] LCMHC submission, 21 December 2004, p25.
[40] DVA submission, 25 January 2005, p3.
[41] LCMHC submission, 15 February 2004, p16.

Product market

5.25 A key product market issue is whether the potential for hospital service purchasers to rely on being able to admit their members to:

- LGH; or
- the Eye Hospital or Gynaecological Clinic in Launceston

would constrain the merged hospital from profitably imposing a small but significant price increase.

5.26 As regards LGH, the Commission understands that:

- private patients in Tasmanian public hospitals are subject to public hospital waiting lists, but are able to choose their doctor and possibly obtain a single room;[43] and
- health funds pay public hospitals a default benefit set by the Australian Government for treating private patients.[44] The DHHS submits that 'the default benefit for the public sector is less than half the real cost of care'.[45]

5.27 LCMHC submits that:

> Launceston General Hospital provides effective competition to St Vincent's and St Luke's... 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.[46]

5.28 It highlights data showing:

- that between 1999-2000 and 2001-02, the number of private patients admitted to public hospitals in Tasmania increased by more than the number of patients overall (meaning that the number of public patients fell); and
- increases in health fund payments to public hospitals in Tasmania:

  > 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. Recently published data from the Private Health Insurance Administration Council… shows a sharp increase in private patient bed days and revenue in Tasmanian public hospitals in 2004.[47]

5.29 However, LGH submits that the percentage of private patients treated at LGH 'is reasonably constant, around 9 per cent of our overall overnight admissions'. However, overall admissions have increased, including the number of private patients.[48]

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[42] LCMHC submission, 21 December 2004, p54.
[43] See *Public hospital and ambulance services provided for the Tasmanian community*, Tasmania Department of Health Human Services, January 1999, p6 (http://www.dhhs.tas.gov.au/hospitals/pdfs/tashospambservices.pdf; accessed on 9 March 2005).
[44] ARHG submission, 10 January 2005, p2.
[45] DHHS submission, 2 February 2005, p2.
[46] LCMHC submission, 21 December 2004, pp55-56.
[47] LCMHC submission, 21 December 2004, pp24-25.
[48] LGH submission, 21 February 2004, p1.

5.30 MBF, Medibank Private and DVA submit that they do not consider LGH as an alternative to a HPPA with the merged hospital, particularly because of the waiting lists at LGH.[49] For example, Medibank Private submits:

> If Launceston General Hospital was able to deliver such certainty of access, members would more likely cease to hold their private health insurance, as little benefit would be seen in the product as compared to being a public patient.[50]

5.31 The DHHS submits that:

> The LGH has private patients but mainly in areas where services are not currently available in the private sector.[51]

5.32 The DVA currently has contracts with LGH, St Luke's and St Vincent's. It submits that about 50 per cent of its veterans were treated at LGH and 50 per cent at either St Luke's or St Vincent's.[52] While this might suggest that it considers that LGH and the two private hospitals are substitutable, the DVA further submits that:

> … the LGH is the only hospital in Launceston with an Intensive Care Unit. For this reason, the more complex cases, both surgical and medical, would tend to go to the LGH.
>
> … for lower acuity surgery there are often longer waiting times at the LGH, than there are for admission to the private hospitals. For some categories of surgery, the waiting times at the LGH can be 12 months or more. For this reason, many veterans, in consultation with their treating doctor, choose to go to one of the private hospitals, where that hospital can cater for their needs.[53]

5.33 This suggests that LGH and the two private hospitals play different roles in the view of the DVA.

5.34 In light of these submissions, the Commission agrees that hospital service purchasers are unlikely to rely on LGH as an alternative to having a HPPA with the merged hospital.

5.35 The ACCC recognises that the number of private patients being treated at LGH is increasing. However, it considers that this might be explained, possibly to a significant degree, by an increasing number of:

- patients admitted to public hospitals for treatment unavailable at private hospitals (for example, obstetrics[54]); or
- emergency patients (where they are fit enough to make this choice) choosing to be admitted as private rather than public patients.

5.36 In particular, the Commission notes that the description of the LGH Admissions Office on the LGH website includes the following statement:

> The fundamental role of the three Admissions Co-ordinators is to book patients for both their assessment and relevant procedures along with ensuring that patients are admitted accurately and efficiently. This

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[49] MBF submission, 20 January 2005, p3; DVA submission, 25 January 2005, p5; Medibank submission, 25 January 2005, p2.
[50] Medibank submission, 25 January 2005 p2.
[51] DHHS submission, 2 February 2005, p3.
[52] DVA submission 15 February 2005.
[53] DVA submission 15 February 2005.
[54] Although post-natal maternity care is available at St Luke's: LCMHC submission, 21 December 2004, p7.

position is the first line in ensuring that legitimate revenue-raising opportunities are undertaken by correctly interviewing and informing patients of their rights as a private patient.[55]

5.37 As regards the Eye Hospital and Gynaecological Clinic, LCMHC submits that:

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 Hospital has also provided an IVF service.[56]

5.38 It further submits that:

The Gynaecological Clinic was recently opened to provide a limited range of same day procedures related to fertility.[57]

5.39 The Commission understands that the services provided by the Clinic are not provided by either St Vincent's or St Luke's.

5.40 LCMHC submits that:

new and existing day surgery facilities will continue to provide effective competition to the merged St Vincent's/St Luke's… 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.[58]

5.41 However, most interested parties questioned whether hospital service purchasers would view an arrangement with the Eye Hospital or the Gynaecological Clinic as an alternative to one with the merged hospital, given the narrow range of services provided by the two day centres.[59]

5.42 The Commission agrees. Indeed, it considers that health funds and the DVA would be unlikely to regard an arrangement with a larger day surgery offering a broader range of surgical and medical services, or several smaller day surgeries offering different services,[60] as an alternative to one with the merged hospital. If they did, health funds would be offering consumers cover for day, but not overnight, surgery in Launceston. This seems likely to make their product significantly less attractive to consumers. Similarly, the DVA would be leaving veterans requiring an overnight procedure without the option of attending a private hospital.

5.43 Having said this, the existence of, for example, a larger day surgery might allow hospital service purchasers to negotiate down the price sought by the merged hospital if they were able to direct or provide an incentive for[61] day patients to be treated at the day surgery.[62] However, neither the DVA[63] nor, the Commission understands, health funds are able to do this.

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[55] See: http://www.lgh.dhhs.tas.gov.au/departments/pims/#admiss; accessed on 21 February 2005.
[56] LCMHC submission, 21 December 2004, pp27-28.
[57] LCMHC submission, 21 December 2004, p58.
[58] LCMHC submission, 21 December 2004, p56.
[59] AMA submission, 14 January 2005, p2; MBF submission, 20 January 2005, p2; St Vincent's MAC submission, 10 January 2005, p1; DVA submission, 25 January 2005, p5; LGH submission, 24 January 2005, p2; Medibank submission, 25 January 2005, p2; ARHG submission, 10 January 2005, p2.
[60] For example, if there existed separate day surgeries specialising in orthopaedics, urology, obstetrics and gynaecology, general surgery, etc.
[61] For example, by requiring the health fund member to pay an excess if they are treated at the private hospital with the higher reimbursement rate.
[62] Assuming the relevant doctors had admitting rights.

Geographic market

5.44 Generally, the Commission expects that the hospital services market will be local or regional, as patients prefer to be treated at a hospital close to home where they can be near family, friends, known medical practitioners and follow up hospital care if needed. However, there may be sub-markets for hospital services associated with particular medical or surgical procedures. Some of these sub-markets may have wider geographic dimensions – for example, hospitals services associated with highly specialised procedures.[64]

5.45 LCMHC submits 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… 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.
>
> [B]oth 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… to attend the facilities. To the west, the catchment only extends approximately 50 kilometres…. 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 Northeastern Tasmania, and 5 per cent from elsewhere.[65]

5.46 LCMHC also submits that around four per cent of patients at its Hobart facilities reside in northern Tasmania and that these admissions tend to be for services not available in northern Tasmania.[66]

5.47 Almost all interested parties question whether hospital service purchasers would consider negotiating HPPAs with hospitals outside Launceston as an alternative to negotiating one with the merged entity. For example, DHHS submits that:

> Given the general reluctance of the community to travel, any fund not having a HPPA with the merged entity would be likely to lose membership to funds which did. It is therefore considered unlikely that any fund would not seek a HPPA with the merged entity.[67]

5.48 Ultimately, the Commission remains of the view that the market for the supply of prive hospital services to hospital service purchasers is local or regional, particularly given the data above (paragraphs 5.45-5.46) suggesting that northern Tasmanian patients largely choose to be treated in Launceston.

5.49 The Commission accepts that the regional market in this case is no larger than set out in LCMHC's submission (see paragraph 5.45). It is not necessary to determine whether the geographic market is smaller than this, as this would not affect the analysis of, in particular, the effect on competition of the proposed merger.

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[63] DVA submission, 15 February 2005.
[64] Final Determination, *Sisters of Charity Health Service Ltd*, 5 March 2004, paragraph 9.8.
[65] LCMHC submission, 21 December 2004, p49.
[66] LCMHC submission, 11 February 2005.
[67] DHHS submission, 2 February 2005, p2. See also LGH submission, 24 January 2005, p2; Medibank submission, 25 January 2005, p2, AMA submission, 14 January 2005, p2; DVA submission, 25 January 2005, p5; St Vincent's MAC submission, 10 January 2005, p1; MBF submission, 20 January 2005, p3; ARHG submission, 10 January 2005, p2.

Public system

5.50 Possibly, health fund members might switch to the public system if the merged hospital raised prices and this resulted in higher health fund premiums.

5.51 The Commission understands that health funds set premiums on a state-by-state basis. For example, MBF and Medibank quote the following monthly rates for a single person (under 30) for premium health cover.

Table 2: MBF and Medibank Private premiums by state and territory[68]

State/Territory	Medibank ($)	MBF ($)
NSW/ACT	72.10	80.90
VIC	93.25	94.80
SA	81.40	92.40
WA	66.15	68.40
NT	44.70	56.20
QLD	79.45	85.20
TAS	84.00	90.60

5.52 Using Private Health Insurance Administration Council data, in Tasmania:

- health fund benefit payments constitute approximately 90 per cent of health fund costs;
- payments to hospitals constitute around 75 per cent of health fund benefit payments; and
- payments to private hospitals constitute 68 per cent of benefit payments to hospitals.[69]

5.53 The LCMHC submits that it can be assumed that Launceston represents around 40 per cent of the Tasmanian market.[70]

5.54 Consequently, for example, a ten per cent increase in the charges that health funds pay the merged hospital would translate into around 1.8 per cent increase in health fund premiums (or just over $1.50 per month on the figures in Table 2 above). A five per cent rise would be half of this.

5.55 The issue is how many health fund members in northern Tasmania would switch to the public system in response to an increase of this magnitude.

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[68] See www.medibank.com.au; www.mbf.com.au. Websites accessed on 23 February 2005. The rates provided are for single premium hospital care. The Australian Government's 30 per cent rebate has been deducted from the rates.
[69] 2003-04 PHIAC Annual Report, pp 19, 22, 60, 61.
[70] LCMHC submission, 15 February 2005, p20.

5.56 Between 30 June 2001 and 30 June 2004, the number of persons nationally with health insurance fell by about 1 per cent.[71] During this time, the Commission understands that health insurance premiums have increased by almost 15 per cent.[72] This suggests that an increase of around 1-2 per cent in health fund premiums would result in few fund members switching to the public system.

5.57 The Commission therefore concludes that the potential for patients with health insurance to switch to the public system would be unlikely to constrain a price rise by the merged hospital.

Conclusion

5.58 The Commission concludes that the relevant market is for the supply of general overnight hospital services by private hospitals to hospital service purchasers. The geographic region is no broader than northern Tasmania (as described in paragraph 5.45).

Hospital-self funded patient market

5.59 This market involves the supply of hospital services to patients who pay for their treatment themselves at the time they are treated. The Productivity Commission reported in 1999 that, across Australia, nine per cent of private patients paid for their treatment themselves.[73] Given the market shares of hospital service purchasers (see paragraph 5.24), the proportion would appear to be slightly lower in northern Tasmania.

Product market

5.60 A key issue is whether the potential for self-funded private patients to switch to:

- LGH as a private or public patient; or
- a day surgery

would constrain the merged hospital from profitably imposing a small but significant price increase on these patients.

5.61 Some interested parties point to the waiting lists at LGH, and the potential for surgery to be postponed at short notice and conclude that few self-funded private patients would switch to LGH as private or public patients if the merged hospital raised its prices.[74]

5.62 Other interested parties suggest that price would be a factor, and that therefore some self-funded private patients might switch to LGH as private or public patients but do not comment on the proportion of patients who might do this.[75]

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[71] See: http://www.phiac.gov.au/statistics/membershipcoverage/hosquar.htm. Website accessed on 24 February 2004.
[72] Information provided by Australian Department of Health and Ageing on 24 February 2005.
[73] Productivity Commission 1999, *Private Hospitals in Australia*, Commission Research Paper, AusInfo, Canberra, p22.
[74] As regards seeking treatment as a private patient at LGH: St Luke's MAC submission, 13 January 2005, p1; St Vincent's MAC submission, 10 January 2005, p1; DHHS submission, 2 February 2005, p1. As regards seeking treatment as a public patient: LGH submission, 24 January 2005, p2; DHHS submission, 2 February 2005, p2; AMA submission, 14 January 2005, p1; St Vincent's MAC submission, 10 January 2005, p1; ARHG submission, 10 January 2005, p1.

5.63 The Commission considers that the nature of self-funded patients is likely to be important in determining whether the prospect of them switching to LGH might constrain the merged hospital from raising prices. In particular, it is likely that there exists a qualitative difference between the small proportion of self-funding private patients and the great majority who rely on health insurance. While it has no empirical information about the nature of self-funded private patients, it seems that they:

- would need to have significant funds available to pay for hospital care or be able to raise the necessary funds in some way; and
- would presumably not be expecting to need frequent (private) hospitalisation. If they did, purchasing health insurance would be less expensive.

5.64 For example, a wealthy and usually healthy patient might be unlikely to switch to the public system in response to a small price rise at the merged hospital.

5.65 Ultimately, the Commission's inclination is that the potential for self-funded patients to be admitted to LGH as a public or private patient is unlikely to constrain the merged hospital from imposing a small but significant price increase. However, this conclusion is necessarily a tentative one given the lack of relevant empirical data. In any case, this issue is less important given the Commission's conclusions on the potential constraint imposed by new day surgeries – see paragraph 5.113.

5.66 As regards day surgeries, LCMHC submits that:

> The majority of self-funding patients undergo same day procedures, with very few admitted as overnight stay admissions.[76]

5.67 It seems likely that self-funded private patients needing surgery not requiring an overnight stay would consider an appropriately equipped day surgery in Launceston as a substitute for the merged hospital (assuming their doctors had admitting rights).

5.68 Consequently, the Eye Hospital would be likely to restrain the prices charged by the merged hospital for procedures that can be undertaken in the Eye Hospital, assuming that it had sufficient capacity for the extra patients.

5.69 Similarly, a larger day surgery entering the market and offering a broader range of surgical and medical services, or several smaller day surgeries offering different services, would be likely to constitute a constraint on the merged hospital for the relevant services.

Geographic market

5.70 The geographic dimension of this market is likely to be the same as that for the hospital-hospital services purchasers market – that is, northern Tasmania – given the data at paragraphs 5.45-5.46 suggesting that northern Tasmanian patients largely choose to be treated in Launceston.

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[75] ARHG submission, 10 January 2005, p1; LGH submission, 24 January 2005, p1; AMA submission, 14 January 2005, p1. DHHS submission, 2 February 2005, p1.
[76] LCMHC submission, 15 February 2005, p12.

Conclusion

5.71 The Commission concludes that the relevant market is for the supply of hospital services by, at the least, private day surgeries and general overnight private hospitals to self-funding patients.

Public Benefits

LCMHC submission

5.72 Generally, LCMHC submits that allowing the merger of St Luke's and St Vincent's 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.[77]

5.73 LCMHC submits that cost savings will arise particularly in the following areas:

- clinical service rationalisation;
- purchasing; and
- administrative and non-clinical synergies.

5.74 LCMHC submits that:

> Both St Vincent's and St Luke's offer acute medical and surgical services of similar complexity...
>
> 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…
>
> Should the Acquisition proceed, it is expected that one campus will be developed as the location of acute services… while the alternative campus will specialise in the provision of short stay procedures, less acute admissions and, perhaps, post-natal care…
>
> Service rationalisation will generate significant savings in capital investment over time, as duplication of equipment and instruments will be minimised…
>
> The time frame for any changes is at least 12 months to three years, and involves further financial and business analysis…[78]

5.75 LCMHC further submits that:

> duplication across the two hospitals will be reduced, within a short period following the merger, from approximately 90 per cent to 30 per cent. At this stage, duplication cannot be completely removed because neither site can currently accommodate all surgical activity, or all day patient activity.[79]

5.76 Regarding purchasing, LCMHC submits that the proposed merger will increase its purchasing power, particularly over 'local Tasmanian companies' supplying '[i]tems such as fresh foods, allied health, linen and laundry, service utilities, and maintenance'.

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[77] LCMHC submission, 21 December 2004, pp31-32.
[78] LCMHC submission, 21 December 2004, p39.
[79] LCMHC submission, 15 February 2005, p28.

LCMHC estimates that this will provide an annual cost saving of approximately $30,000 (and possibly some administrative cost savings).[80] It submits that the:

> The time frame for any savings may be 12 months, depending upon expiry/review dates of existing contracts.[81]

5.77 LCMHC submits that if the merger occurs, in the short term, synergies will be achieved in areas such as: finance; payroll; health information services; accommodation services; risk management; administration and document management; catering; maintenance; and domiciliary care.[82] It submits that:

> 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.[83]

5.78 LCMHC also identifies a range of other potential synergies from the proposed merger including: a single switchboard; 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.[84]

5.79 LCMHC submits that the efficiencies identified above will, in particular, enable it to:

- provide new and expanded services. It submits that:

  > 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.[85]

  LCMHC further submits that:

  > 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…[86]

- improve quality of the services provided. LCMHC submits that:

  > 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,

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[80] LCMHC submission, 21 December 2004, p41.
[81] LCMHC submission, 21 December 2004, p41.
[82] LCMHC submission, 21 December 2004, p35.
[83] LCMHC submission, 21 December 2004, p35.
[84] LCMHC submission, 21 December 2004, pp41-42.
[85] LCMHC submission, 21 December 2004, p32.
[86] LCMHC submission, 21 December 2004, p32.

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;[87] and

- reduce the demand for price increases from health funds by the two hospitals.[88]

5.80 LCMHC submits that the potential public benefits from the proposed merger are illustrated by the merger of its hospital at Lenah Valley, Hobart with St John's Hospital, Hobart in 2000. LCMHC submits that:

> Lenah Valley Campus was a high acuity facility… When it was acquired by CHCT, St John's was a low acuity facility… St John's did, however, have an excellent day surgery unit...
>
> The benefits to the community brought about by the merger… 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… 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…
>
> 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… A number of benefits have resulted from this strategy. First, the removal of service duplication between the two campuses … CHCT has invested significantly in the provision of the latest technology for eye surgery… Second, CHCT now has a core team of expert ophthalmology nurses based on a single campus… Third, the establishment of a pre-admission clinic… has led to a significant reduction in both pre-operative cancellations and unplanned overnight admissions.[89]

5.81 LCMHC submits that the public benefits listed above will also:

- reduce the need for patients to travel outside of Launceston for treatment. LCMHC submits that:

  > 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.[90]

- improve the recruitment and retention of health care professionals in Launceston;[91] and

- assist health funds to retain members and recruit new members in northern Tasmania.[92]

5.82 LCMHC also submits that:

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[87] LCMHC submission, 21 December 2004, p33.
[88] LCMHC submission, 21 December 2004, p36.
[89] LCMHC submission, 21 December 2004, pp34-35.
[90] LCMHC submission, 21 December 2004, p36.
[91] LCMHC submission, 21 December 2004, p37.
[92] LCMHC submission, 21 December 2004, p38.

> 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.[93]

5.83 Finally, LCMHC submits that, if the proposed merger proceeds, it will continue 'the highly valued Devonport-based counselling service currently provided to the community of northern Tasmania by the Sisters of Charity'.[94]

Interested party submissions and LCMHC response

5.84 Most interested parties agree or largely agree with the LCMHC's public benefit claims.[95]

5.85 However, MBF and the DVA, while both recognising the potential for many of the claimed public benefits to arise, were concerned about whether they would actually arise. The DVA submits that:

> the efficiencies listed will lead to cost savings for the merged entity. Whether these cost savings will then translate into improvements in quality and an increase in the range of services, which would then become a public benefit, is not guaranteed.[96]

5.86 MBF submits that:

> As a significant proportion of the public in this market, we believe that MBF members could benefit from the proposed acquisition because:
>
> - reduced costs of services due to efficiencies gained; and
> - increase in quality with concentration of service delivery to one area.
>
> However, the mechanism for ensuring that these benefits are shared by all patients and does not lead to increased profits of the hospitals (to be spend in accordance with LCHMC's wishes) needs to be developed further. That is, the "Public Benefit" generated by this acquisition should accrue to the public and not just the new owner.[97]

5.87 In response, LCMHC submits that:

> the examples of Calvary Health Care Riverina… and Calvary Cairns are evidence that LCMHC's service profile is driven by what services can be affordably extended to the local community, rather than concern for profit maximisation.[98]

5.88 Both Calvary Health Care Riverina and Calvary Cairns are the only private hospitals in their region. LCMHC states that its Riverina hospital (purchased in 2002):

> has developed a number of new and/or expanded services to meet community needs. These include the following:

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[93] LCMHC submission, 21 December 2004, p38.
[94] LCMHC submission, 21 December 2004, p38.
[95] ARHG submission, 10 January 2005, p2; AHSA submission, 6 January 2005, p3; St Luke's MAC submission, 13 January 2005, p2; St Vincent's MAC submission, 10 January 2005, p2; AMA submission, 14 January 2005, p3; LGH submission, 24 January 2005, pp3-4; and DHHS submission, 2 February 2005, p3.
[96] DVA submission, 25 January 2005, p7.
[97] MBF submission, 20 January 2005, p4.
[98] LCMHC submission, 15 February 2005, p30.

- the provision of alcohol and other drug services… While these services receive government funding, [Riverina] makes a significant financial contribution to their ongoing functioning, and derives no financial profit from their operation;

- the introduction of a dedicated palliative care service…; and

- the introduction of interventional cardiac services.

A further example of CHCR's continuing commitment to the local community is its ongoing provision of a private maternity unit, which has been in operation since 1959, despite the fact that this service is marginal in terms of its financial viability. CHCR has demonstrated its commitment to maintaining this service through investing in the recruitment, training and retention of medical and nursing staff. CHCR also provides inpatient services, such as cataracts treatment and sleep studies, to pensioners at reduced rates.[99]

5.89 LCMHC highlights that:

Last year, MBF undertook a national patient satisfaction survey of hospitals in Australia. Of the 90 hospitals surveyed, [Riverina] was rated by MBF as the number one hospital in Australia.[100]

5.90 Calvary Cairns was originally operated by LCMHC, reverted to the local Catholic diocese 'several years ago', and has now been sold to Ramsay Healthcare. LCMHC submits that:

Despite the existence of only one private inpatient hospital in Cairns, Calvary Cairns developed an extensive range of clinical services to support the needs of the community. Services extended to a cardiac catheter laboratory, and coronary care and intensive care beds. In addition to a full range of medical and surgical services, the hospital also offered formal palliative care, renal dialysis, oncology and obstetric services. The service range offered by the hospital was considerably more extensive than that currently existing in Launceston, a fact which supports LCMHC's contention that its service profile is driven by what services can be affordably extended to the community rather than what activity will best maximise profit.[101]

5.91 LGH raises a concern that the merged hospital would employ fewer healthcare professionals and general staff.[102]

Conclusion

5.92 The Commission accepts that the proposed acquisition will generate cost savings along the lines identified by LCMHC (see paragraphs 5.73-5.78).

5.93 However, cost savings arising from improved bargaining power with suppliers (see paragraph 5.76) do not constitute a *public* benefit. Rather, they constitutes a transfer from one business to another without there being, for example, any increase in economic efficiency.

5.94 The remaining cost savings essentially flow from achieving economies of scale and therefore constitute improvements in economic efficiency. An issue arises as to whether these efficiencies, by themselves, would constitute a public benefit. Tribunal statements exist which appear to limit the circumstances where a benefit to a business (and particularly its shareholders) would constitute a public benefit, thereby suggesting that

[99] LCMHC submission, 15 February 2005, p31.
[100] LCMHC submission, 15 February 2005, p31.
[101] LCMHC submission, 15 February 2005, pp31-32.
[102] LGH submission, 24 January 2005, p3,4.

public benefits are largely benefits that are passed on to consumers.[103] Other Tribunal statements suggest a wider conception of public benefit.[104]

5.95 However, this issue does not arise in this case, as the Commission is satisfied that LCMHC is likely to use the cost savings to improve the range and quality of services available to private patients in northern Tasmania. In reaching this view, the Commission relies particularly on:

- the fact that LCMHC, as a charitable organization for taxation purposes, is required to apply all its income and assets to its charitable purposes (see paragraph 2.2);
- the Lenah Valley/St Johns, Riverina and Cairns examples given by LCMHC (paragraph 5.80, 5.88-5.90); and
- the apparent strong support for the proposed merger within the medical community in Launceston. A decision not to pursue improving the range and quality of services offered may affect the ability of the merged hospital to recruit and retain medical specialists, which would detrimentally affect its long-term prospects.

5.96 However, the Commission is concerned that, particularly the first two considerations would not apply if LCMHC were to sell the merged hospital, and particularly if it sold it to a for-profit hospital operator. Such a sale might significantly reduce the public benefit generated by the merger.

5.97 LCMHC's application for authorisation did not raise any issues relating to exports, import substitution or Australia's international competitiveness (see paragraph 4.4-4.5).

Public detriment

5.98 Any public detriment arising from the proposed acquisition would arise from a lessening of competition in either relevant market. The issue is whether the merged hospital would be able to exercise market power by unilaterally raising its prices.

5.99 The key factors relevant to assessing whether the merged hospital would be able to unilaterally raise its prices in the markets for the supply of hospital services to hospital services purchasers and self-funding patients are:

- market concentration in each market;
- entry barriers to each market; and
- the degree of countervailing power in each market (and particularly the hospital-hospital service purchaser market).

5.100 However, at the outset, the Commission's conclusion on the counterfactual – that either St Vincent's or St Luke's is likely to close within approximately two-to-five years –

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[103] See, for example: *Queensland Co-operative Milling Association Ltd.* (1976), ATPR 40-012, at 17,242; *Re Rural Traders Co-operative (WA) Ltd* (1979) ATPR 40-110 at 18,123; *Howard Smith Industries Pty Ltd* (1977), ATRP 40-023, at 17,334; *Re Queensland Independent Wholesalers Ltd* (1995) ATPR 41-438 at 40,928; *Re: Alliance Agreement — application by PK Wakeman* (1999) ATPR ¶41-675 at 42636.

[104] See *Australian Performing Rights Association* (1999) ATPR 41-701 at 42985; *Re Queensland Independent Wholesalers Ltd* (1995) ATPR 41-438 at 40965.

imposes a longer term limit on the public detriment from the proposed merger. With or without the merger, hospital services purchasers and self-funded patients will be supplied by one hospital within two-to-five years.

Market concentration

5.101 Given that St Luke's and St Vincent's are the only two general overnight private hospitals in northern Tasmania (as defined in paragraph 5.45), the merged hospitals would be the only general overnight private hospitals in this region. Consequently, it would be the only supplier in the hospital-hospital service purchaser market.

5.102 The merged hospital's only competitor in the hospital-self-funded patient market would be the Eye Hospital (and possibly the LGH). Its market share would be nearly 100 per cent.[105]

Barriers to entry

LMCHC submission

5.103 LCMHC submits that:

- the acquisition would not create any new barriers to entry;
- it is unlikely that a new, general service hospital would enter the northern Tasmanian market; and
- the most significant competitive threat to St Vincent's and St Luke's is the entry of a new day surgery or further expansion of the existing day surgery facilities.[106]

5.104 More specifically, LCMHC submits that:

> 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 a new hospital is $250,000 to $400,000 per bed, and much of this is sunk cost. 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 approxiately $20-$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.

5.105 As regards the threat from day surgeries:

> The Eye Hospital has already expanded significantly since its inception as an ophthalmological practice, introducing first plastic 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 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 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.

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[105] LCMHC submission, 21 December 2004, p57.
[106] LCMHC submission, 21 December 2004, p57.

> The Gynaecological Clinic was recenty opened to provide a limited range of same day procedures related to fertility… 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.[107]

Interested party submissions

5.106 The DHHS submits that:

> There are legislative barriers to market entry in that private hospitals must be licensed by the Minister who may refuse a licence if sufficient services are already available. However, in recent years all applications for new licences or increased bed capacity at existing private hospitals have been approved.[108]

5.107 The DVA submits:

> LCM[HC] has placed great emphasis on the significant increase in Day Procedure Centres… While there may have been a significant increase in the number of these facilities nationally, in Tasmania there has been no such dramatic increase. In 1994/95 there were two Day Procedure Centres and there are still two – one in Launceston and one in Hobart.[109]

5.108 In response, LCMHC points to the recent establishment of the Gynaecological Clinic, and to a feasibility study it states is currently being undertaken by a group of Launceston-based doctors (led by IVF specialists) in relation to a new day surgery centre to be located opposite St Luke's.[110]

Conclusion

5.109 The Commission agrees that barriers to entry for the establishment of a new, general overnight private hospital in northern Tasmania are high. It is highly unlikely that a new private overnight hospital provider would be established in Launceston given the investment required and the demand for hospital services in the area.

5.110 The possibility of new entry by day surgeries is relevant to the market for the supply of hospital services to self-funded patients – that is, the potential for these patients to switch to a day surgery would be likely to constrain the merged hospital from raising its prices. Self-funded patients constitute less than 10 per cent of the total number of private hospital patients in northern Tasmania, and most are treated for procedures requiring day surgery (see paragraph 5.66).

5.111 The issue is whether one or more new day surgeries would enter the market within two years.[111] On one hand:

- a substantially smaller capital investment is required than for an overnight hospital;
- the relatively small number of self-funded patients would seem likely to reduce the size of the day surgery needed to act as a constraint on the merged hospital;
- the Commission understands that most day surgery facilities are established by medical practitioners, who presumably then work at the day surgery. These medical

[107] LCMHC submission, 21 December 2004, p57.
[108] DHHS submission, 2 February 2005, p3.
[109] DVA submission, 25 January 2005, p5.
[110] LCMHC submission, 15 February 2005, p14.
[111] ACCC Merger Guidelines, 1999, paragraph 5.126.

practitioners would have some influence over where patients were treated. This would be likely to assist a day surgery in remaining viable even if the merged hospital lowered its prices back to pre-merger levels. Moreover, once established, the day surgery would also be likely to attract health fund members (if waiting lists formed, health fund members could be expected to switch back to the merged hospital);

- at least some Launceston doctors appear interested in opening a day surgery.

5.112 On the other hand, there is little evidence of recent new entry:

- while the Gynaecological Clinic opened recently, it provides services no longer provided by St Luke's;
- the feasibility study currently being undertaken in Launceston is being led by IVF specialists (that is, by specialists whose services would not be available at the merged hospital); and
- in 2001-02, a private orthopaedic group undertook feasibility studies on a day surgery in Ulverstone in north-western Tasmania, but has not proceeded.[112]

5.113 While recognising the uncertainty inherent in any conclusion reached on this issue, on balance, the Commission considers that the potential entry of a day surgery would be likely to constrain the merged hospital from raising its prices by at least a small but significant amount for procedures required by self-funded patients. In particular, there appears to be general interest among medical practitioners in Tasmania in establishing day surgeries, and the merged hospital raising its prices would seem likely to create an opportunity for a day surgery to be established.

Countervailing power

5.114 The key issue as regards public detriment in the hospitals-hospital service purchasers market is whether hospital service purchasers would possess sufficient countervailing power to prevent the merged hospital from exercising market power – that is, obtaining higher reimbursements.

LCMHC submission

5.115 Generally, LCMHC submits that:

> 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 increase 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.[113]

5.116 In particular, LCMHC submits that:

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[112] LCMHC submission, 15 February 2005, p14.
[113] LCMHC submission, 21 December 2004, p54.

> While the Acquisition will improve the negotiating position 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.[114]

5.117 LCMHC further submits that:

> 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 [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).[115]

Interested party submissions and LCMHC response

5.118 Interested parties other than health funds and the DVA believe, although not always with great certainty, that health funds and the Repatriation Commission currently have greater bargaining power than St Vincent's and St Luke's.[116] For example, LGH submits that:

> I am uncertain of the answer for this, however I would believe that the health funds and Repatriation Commission would have the greater bargaining power.[117]

5.119 DHHS submits that:

> It is considered that the health funds and the Repatriation Commission have the greater bargaining power in the negotiation of Hospital Purchaser-Provider Agreements (HPPAs)… There is a large incentive on private hospitals to agree an HPPA as they will only receive the second tier default benefit if they do not.[118]

5.120 MBF and the ARHG submit that bargaining power is currently evenly shared between health funds and St Vincent's and St Luke's.[119]

5.121 The DVA submits:

> the Launceston area is over-bedded when compared to other regional areas of Australia and it could be expected that health funds and DVA would have the balance of power. But local access and ongoing relationships with hospital owners are important to DVA. In addition, both LCM[HC] and the current owner of St Vincent's, SCHS, own hospitals on the mainland and so their bargaining power is enhanced… [and] St Vincent's and St Luke's are already achieving rates with DVA that are equal to or better than comparable hospitals elsewhere.[120]

5.122 Several interested parties consider that the merged hospital would be able to negotiate higher reimbursements from hospital service purchasers than St Vincent's and St Luke's separately.[121] For example, MBF submits that:

> the proposed aquisition will increase St Vincent's and St Luke's countervailing power in negotiating [HPPAs] with our fund. Such market power could be used to leverage higher HPPA charges ultimately resulting in greater costs to our members. Given the slim margins on private health insurance, such

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[114] LCMHC submission, 21 December 2004, pp54-55; LCMHC submission 15 February 2005, p3.
[115] LCMHC submission, 21 December 2004, p4.
[116] LGH submission, 24 January 2005, p2; AMA submission, 14 January 2005, p2; St Vincent's MAC submission, p1; DHHS submission, p2.
[117] LGH submission, 24 January 2005, p2.
[118] DHHS submission, 2 February 2005, p2.
[119] MBF submission, 20 January 2004, p1; ARHG submission, 10 January 2005, p2.
[120] DVA submission, 25 January 2005, pp3-4.
[121] DVA submission, 25 January 2005, p4; MBF submission, 20 January 2005, p2-3; AHSA submission, 6 January 2005, p2; AMA submission, 14 January 2005, p2.

increases cannot be absorbed and translate directly into increased costs to members of health insurance generally.

We do not agree with the LCMHC submission… that MBF being a national organisation will assist MBF with maintaining a strong negotiating position in relation to the merged entity. The relevant market is hospital services in Launceston not the national market and therefore, MBF's national presence has no effect on the power it would have in negotiations with the merged entity.

It is important to MBF to have agreements with St Vincent's and St Luke's in order to be able to sell private health insurance in Tasmania (or at least Northern Tasmania) because a key element of the value proposition of private health insurance is access to private hospitals and there are almost no other alternatives in the region which would satisfy prospective members. Existing members could not be serviced by the smaller hospitals in the region.[122]

5.123 The AHSA submits that it:

expects CHCT to have significant power with funds becoming "price takers" rather than having transparent negotiations.[123]

5.124 The DVA submits:

if the merger is successful LCM[HC] will own 73% of the overnight acute hospital beds in Tasmania…Because of this increased market share, LCM[HC] may exert considerable pressure to achieve higher hospital rates in Tasmania and this may in turn have a flow-on effect in other states. It is DVA's experience in its past dealings with LCM[HC] that it has attempted to use its market share to achieve higher rates of indexation.[124]

5.125 However, the ARHG submits that:

We acknowledge that merged hospitals would obviously have increased power in negotiating HPPA's, especially given that there is only two overnight inpatient private Hospitals in Launceston. We have however been able to negotiate HPPA's to the satisfaction of both parties to-date and believe they will continue at the appropriate time and with the same outcomes.[125]

5.126 The Chairman of the Medical Advisory Committee St Vincent's submits that:

I believe that the merged hospitals would be in a stronger bargaining position as they could not be played off one another. However, I would expect their costs would be better constrained by a merger and, since they are 'not-for-profit' organisations, they would have no need for 'significantly higher reimbursements' unless to improve patient services.[126]

5.127 The DHHS and LGH consider that the proposed merger would not change the current situation.[127]

5.128 In response, LCMHC considers that MBF's submission:

is greatly exaggerated… While LCMHC agrees that, to some extent, it is important for MBF to have agreements with St Vincent's and St Luke's in order to sell private health insurance in Northern Tasmania, the commercial reality is that Northern Tasmania represents only a very small precentage of MBF's business nationally, and MBF's business means a great deal more to the merged entity than the merged entity's business means to MBF… St Luke's and St Vincent's combined represents just 0.4 per cent of MBF's hospital outlays so clearly, MBF can choose to abandon one or both hospitals with little impact on

[122] MBF submission, 20 January 2005, pp2-3.
[123] AHSA submission, 6 January 2005, p2.
[124] DVA submission, 25 January 2005, p4.
[125] ARHG submission, 10 January 2005, p2.
[126] St Vincent's MAC submission, 14 January 2005, p1.
[127] DHHS submission, 2 February 2005, p2; LGH submission, 24 January 2005, p2.

its national business, whereas the failure of the merged entity to obtain a contract with MBF would threaten 25 per cent of its turnover…[128]

5.129 LCMHC submits that AHSA's submission is also 'greatly exaggerated'. Instead:

> AHSA is a small fund in the Northern Tasmanian market (with approximately five per cent market share), and Northern Tasmania accounts for an even smaller percentage of AHSA's national business (LCMHC estimates that Launceston accounts for less than 0.2 per cent of AHSA's national business). Consequently, the impact of any change in ownership of the private hospitals in Launceston will have very little impact on AHSA…
>
> With AHSA having approximately five per cent of the market in Launceston, if LCMHC went out of contract with AHSA, then there is the potential for the merged entity to lose up to five per cent of separations. Such a loss would be significant to the hospital, especially given its low margins.[129]

5.130 LCMHC also lists other regional centres with only one private hospital (see paragraph 5.2) and submits that:

> There is no evidence that hospitals in such centres enjoy higher health fund reimbursement rates than hospitals located in cities with one or more competing hospitals.[130]

5.131 LCMHC notes that the ARHG – which believes it would be able to negotiate satisfactory outcomes with the merged entity – includes St Luke's Health, which is based in Launceston and has approximately 25 per cent market share in northern Tasmania.[131] It submits that St Luke's Health:

> has a better understanding of the local market and its dynamics than any other health fund. [132]

5.132 Finally, LCMHC submits that:

> In its recently completed negotiations… MBF took a group approach requiring acceptable outcomes in relation to all sites prior to finalising agreements as a whole.[133]

Conclusion

5.133 An important determinant of the ability of the merged hospital to negotiate higher reimbursement rates is whether it would be willing to go out of contract with one or more, but obviously not all, hospital service purchasers. However, a number of factors suggested that its ability to do this would be limited.

5.134 First, there are several regional areas with only one general overnight private hospital (see paragraph 5.2). The Commission is not aware of any hospitals in these areas going out of contract with a health fund. Further, confidential information available to the Commission suggests that private hospitals in regional areas are generally able to negotiate higher reimbursement rates than private hospitals in metropolitan areas. However, the information also suggests that 'monopoly' private hospitals in regional areas have not usually been able to negotiate higher rates than private hospitals in regional areas where there is more than one private hospital.

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[128] LCMHC submission, 15 February 2005, p21.
[129] LCMHC submission, 15 February 2005, pp16-17.
[130] LCMHC submission, 15 February 2005, p18.
[131] LCMHC submission, 15 February 2005, pp17-18.
[132] LCMHC submission, 15 February 2005, p18.
[133] LCMHC submission, 15 February 2005, p22.

5.135 Second, LCMHC submits that MBF negotiates on a 'one-out-all-out' basis (see paragraph 5.132). The Commission is not aware of anything that would prevent, in particular, Medibank Private or the LCMHC from doing the same. This changes the dynamics of the negotiations somewhat.

5.136 On one side, LCMHC would be risking losing contracts for its private hospitals, in particular, in Sydney (Hurstville) Adelaide and Canberra. Medibank Private and MBF each have significant market shares in these cities, which each have a number of private hospitals. The Commission notes that Medibank Private intends to implement a new competitive selection process to identify which hospitals it will contract with in a number of cities, including Sydney and Adelaide. It anticipates a small reduction of contracted hospitals in some markets.[134]

5.137 A hospital going out of contract with a health fund would receive second tier default payments from the fund. This assumes that the hospital meets the criteria set by the Australian Department of Health and Ageing covering quality standards, informed financial consent and simplified billing.[135] LCMHC submits that default payments are 85 per cent of average payments made by that health fund to hospitals in the same class.[136] While a hospital could impose a surcharge on the patient, this may make it uncompetitive with other private hospitals in the relevant market. Consequently, a hospital going out of contract with a health fund in a market such as Sydney, Canberra or Adelaide would seem likely to suffer financially.

5.138 On the other side, Medibank Private and MBF would risk losing customers in Launceston and Wagga Wagga, where LCMHC operates the only private hospital. Medibank Private and MBF each have around 25 per cent of the Launceston market. They also have significant market shares in New South Wales, although the Commission is not aware of their market share in Wagga Wagga. However, Launceston and Wagga Wagga are smaller markets.

5.139 Overall, the ACCC considers that the use of 'one-out-all-out' negotiating stances are likely to limit (although not remove completely) the ability of the merged hospital to seek higher reimbursement rates from Medibank Private and MBF.

5.140 The vast majority of members of St Luke's Health are in Tasmania, where LMCHC has a substantial proportion of beds (see paragraph 5.124). St Luke's Health would therefore have little ability to threaten not to have a contract with LCMHC in Hobart unless it negotiates a satisfactory outcome with the merged hospital. However, the ARHG, which includes St Luke's Health, is not concerned about its ability to negotiate appropriate outcomes with the merged hospital (see paragraph 5.125). Further, it would not seem to be in the merged hospital's longer term interests to weaken St Luke's Health relative to MBF and Medibank Private.

5.141 While the DVA would appear, theoretically, to be able to threaten to go out of contract with LCMHC hospitals in, for example, Sydney and Adelaide if it was unable to negotiate a satisfactory deal with the merged hospital, its statutory role to obtain health

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[134] *Medibank Private targets health care costs*, Medibank Private press release, 14 February 2005.
[135] LCMHC submission, 15 February 2005, p17.
[136] LCMHC submission, 15 February 2005, p17. LCMHC also submits that classes are based on size and services, and then State by State; ibid.

care for veterans across Australia would restrict its ability to do this. Consequently, it also would appear to have little 'other-market' leverage.

5.142 On the other hand, the DVA would supply 10-15 per cent of the merged hospital's patients. The loss of these patients even for a short period – which the DVA might consider if it concluded that negotiations had broken down – or possibly more likely, these patients continuing to be reimbursed at the previous year's rates for a short period, would increase the DVA's bargaining power.

5.143 Finally, the Commission understands that, under the *National Health Act 1953*, the Minister for Health and Ageing may disallow proposed health fund premium increases.

5.144 As noted at paragraph 5.54, the increase in premiums (in Tasmania) from, for example, a ten per cent increase in prices by the merged hospital is likely to be around two per cent. Nationally, premiums have been increasing, on average, by between six and seven per cent annually.[137] Consequently, the increase in premiums caused by the merged entity raising prices would not be insignificant relative to the overall increase, and there would be some risk that the Minister might disallow a premium increase claim including the increase arising from the merged hospital. This possibility would seem likely to add to the bargaining power of health funds against the merged hospital, although possibly not substantially.

5.145 Overall, the Commission concludes that, while the merged hospital would be likely to be able to negotiate higher reimbursement rates from hospital service purchasers – indeed, LCMHC essentially concedes this – any increase would be likely to be limited.

5.146 The Commission also understands that, under the portability provisions of the *National Health Act 1953*, people can move freely between health funds (in particular, they do not have to re-serve waiting periods when transferring, unless they choose a higher level of cover). However, it is also aware that during a previous contractual dispute between a health fund and a hospital group, members of the health fund began transferring to other funds. One fund sought to impose certain restrictions on new members transferring from the fund in dispute. Further, the difficulties associated with accommodating a large number of transferring members – particularly members with pre-existing conditions – is of particular concern to smaller funds.[138]

5.147 This suggests that, in practice, there would be some risk for the merged hospital in relying on significant numbers of health fund members – MBF, Medibank Private and St Luke's Health each have a 25 per cent market share – smoothly transferring funds in response to their fund going out of contract with the merged hospital.

5.148 This would mean that, for a period of time until either a HPPA was settled or health fund members were able to transfer to a fund with a HPPA with the merged hospital, the merged hospital would be relying on second tier default payments from health funds.[139] However, it would be possible for the merged hospital to impose a surcharge on private patients to 'top-up' the default benefit received from the health fund. The size of this

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[137] Information provided by Australian Department of Health and Ageing on 24 February 2005.
[138] ACCC Senate Report on anti-competitive and other practices by health funds and providers in relation to private health insurance, 30 June 2004, p13.
[139] It seems reasonable to assume that the merged hospital would meet the standards required to qualify for second tier default benefits.

surcharge could be expected to reflect its status as the only private overnight hospital in Launceston, although this would generate pressure to ensure that members of the health fund that has gone of out contract were able to transfer to funds with a contract. In any case, the Commission considers it unlikely that the merged hospital would go out of contract with any health fund, for the reasons given above.

X-inefficiency

5.149 The Commission considers that there is minimal risk of the merged hospital generating x-inefficiency (that is, becoming slack) given its need to negotiate HPPAs with, in particularly, Medibank Private and MBF.

Conclusion on public detriment

5.150 Overall, the Commission considers that the proposed merged would generate public detriment primarily in the form of an increase in reimbursements from hospital service purchasers, although this would be limited by:

- the countervailing power of hospital service purchasers;
- in the longer term, the Commission's conclusion that either St Lukes or St Vincent's is likely to close within two to five years.

Balance of public benefit and detriment

5.151 The ACCC considers that the proposed merger would generate limited public detriment. The public benefit is also limited given the possibility of the merged hospital being sold to a for-profit hospital operator.

5.152 However, LCMHC has offered a section 87B undertaking to the following effect: that it will not, and will ensure that its subsidiaries will not, sell the merged facilities to a for-profit operator for a period of three years. The undertaking is at Attachment A.

5.153 Given this undertaking, the Commission is satisfied that the public benefit outweighs the public detriment.

5.154 Some interested parties propose that authorisation be granted subject to other conditions or undertakings.[140]

5.155 MBF submits that authorisation be granted subject to conditions that:

> 1. Separate negotiation of HPPAs by St Vincent's and St Luke's;
>
> 2. That neither company within the group be permitted to make the signing of one HPPA contingent on the execution of the other; and
>
> 3. Subject to appropriate rationalisation where there is duplication, St Vincent's and St Luke's should continue to between them offer the full range of hospital services at a level required by the community.[141]

5.156 Similarly, the DVA submits that:

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[140]Medibank submission, 25 January 2005, p3; MBF submission, 20 January 2005, p5;DVA submission, 25 January 2005, p8.
[141] MBF submission, 20 January 2005, p5.

> LCM[HC] would need to give clear commitments as to how it intends to improve medical coverage, length of stay, discharge planning, care planning and patient management issues, without lessening the range of private hospital services available to veterans in the area, to ensure continuation of DVA's support at its existing levels. LCM[HC] should also give firm undertakings that they would not unfairly exercise their monopoly power in the area, and in the rest of Tasmania, to attempt to extract unreasonable and unrealistic arrangements for the services on offer after any rationalisation.[142]

5.157 The ACCC considers that, even if it had not concluded that the public benefit outweighs the public detriment (with the undertaking at Attachment A), the conditions and undertakings proposed above would be unworkable. In particular, there would inevitably be considerable uncertainty about whether the proposed conditions/undertakings were being complied with.

[142] DVA submission, 25 January 2005, p8.

6. FINAL DETERMINATION

The Applications

6.1 On 21 December 2004, Little Company of Mary Health Care (LCMHC) lodged application for authorisation A90974 with the Australian Competition and Consumer Commission (the ACCC).

6.2 Application A90947 was made using Form F, Schedule 1, of the *Trade Practices Regulations 1974.* The application was made under subsection 88 (9) of the *Trade Practices Act 1974* (the TPA), and sought authorisation to acquire shares in the capital of a body corporate or to acquire assets of a person.

The Statutory Tests

6.3 For the reasons outlined in Chapter 5 of this determination, the ACCC concludes that in all the circumstances the proposed acquisition would be likely to result in such a benefit to the public that it should be allowed to take place.

6.4 The ACCC therefore **grants** authorisation to application A90947.

Conduct for which the ACCC grants authorisation

6.5 The ACCC authorises the Little Company of Mary Health Care Ltd to acquire St Vincent's Hospital, Launceston, Tasmania.

Date authorisation comes into effect

6.6 This determination is made on 11 March 2005.

6.7 If no application for review of the determination is made to the Australian Competition Tribunal, it will come into force on 1 April 2005.

6.8 If an application is made to the Tribunal, the determination will come into force:

- where the application is not withdrawn – on the day on which the Tribunal makes a determination on the review; or
- where the application is withdrawn – on the day on which the application is withdrawn.