Australian Government
Department of Veterans' Affairs

TASMANIAN OFFICE

Mark Pearson
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Australian Competition & Consumer Commission
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Dear Mr Pearson

RE: APPLICATION FOR AUTHORISATION A90947 LODGED BY THE LITTLE COMPANY OF MARY HEALTH CARE LIMITED

Thank you for giving the Repatriation Commission, through the Department of Veterans' Affairs (DVA), this opportunity to comment on the Application for Authorisation A90947 lodged by the Little Company of Mary Health Care Limited (LCM). I have previously written on behalf of DVA to the Australian Competition and Consumer Commission (ACCC) giving DVA's views on the proposed acquisition by LCM of St Vincent's Hospital (Launceston) Ltd (St Vincent's), in the context of section 50 of the *Trade Practices Act, 1974.* Much of that response is relevant to the current Application and will be included here.

I would like to preface this response by making an overall comment. DVA is aware of the problems that Calvary Health Care Tasmania Inc. - St Luke's Campus (St Luke's) and St Vincent's have been experiencing in maintaining the financial viability of both hospitals, sympathises with their predicament and is willing to work with the parties in their endeavours to maintain a viable private hospital presence in the Launceston area.

The current proposed acquisition will most probably lead to decreased competition (the current Applications would not have been made unless this was a real risk) and will result in a monopoly supplier of private hospital services in the Launceston area. This will reduce competition and may place pressure on prices in that market. It will give LCM increased bargaining power in the State of Tasmania, where there is already a limited number of competitors in the market for private hospital services. The acquisition will also have ramifications for LCM's bargaining position in the rest of Australia.

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DVA would now like to comment on the questions raised in your letter of 23 December 2004 on whether any public benefit arising from the proposed merger outweighs any public detriment.

The questions posed by the ACCC

1. Self-paying patients

The Productivity Commission reported in 1999 that nine percent of private patients paid for their treatment themselves – that is, their treatment was not funded by, for example, health insurance or the Repatriation Commission.

1.1 Do you consider that a significant number of these self-funded private patients would choose to be treated in the following facilities if the merged hospital raised its prices?

- *Launceston General Hospital (as a private patient), the Eye Hospital or the Gynaecological Clinic: or*
- *In Hobart, North Western Tasmania or Melbourne.*

1.2 Do you consider that a significant number of these self-funded private patients would choose to be treated in Launceston General Hospital as a public patient if the merged hospital raised its prices?

DVA believes that hospitals would be best placed to address this question as they would have insurance status data for each admission before and after a price change. They would be able to report whether the percentage of self-funded patients decreased consequent to a price change. Having said this DVA would suggest that if the merged hospital raised its prices, individual decisions would be based on factors such as:

- The urgency of the need for treatment;
- The waiting time in the public hospital for that type of treatment;
- The ability of the patient to pay as a self-funded patient;
- Availability of alternatives;
- Whether the treating doctor has admitting rights to another hospital;
- Geographical access to other hospitals; and
- The possibility of postponing or going without clinically necessary treatment.

2. Patients whose treatment is paid for (fully or substantially)by health funds, the Repatriation Commission or another entity.

2.1 Currently, who has greater bargaining power – the health funds and Repatriation Commission or the hospitals?

DVA's intention is to purchase cost effective, quality, timely hospital services for veterans that enables access to the nearest suitable facility for their treatment needs. From DVA's point of view, efficient hospitals offering the services that veterans need, will always be able to negotiate reasonable reimbursement

In March 2004 both LCM and St Vincent's requested significant price increases from DVA. Benchmarking of Calvary, Hobart (owned by LCM) and St Vincent's against comparable hospitals on the mainland indicated that their rates were already comparable or better than that

paid elsewhere. In each case DVA worked with the organisations to achieve acceptable outcomes.

Calvary now has more than 50% of the private hospital beds in Hobart and, with the acquisition of St Luke's and merger with St Vincent's, it will have 100% of the private hospital beds in Launceston.

Healthscope (for profit) owns Hobart Private Hospital and North West Private Hospital. It also owns a number of private hospitals on the mainland, as does LCM. Healthscope provides countervailing power in the Hobart region, and as a comparator private hospital operator, provides an element of competition in the north of Tasmania.

The presence of Healthscope in Tasmania has not led to decreased demands for rate increases from DVA by Calvary, St Luke's or St Vincent's. No doubt the ongoing negotiations on price for the services provided at the two hospitals will continue to be robust. DVA is certainly prepared to continue to work with LCM and the two Launceston private hospitals through this difficult period. It is not in veterans' interests for these hospitals to close and DVA would prefer to see a viable and effective private hospital presence in Launceston offering a comprehensive range of services.

DVA represents a significant percentage of the total private hospital business in the Launceston area. Until veteran partnering was introduced and DVA contracted with St Luke's in 2000, St Vincent's was the sole private hospital provider for veterans in the Launceston area. Since then DVA's business has been split between the two. For the 6 months July to December 2003 DVA represented 14.5% of total separations at St Vincent's.

DVA's aim has been to negotiate effective outcomes and to ensure timely access to hospital services. DVA is aware that some moves by St Vincent's to expand its services in the late 1990s were unsuccessful (for example the Accident & Emergency Unit) and have had ongoing financial effects. However DVA cannot be expected to subsidise the financial costs of infrastructure for services no longer offered.

Currently there is very little to distinguish St Vincent's and St Luke's or to give either any competitive advantage in any of the services offered. The services offered are virtually the same and, while they are competing for the same patients and specialists, it would be difficult to characterise the competition as vigorous and it certainly is not effective, in that both hospitals are struggling to maintain viability and there are increasing demands on public hospital services, as specialists find their requirements for medical backup cannot be met by either private hospital. This inevitably compromises the range of services available in the private hospitals.

In theory, if a hospital provider has spare capacity (ie. supply outstrips demand), then the balance of bargaining power is with the purchaser. Likewise, if the hospital is operating at full capacity (ie. demand exceeds supply) then the balance of power lies with the hospital. However this must be balanced against DVA's need to ensure that veterans have local access to appropriate private hospital services. In most cases it is in both parties' interests to reach agreement.

As LCM points out in its submission, 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 and the current owner of St Vincent's, the Sisters of Charity Health Service Ltd (SOC), own hospitals on the mainland and so their bargaining power is enhanced. As noted above St Vincent's and St Luke's are already achieving rates with DVA that are equal to or better than comparable hospitals elsewhere.

2.2 To what extent would this change if the proposed merger proceeded? Would St Luke's and St Vincent's be able to obtain significantly higher reimbursements from health funds? If so, why?

When DVA expresses support for the development of a single private hospital service provider in northern Tasmania[1] it is in the context of the development of a comprehensive, effective private hospital service in Launceston offering an appropriately priced, cost-effective range of services.

If the merger goes ahead LCM will own the two private hospitals in an area that is overbedded. They can either increase demand and fill the beds, or decrease the supply of beds, making each bed more profitable. It would obviously be DVA's preference that the range and quality of services at both hospitals be improved and expanded to increase demand for those services. This would require considerable investment and long-term financial planning. Success would depend on LCM being able to attract specialists and medical support services.

It could be that with a decreased supply of beds, LCM may attempt to negotiate higher rates for the remaining beds to cover the cost of necessary short and long term investment in the merged facility. We believe that support for the proposal should be conditional on the implementation of the commitments made by LCM to constrain price increases, reflecting the benefits of improved operational effectiveness.

The submission states[2] that $2.8 million will need to be spent on St Luke's over the next five years simply to bring it up to current industry standards and that at St Vincent's[3], profitability has come at the cost of cutting services. Hospitals need to constantly update their facilities and technology to keep up with developments in the industry[4]. On its own, St Vincent's does not have the capital to increase existing services or introduce new services. In fact, given "...Launceston's size, the parties believe that its population is best serviced by one private hospital."[5] This appears to DVA to be a realistic assessment.

As noted earlier the merger will have an effect on LCM's bargaining position in Tasmania and, potentially, across Australia. If the merger is successful LCM will own 73% of the overnight acute hospital beds in Tasmania (net of psychiatric beds). Because of this increased market share, LCM 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 that it has attempted to use its market share to achieve higher rates of indexation.

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[1] Little Company of Mary Health Care Ltd, Application for Authorisation A90947, 20 December 2004, page 55.
[2] Ibid, page 9.
[3] Ibid, page 11.
[4] Ibid, page 46.
[5] Ibid, page42.

2.3 Could health funds credibly threaten to enter into an HPPA with the Eye Hospital or Gynaecological Clinic in Launceston, or private hospitals in Hobart, Melbourne or North-Western Tasmania in place of an HPPA with the merged entity?

DVA already has contracts with a number of the above facilities. The question for DVA would be whether veterans would be inconvenienced and treatment delayed, if access to a merged entity was limited or denied. The answer is that they would, with waiting times at the public hospital being lengthy and limited alternative options. Consequently, it is important that as wide a range of services as possible is maintained in the area.

In its submission, LCM has placed great emphasis on the significant increase in Day Procedure Centres and the innovative and ever-increasing types of services that these facilities offer. 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.

2.4 Is it possible to enter into a HPPA with Launceston General Hospital? If not how are reimbursement rates determined for private patients treated at this hospital?

DVA does not have HPPAs with hospitals as it is not bound by the *National Health Act, 1953.* Under the provisions of the *Veterans' Entitlement Act, 1986* and the *Military Rehabilitation & Compensation Act, 2004*, DVA is enabled to enter into arrangements with the providers of private hospital services and State Governments for the provision of public hospital services to veterans and entitled persons under the two Acts. Further detail regarding these arrangements can be supplied if necessary[6].

The Arrangement between DVA and the Tasmanian Government includes public hospital services provided at Launceston General Hospital. For all of the period that there have been arrangements with the two private hospitals in Launceston, DVA has had an arrangement in place for public hospital services as well. It is worth noting that veteran patients are subject to the same waiting times as public patients in the public system. The private hospital system is of great importance in ensuring that veterans get timely local access to hospital care.

3. If authorisation is not granted

3.1 Are two private hospitals sustainable in Launceston? If not, and if authorisation is not granted, which hospital is more likely to close? Broadly, when might this happen?

As stated previously it appears that two private hospitals offering the same range of services and competing for the same limited number of patients, would be unsustainable in the Launceston area. However were the private hospitals to cooperate to differentiate their services then a different outcome might be achieved. It appears that the success of the merger depends on this occurring – as suggested in the submission, St Luke's concentrating on acute services and St Vincent's on lower acuity services.

If the two hospitals continue as they are, then whichever hospital owner first stops financing continued activity or fails to provide financing for improvements and/or change, will

[6] A comprehensive analysis of the Repatriation Commission's purchasing arrangements can be found in its submission to the ACCC regarding the Application from the Sisters of Charity Health Service Limited & Others for an authorisation under section 88 of the *Trade Practices Act 1975* - A30216 and A30219.

determine which one closes first. DVA does not see the current situation as sustainable and would expect one of the hospital owners to withdraw from the Launceston market within a few years.

3.2 If two private hospitals are sustainable in Launceston, would any of the public benefits identified by the Applicant be likely to arise if both hospitals continued to exist as competitors? Alternatively, would the quality of services stay about the same or even fall over time?

It is probably fair to say that two private hospitals in the Launceston area, offering the same range of services, are not sustainable even if a third party could be found to buy St Vincent's and operate it as a competitor to St Luke's. It is also fair to say that if the current situation continues, the quality of those services will continue to decline over time. The Applicant states[7] that, should the acquisition proceed, it is expected that one campus will be developed as the location of acute services while the other will specialise in the provision of short stay procedures, less acute admissions and possibly post-natal care. This implies that they believe that a two campus arrangement is sustainable, if not competing, and would appear to be the best outcome in the current climate.

4. Do you think the public benefits listed are likely to arise as a result of the authorised merger?

DVA would like to make the following comments, noting that the benefits listed are possible but not guaranteed if the merger is authorised.

New and expanded services

LCM's argument relies on the merged hospitals immediately achieving critical mass in terms of patient throughput, to sustain more complex services. LCM states this will not occur without one or the other of the two hospital locations becoming non-viable as a stand-alone facility. In the short term it would appear that the range of services will decrease, unless there is an injection of funds to both campuses to finance the provision of the range of services envisaged.

Before increased throughput is possible, LCM will need to reassure specialists that medical coverage is available to support the type of services LCM wishes to offer.

Improvements in quality

DVA expects that services offered will be provided to industry standards as well as those embodied in a contract with the merged entity.

A reduction in demand to increase prices by health funds for hospitals

The Applicant claims that operating efficiencies gained through the acquisition will reduce demand for price increases by the hospital. It is our hope and expectation that this will occur, and we would seek to see such a commitment incorporated into the decision.

[7] Ibid, page 39

Benefits to health funds

It should be noted that, although the Applicant states that direct charges to health fund members are unlikely to reduce, any increase in rates charged by the merged entity will come out of premium income and put upwards pressure on those premiums. Veterans and other entitled persons are not charged directly. DVA pays for all of their treatment costs and so any price increase has a direct effect on total expenditure.

DVA agrees that it is beneficial if veterans do not have to travel outside their local area to access comprehensive treatment. A more efficient private hospital sector in Launceston will be of benefit to veterans and health fund members.

Reduced waiting lists

DVA agrees that more efficient management of theatre lists would be a public benefit, however there are a limited number of treating specialists in Launceston and better management of their time will have only a marginal effect on waiting times in the private sector.

If LCM rationalises services, there may be increased waiting lists for those services at the public hospital. If a service is no longer provided by the merged entity, patients will be forced onto public waiting lists or have to travel to Hobart or Melbourne for services no longer offered, except for simple day procedures that are provided in the local day procedure centres. The ACCC would need to be assured that authorisation of the merger does not lead to pressure on public waiting lists and especially, additional risk for older patients.

Reduced need for patients to travel to Hobart or Melbourne

If the services that ageing veterans need can be provided locally, it would certainly be in their interests to access them locally, close to family and friends and without the potentially detrimental effect on their health that travel may entail.

Improved recruitment and retention of health care professionals in Launceston

The supply of health care professionals is an issue throughout Tasmania. While the merger may encourage those health care professionals already resident in the area to stay, it is no guarantee that new entrants will be attracted to Launceston. We would strongly encourage any efforts by LCM to achieve this outcome.

Benefits to doctors

Specialists will only refer patients to a hospital if they believe that the standard of clinical care is adequate. It is certainly possible for the merged entity to improve the standard of care currently provided by both hospitals.

Efficiencies generating public benefits

DVA agrees 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.

5. General

Did a similar acquisition by Calvary Health Care Tasmania of St John's Hospital generate benefits for the community?

The merger of Calvary Health Care Tasmania and St John's hospital reduced duplication. Prior to the merger, St John's was performing a similar range of services as Calvary. Since the merger, services have been rationalised, with St John's essentially becoming a specialised campus focussing, for example, on rehabilitation, oncology and day-only procedures.

Conclusion

DVA recognises that currently the two Launceston private hospitals are struggling to maintain viability and agrees that change is needed. However it is not clear that allowing LCM to achieve monopoly power in the area is the way to ensure a robust private hospital market. It will depend on how LCM uses that monopoly power. Attempting to force rate increases without addressing the underlying problems would not be in the public interest.

DVA is more concerned that the provision of quality, range and access to services that LCM proposes comes to fruition, rather than with the merger itself. Our experience with St Vincent's and St Lukes's indicates that there is unused capacity, there are inefficiencies in service delivery in the private hospital sector in Launceston, and St Vincent's has a high cost structure that does not reflect the casemix level of activity.

LCM 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. Further, LCM 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.

Yours sincerely

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25 January 2005