Freehills

15 February 2005

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Attention: Paul Palisi / Jacqueline Brown

Australian Competition & Consumer Commission
470 Northbourne Avenue
DIXON ACT 2602

Dear Paul and Jacqueline

Little Company of Mary Health Care Ltd - Response to interested parties' submissions

We enclose the following:

- LCMHC's response to interested parties' submissions (confidential version);
- a document containing a list of the parts of the confidential response over which confidentiality is claimed and the reasons for claiming confidentiality; and
- LCMHC's response to interested parties' submissions (public version).

Please do not hesitate to contact Michael Gray or me if you have any questions.

Yours faithfully
Freehills

Lisa Emanuel
Solicitor

PUBLIC VERSION

Application for authorisation regarding proposed acquisition of St Vincent's Hospital Launceston – Response to interested parties' submissions

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1 Introductory summary

1.1 Introduction

This is Little Company of Mary Health Care's (**LCMHC**) response to submissions lodged by interested parties in respect of LCMHC's proposed acquisition of St Vincent's Hospital Launceston Limited (**St Vincent's**) (**Acquisition**). Submissions have been lodged by the following interested parties:

- Launceston General Hospital (**LGH**),
- the Australian Health Service Alliance (**AHSA**),
- the Australian Regional Health Group (**ARHG**),
- St Luke's Hospital Medical Advisory Committee (**St Luke's MAC**),
- St Vincent's Medical Advisory Committee (**St Vincent's MAC**),
- the Tasmanian branch of the Australian Medical Association (**AMA Tasmania**),
- MBF Australia Limited (**MBF**),
- Medibank Private (**Medibank**),
- the Department of Veteran Affairs (**DVA**), and
- the Tasmanian Department of Health and Human Services (**DHHS**).

With regard to the weight to be given to the various third party submissions, LCMHC submits that DHHS's submission should carry the greatest weight because it is submitted on behalf of the Tasmanian Government, which has no self-interest in the Acquisition except in relation to the maximisation of community and consumer welfare. While all the submissions provide broad support for the Acquisition, it should be recognised that doctors, health funds, and providers of health care services each have their own particular partiality in relation to the Acquisition.

The interested parties' submissions generally address four broad themes relating to the Acquisition – the counterfactual, the competitive effects, the public benefits, and undertakings. Therefore, our response is presented thematically.

1.2 The counterfactual

LCMHC's submission to the Australian Competition and Consumer Commission (**Commission**) regarding the Acquisition (**LCMHC's submission**) presented a counterfactual that is overwhelmingly supported by the third party submissions. If anything, the view of the future without the Acquisition presented by third parties is even more pessimistic than that put forward by LCMHC. There is almost universal acceptance among third parties that the relevant market is over-bedded,

with low occupancy levels at both facilities. Almost all interested parties accept that two private hospitals in a city the size of Launceston are unsustainable and that, if the Acquisition does not proceed, there will be a continuation of the current wasteful duplication, a deterioration in the provision of private health care services in Launceston, and the closure of one of the two private hospitals.

MBF is the only interested party to advocate the sustainability of two private hospitals in Launceston. However, while MBF ostensibly bases its submission on trends towards increasing health fund membership and private hospital activity in Tasmania (failing to take into account that each admission is accounting for a decreasing number of bed days), the vast majority of evidence establishes that Tasmania is an over-bedded and static, if not declining, market for private health care services. Further, and in apparent contradiction to its submissions regarding the sustainability of two private hospitals in Launceston, MBF's submission states that "the current size of the Launceston market is quite small", that there is "a real opportunity for cost efficient rationalisation of services arising from this proposed acquisition", and that it "does not oppose" the Acquisition for efficiency reasons.

1.3 Competitive effects

In relation to the competitive effects of the Acquisition, the interested parties' submissions focus on the effects of the Acquisition on self-funding private patients and on health funds.

(a) Self-funding patients

The third party submissions do not evidence widespread concern that the Acquisition will lead to an increase in the fees charged to self-funding patients. This absence of concern is appropriate because effective competition to the merged entity will be provided by LGH and by new and existing day surgery facilities, and efficiencies resulting from the merger will enable the merged entity to achieve significant cost savings.

A number of third parties acknowledge that, while waiting lists at LGH may act as a disincentive to self-funding patients, if the merged hospital raised its prices, a number of these patients would choose to be treated at LGH as private patients. In this regard, third parties acknowledge as relevant the fact that the same practitioners operate at both St Luke's Campus of Calvary Health Care Tasmania (**St Luke's**) and St Vincent's and also have visiting privileges at LGH, and that there are not any services undertaken at St Vincent's and St Luke's that are not also undertaken at LGH.

While interested parties recognise that the Eye Hospital and the Gynaecological Clinic do not currently offer the range of services so as to be closely substitutable to the merged entity, none dispute LCMHC's submission regarding the dramatic rise of day surgery procedures as a percentage of procedures performed by St Vincent's and St Luke's, and the relative ease with which existing day surgery facilities could expand the range of services they provide and new players could enter the market. These factors mean that day surgery centres will be an effective competitive threat to the merged entity.

In addition to the competitive constraints imposed on the merged entity by LGH and day surgery centres, a number of third parties submitted that self-funding patients will be prepared to travel to receive treatment in Hobart, north-western Tasmania or Melbourne.

(b) Health funds

Most third party submissions have been provided to the Commission by health funds. It is not surprising, therefore, that these submissions focus, to a considerable extent, on whether the merged entity will have increased bargaining power in negotiations with health funds. While third parties overwhelmingly recognise the necessity for the Acquisition to take place, largely because of the unsustainability of two private hospitals in Launceston and the wasteful duplication that currently takes place, a small number of health funds argue that the merged entity will have increased power in negotiations with health funds, and that this will enable it to achieve higher reimbursement rates.

These claims are greatly exaggerated. The transaction being considered here involves an increase by LCMHC of just 60 operating hospitals beds. While LCMHC accepts that the merged entity will have a better negotiating position (as compared to St Vincent's and St Luke's negotiating separately) in relation to the health funds, in reality, the Acquisition will only improve the hospital's negotiating position from a very weak position to a slightly stronger one. An examination of the balance of power between St Luke's or St Vincent's on the one hand, and the health funds on the other, shows that the health funds are currently in a structurally dominant position in the negotiation of Hospital Purchaser Provider Agreements (**HPPAs**). Put simply, it is more important for the hospitals to be "in contract" with any of the major health funds than it is for the health funds to reach agreement with the hospitals, and the Acquisition will only go a small way towards addressing this imbalance in negotiating power.

Further, an improvement in LCMHC's bargaining power as a result of the Acquisition does not, in itself, imply a significant increase in market power. The merged entity's improved bargaining power in HPPA negotiations will be explicable by a number of factors, including a better product offering and a wider range of services.

Moreover, an examination of LCMHC's behaviour in analogous situations suggests that the merged entity will not be in a position to obtain significantly higher reimbursement rates. Material provided by LCMHC to the Commission shows that LCMHC hospitals located in regional cities, which do not have a competing overnight hospital, do not receive higher reimbursement rates than St Luke's.

Further, the Acquisition will enable the merged entity to contain the increasing costs of providing private health care services and thereby will potentially reduce (or at least contain) the upward pressure on health fund reimbursement rates.

1.4 Public benefits

LCMHC's submission to the Commission outlines the numerous significant public benefits that are expected to result from the Acquisition, and third party submissions overwhelmingly support LCMHC's submission in this regard. However, a small number of interested parties, while recognising the efficiencies to result from the Acquisition, express concern regarding whether or not these benefits will be passed on to consumers through new and expanded services and/or reduced fees.

In response, LCMHC provides evidence of its behaviour in analogous situations to show that the absence of a competing private inpatient hospital in Launceston will not lead the merged entity to reduce services or increase prices.

Further, LCMHC emphasises that its economic imperative (which is underpinned by its mission as a not-for-profit health care provider) is to expand the services provided by the merged entity, as outlined in its submission. Economies of scale and scope dictate that simply merging the two hospitals and stripping out the costs of duplication will not result in the financial viability of the merged entity in the long term. Rather, the merged entity will need to work with existing doctors to attract additional medical specialists to the area to meet community demand. By necessity, this will require an expansion in the range and extent of the services provided by the hospital.

In this regard, the competition for medical specialists is a key factor driving the Acquisition. Given the strong competition for specialists from cities other than Launceston, doctors will go to those cities that offer broad and up-to-date facilities, and such facilities are not currently available in Launceston. This inter-regional competition will also motivate the merged entity to expand the range of services it offers.

1.5 Undertakings

Three third party submissions suggest that there is a need for LCMHC to give undertakings in relation to the Acquisition. Where specific undertakings are suggested by interested parties, these relate to the separate negotiation of HPPAs by St Vincent's and St Luke's, the arrangements under which services are offered by the merged entity, the constraining of price increases, the achievement of nominated public benefits, and the provision of services. LCMHC rejects these suggestions for a number of reasons.

The broad acceptance by interested parties of the counterfactual put forward by LCMHC, and the evidence as to the substantial net benefit resulting from the Acquisition, make the imposition of undertakings wholly inappropriate.

Some of the undertakings would, perversely, negate some of the benefits that would otherwise be achieved through the Acquisition.

Further, even if the Commission were minded to entertain the idea of undertakings, they are unworkable in the circumstances considered here, either in the form suggested by interested parties or in any other form, and would be extremely costly to implement and monitor effectively.

1.6 Conclusion

The interested parties' submissions give substantial support to LCMHC's submission that this is a merger that should be allowed to proceed.

2 The counterfactual

2.1 LCMHC's submission

As stated in LCMHC's submission, if the Acquisition does not take place, then there is a strong likelihood that St Vincent's will eventually close. While, in the

short term, St Vincent's and St Luke's will continue to operate, the presence of two hospitals in a city the size of Launceston will inevitably lead to more duplication and waste, at a high cost to the community. The Acquisition is therefore essential to ensure the ongoing viability of the private health care system in Northern Tasmania.

2.2 Interested parties' submissions

The interested parties' submissions lend overwhelming support to LCMHC's submission regarding the future without the Acquisition. If anything, the view of the future without the Acquisition presented by third parties is even more pessimistic than that put forward by LCMHC. The third party submissions confirm that the relevant market is and will continue to be over-bedded, with low occupancy levels at both facilities.[1] These factors mean that, if the merger of St Vincent's and St Luke's does not go ahead, then there will be a deterioration in the provision of private health care services in Launceston and, in the medium to long term, the closure of one of the two private hospitals.

DHHS's submission states:

> *"It is the Department's view that two private hospitals are not sustainable in Launceston. The patient load is insufficient to sustain each hospital at above 80% occupancy, and at just over 100 licensed beds at each facility, each of the hospitals is too small to achieve reasonable economies of scale. St Vincents, being a stand alone facility, is the most likely to close in the foreseeable future. The last major capital investment in 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.*
>
> *The retention of two small private hospitals in Launceston is unlikely to result in additional services being provided and the lack of economies of scale, duplication of services and administration and competition for staff will see consumers receiving lesser services than a merged entity could provide. The splitting of services between the two entities is also likely to impact on quality due to the absence of sufficient patients to achieve quality standards."*[2]

In relation to the current level of competition between the facilities and the sustainability of two private hospitals in Launceston, DVA's submission states:

> *"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.*
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> ...

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[1] See submissions of AMA, AHSA, LGH, St Luke's MAC, ARHG and DHHS.

[2] At [3.1] and [3.2].

> *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...*
>
> *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 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]

ARHG's submission states:

> *"Both Hospitals offer similar services and the catchment area of Launceston is about 120,000 persons. It is our view that two private Hospitals in Launceston in their current state are not likely to be viable in the long term. We believe that St. Vincents is more likely to close if authorization is not granted as St. Lukes is a larger and more modern facility."*[4]

AHSA's submission states:

> *"AHSA is of the view that both hospitals run at a low percentile of occupancy (around 60%) and that services are duplicated. High acuity cases travel to Hobart or Melbourne due to the fact that neither hospital has intensive care facilities. Consequently the long term viability of two facilities operating in Launceston must be questioned."*[5]

St Vincent's MAC's submission states that "the very strong feeling from the medical specialists in Launceston for some years has been that two private hospitals are not viable in the long term".

Similarly, the Chairman of St Luke's MAC, Dr Monsour, submits that, without the merger,

> *"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 the inevitable deterioration in the medium to long term with spiralling costs in maintaining a facility."*[6]

St Vincent's MAC points out that, if the merger does not go ahead and one of the two hospitals was to close, then the other hospital would struggle to provide the necessary volume of service in the short to medium term due to insufficient theatres and beds, and insufficient physical room for expansion.[7]

2.3 LGH's submission

While agreeing that two private, overnight hospitals are not sustainable in Launceston, LGH contends that the benefits of new and expanded services could

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3 At pp 3, 5-6.

4 At [3.1].

5 At p 1.

6 At [3.2].

7 At [3.1].

be achieved absent the proposed merger, through the hospitals' specialisation and investment in certain areas where the facilities are not in competition.[8]

In response to this submission, LCMHC submits that one of the key benefits to be achieved as a result of the Acquisition is the introduction of new and expanded services by the merged entity. While LGH does not explain how it expects the hospitals to unilaterally specialise and invest in areas where they are not in competition, LCMHC submits that neither hospital will be able to increase and expand its services without the opportunities for rationalisation and coordination that the Acquisition provides. Absent a merger or some other legal arrangement, the development of a cooperative plan by the two hospitals to rationalise their services and minimise duplication between the two sites would almost certainly contravene the competition law provisions of the *Trade Practices Act 1974* (Cth) (**Act**). Without such a cooperative arrangement, and with both hospitals running at low occupancies, the competitive behaviour of St Vincent's and St Luke's is to match each other's moves piece by piece, and thereby avoid any loss of admissions. In such a competitive environment, neither hospital is prepared to vacate a range of services to concentrate on expanding or introducing other services in the hope that the competitor will not also seek to offer these services. Should one of the hospitals pursue such a strategy in the current environment, the most likely reaction of the other hospital would be to match the hospital's new services, while also continuing to provide those services that its competitor no longer provides. Consequently, such behaviour by the first hospital would constitute an extremely risky financial strategy.

LCMHC's submission regarding the competitive behaviour of the two hospitals absent the Acquisition is strongly supported by the empirical evidence. There is widespread recognition among interested parties that it is in response to the need to compete against each other that the two hospitals have duplicated facilities and services over many years, and that this wasteful duplication, as well as the ensuing unprofitable environment, has held back the development of new services and the updating of existing ones. As submitted by St Luke's MAC, the competition between the two hospitals,

> *"has necessitated the duplication of facilities and services with subsequent financial constraints limiting the acquisition by either hospital of new equipment requested by practitioners to maintain contemporary services to the benefit of patients ... It has been difficult for either hospital to improve the range of services in Launceston because both operators are competing for a limited patient population."*[9]

Academic studies of the hospital industry also provide support for the proposition that hospitals compete with one another by offering duplicative services. Connor, Feldman, Dowd and Radcliff[10] cite a variety of cross-sectional studies of hospitals that indicate that hospital costs are higher in areas with more hospitals.[11] The

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[8] At [4].

[9] At [3.1].

[10] R Conner et al, "Which Types of Hospital Mergers Save Consumers Money" (1997) 16(6) *Health Affairs* 62.

[11] The studies cited by the authors include the following: H Luft et al, "The Role of Specialized Clinical Services in Competition among Hospitals" (Spring 1986) *Inquiry* 83; L Manheim, G Bazzoli and M Sohn, "Local Hospital

authors state that "these results have been attributed to nonprice competition in the form of a 'medical arms race' in which competing hospitals offer duplicative high-technology services".[12]

As well as being supported by the empirical evidence, LCMHC's submission regarding the counterfactual is supported by economic theory. Location models are economic models in which products are modelled as having a particular location in geographic or product space. The original location model, developed by Hotelling and published in 1929,[13] demonstrates conditions in which two competing suppliers will mimic the location decisions of each other. Hotelling concludes that "buyers are confronted everywhere with an excessive sameness".[14] The principle of minimum differentiation in the geographic or product space of competing suppliers extends directly from Hotelling's model.

Hotelling's location model, and various developments upon it, have since been applied to a variety of industries to model the competition of suppliers in product space. It is commonly argued, for instance, that competition in the network television and aviation industries leads to minimum differentiation. In the network television industry, broadcasters tend to mirror the broadcasting times and programming choices of their competitors. In the aviation industry, airlines tend to mirror the departure times of their competitors, leading to what is known in the industry as 'wing-tip flying'.

Hotelling's location model has also been applied to the hospital industry. Calem and Rizzo[15] develop a variant of the Hotelling model in which hospitals compete with respect to speciality mix and quality of service. The authors' model highlights the impact of several variables on a hospital's choice of specialty mix, including that, "as in the standard Hotelling model, each hospital is drawn toward the median service mix by the desire to increase its patient revenues".[16] The authors find that the service mix chosen by competing hospitals will not be the social optimum.

2.4 MBF's submission

MBF is the only interested party to submit that two private, overnight hospitals in Launceston are sustainable. MBF's submission is based on recent activity and membership trends, as well as current opportunities for service improvements. In relation to membership trends, MBF refers to figures released by the Private Health Insurance Administration Council (**PHIAC**), which show an increase in the total number of Tasmanians with private hospital cover during the periods of

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Competition in Large Metropolitan Areas" (1994) 3(1) *Journal of Economics and Management* 143; Hospital Research and Educational Trust, *Effects of Horizontal Consolidation on Hospital Markets: Executive Summary*, 1993, R01 HS06250-02, Chicago, American Hospital Association.

[12] Conner et al, "Which Types of Hospital Mergers Save Consumers Money" at 64.

[13] H Hotelling, "Stability in Competition" (1929) 39 *Economic Journal* 41.

[14] *Ibid* cited in D Capozza and R Van Order, "Spatial Competition" in J Eatwell, M Ligate and P Newman (eds) *The New Palgrave Dictionary of Economics* (1998, MacMillan, London).

[15] P Calem and J Rizzo, "Competition and Specialization in the Hospital Industry: An Application of Hotelling's Location Model" (1995) 61(4) *Southern Economic Journal* 1182.

[16] *Ibid* at 1195.

September 1999 to September 2004, and June to September 2004. In relation to recent activity, MBF uses its own funding of bed days at St Luke's and St Vincent's to estimate the total number of bed days across both facilities in the 2004 financial year. MBF submits that the current level of activity at the hospitals requires an allocation of 122 beds and that there are only 88 utilised beds at St Luke's and 74 at St Vincent's. MBF also refers to the "current trend of increasing utilization through technological advances and ageing of the population" to argue that, even if private health insurance membership remains stable, demand will increase beyond current levels.[17]

MBF submits that, on the basis that both private health insurance membership and MBF's activity in Tasmania is growing, one private hospital facility in Launceston would be insufficient to cater for the needs of its members in Northern Tasmania.[18] It is not clear, here, whether MBF is referring to a single site as being insufficient to meet future demand (ie St Vincent's or St Luke's), or whether MBF is contending that the two facilities under the one ownership will be insufficient to meet demand. Given that MBF's submission goes on to state that it does not oppose the Acquisition for "efficiency reasons", we assume that the former interpretation is the correct one, and that what MBF is submitting is that one facility alone would not have enough beds to cater for current and future utilisation rates.

LCMHC responds to MBF's submission as follows:

- First, LCMHC disputes MBF's calculation of current activity in Launceston. MBF's calculation is flawed because it is based on the incorrect assumption that MBF only constitutes 20 per cent of the Northern Tasmanian market. In fact, and as evidenced by the data contained in LCMHC's submission,[19] MBF accounts for more than 25 per cent of the market. Consequently, MBF has overestimated Launceston's total bed days and total bed requirements.

  Using MBF's methodology and the correct data, this means that there are approximately 35,700 bed days (not 44,700), requiring only 98 beds (at full 100 per cent utilisation) not 122. In other words, the market requires 122 beds at 80 per cent occupancy to service the existing market. At present, 162 beds exist.

- Second, LCMHC relies on the submission of DHHS that 80 per cent occupancy in a hospital of at least 100 beds is viewed by the Tasmanian Government as the minimum occupancy necessary for a sustainable hospital.[20] This is because it is necessary for a hospital to achieve economies of scale and scope to operate effectively in a price sensitive national market. Currently, each of St Vincent's and St Luke's is operating at around 55 to 60 per cent occupancy. If either of St Luke's or St Vincent's achieved 80 per cent occupancy of 100 beds in the current or future environment without the Acquisition, then the other hospital would be financially unviable and would be forced to close.

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[17] At p 3.

[18] At p 4.

[19] At 5.2(f).

[20] At [3.1].

- Third, all of MBF's contentions with regard to current and future trends in health fund membership and private hospital activity go against the vast majority of evidence, which establishes that Tasmania is an over-bedded and static, if not declining, market for private health care services. LCMHC's submission sets out in detail, at 4.1 and 5.2, the considerable evidence substantiating its contention that the private health care market in Northern Tasmania cannot sustain two private, full-service hospitals in the medium to long term. In relation to the supply of private hospital beds, LCMHC refers to the 2002 Final Report of Australian Healthcare Associates into "Strategic Services Planning for St Vincent's Hospital Launceston", which found that there was a 21 per cent surplus of private hospital beds in Northern Tasmania, and concluded that "[w]ithin the Northern region of Tasmania there appears to be an excess of private hospital beds exacerbated by an ongoing decline in bed demand".[21] Further, and as set out in LCMHC's submission at 5.2(b), health insurance participation rates as a percentage of the population in Tasmania has decreased steadily, from 44.7 per cent in September 2001 to 42.5 per cent in March 2004. Not only is the current level of private health insurance coverage in Tasmania considered by Australian Health Associates and others to be unsustainable, due to inevitable increases in private health insurance premiums,[22] but the Australian Bureau of Statistics has estimated that the Northern Tasmanian population will decline by approximately 30 per cent between 2000 and 2051.[23]

  Further, while it is true that the Tasmanian population is ageing, and that the number of patients requiring care (and, therefore, the number of admissions) by reason of ageing is increasing, MBF's submission ignores the clear trend in healthcare towards patients spending fewer days in hospital on each occasion as a result of improved treatments and an emphasis on home-based care. This omission by MBF is critical, as the trend towards reduced length of stay means that overall demand for bed numbers is stable or declining despite the ageing population. Therefore, while LCMHC's submission recognises that the admission rates of Australian hospitals, both public and private are rising, this increase is insufficient to counterbalance the decline in the number of days spent in hospital.

[Confidential material deleted]

MBF points to technological advances as a reason why demand for private hospital care is increasing.[24] In reality, however, technological advances are reducing the amount of time patients spend in hospital, while concurrently increasing demand for health care providers to expend significant capital to ensure that their facilities are state-of-the-art. Technology and funding pressures are driving down the length of stay of inpatient admissions and converting many of these admissions into same day or out-of-hospital

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[21] Final Report, *Strategic Services Planning for St Vincent's Hospital Launceston*, December 2002 at 130.

[22] *Ibid* at 16.

[23] Australian Bureau of Statistics, 2000, *Population Projections Australia 1999-2000.*

[24] At p 3.

procedures. This trend is evidenced by data contained in LCMHC's submission showing a rapid increase in same day facilities and a decrease in inpatient hospital beds.[25]

MBF's suggestion that demand for private hospital beds in Tasmania will increase rather than remain static or decline goes against all current public health planning in Australia. State Governments throughout Australia recognise that, despite the ageing of the population, alternatives such as same day admissions, home based care, and ambulatory outpatient centres are leading to, and will continue to lead to, a reduced need for inpatient beds, and they have therefore reduced the number of public hospital inpatient beds substantially over the past decade.

- Fourth, while MBF may be correct in asserting that St Vincent's or St Luke's alone does not currently have sufficient capacity to cater for current and future utilisation rates, the reality is that Northern Tasmania is an over-bedded and static or declining market. LCMHC accepts that Launceston may require the continued operation of both the St Vincent's and the St Luke's campuses in order to meet current and future demand for beds. However, it maintains that it is essential to the future sustainability of private health care services in Northern Tasmania that ownership of the two hospitals is merged in one player so that activity on the two sites can be consolidated and duplication minimised to correct low utilisation rates.

  Further, MBF's submission assumes that the merged entity will make no attempts over time to rationalise into a single larger campus. While a single campus is not achievable in the short term, by reason of physical capacity issues, it would certainly be an option that would be considered in the longer term should the Acquisition proceed.

3 Competitive effects

3.1 LCMHC's submission

LCMHC's submission describes the Acquisition as primarily affecting the following markets:

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

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

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

The questions posed by the Commission in its letter to interested parties (**Commission's letter**) as to the competitive effects of the Acquisition primarily concern the first and the third of these markets. In particular, the Commission's letter asks questions regarding the ability of the merged entity to raise its prices in relation to self-funding private patients and to obtain significantly higher reimbursements from health funds.

[25] At 4.2(b).

3.2 Self-funding patients

As recognised by the Commission in its letter to interested parties, self-funding patients constitute less than 10 per cent of all admissions to St Luke's and St Vincent's. The majority of self-funding patients undergo same day procedures, with very few admitted as overnight stay admissions.

The Acquisition will not lead to an increase in fees to self-funding patients because effective competition to the merged entity will be provided by LGH and by new and existing day surgery facilities. In addition, the efficiencies resulting from the merger of the two hospitals will enable the merged entity to achieve significant cost savings. Support for this submission is provided by DHHS, which states in its submission that it "does not expect that the merger will lead to increased costs of accessing services or increased prices for the provision of hospital services" and that it "would expect prices to remain the same in real terms but ... over time the range of services will expand".[26]

(a) LGH

A number of interested parties provide support for LCMHC's submission that LGH could act as a substitute to the merged entity. Almost all of the responses acknowledge that, if the merged hospital raised its prices, a number of self-funding private patients would choose to be treated at LGH as private patients. While some interested parties submit that this number is unlikely to be significant due to the waiting lists in public hospitals,[27] ARHG points out that, as the same practitioners operate at both St Luke's and St Vincent's and also have visiting privileges at LGH, practitioners may admit more patients to the public hospital should the merged entity increase its prices.[28] Further, both LGH and AMA Tasmania submit that price would be an important factor in self-funding private patients' selection of hospital, and that there are not any services undertaken at St Vincent's or St Luke's that could not be undertaken at LGH or another facility.

In this regard, LCMHC submits that the reality on the ground in Northern Tasmania is that LGH provides effective competition to St Vincent's and St Luke's. LCMHC believes that this is part of a deliberate policy pursued by the Tasmanian public hospital system actively to compete for private patients to supply funding for its services. LCMHC's submission contains detailed information regarding the increasing number of private patients attending public hospitals in Tasmania at 5.2(e). Further, and as mentioned above, almost all (if not all) of the doctors working at St Vincent's and/or St Luke's have visiting rights at LGH, and all in-patient services provided by St Luke's and St Vincent's are duplicated by LGH. As stated in LCMHC's submission,[29] LGH is the only hospital in Launceston with an emergency room, and this provides a further avenue through which the hospital attracts numerous private patients. While waiting lists at LGH could be a disincentive to private patients in some cases, not all of the services provided by the public hospital have waiting lists, and LCMHC understands that waiting lists at LGH are low. Further, because LGH admits patients in order of clinical severity, it cannot be assumed that self-funding

[26] At [5].

[27] St Vincent's MAC; LGH; DHHS.

[28] At [1.1]. See 5.2(f) of LCMHC's submission.

[29] At 8.1.

patients attending LGH will necessarily join the end of a queue – some will jump to the front.

(b) Facilities located outside Launceston

A number of interested parties recognise that self-funding private patients may seek treatment at hospitals located outside Launceston in response to the merged entity raising its prices. DHHS submits that,

> *"It would be expected that patients who fund their own treatment (usually in relation to elective procedures) would be prepared to travel to receive treatment in either Hobart, the North West or Melbourne."*[30]

DHHS's submission also states that "[t]here is a competitive market for private patients in Tasmania". While, "[p]atients will generally be treated within their own region ... there are a small number of out of region referrals, especially from the North West to the North".[31]

As recognised by AMA Tasmania and LGH, there are no particular services conducted at St Vincent's or St Luke's that cannot be conducted in or substituted by any of the Tasmanian hospitals.[32] AMA Tasmania submits that self-funding private patients will consider the full costs, including transport and accommodation, if considering receiving care at hospitals other than those located in Launceston.[33] DHHS asserts that St Vincent's and St Luke's compete with the North West Private Hospital, especially for patients from the Devonport, La Trobe, Kentish and Central Cost Municipalities.[34] Both LGH and AMA Tasmania submit that it would be possible for patients to see Melbourne as a viable alternative should the merged entity significantly raise its prices.[35]

MBF's submission refers to the transfer in December 2004 of Mersey Hospital in La Trobe, Devonport from Healthscope Limited (**Healthscope**) back to DHHS.[36] Contrary to MBF's submission, however, this transfer does not reduce competition in the Tasmanian hospital market. Mersey Community Hospital was a privately-operated public hospital, with the vast majority of admissions funded under a contract with DHHS (not private health funds) and only a small private ward. Prior to the transfer, Healthscope was the only private hospital operator in north-western Tasmanian, and this has not altered. All that has changed is that Healthscope now operates at only one campus in Burnie rather than at two campuses (Burnie and Devonport).

(c) Day surgery facilities

While DHHS's submission recognises that "[t]he Eye Hospital, the Gynaecological clinic and other day surgeries do compete with the merger parties for day only patients",[37] the view of many interested parties in relation to day

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30 At [1.1].

31 At [5].

32 AMA Tasmania at [1.1]; DHHS at [5].

33 At [1.1].

34 At [5].

35 LGH at [1.1]; AMA Tasmania at [1.1].

36 At p 3.

37 At [5].

surgery facilities is that the Eye Hospital and the Gynaecological Clinic do not currently offer the range of services so as to be closely substitutable to the merged entity. While LCMHC acknowledges that this is currently the case, the dramatic rise of day surgery procedures as a percentage of procedures performed by St Vincent's and St Luke's, and the relative ease with which existing day surgery facilities could expand the range of services they provide and new players could enter the market, mean that day surgery facilities will provide effective competition to the merged entity.

As described in LCMHC's submission at 4.2(b), a major trend in private health care in Australia is the move to day surgery centres, as bed days decrease and the number of procedures being performed as day procedures increases. Already, approximately 60 per cent of the procedures performed at St Vincent's and St Luke's are day surgery procedures, and this percentage is likely to increase significantly in the future. Further, the relative ease with which an existing day surgery facility can expand its services, or a new player can enter the day surgery market, means that day surgery facilities will present a serious competitive threat to the merged entity.

DVA is the only interested party to question the potential of day surgery centres to provide effective competition to the merged entity, citing a lack of any new day surgery centres in Tasmania in the past decade as support for its claim.[38] However, DVA is incorrect on this point. A gynaecological day surgery centre, the Gynaecological Clinic, has recently opened in Launceston, and a feasibility study 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.[39] The most significant barrier to entry of new day surgery facilities at present is the oversupplied market – in Launceston alone, there is a large public hospital, two private hospitals, two day surgery centres, and a small palliative care unit. In 2001-02, for example, a private orthopaedic group undertook feasibility studies on a day surgery in Ulverstone in North-Western Tasmania, but has not proceeded. If the Acquisition is perceived to lead to a reduction in competition, then there will be increased likelihood that a new day surgery centre will enter the market.

3.3 Health funds

All interested parties, excluding health funds, DVA and those not in a position to comment,[40] agree that health funds and the DVA currently have the greater bargaining power in HPPA negotiations with St Vincent's and St Luke's.[41] DHHS's submission states:

> *"[T]he health funds and the Repatriation Commission have the greater bargaining power in the negotiation of Hospital Purchaser-Provider Agreements (HPPAs). Nationally funds have increased premiums by 7% per annum over the*

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[38] At [2.3].

[39] As both of these centres predominantly offer services to women of child-bearing age, who do not form a significant part of DVA's constituency, it is understandable that DVA is unaware of these developments.

[40] St Luke's MAC.

[41] LGH; AMA Tasmania, St Vincent's MAC.

last three years but the bed day fees paid to private hospitals have increased by less than this amount."[42]

LCMHC submits that this imbalance in negotiating power is significant, and structural, and is evidenced by the relatively low reimbursement rates provided by health funds to St Luke's and St Vincent's.

[Confidential material deleted]

LCMHC submits that the relative bargaining power of the hospitals and the health funds in relation to the negotiation of HPPAs will not change significantly as a result of the Acquisition. This submission is supported by DHHS, which considers it to be "unlikely" that the current situation in relation to bargaining power will change because "[t]here 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".[43]

While some interested parties submit that the merged hospital may be in a position to obtain higher reimbursement rates from health funds by reason of a lack of local alternative private facilities,[44] only AHSA and MBF strongly argue that the Acquisition will result in the merged entity achieving significant bargaining power in relation to health funds. Each of the health funds' submissions in this regard is addressed below.

(a) AHSA's submission

AHSA represents a group of member health funds constituting approximately five per cent of the private health insurance market in Northern Tasmania. It currently has separate HPPAs with St Vincent's and St Luke's. Its submission claims that:

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[42] At [2.1].

[43] At [2.2].

[44] AMA Tasmania, LGH, MBF, DVA.

- when CHCT purchased St Luke's, it sought immediate parity of pricing rates with its Hobart facilities. Negotiations were difficult, but a compromise position was found;
- extending AHSA's current HPPA with St Luke's to cover the merged entity will lead to an increase in fees charged to health funds of between five per cent and 11 per cent;
- AHSA expects CHCT to have significant power in future negotiations for HPPAs as a result of the Acquisition, with funds becoming "price takers" rather than having transparent negotiations;
- AHSA is concerned about the increase in costs of private hospital and medical services to patients and the reimbursement levels that must be paid by private health funds, thereby resulting in higher premiums and a potential decrease in membership levels; and
- AHSA is concerned about the possible effect the acquisition will have on Gap Cover arrangements with individual practitioners.

LCMHC responds to the claims made by AHSA as follows:

- First, AHSA's submission that allowing the two hospitals in Launceston to merge into one will drastically realign the balance of negotiating power between the merged hospital and health funds in Launceston, with serious consequences for AHSA, is greatly exaggerated. The transaction being considered here involves an increase by LCMHC of just 60 operating hospital beds. While LCMHC accepts that the merged entity will have a better negotiating position (as compared to St Vincent's and St Luke's negotiating separately) in relation to health funds, in reality, this will only improve the hospital's negotiating position from a very weak position to a slightly stronger one. This becomes evident both through a consideration of the balance of power between the merged entity and AHSA, and by examining the empirical evidence regarding reimbursements by health funds to private hospitals.

    (1) In relation to the balance of power between the merged entity and AHSA, it is clear that, while the acquisition may enable the merged entity to better ensure that the prices charged for its services (to health funds) are appropriate, the same reasons that stop the two facilities going out of contract with AHSA today will continue to influence the merged entity going forward, and will continue to place AHSA in a strong bargaining position.

    In this regard, the following factors illustrate the dynamics of the bargaining positions of the merged entity and AHSA if the Acquisition proceeds:

    - 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.

- If AHSA does not have a contract with the merged entity, then there is a possibility that LCMHC's other Tasmanian facilities will go out of contract and LCMHC's relationship with AHSA will suffer. A consequence will be that LCMHC's negotiations with AHSA in relation to facilities in other States (where AHSA has a larger market share) could become more difficult.
- The effect to AHSA (of being out of contract with the merged entity) is that members requiring hospitalization will possibly not be fully covered at the merged entity. If the member attends St Luke's, he or she will receive second tier default payments, which are 85 per cent of average payments made by that health fund to hospitals in the same class (eg members will face a 15 per cent gap if full fee recovery is pursued by the hospital).[45] As St Vincent's currently does not have second tier default status (although its application to be granted this status is completed and currently being lodged), members attending St Vincent's will pay a higher gap. Some members may switch funds as a result, some may choose to utilise their Medicare entitlement and obtain care at a public facility, some will pay the gap, and some will go elsewhere (in Tasmania or Melbourne).
- 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.[46] Such a loss would be significant to the hospital, especially given its low margins.

In contrast to the submission made by AHSA, ARHG submits that, while the merged hospital would have increased power in negotiating HPPAs, ARHG has been able to negotiate HPPAs to the satisfaction of both parties to date and believes that these negotiations will continue at the appropriate time with the same outcomes. When considering what weight should be given to these contradictory submissions, it is noteworthy that ARHG, which

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[45] Generally, classes are based upon size and service, and then State by State. In small States, such as Tasmania, there are insufficient hospitals to derive these averages, so the calculation of the average rate would be linked to a national category or appended to another region (eg Victoria). It is then up to the hospital to determine what its price will be. Generally, a hospital will charge the price it was seeking under the HPPA negotiation. The difference between this price and the second tier default benefit is recovered from the patient. In practice, competitive pressures, and loss of volume may force hospitals to make different decisions (eg charge a lower rate than that sought in HPPA negotiations).

Second tier default benefits are available to all private hospitals and are approved through the Commonwealth Government's Department of Health and Ageing. Hospitals must be able to meet a range of criteria covering quality/accreditation, informed financial consent and simplified billing. External auditing is required against these criteria.

[46] The merged entity would be unlikely to lose the entire five per cent of separations, given the options available to patients outlined above.

includes St Luke's Health, has a far larger percentage of its business in Northern Tasmania than does AHSA.[47] Further, as St Luke's Health is based in Launceston, LCMHC submits that it has a better understanding of the local market and its dynamics than any other health fund.

DVA's submission states that, in the past, it has worked with both LCMHC and SCHS to achieve mutually acceptable outcomes and that it will continue to do so. This is because, "[i]n most cases, it is in both parties' interests to reach agreement".[48]

(2) In addition to the above considerations, evidence of analogous situations strongly supports LCMHC's submission that the Acquisition will not result in the merged entity obtaining significantly higher reimbursement rates. Even if it is accepted, which it is not, that there will be no substitutes to the merged entity, the result of the merger will be no different to circumstances existing in many other regional cities around Australia.

In its submission, at 4.2(c), LCMHC lists numerous comparable regional centres that have only one private hospital. 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 private hospitals.

[Confidential material deleted]

Similarly, MBF's submission states that hospital charges are generally higher in Melbourne and Hobart than in Launceston.

- Second, it is incorrect and misleading to apply AHSA's claim of a five to 11 per cent increase in reimbursements to the merged entity to health funds generally. At best, the claim can only be applied to AHSA, which accounts for a very small percentage of the Launceston market.

  The claim itself appears to be based on the fact that AHSA patients at St Vincent's are being funded at a lower level than at St Luke's. This, in itself, is evidence that AHSA uses its bargaining power where it can, and that hospitals are not reimbursed at equivalent rates, despite having analogous services and geographic location.

  AHSA assumes that CHCT will seek parity in AHSA's reimbursements to the facilities if the merger proceeds, which will necessitate AHSA increasing its payments to St Vincent's to match those it pays to St Luke's. LCMHC cannot

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[47] St Luke's Health has approximately 25 per cent market share in Northern Tasmania.

[48] At p 3.

comment on the specifics of AHSA's claim because it is not privy to St Vincent's arrangements with health funds. However, it would be wrong to assume that such a disparity in fees charged to health funds by St Luke's and St Vincent's applies in the case of all, or even most, health funds.

Further, while AHSA appears to base its claims regarding an increase in reimbursement rates on its experience negotiating its HPPA with CHCT following CHCT's purchase of St Luke's, LCMHC disputes AHSA's description of those negotiations. When CHCT purchased St Luke's, its opening position to each health fund was that it wanted a single contract rate for all its sites in Tasmania. As AHSA correctly states, the parties entered into negotiations and reached a mutually acceptable outcome. However, contrary to AHSA's submission, the negotiations were not protracted or difficult, and the outcome maintains a difference between the rates paid in Hobart and in Launceston to CHCT for a patient undergoing identical care (a distinction that is difficult to justify). In current negotiations between the LCMHC group and AHSA for the renewal of HPPAs across Australia, AHSA is making offers below national CPI.

- Third, AHSA's submission states that it is concerned about the increasing cost of providing private hospital and medical services to patients, and about rising reimbursement levels, which have the effect of raising health fund premiums and potentially decreasing membership levels. In response, LCMHC submits that the Acquisition is the best means by which these concerns can be addressed in Northern Tasmania.

  LCMHC's submission, at [7], details the numerous public benefits that will result from the Acquisition, including significant cost savings and the provision of new and expanded services to patients. In relation to health funds, LCMHC's submission states that the Acquisition will provide a number of benefits, including ensuring the sustainability of the private health care market in Northern Tasmania in the long term, providing a more attractive product (better range of services) to market to existing and prospective new members, and creating greater efficiencies and the ability to contain costs. In its submission, AHSA states that it does not disagree with LCMHC's submission in this regard.

  While AHSA members in Northern Tasmania currently have access to a limited range of private hospital services unless they travel to Hobart or inter-State, the Acquisition is designed to enhance the range of services available in Launceston to AHSA members, thereby increasing the value of the health insurance they purchase from AHSA and preventing decreases in membership. Further, and as submitted by St Vincent's MAC, the significant cost savings to be achieved through the merger will help the merged entity to contain the increasing cost of providing private health care services and thereby help to minimise the constant pressure on the hospitals to achieve higher reimbursement rates from health funds.[49]

- Fourth, while the Acquisition will result in a number of benefits for health funds, the reality of the private health insurance market means that what happens in Launceston will have very little impact on health fund premiums.

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[49] St Vincent's MAC.

This is because health fund premiums are set nationally, and Launceston is a tiny percentage of the market. In this regard, AHSA's concern regarding premiums appears to be related generally to the health fund market rather than specifically to the Acquisition.

The inconsequence of St Vincent's and St Luke's reimbursement rates to private health insurance premiums is illustrated by reference to data published in PHIAC's 2002/03 Annual Report.[50] The PHIAC data shows that, of the benefit payments made by health funds to members, 29 per cent are for ancillary services and 71 per cent are for hospitals.[51] However, the figure for hospitals includes payments to doctors (which account for 14 per cent of 71 per cent), payments for prosthesis (11 per cent), payments to public hospitals (6 per cent), payments to day surgery centres (3 per cent), and payments to private hospitals (66 per cent).[52] Further, the benefit payments constitute just under 90 per cent of the health funds' total costs, with administration costs accounting for the remaining 10.5 per cent.[53] Therefore, private hospital benefits total just 42 per cent of health fund costs.

Approximately 206,000 people in Tasmania have private hospital cover, representing only two per cent of the Australian private health insurance market (8,639,000 insured).[54] Assuming that Launceston has approximately 40 per cent of the Tasmanian market, it represents just 0.3 per cent of the Australian health insurance market. Assuming that health fund premiums accurately reflect the distribution of health funds' costs, this means that reimbursements paid to private hospitals in Launceston account for, on average, just 0.3 per cent of health fund premiums. In other words, of every $100 of health fund premium, private hospitals in Launceston represent just 30¢.

- Fifth, an improvement in LCMHC's bargaining power as a result of the Acquisition does not, in itself, imply a significant increase in market power. The merged entity's bargaining power in HPPA negotiations will be explicable by a number of factors, including a better product offering and a wider range of services.
- Sixth, AHSA's comments regarding the effect of the Acquisition on "Gap Cover arrangements with individual practitioners" are difficult for LCMHC to understand and respond to. Medical gap schemes are arrangements AHSA has entered into with individual doctors to cover out-of-pocket medical fees for patients the doctors are treating in hospital. AHSA has public "No Gap" reimbursement rates for doctors, but these are neither doctor specific nor hospital specific (ie all doctors work at both St Vincent's and St Luke's and charge the same rates at each hospital). Therefore, LCMHC cannot see that the Acquisition will have any impact on the gap schemes, and AHSA provides no explanation in its submission as to how or why it expects gap cover arrangements to be affected by the Acquisition. There is nothing to suggest that

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[50] The 2003/04 data is yet to be published.

[51] At p 21.

[52] At p 21.

[53] At p 33.

[54] At p 42.

doctors will cease using AHSA No Gap Cover and start charging higher gaps simply because the arrangements between the two hospitals change.

(b) MBF's submission

MBF is a national health insurance fund with approximately 40.5 per cent market share in Tasmania and 25 per cent market share in Northern Tasmania. It currently has separate HPPAs with St Vincent's and St Luke's. Its submission claims that:

- the Acquisition will increase St Vincent's and St Luke's countervailing power in negotiating HPPAs with MBF;
- such bargaining power could be used to leverage higher HPPA charges, ultimately resulting in greater costs to MBF members;
- given the slim margins on private health insurance, such increases cannot be absorbed and translate directly into increased costs to members of private health insurance generally;
- MBF's national presence has no effect on the power it would have in negotiations with the merged entity; and
- 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, in Northern Tasmania).

LCMHC responds to the claims made by MBF as follows:

- First, in relation to MBF's contentions regarding the increased countervailing power of the merged entity and its ability to leverage higher HPPA charges, LCMHC refers to its response to AHSA's submission above, in relation to the negotiating power of the merged entity. Again, MBF's submission regarding the merged entity's negotiating power with health funds is greatly exaggerated, as illustrated by an examination of the bargaining positions of the parties and the empirical evidence. 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 percentage 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. To illustrate: MBF payments to St Luke's and St Vincent's total approximately $7 million per annum, while MBF's hospital outlays nationally in 2003-04 totalled approximately $1,640 million.[55] St Luke's and St Vincent's combined therefore represent just 0.4 per cent of MBF's hospital outlays. Clearly, MBF can choose to abandon one or both hospitals with little impact on its national business, whereas the failure of the merged entity to obtain a contract with MBF would threaten 25 per cent of its turnover.
- Second, MBF's own submission recognises the potential for the Acquisition to reduce HPPA charges due to the opportunity for "cost efficient rationalisation of services".[56] As stated in LCMHC's submission, the Acquisition will enable the merged entity to contain the increasing costs of providing private health

[55] PHIAC Annual Report 2002-03.

[56] At p 4.

care services and thereby will potentially reduce (or at least contain) the upward pressure on health fund reimbursement rates.

- Third, what happens between the merged entity and MBF in Launceston will have very little, if any, direct impact on premiums for MBF members generally. This is largely because health fund premiums are set nationally, and Launceston is a tiny percentage (less than 0.5 per cent) of MBF's national market, but also because the link between hospital reimbursement rates and health fund premiums is not as direct as may first appear. Although the fees paid to hospitals by health funds come directly from member contributions to those health funds, as detailed above in relation to AHSA's submission, health fund payments to private hospitals account for, on average, just 42 per cent of health funds' costs. Health funds also pay ancillary benefits to other service providers, such as optometrists, chiropractors, and dentists; medical gap fees to doctors; and for the purchase of prostheses (implantable items), which are arranged through the admitting hospital. In recent years, the increase in health fund outlays on these items in percentage terms has far outweighed the percentage increase in payments made to hospitals. While health fund premiums increased by 7.6 per cent on average in 2004, to the best of LCMHC's knowledge, no hospital in Australia has been able to negotiate a fee increase even close to this figure, with industry information suggesting four per cent to be the top end of the increases received by hospitals. This discrepancy shows that MBF (and other health funds) are actively choosing to reallocate additional funds away from hospital fees to other items, with many funds acknowledging that their outlays on medical gap fees, lifestyle products and prostheses are increasing far more rapidly than their outlays on hospitals. The fact that this reallocation of funding is occurring despite the industry trend towards consolidation of hospital ownership, directly contradicts MBF's assertion that such consolidation significantly increases the bargaining power of hospitals in HPPA negotiations.
- Fourth, LCMHC disputes MBF's claim that its national presence has no effect on the power it would have in negotiations with the merged entity.

[Confidential material deleted]

Another example of MBF's use of its national presence is its decision three years ago to move to selective tenders for hospital HPPAs, and its public disclosure that, in accordance with the tender process, it would not enter into HPPAs with many hospitals. The adoption of this approach clearly evidences MBF's recognition that hospitals need HPPAs with MBF far more than MBF needs an HPPA with any particular hospital. It is also an example of the use by MBF of its greater bargaining power as compared to hospitals to drive down price on a national/State basis.

In its recently completed negotiations with LCMHC, MBF took a group approach, requiring acceptable outcomes in relation to all sites prior to finalising agreements as a whole. This means that, even if it had the bargaining

power to do so, LCMHC would not be able unreasonably to seek increases in its reimbursement rates in Launceston without risking the loss of its contracts between MBF and each of its other services.

- Fifth, in relation to MBF's assertion that it is important for it to have agreements with St Vincent's and St Luke's in order to sell private health insurance in Tasmania (or at least Northern Tasmania), LCMHC points out that MBF may choose not to market to the Northern Tasmanian population without suffering significant damage to its revenue. Further, not all health funds have HPPAs with every hospital and their members can still access these hospitals if they choose. For example, HCF does not hold an HPPA with CHCT, but its members can still access CHCT's hospitals. This is done via CHCT charging its standard rates and seeking confirmation from HCF of what payment it will make for any particular service. Members can then be informed of out-of-pocket costs.

4 Public benefits

LCMHC's submission outlines the numerous and significant public benefits that are expected to result from the Acquisition, including:

- new, expanded and better services for patients;
- a synergistic approach to health care service delivery;
- a reduction in pressure to increase charges to patients;
- reduced waiting times;
- greater opportunities for comprehensive care in Launceston;
- better opportunities to recruit and retain skilled health care professionals, and thereby offset the current under-resourcing of doctors, and the loss of specialists from Northern Tasmania;
- the potential for new technology and specialist support services for doctors; and
- a more attractive private health care product to market to existing and prospective health fund members, resulting in a higher likelihood that members will retain their private health insurance, and that new members will join a health fund.

The interested parties' responses overwhelmingly support LCMHC's submission regarding the public benefits to be achieved through the Acquisition. For example, in relation to public benefits, DHHS's submission states that the Department,

> *"[S]upports the contention by LCMHC that a merged hospital would be a more efficient service provider with less duplication of resources and would provide higher quality services and be in a better position to expand the range of services provided and be able to invest in capital replacement.*
>
> *Recruitment and retention of staff at both the merged hospital and the LGH is likely to be enhanced by the merger."*[57]

[57] At [4].

DHHS expects the price of hospital services to remain the same in real terms, but the range of services to expand over time, as a result of the Acquisition. In summary,

> *"DHHS expects the merger to improve service quality, the standard of facilities available and the range of private hospital services provided in the North and see[s] the proposed merger as offering an overall benefit to consumers."*[58]

The Chairman of St Luke's MAC, Mr Monsour, submits that,

> *"It is my personal view, shared by every colleague I have spoken to, that this merger would be a positive move for ALL of the reasons listed in the submission by LCMHC ... By improving economy of scale with rationalization rather than duplication of services, the effect can only be positive for the community. This increase in quality and growth of services will also help attract and retain practitioners to our regional area, lowering the need for patients to travel elsewhere for treatment."*[59]

St Luke's MAC's submission also states that "the opinion expressed by members of our community, non medical friends and patients is that the need to retain specialists in our region (by growth of new facilities) far outweighs any perceived detriment that might attend a merger of the two private hospitals".[60] Similarly, AMA Tasmania's submission states that it is its "strong view" that "a merger of these two institutions would be in the very best interests of the citizens of Launceston".[61]

MBF's submission states that it does not oppose the Acquisition because of the efficiencies it will create. The submission states:

> *"As health fund members often end up sharing a significant proportion of the cost of infrastructure duplication and the current size of the Launceston market is quite small, we do not think it is in our members' interests that there is excessive duplication of services. We do see a real opportunity for cost efficient rationalisation of services arising from this proposed acquisition and we hope that such cost efficiencies are reflected in the HPPA charges sought by St Vincent's and St Luke's when negotiating HPPAs with MBF.*
>
> *As a significant proportion of the public in this market, we believe MBF members could benefit from the proposed acquisition because:*
>
> - *Reduced costs of services due to efficiencies gained*
> - *Increase in quality with concentration of service delivery to one area".*[62]

Both AHSA and ARHG express agreement with LCMHC's submission in regard to public benefits.[63]

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[58] At [5].

[59] At [4].

[60] At [5].

[61] At p 3.

[62] At p 4.

[63] AHSA at p 3; ARHG at [4].

4.1 LGH's, MBF's and the DVA's submissions

The only interested parties to question some of the public benefits LCMHC submits will arise as a result of the Acquisition are LGH, MBF and DVA. LCMHC addresses each of the parties' concerns in this regard below.

(a) New and expanded services

None of the parties suggest in their submissions that there will be no increase in services as a result of the Acquisition. Rather, they raise questions in relation to specific services within the range suggested by LCMHC for further review.

(1) MBF's submission

MBF's submission refers to St Vincent's 20 mental health beds and St Luke's post-natal obstetric service, which has been prevented from expanding to include ante- and peri-natal care due to licensing issues, and concludes that a merger may not necessarily, and of itself, assist St Luke's in overcoming these issues.

It is unclear to LCMHC what point MBF is seeking to make in regard to St Vincent's mental health beds. While St Vincent's currently has 20 mental health licensed beds, it has not pursued an approved mental health program by reason of the limited market for such services in Launceston, and the risk of isolating hospital wards if activity is not strong. The provision of mental health services will be reviewed by LCMHC if the Acquisition proceeds. However, until future demand has been assessed, LCMHC is unable to commit to expanding its current range of mental health services.

In relation to post-natal services, LCMHC submits that a significantly enhanced private hospital offering high quality services is far more likely to achieve obstetric licence approval than either of St Vincent's or St Luke's as they currently are.

More generally, the Acquisition will create the opportunity for new and expanded services to be introduced, where no opportunity currently exists, and LCMHC has made a firm commitment, and has a strong incentive, to pursue service expansion in Launceston. In contrast, if the Acquisition does not proceed, the lack of service expansion in the future, in the absence of the closure of one of St Vincent's or St Luke's, is assured. This is illustrated by the hospitals' failure to update and expand service delivery in accordance with national standards over the past decade, and is emphasised by the complaints of medical staff at both hospitals that the hospitals are falling behind facilities in comparative centres.

(2) DVA's submission

DVA's submission raises the prospect of decreases in services in the short term if the Acquisition proceeds. Its submission states:

> *"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."*[64]

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[64] At p 6.

While it is true that both hospitals are currently "capital poor" and in need of re-investment, this process has already begun at St Luke's, with the purchase of new sterilisers and the commencement of building safety upgrades. LCMHC has no plans to reduce or remove any existing service as a result of the Acquisition. The only reduction in service delivery will be that some services will cease being offered at one of the two sites, but will still be available at the other site, which will be capable of supporting the entire patient loads for that service. As the hospitals are located only three kilometres apart, the removal of separate geographic choices in relation to some services is not a real loss.

DVA's submission also states that, "[b]efore 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".[65] While medical coverage is a concern of specialists in Launceston, it is not their only or even their major concern. Outdated technology and the loss of skills among nursing staff due to low volume services are equally important concerns. The specialists in Launceston are overwhelmingly in support of the Acquisition, as evidenced by the submissions of St Luke's and St Vincent's medical advisory councils and AMA Tasmania. DVA is effectively making comments on behalf of medical practitioners that contradict the submissions of the doctors themselves.

(b) Recruiting and retaining specialists

While most interested parties emphasise the fact that the Acquisition will greatly enhance Launceston's ability to recruit and retain high quality specialists, LGH's submission questions the Acquisition's benefits in this regard.[66] In doing so, LGH appears to misunderstand LCMHC's submission. While LGH submits that the merger will lead to a reduction in the number of available positions for healthcare professionals, LCMHC's submission is concerned with the hospitals' ability to recruit and retain much-needed specialists (who will work at both the public and the private facilities, as is currently the case), rather than the number of healthcare positions available. The problem in Launceston is not with the number of positions available (there is currently a serious shortage of specialist doctors, as detailed in LCMHC's submission at 7.1(h)), but with the recruitment of highly qualified specialists who will remain in the city.

While it is true, as stated in St Luke's MAC's submission, that Launceston has recently attracted several new specialists,[67] many more are required. As recognised by St Luke's MAC, "the need to retain specialists in our region ... far outweighs any perceived detriment that might attend a merger of the two private hospitals".[68] The merged entity will be in a better position to attract good specialists to Launceston because a sustainable and growing private health sector presents a far more attractive professional opportunity to prospective doctors than does an underperforming one. While, as submitted by DVA, the merger is "no guarantee" that new specialists will be attracted to Launceston,[69] the city will be in a far better position to attract badly needed doctors should the Acquisition

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[65] At p 6.

[66] At [4].

[67] At [5].

[68] *Ibid.*

[69] At p 7.

proceed. This benefit is emphasised in DHHS's submission, which states that "[r]ecruitment and retention of staff at both the merged hospital and the LGH is likely to be enhanced by the merger".[70]

(c) Reduction in the demand to increase prices by health funds for hospitals

LGH questions how the Acquisition will have the effect of reducing the demand for increases in the reimbursement rates private health funds pay to hospitals.[71] This issue is addressed above at 3.3.

(d) Benefits to health funds

LGH questions the benefits to health funds resulting from the Acquisition.[72] Again, this issue is addressed above at 3.3.

(e) Reduced waiting times

LGH submits that there will be some capacity to reduce waiting lists as a result of the Acquisition, but that there are not significant waiting periods in the private sector for surgery.[73] MBF submits that a reduction in waiting lists is only likely to occur if there is a dramatic reduction in demand for hospital care or extra resources are provided to LGH.[74]

While LCMHC agrees that waiting times in the private sector are already short, it submits that the Acquisition will result in reduced waiting times in both the public and the private sector in Northern Tasmania. At the moment, there are three procedural lists, one for each of St Vincent's, St Luke's and LGH. Many Launceston doctors have patients on all three lists. If the three lists are reduced to two, then greater efficiencies will be achieved, with doctors working in the private hospital no longer needing to travel between sites. This increased efficiency in the private sector will open up more time for doctors to take on public patients, thereby reducing waiting lists at LGH. Further, any expansion of services resulting from the Acquisition will allow patients with private health insurance to access the new services within the private sector rather than at LGH or another facility, thereby reducing the public hospital waiting lists for those services. Clearly, reductions in waiting lists in the public sector will also be achieved through the allocation of additional resources to LGH and/or a reduction in demand for hospital care.

(f) Clinical services rationalisation

(1) LGH's submission

LGH questions the extent to which clinical services rationalisation can occur as a result of the Acquisition. It submits that, if both campuses continue to operate, then it is likely that there will still be a need for duplication of services at both sites, particularly in some of the acute care areas, and continued duplication of equipment.[75]

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[70] At [4].

[71] At [4].

[72] *Ibid.*

[73] *Ibid.*

[74] At p 4.

[75] At [4].

LCMHC agrees that, while two separate sites exist, some level of duplication will occur. However, such duplication will be significantly reduced as a result of the Acquisition. In this regard, LCMHC predicts 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. The removal of almost all duplication between the two hospitals requires the creation of a single acute care campus. While LCMHC will consider the creation of such a campus should the Acquisition proceed, such an option is several years away and will require significant rebuilding of the physical environment.

(2) MBF's submission

While recognising that the rationalisation of service delivery across the two sites will create welcome cost-efficiencies, MBF submits that such rationalisation will "reduce choice of treatment location for members".[76] As discussed above at 4.1(a)(2), LCMHC accepts that, in some instances, MBF members may have to go to a different street address in Launceston in order to access certain health care services, but does not consider this to be a detriment to health fund members. All services currently available to health fund members will remain available, and new services will be introduced – they simply will not be duplicated at both sites. The fact that a few patients may have to travel an additional three kilometres to access a particular service is more than outweighed by the benefits of rationalisation, most importantly the opportunities it provides to introduce new, expanded and better services.

(g) Capital equipment replacement

LCMHC's submission, at 7.2, states that the Acquisition will allow greater standardisation of equipment in Launceston and, where appropriate, in CHCT Hobart/Launceston linkages. In response, LGH's submission states:

> *"It is more appropriate that standardisation of equipment between the private and public sector occur where the clinicians are working in both facilities rather than in the linkages between Hobart and Launceston."*[77]

LCMHC submits that the option exists to standardise equipment between St Vincent's and St Luke's, between the merged entity and LGH, and between the merged entity and CHCT's Hobart facilities.

Between St Vincent's and St Luke's, standardisation of equipment can occur and assist to reduce duplication of rarely used items that currently are maintained on both sites. If equipment is standardised, one back-up unit can be shared across the two private hospital campuses.

Although, in theory, such standardisation could extend to LGH when equipment replacement is occurring, the replacement time cycles in separately owned hospitals rarely coincide. For example, LGH may budget to replace all its anaesthetic monitors in 2005, because they are old and need replacement, whereas LCMHC's monitors are much newer and don't need replacing. Because

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[76] At p 4.

[77] At [4].

manufacturers continually are upgrading their equipment, it is unlikely that identical models will be available in a few years time when LCMHC wishes to upgrade its equipment. However, while timing issues limit opportunities to standardise equipment between the public and private sectors, it can nevertheless occur. For example, CHCT recently replaced all defibrillators in its Hobart facilities and deliberately selected the same units as those recently purchased by Royal Hobart Hospital and Hobart Private Hospital. This means that doctors and nurses working across the three hospitals can use identical equipment to treat cardiac arrests.

(1) Synergies

In relation to the potential synergies identified by LCMHC, LGH questions how the maximising of doctors' leave at Christmas and Easter, the creation of a single pharmacy, and the expansion of community nursing will occur in the merged entity.[78]

In response, LCMHC submits that the submission's reference to maximising doctors' leave at Christmas and Easter refers to the greater ease with which the merged entity can manage the consequences of doctors' leave during these periods. Each hospital currently has 10 to 12 patients admitted to the hospital each Christmas, but must still operate with safe staff levels. If the Acquisition proceeds, then one site will close during the Christmas period, with all patients located at the other site.

In relation to the creation of a single pharmacy, each site currently uses a part-time external visiting pharmacy provider. If the Acquisition proceeds, then it may be possible to move to a single provider with a greater on-site presence.

In relation to community nursing, neither St Vincent's nor St Luke's has sufficient demand to operate an adequate community nursing service. If the Acquisition proceeds, then there may be sufficient volume of demand to maintain a full-time community nurse.

4.2 AHSA's submission

On the one hand, AHSA's submission states that it does not disagree with the submission made by LCMHC regarding the public benefits resulting from the Acquisition. On the other hand, however, AHSA appears to submit that the Acquisition will not improve the long term viability of St Vincent's and St Luke's. The relevant section of AHSA's submission states:

> *"... with a significant increase in day surgery procedures (over 61% of cases at both facilities), one must question the long term viability of two large overnight facilities in a market that has seen a reduction in utilisation of 8% at St Lukes with a corresponding increase of 8% at St Vincents. Change of ownership will not influence these figures."*[79]

In response, LCMHC submits that the main rationale for the Acquisition is to ensure the long term viability of the two facilities through the rationalisation of their services and the minimisation of duplication. Certainly, if LCMHC were to acquire St Vincent's and then do nothing to change the manner in which St

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[78] *Ibid.*

[79] At p 3.

Vincent's and St Luke's currently operate, then the Acquisition may not solve the problems of over-bedding and under-utilisation in the Northern Tasmanian private health care market. However, it is precisely because it is not viable to have two large, overnight facilities in Launceston that LCMHC is proposing to acquire St Vincent's, and to submit that the Acquisition will not address this situation is to ignore the rationale driving the proposed merger. Clearly, LCMHC's submission lays out a plan to overhaul the entire clinical model to eliminate duplication as much as possible, which will involve concentrating activity and altering bed configuration to reduce low utilisation.

4.3 Benefits to consumers

While third party submissions overwhelmingly support LCMHC's submission regarding the benefits to be achieved as a result of the Acquisition, particularly in relation to efficiencies, some submissions express concern regarding the pass-through of efficiencies to consumers through lower prices and/or better services.[80]

In response, LCMHC submits that the examples of Calvary Health Care Riverina (**CHCR**) 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.

(a) CHCR

The example of CHCR, the only hospital provider in Wagga Wagga, and, indeed, in the Riverina region of New South Wales, is illustrative of the socially responsible approach that LCMHC has taken in a situation similar to that proposed in Launceston (indeed, LCMHC is in a slightly stronger position in the Riverina as compared to in Launceston should the Acquisition proceed).

CHCR, which is part of LCMHC, operates the only private hospital in Wagga Wagga, Calvary Hospital Wagga Wagga, which is a 104-bed private hospital. It also operates Calvary Day Procedure Centre (**CDPC**), which is a 13 bed recovery space stand-alone day surgery. There is also a private endoscopy unit located in Wagga Wagga.

The level of community participation in private health insurance in the Riverina region has remained relatively high for a regional area, and has been above the national average during some periods in recent years. This high participation rate is indicative of the community's recognition of the high level of service provided by CHCR, and its affordability. Wagga Wagga provides a clear example of LCMHC's strong position in a particular location not resulting in the limitation of services, a reduction in quality, or increases in price.

In Wagga Wagga, as elsewhere, LCMHC operates to further the mission and values of the Sisters of Little Company of Mary. This means that CHCR develops its strategic direction primarily through the identification of community needs, and is committed to providing a comprehensive range of services to meet those needs. The cornerstone of CHCR's success is its reputation with the Riverina community, doctors, and staff. These interest groups would quickly abandon a health care provider that sought to capitalise on its "monopoly" position to the detriment of the community it serves.

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[80] See, for example, MBF's submission.

As the sole private inpatient provider in Wagga Wagga, CHCR has developed a number of new and/or expanded services to meet community needs. These include the following:

- The provision of alcohol and other drug services, including: O'Connor House, a ten bed alcohol unit; The Peppers, a 12 bed illicit drug unit; and a home detoxification service. While these services receive government funding, CHCR 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 with specialist equipment and furnishings and a significant investment in staff and training.
- 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.

Since being purchased in 2002 by CHCR, CDPC has continued to offer an expanding range of services to the community. The provision of day surgery is now more streamlined and accessible, with CHCR's acquisition of a day surgery centre freeing up capacity for inpatients at the main hospital campus.

The value that CHCR provides to the Riverina community has been recently recognised by MBF. Last year, MBF undertook a national patient satisfaction survey of hospitals in Australia. Of the 90 hospitals surveyed, CHCR was rated by MBF as the number one hospital in Australia.[81]

(b) Calvary Cairns

Calvary Cairns, now known as Cairns Private Hospital, was originally owned and operated by LCMHC. Several years ago, operation of the hospital reverted back to the local Catholic diocese. Approximately two years ago, the hospital was sold to Ramsay Healthcare.

The competitive landscape in Cairns is not dissimilar to that which will exist in Launceston if the Acquisition takes place. The population of the Cairns region is approximately 230,000, with approximately 120,000 people living in the city of Cairns itself. Cairns has one public base hospital, a 140 bed private hospital (Cairns Private Hospital), a large day surgery centre, and at least one other small day surgery facility. Out of region competition comes from Townsville and Brisbane.

Despite the existence of only one private inpatient hospital in Cairns, Calvary Cairns developed an extension 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

[81] See www.mbf.com.au/about/mediareleases/calvary.html.

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.

LCMHC does not know whether these services have been maintained since the hospital's purchase by a for-profit operator. However, under the previous not-for-profit ownership of the local Catholic diocese, very extensive services continued to be offered to the Cairns community.

4.4 St John's case study

(a) LCMHC's submission

LCMHC's submission draws on the example of CHCT's acquisition of St John's Hospital Hobart (**St John's**) in October 2000 to illustrate the opportunities that the Acquisition provides to improve the delivery of private health care services in Northern Tasmania.[82] LCMHC is confident that the same sort of benefits can be achieved in Launceston as a result of the Acquisition as those that were achieved in Hobart following CHCT's acquisition of St John's.

LCMHC's submission in this regard is supported by DHHS. Its submission states:

> *"The Calvary and St Johns merger has lessened duplication of services by a more rational distribution of services across the two campuses, with the New Town campus concentrating on the more specialised inpatient procedures and the South Hobart campus on day surgery and ophthalmology in particular. Consumers benefit by having improved access to specialist services not available at St Johns (emergency department, cardiology, MRI, lithotripsy, obstetrics, nuclear medicine) while ophthalmology services have been enhanced and day surgery services made more efficient. The range of services available to consumers has thus been enhanced through the merger. The elimination of duplicated services across the sites in both the clinical and non clinical areas has benefited consumers by reducing the pressure for premium increases."*[83]

ARHG's submission also supports LCMHC's assertions in relation to St John's:

> *"We believe that the acquisition by Calvary Health Care Tasmania of St. John's Hospital has delivered similar benefits to those expressed in the public benefits for this application and clearly both hospitals continue to be viable and have good levels of patient activity which supports the benefit and need to the communities they serve."*[84]

Similarly, DVA's submission states:

> *"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."*[85]

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[82] See LCMHC's submission at 7.1(c).

[83] At [5].

[84] At [5].

[85] At p 8.

(b) Third party submissions

Despite the above, several interested parties submit that the St John's acquisition is not analogous to the merger being considered here because, in the case of St John's, there were significant differences between the two facilities, whereas in the case of the proposed merger, the two private hospitals are similar in the services they provide.[86]

To some extent, these submissions are correct. St John's was a much lower acuity hospital than CHCT's existing facility in Hobart, Calvary Hospital Hobart, or the competing facility, Hobart Private Hospital. However, the two acquisitions are similar in that, in both cases, rationalisation can occur across the merged sites to reduce duplication and enhance service range, as detailed in LCMHC's submission.

Economic investigations of mergers in the hospital industry highlight the importance of the consolidation of physical facilities to the achievement of merger efficiencies. Dranove and Lindrooth, in a recent paper in the *Journal of Health Economics*,[87] investigate whether hospital consolidation leads to cost savings. The authors note that previous economic investigations of hospital mergers have not fully answered the question of whether mergers generate efficiencies. While several studies find significant efficiencies,[88] others have failed to do so. Building on these earlier studies, the authors find that the creation of hospital systems, in which the physical facilities of the merging hospitals remain separate, do not generate efficiencies, but true hospital mergers, which involve consolidation of some physical facilities, do generate efficiencies:

> *"We find that consolidation into systems does not generate savings, even after 4 years. These results are robust and consistent over many different specifications, for both 3 and 4 years after the acquisition. We find significant, robust, and persistent savings for mergers 2, 3 and 4 years after consolidation. These savings may be primarily due to capacity reduction as reflected in our means, though to some extent, they may also reflect synergies achieved through merger. Our results are consistent with the previous studies cited above that found that mergers were associated with significant costs savings."*[89]

(c) MBF's submission

While acknowledging that benefits in the areas of clinical services rationalisation and improved deployment of clinical expertise may have occurred as a result of the acquisition of St John's by CHCT, MBF submits that a negative outcome of the acquisition is that HPPA charges at St John's are expected to be on par with

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[86] See submissions of LGH and AMA Tasmania.

[87] D Dranove and R Lindrooth, "Hospital Consolidation and Costs: Another Look at the Evidence" (2003) 22 *Journal of Health Economics* 983.

[88] Connor et al, "find that hospitals that have merged experience smaller cost increases than those that have not." See: R Connor et al, "Which Types of Horizontal Mergers Produce Cost Savings and Which Do Not?" (1997) 16(6) *Health Affairs* 62; R Connor, R Feldman and B Dowd, "The Effects of Market Concentration and Horizontal Mergers on Hospital Costs and Prices" (1998) 5(2) *International Journal of Economics and Business* 159. Sprang et al, "find that merging hospitals experienced 6.6% (13%) lower cost growth than did rivals (non-rivals)." See: H Sprang, G Bazzoli and R Arnould, "Hospital Mergers and Savings for Consumers: Exploring New Evidence" (2001) 20(4) *Health Affairs* 150.

[89] D Dranove and R Lindrooth, "Hospital Consolidation and Costs: Another Look at the Evidence" (2003) 22 *Journal of Health Economics* 983 at 996.

those at Calvary Hospital, Lenah Valley, even though one campus provides more acute services than the other. MBF also submits that the acquisition of St John's by CHCT has had little effect on waiting lists in Hobart.

LCMHC disputes MBF's submission regarding reimbursement rates at St John's and Calvary Hospital, Lenah Valley. While LCMHC agrees that the services offered at St John's are generally lower in complexity than the services delivered at the Lenah Valley campus, the average revenue per bed day on the St John's campus is lower than at the Lenah Valley campus. This is appropriate as lower complexity patients require lower levels of support and their treatment is therefore less costly.

In relation to waiting lists, MBF is correct in stating that the acquisition of St John's did not coincide with a drop in hospital waiting lists. However, the timing of the acquisition needs to be considered. St John's was transferred to CHCT in October 2000, just prior to the Commonwealth Government's intervention in the market through the 30 per cent rebate and lifetime ratings. This intervention caused private health insurance coverage to increase from just over 30 per cent of the Australian population to more than 45 per cent, involving an increase of almost one third in demand for private hospitals. Because any improved capacity generated by the acquisition of St John's by CHCT was overwhelmed by these changes in private health insurance, it is impossible to isolate any gains made solely by reason of the acquisition.

Although private sector waiting lists in Hobart are almost non-existent, they have more to do with doctor availability than hospital availability. For example, in Hobart the waiting period for an appointment to see one of the private neurosurgeons is four months for non-critical situations, and the specialist's operating lists are full a month in advance at CHCT's hospital. However, the limiting factor here is the doctor's consulting/operating time, not the hospital. While the availability of doctors is also an important, if not the key, factor contributing to waiting lists in Launceston, the Acquisition will enable the recruitment of more specialists to Launceston, and improve the efficiency of existing doctors, thereby resulting in reduced waiting lists in both the public and private sectors.

5 Undertakings

5.1 LCMHC's submission

LCMHC's submission argues at length that the Acquisition will lead to a significant increase in the quality and nature of the services provided to doctors and patients at St Vincent's and St Luke's without increasing pressure to raise prices for self-funding patients or health funds. The Acquisition will clearly result in a substantial net benefit, which will outweigh any competitive detriment – and the third party submissions confirm this. Consequently, LCMHC considered that there was no need to address the question of undertakings in its submission.

However, some of the interested parties have suggested the need for undertakings, and these submissions are directly addressed below. At the outset, however, LCMHC submits that, given the broad acceptance among the interested parties for the counterfactual in which one of St Vincent's or St Lukes's will close, and the

substantial public benefits to arise from the Acquisition, it is wholly unnecessary to require LCMHC to give undertakings as a condition of authorisation.

5.2 Submissions of interested parties

Only three interested parties suggest that LCMHC should give undertakings; namely, MBF, Medibank and DVA. LCMHC addresses the suggested undertakings below.

(a) Negotiation of HPPAs

MBF's submission recommends that the Commission should seek, as part of the merger authorisation, two conditions from LCMHC regarding the negotiation of HPPAs:

> *"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 . . ."*[90]

There is no reason that conditions of the type suggested by MBF should be required of LCMHC. As discussed at length in LCMHC's submission, and again in this response, the merger will not lead to any substantial increase in the reimbursement rates that LCMHC receives from health funds. Empirical evidence from comparable regional centres that have only one private hospital shows that the reimbursement rates achieved by these hospitals are not higher than those received by hospitals located in cities with one or more competing private hospitals. Consequently, there is no reason to suspect that the imposition of such undertakings is necessary to ensure competitive reimbursement rates.

Further, the imposition of the above undertakings will prevent the achievement of some of the substantial public benefits that would otherwise flow from the merger. As set out in detail in LCMHC's submission, one of the key benefits to be achieved through the Acquisition is the rationalisation of services between the two sites so as to achieve substantial efficiencies and service improvements. While the separate negotiation of HPPAs will not prevent the rationalisation hoped to be achieved as a result of the Acquisition, it will mean that relativities and differences in price structures (rather than the desire for efficiencies and service improvements) will drive the clinical services plan. In such a situation, LCMHC will face price incentives to move particular patients/services to the site receiving the highest fees for that particular service, rather than moving services to the site best equipped to support the service.

To require undertakings of the type suggested by MBF will impose substantial, and unnecessary, costs on LCMHC. These will include the costs of ongoing separate management of patient and financial data by site, and duplicated negotiation and management of HPPAs, including separate management of HPPA terms and conditions between the two sites.

While it will theoretically be possible for the merged entity to maintain two separate HPPAs with each health fund following the Acquisition, both of these agreements will be between the health fund and CHCT. The negotiation of the two HPPAs will be undertaken by the same people at CHCT and, presumably, the health fund, so both parties will be fully aware of the content of each document.

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[90] At p 5.

This is vastly different to the current situation in which CHCT is not privy to St Vincent's arrangements with health funds and vice versa. The purpose of using two documents to capture what will effectively be a single commercial arrangement is unclear.

The second undertaking suggested by MBF, "that neither company within the group be permitted to make the signing of one HPPA contingent on the execution of the other", involves giving health funds the ability to have an HPPA with only one of merged entity's two sites in Launceston. Such an arrangement will achieve nothing for the health funds. If, for example, MBF and CHCT can not reach agreement on prices for services provided at the St Vincent's location, but achieve agreement in relation to the St Luke's site, then CHCT can simply admit all MBF members to the St Luke's site. As stated above, the only benefit achieved by differential pricing between the two sites is that clinical service rationalisation will be driven by a price schedule rather than appropriate clinical planning.

(b) Price of hospital services

DVA's submission recommends that LCMHC "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".[91]

LCMHC submits that, even if undertakings of the type recommended by DVA could be made workable, there is no reason to require LCMHC to give such undertakings. First, as argued in LCMHC's submission, LCMHC will not have market power following the Acquisition. New and existing day surgery facilities, LGH, and the countervailing power of health funds will exercise significant competitive constraints on the merged entity.

Second, as seen by an analysis of the counterfactual, the Acquisition will not lead to a substantial lessening of competition. DVA states in its submission that it "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".[92] On this view of the counterfactual, a forward looking analysis suggests that there will be no substantial lessening of competition and, therefore, no reason for LCMHC to give undertakings to maintain reasonable or realistic arrangements.

Requiring LCMHC to give undertakings of the form suggested by DVA will also likely cause LCMHC to incur substantial compliance costs, particularly given the difficulty in clearly specifying prices and the nature of services in the health care industry.

(c) Public benefits

Medibank's submission appears to recommend that the Commission should seek undertakings to ensure that the public benefits outlined in LCMHC's submission are achieved:

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[91] At p 8.

[92] At p 6.

> *"Should the authorisation be allowed, Medibank would be supportive of the nominated public benefits should the parties agree to behavioural undertakings to perform such remedial actions."*[93]

LCMHC submits that, even if it is possible to formulate workable undertakings to ensure that the public benefits outlined by LCMHC are achieved, there is no reason to require LCMHC to provide these undertakings.

LCMHC will have every incentive to achieve the public benefits outlined in its submission, even in the absence of undertakings. Medibank's recommendation that undertakings should be provided appears to rest upon the theory that firms with market power will not have as strong an incentive to innovate and to lower costs as firms without power. In general, the empirical evidence on whether or not this is the case is uncertain. More importantly, the argument does not apply to LCMHC. As discussed at length in LCMHC's submissions, LCMHC will remain subject to competitive constraints if the Acquisition proceeds. These constraints, from other health care providers and from health funds, will provide LCMHC with strong incentives to ensure that it introduces profitable new services and lowers its costs.

That LCMHC has an incentive to achieve the public benefits discussed in its submissions is supported by evidence of LCMHC's behaviour in Wagga Wagga and Cairns, cities that are comparable to Launceston and which have only one private hospital. LCMHC's provision of services in Wagga Wagga and Cairns is discussed in detail above at 4.3.

(d) Undertakings on the range of hospital services

Both MBF and DVA recommend that the Commission require undertakings to ensure that LCMHC continues to offer a broad range of hospital services. In its submission, DVA states that:

> *"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."*[94]

MBF's submission states:

> *"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."*[95]

As discussed in LCMHC's submission, one of the primary rationales for the Acquisition is the opportunity to offer new and expanded services. That the expansion of services to patients is one of the central motivating factors behind the Acquisition is clear from contemporary internal documents provided to the Commission, and is consistent with LCMHC's stated mission and values as a not-for-profit health care provider. LCMHC's intention to pursue its objective of expanding and improving the range of services it currently provides to the people

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[93] At [3.2].

[94] At p 8.

[95] At p 5.

of Northern Tasmania is further evidenced by LCMHC's behaviour in Wagga Wagga and Cairns, cities that are comparable to Launceston and which have only one private hospital. LCMHC's provision of services in Wagga Wagga and Cairns is discussed in detail above at 4.3.

(e) Public waiting lists

DVA's submission states that,

> *"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."*[96]

In response, LCMHC submits that DVA is making a number of "what if" statements, with no evidence or indication that these scenarios will arise. As stated repeatedly throughout this response, none of the services currently provided by either St Luke's or St Vincent's will cease as a result of the Acquisition. On the contrary, the Acquisition is based on the need to expand and increase the range and scale of private hospital services in Launceston in order to build a viable future health care structure. As discussed in detail above at 4.1(e), the Acquisition will result in a reduction rather than an increase in public hospital waiting lists in Launceston.

5.3 The difficulty of giving workable undertakings

In addition to the fact that undertakings are unwarranted and unnecessary, LCMHC submits that it would be impossible to draft any form of undertakings relevant to the proposed Acquisition. The hospital services offered by St Vincent's and St Luke's are such that there is no sufficiently general measure of price or output. Hospitals offer a vast array of services, and these services are strongly differentiated both within and between hospitals. Consequently, there is no sufficiently general measure of a unit of hospital output. Similarly, because different services and differentiated services are charged at different prices, there is no sufficiently general measure of price. In addition, pricing in the relevant market is not transparent, with pricing structures formulated through one-on-one, confidential agreements with health funds and the DVA in the context of HPPA negotiations. Without an appropriate measure of output or price, undertakings cannot be usefully draft or enforced.

If, despite the difficulties outlined above, the Commission does contemplate undertakings on price, LCMHC would require such undertakings to be based on real benchmark payments made by health funds to other, comparable hospitals. Such benchmarks would need to be open and completely transparent – a scenario no health fund has been willing to contemplate to date.

The problems with giving undertakings become clearly apparent upon consideration of the undertakings recommended by interested parties. Almost without exception, the undertakings recommended are of such a general nature as

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[96] At p 7.

to be meaningless. For instance, the recommendation that an undertaking should be given that prices be "not unreasonable or unrealistic" is too opaque to be of use. Without a clear and precise definition of the service in question, including all the relevant dimensions of that service, it is impossible to provide a meaningful undertaking to ensure reasonable and realistic prices are achieved.

Further, and assuming that undertakings can be formulated, it will be extremely costly and largely impractical for the merged entity to ensure compliance with such undertakings, especially given the difficulties in formulating a measure of the hospital's price or output. The imposition of such a cost burden, as well as being wholly unnecessary, would negate some of the much needed cost savings sought to be achieved through the Acquisition.

6 Conclusion

The interest parties' submissions address four broad themes relating to the Acquisition – the counterfactual, the competitive effects, the public benefits, and undertakings.

In relation to the counterfactual, third party submissions overwhelmingly support LCMHC's submission that, if the Acquisition does not take place, then wasteful duplication will continue, the provision of private health care services to the people of Northern Tasmania will deteriorate, and one of the two private hospitals will eventually close. Almost all third party submissions, health funds included, recognise the necessity for the Acquisition to take place.

With respect to the competitive effects of the Acquisition, third party submissions do not evidence widespread concern that the Acquisition will lead to an increase in the fees charged to self-funding patients. LCMHC submits that this lack of concern is appropriate, because effective competition to the merged entity will be provided by LGH and new and existing day surgery facilities, and the merger will create significant efficiencies that will help to reduce pressure to increase fees.

Given that most third party submissions have been provided by health funds, it is not surprising that these submissions focus, to a considerable extent, on whether the merged entity will have increased bargaining power in negotiations with health funds. While a small number of health funds submit that the merged entity will have increased power in HPPA negotiations, which will enable it to achieve higher reimbursement rates, LCMHC submits that these claims are greatly exaggerated. An examination of the balance of power between the merging parties on the one hand, and the health funds and DVA on the other, shows that the health funds and DVA are currently in a structurally dominant position in the negotiation of HPPAs, and the Acquisition will only go a very small way towards correcting this imbalance. Further, an examination of LCMHC's behaviour in analogous situations demonstrates that the merged entity will not be in a position to obtain significantly higher reimbursement rates from health funds than St Vincent's or St Luke's negotiating separately. In fact, the Acquisition will enable the merged entity to contain the increasing costs of providing private health care services and thereby will potentially reduce (or at least contain) the upward pressure on health fund reimbursement rates.

Third party submissions provide considerable support for LCMHC's submission regarding the numerous significant public benefits that are expected to result from

the Acquisition. In particular, interested parties stress that the Acquisition will lead to improved services, new services, and the ability to recruit and retain high quality specialists. There is also widespread recognition that the Acquisition will help to ensure the future sustainability of private health care in Northern Tasmania. In response to concerns raised by some third parties regarding whether the efficiencies to be achieved through the Acquisition will be passed on to consumers, LCMHC has provided evidence of its behaviour in analogous situations (Wagga Wagga and Cairns) to show that the absence of a competing private inpatient hospital in Launceston will not lead the merged entity to reduce services or increase prices.

The broad acceptance by interested parties of the counterfactual, and the evidence as to the substantial net benefit resulting from the Acquisition, make undertakings by LCMHC in relation to the Acquisition wholly unnecessary and inappropriate. Where undertakings have been suggested by interested parties, these would:

- negate some of the benefits that would otherwise be achieved through the Acquisition,
- be impossible to draft and unworkable in the circumstances, and
- be extremely costly to implement and monitor.

The contemplation of undertakings in relation to the Acquisition is therefore strongly opposed by LCMHC.

In conclusion, third party submissions overwhelmingly support the Acquisition. This is a merger that should be allowed to take place.