Public Competition Assessment

27 August 2014

Healthscope Limited – proposed acquisition of the Brunswick Private Hospital

Introduction

1. On 12 June 2014, the Australian Competition and Consumer Commission (**ACCC**) announced its decision to oppose the proposed acquisition by Healthscope Limited (**Healthscope**) of the Brunswick Private Hospital owned by Healthe Care Pty Ltd (**Healthe**) (**proposed acquisition**).
2. The ACCC decided that the proposed acquisition would be likely to have the effect of substantially lessening competition in a market in contravention of section 50 of the *Competition* and *Consumer Act 2010* (**the Act**).
3. The ACCC made its decision on the basis of the information provided by the parties to the acquisition (the **parties**) and information arising from its market inquiries. This Public Competition Assessment outlines (subject to confidentiality considerations) the basis on which the ACCC has reached its decision on the proposed acquisition.

Public Competition Assessment

4. To provide an enhanced level of transparency in its decision making process, the ACCC issues a Public Competition Assessment for all transactions reviewed by the ACCC where:

   - an acquisition is opposed;
   - an acquisition is subject to enforceable undertakings;
   - the parties to the acquisition seek such disclosure; or
   - an acquisition is not opposed but raises important issues that the ACCC considers should be made public.

5. This Public Competition Assessment has been issued because the proposed acquisition was opposed by the ACCC.
6. By issuing Public Competition Assessments, the ACCC aims to provide the public with a better understanding of the ACCC's analysis of various markets and the

associated merger and competition issues. Public Competition Assessments can also alert the public to circumstances where the ACCC's assessment of the competition conditions in particular markets is changing, or likely to change.

7. Each Public Competition Assessment is specific to the particular transaction under review by the ACCC. While some transaction proposals may involve the same or related markets, it should not be assumed that the analysis and decision outlined in one Public Competition Assessment will be conclusive of the ACCC's view in respect of other transaction proposals, as each matter will be considered on a case-by-case basis.
8. Public Competition Assessments outline the ACCC's principal reasons for forming views on a proposed acquisition at the time the decision was made. As such Public Competition Assessments may not definitively identify and explain all issues that the ACCC considers arise from a proposed acquisition. Further, the ACCC's decisions generally involve consideration of both non-confidential and confidential information provided by the parties and market participants. In order to maintain confidentiality, Public Competition Assessments do not contain any confidential information nor identify its sources.

The parties

The acquirer: Healthscope Limited

9. Healthscope was formed in 1985 and provides private hospital, medical centre and pathology services across Australia. It has a portfolio of 44 private hospitals nationwide which includes three hospitals operated on behalf of the Adelaide Community Healthcare Alliance.
10. Healthscope was listed on the Australian Securities Exchange (**ASX**) in 1994. In October 2010, Healthscope Limited was acquired by a consortium comprising funds advised and managed by private equity firms The Carlyle Group and TPG, and was subsequently de-listed from the ASX.
11. Healthscope operates several hospitals in the Melbourne area including:

    - John Fawkner Private Hospital in Coburg, a 147 bed major surgical, medical and emergency hospital;
    - Melbourne Private Hospital in Parkville, a 124 bed hospital offering various general medical and surgical services;
    - Northpark Private Hospital in Bundoora, a 153 bed hospital providing surgical, medical, mental health, maternity and nursery services;
    - Cotham Private Hospital in Kew, a 60 bed hospital providing surgical, general medical and rehabilitation services;
    - Dorset Rehabilitation Centre in Pascoe Vale (**Dorset**), a 30 bed rehabilitation facility;
    - North Eastern Rehabilitation Centre (**NERC**) in Ivanhoe, a 46 bed rehabilitation facility; and

- The Victorian Rehabilitation Centre in Glen Waverley, a 143 bed rehabilitation facility providing an extensive range of inpatient and outpatient services including an acquired brain injury unit.

The target: Brunswick Private Hospital

12. Brunswick Private Hospital (**Brunswick Private**) is a 128 bed hospital located in Brunswick, a suburb in northern Melbourne. Brunswick Private offers rehabilitation services and general medical services. Currently, 98 beds are allocated to rehabilitation services and 30 beds are allocated to general medical services.

13. Brunswick Private's general medical service offering provides accommodation and services for patients being treated by doctors and specialists in the following areas:

- General practice
- Cardiology
- Psychiatry
- Respiratory
- Rheumatology

14. The rehabilitation services offered at Brunswick Private consist of both inpatient and outpatient facilities and include treatment from rehabilitation physicians and specialist rehabilitation nurses, as well as allied health professionals (e.g. physiotherapists, occupational therapists and speech pathologists).

The seller: Healthe Care Pty Ltd

15. Healthe was formed in 2005 and it employs approximately 4,000 people across a portfolio of 14 hospitals in Queensland, New South Wales, Victoria and Tasmania. Healthe was acquired by Archer Capital, an Australian private equity firm, in June 2011.

16. In Melbourne, Healthe operates the Brunswick Private Hospital, La Trobe Private Hospital, the Valley Private Hospital, and South Eastern Private Hospital.[1]

Other industry participants

17. The following private hospital groups also provide private general medical, surgical and/or rehabilitation services in Melbourne:

- Epworth HealthCare
- Cabrini Health
- St Vincent's Private Hospital
- Ramsay Health Care

[1] On 2 June 2014, Healthe Care announced that it will close the La Trobe Private Hospital on 29 August 2014.

Epworth HealthCare

18. Epworth HealthCare is a major private not-for-profit hospital group in Victoria. Its hospital network covers all major surgical specialities. In Melbourne Epworth has hospitals in the following locations:

    - Richmond;
    - East Melbourne;
    - Hawthorn;
    - Camberwell;
    - Box Hill; and
    - Brighton.

19. Epworth offers rehabilitation services from its Richmond, Hawthorn, Camberwell and Brighton hospitals. Epworth's Richmond and Camberwell hospitals also have rehabilitation beds dedicated to treating patients with acquired brain injuries.

St Vincent's Private

20. St Vincent's Private has three hospital campuses in Melbourne:

    - Fitzroy – a surgical hospital with approximately 100 beds co-located with St Vincent's Public Hospital;
    - St Vincent's Private East Melbourne (formerly the Mercy Hospital) – a hospital with approximately 100 general medical beds and 17 rehabilitation beds; and
    - St Vincent's Private Kew – a surgical hospital with 75 general medical beds.

Ramsay Health Care

21. Ramsay Health Care is the largest private hospital group in Australia. Ramsay operates a number of hospitals in Melbourne including:

    - Donvale Rehabilitation Centre;
    - Warringal Private Hospital (in Heidelberg); and
    - The Avenue Private Hospital (in Windsor).

Cabrini Health

22. Cabrini Health operates acute and rehabilitation hospitals and aged care and palliative care facilities in the southern suburbs of Melbourne. Its hospital facilities include:

    - Cabrini Hospital Malvern;
    - Cabrini Hospital Brighton; and

- Cabrini Rehabilitation Service Elsternwick.

The proposed acquisition

23. Healthscope proposed to acquire the Brunswick Private Hospital from Healthe. The proposed acquisition was interdependent with the sale by Healthscope of the Brisbane Waters Private Hospital to Healthe. The ACCC conducted a separate public review of Healthe's proposed acquisition of Brisbane Waters Private Hospital and on 16 April 2014 announced it would not oppose that proposed acquisition.

Review timeline

24. The following table outlines the timeline of key events in this matter.

22 January 2014	ACCC commenced review under the Merger Process Guidelines.
7 February 2014	Closing date for submissions from interested parties.
18 February 2014	ACCC requested further information from the merger parties.
28 February 2014	ACCC received further information from the merger parties. ACCC amended former provisional date for announcement of findings (6 March 2014).
3 March 2014	ACCC received further information from the merger parties.
12 March 2014	ACCC amended former provisional date for announcement of findings (13 March) following its review of additional information received from the merger parties on 3 March.
27 March 2014	ACCC published a Statement of Issues outlining preliminary competition concerns.
10 April 2014	Closing date for submissions relating to Statement of Issues.
17 April 2014	ACCC requested further information from the merger parties.
5 May 2014	ACCC received further information from the merger parties. Acquirer requested more time to provide further additional information. ACCC amended proposed date for announcement of final decision.
21st May 2014	Acquirer requested a delay of the former proposed decision date (22 May) to allow for provision of further information.
3 June 2014	ACCC received further information from the acquirer. ACCC amended proposed decision date.
12 June 2014	ACCC announced it would oppose the proposed acquisition.

Market inquiries

25. The ACCC conducted market inquiries with a range of industry participants and interested parties, including private hospitals, public hospitals, private health insurance funds, medical specialists and health professionals, including rehabilitation assessors and discharge planners.

Statement of Issues

26. The ACCC published a *Statement of Issues* on 27 March 2014. In the *Statement of Issues* the ACCC expressed the preliminary view that the proposed acquisition was likely to raise competition concerns in the market for the supply of private rehabilitation services to patients in the northern suburbs of Melbourne. In particular, the ACCC expressed concern that the proposed acquisition would result in the following effects in the market for the supply of private rehabilitation services to patients in the northern suburbs of Melbourne:

    - the removal of a vigorous and effective competitor;
    - the removal of Healthscope's closest and only competitor;
    - reduced incentives for Healthscope to invest in staff, specialists, facilities and rehabilitation programs;
    - reduced incentives for Healthscope to admit 'slow-stream' rehabilitation patients.

27. The ACCC also expressed the preliminary view that the proposed acquisition was unlikely to raise competition concerns in three other related markets:

    - the supply of private hospital services (encompassing general medical and surgical services) to patients in the inner and northern suburbs of Melbourne;
    - the supply of private hospital services (encompassing general medical and surgical services) to health funds. The ACCC considered that there are national, state-based and local elements to competition in this market;
    - the supply of private rehabilitation services to health funds. As with private hospital services, the ACCC considered that there are national, state-based and local elements to competition in this market.

Areas of overlap

28. At the time of the review, Healthscope and Brunswick Private overlapped in the provision of private general medical services and private rehabilitation services in the northern suburbs of Melbourne. In the absence of the proposed acquisition, the ACCC considered that there was potential for Healthe to expand Brunswick Private and begin providing surgical services at that hospital. In that event, Healthscope and Brunswick Private would also overlap in the provision of private surgical services.

Future with and without the proposed acquisition

29. In assessing a proposed acquisition pursuant to section 50 of the Act, the ACCC considers the effects of the acquisition by comparing the likely future competitive environment if the acquisition proceeds (the "with" position) to the likely future competitive environment if the acquisition does not proceed (the "without" position) to determine whether the proposed acquisition is likely to substantially lessen competition in any relevant market.

30. The ACCC's view was that absent the proposed acquisition (the "without" position), Healthe was likely to continue to operate Brunswick Private as an independent competitor in the relevant markets.

Industry background

Competition to attract doctors and patients

31. Private hospitals provide a range of services to patients, with much of the demand for services generated by doctors on behalf of their patients. Hospitals therefore endeavour to provide an environment in which doctors are willing to refer or treat their patients. Accordingly, competition between hospitals to attract doctors and referrals by doctors is often viewed as a proxy for competition to attract patients.

32. The activities that hospital owners engage in to attract doctors and referrals of patients often involve investment in facilities, equipment, medical professionals (including specialist doctors, nurses and allied health professionals) and support staff. In addition, hospital owners and managers make the necessary resources available to provide for and respond to the input of medical professionals regarding programs offered for the clinical care of patients.

33. Competition between private hospitals for doctors is particularly prevalent with regards to specialists, such as surgeons, who are responsible for referring patients to, or treating patients in, private hospitals for various medical treatments.

Private health insurance funds

34. Most patients who attend private health facilities pay for the services they receive via private health insurance. Changes to private health insurance premiums are regulated by the federal government.

35. Payments from private health funds (**health funds**) make up the vast majority of revenue earned by private hospitals. Most private hospitals and health funds have agreements known as Hospital Purchaser Provider Agreements (**HPPAs**). Private hospitals have equivalent agreements with the Repatriation Commission which are administered by the Commonwealth Department of Veterans' Affairs.

36. An HPPA is an agreement under which a health fund agrees with a private hospital operator that, if and when a member of the health fund presents for treatment at the private hospital, the hospital operator will provide services to the member to a specified standard and for a specified fee, and the operator can bill the health fund for the service (rather than billing the member).

37. HPPAs help to minimise 'gap' or 'out of pocket' payments for a fund's members. If a patient attends a private hospital which has an HPPA with the patient's health fund, the patient will ordinarily not be required to make any payments for

their hospital accommodation (except for any excess or co-payment that the patient is liable to pay under their health insurance plan). If a patient has private health insurance but is treated at a hospital that does not have an HPPA with the patient's fund, the fund is required by legislation to pay at least 'second tier' benefits, provided that the hospital is appropriately registered.[2] Lower minimum default benefits are payable if the hospital is not registered for second tier benefits. The patient may then, at the discretion of the private hospital, be required to pay the difference between the benefit paid by their fund and the hospital's charges.

38. An HPPA generally covers all the services provided by a hospital operator which the health fund has agreed to fund. HPPAs between a hospital operator and health fund are most commonly made on an 'all-in' or 'all-out' basis (i.e. either all of Healthscope's hospitals are included in an HPPA with the health fund or none are). Therefore hospital operators with hospitals in multiple states tend to negotiate HPPAs with health funds on a national basis.

39. The rates and other terms agreed in an HPPA are the result of negotiations between a hospital operator and a health fund, and therefore reflect the balance of bargaining power between the two parties.

40. Most acute medical procedures (such as surgery) are charged as a fixed amount per procedure (known as a 'case payment') which is generally calculated with regard to the cost of the procedure and the average length of hospital stay associated with that procedure. Rehabilitation services (and psychiatric care services) are typically charged on a 'per diem' (daily) basis as the duration of care required is highly variable. However, in some cases the case payment charged by a hospital to a health fund for an acute procedure will include a component for a period of rehabilitation which the patient may also require following the acute procedure.

Rehabilitation hospitals

41. Patients are typically referred to a rehabilitation hospital after receiving treatment at an acute surgical, general medical or emergency hospital department. Rehabilitation hospitals source patients either from upstream hospitals which are part of the same private or public network of hospitals, or via referrals from other hospital groups. Before a patient can be discharged from the originating hospital and referred for admission to a rehabilitation hospital, they will undergo an assessment to determine if they are suitable for admission into the rehabilitation hospital's programs. These assessments are undertaken by a rehabilitation assessor.

42. A rehabilitation assessor is connected to, and employed by, a particular rehabilitation hospital. A rehabilitation hospital commonly has a number of assessors depending on the number of rehabilitation beds at the hospital and the extent to which it needs to seek referrals from third party hospitals. An assessor is generally assigned a selection of referring hospitals that they will visit.

43. The fundamental role of a rehabilitation assessor is to assess patients in order to determine a patient's rehabilitation treatment needs, how long the patient is likely to need to stay in hospital, and whether they are suited to the rehabilitation hospital's programs.

2 Private Hospitals are registered to provide and charge for hospital services by the Commonwealth Department of Health.

44. Additionally, rehabilitation assessors from private hospitals act as a promotional representative for their employing hospital, establishing relationships with the discharge planners of the hospitals they visit and endeavouring to attract referrals of patients.

45. Market inquiries indicated that public hospitals also employ rehabilitation assessors; however their role is generally limited to assessing the condition and suitability of a patient for referral into the public rehabilitation hospital, rather than promoting the public hospital or attempting to attract patients from other hospitals.

Promotion by the rehabilitation assessor

46. The aspects of a rehabilitation facility that rehabilitation assessors promote to patients and referring hospital staff include:

- location (relative to the patient's home or family);
- the 'tailored' nature of the hospital's rehabilitation programs;
- access to complementary facilities and medical staff which may be needed such as GPs and specialists including cardiologists, x-rays, pathology and dieticians;
- the quality of the allied health team and the therapy provided;
- whether the hospital is a modern facility with single rooms, ensuite bathrooms, outdoor areas, a gymnasium, hydrotherapy pool and other facilities where patients can work to regain physical function;
- whether the hospital can admit patients on the same day as they are assessed (this is particularly attractive to the referring hospitals).

47. As patients with third-party funding such as private health insurance are not usually required to pay for their rehabilitation treatment, competition between rehabilitation hospitals to attract patients and referrals from doctors is primarily not on the basis of price.

Deciding where a patient is referred

48. Market inquiries with a range of doctors, discharge planning staff and rehabilitation assessors indicated that the process for discharging a patient and referring them to a rehabilitation hospital can vary depending on the type of rehabilitation required by the patient, their place of residence (or that of their family/carer), and whether they have private health insurance (or some other source of third party funding).

49. The medical staff at the discharging/referring hospital will first consider whether the patient has any specific needs that require specialised rehabilitation. This could include a serious acquired brain injury, amputation or severe spinal injury. If the patient does require specialised rehabilitation, they may have very limited options for rehabilitation (e.g. few private rehabilitation hospitals in Melbourne have acquired brain injury units). If the patient does not require specialised rehabilitation they will have more options available to them.

50. The majority of patients receiving rehabilitation at private hospitals require relatively straight-forward rehabilitation for post-acute procedures (particularly orthopaedic) or reconditioning after a period of hospitalisation.

51. In the cases of planned surgery requiring subsequent rehabilitation, a patient's choice of rehabilitation hospital can be arranged before they undergo their initial acute surgical procedure. These patients often have a number of days to talk to various rehabilitation assessors and decide where they will receive rehabilitation.

52. Most industry participants considered that the patient's preference of rehabilitation facility is always taken into consideration. A number of industry participants submitted that the patient has the ultimate decision as to where they go (within the range of hospitals with available beds and appropriate facilities/programs for that patient).

53. Submissions from market participants were mixed in relation to the influence of the treating doctor as to which rehabilitation facility a patient is referred to. Some industry participants considered that doctors were highly influential with their recommendations while others considered that in many cases the doctors played no role in choosing a rehabilitation facility.

54. A number of market participants considered that previous experiences or recommendations from friends or family who had previously received rehabilitation also influence a patient's choice of rehabilitation facility.

55. The vast majority of market participants considered that the location of a rehabilitation facility, relative to the patient's place of residence (or that of their family) is a major determinant of the rehabilitation facility they are referred to.

Market definition

56. The ACCC assessed the impact of the proposed acquisition in the context of the following markets:

    i. The supply of private hospital services (encompassing general medical and surgical services) to patients in the inner and northern suburbs of Melbourne;

    ii. The supply of private hospital services (encompassing general medical and surgical services) to health funds. As discussed below, the ACCC considers that there are national, state-based and local elements to competition in this market;

    iii. The supply of private rehabilitation services to patients in northern Melbourne; and

    iv. The supply of private rehabilitation services to health funds. As with private hospital services, the ACCC considers that there are national, state-based and local elements to competition in this market.

57. Markets involving the supply of private hospital services to patients are generally local in their geographic scope (at least in metropolitan areas) as patients do not typically travel long distances to access private hospital services (except

perhaps for highly specialised services).[3] The geographic dimensions of these markets are discussed further below.

58. The ACCC considered that the health fund markets are likely to be broader in their geographic scope. Industry participants submitted that because HPPAs between private hospitals and health funds are predominately negotiated on a national basis (for private hospital operators with a multi-state presence), competition between hospital groups on a national and state/territory level is most relevant to the competitive dynamic for determining HPPA rate increases. However, some industry participants considered that local competition between private hospital operators is also a significant influence on HPPA rates. This is because, if a private hospital operator has a particularly strong position in a local area, a health fund that wishes to provide services to members in that area may have no choice other than to deal with that hospital operator. The ACCC considered that national, state and local dimensions were relevant to the analysis of competition for the supply of private hospital services to health funds by Healthscope, the second largest private hospital operator in Australia.

59. The above markets are the same as those outlined in the *Statement of Issues*, except for the geographic scope of market (iii), the market for the supply of private rehabilitation services to patients in the northern suburbs of Melbourne. This is discussed below.

60. Markets (i), (ii), and (iv), were identified in the *Statement of Issues* as markets where the proposed acquisition was unlikely to raise concerns. Market inquiries following the *Statement of Issues* did not reveal any further information to change the ACCC's views in relation to these markets and as such these are not considered further here.

61. This *Public Competition Assessment* therefore focuses on the supply of private rehabilitation services to patients in the northern suburbs of Melbourne.

Market for the supply of private rehabilitation services

Product dimension of the market

62. The ACCC considered the proposed acquisition in the context of a rehabilitation market with a product dimension that includes services provided to:

- inpatients and outpatients with a range of rehabilitation requirements;
- patients that are funded by a number of different third party sources. These are outlined at paragraph 67.

63. The ACCC considered that the product dimension of the relevant rehabilitation market excluded services provided by:

- public hospitals; and
- private hospitals without dedicated rehabilitation offerings.

3 'Highly specialised' hospital rehabilitation services include treatment of patients with acquired brain injuries and spinal injuries.

Rehabilitation services provided in hospitals

64. Rehabilitation services provided in hospitals are 'specialist' services, which require a referral from a doctor. These are provided by a multi-disciplinary team of medical practitioners, allied health professionals and nurses. As such, they differ from services provided outside of a hospital setting, such as physiotherapy or speech therapy which patients can arrange without a medical referral.

65. Rehabilitation services in hospitals can be offered as:

- **inpatient services**: e.g. a 10-15 day stay in order to recover from a hip replacement surgery or an illness; or
- **outpatient services** e.g. a patient may attend the hospital to see a variety of specialists to assist in the recovery from an injury or surgery.

66. Rehabilitation facilities such as Brunswick Private, Dorset and NERC all provide both inpatient and outpatient services. The facilities necessary to provide inpatient and outpatient services are essentially the same, except for the overnight accommodation aspect of the service, which outpatients do not require.

'Chargeable' patients

67. Industry participants noted that private hospitals primarily treat patients who have their medical treatment funded by a third-party. These patients are referred to as 'chargeable' patients. The source of funding for these patients includes:

- private health insurance funds;
- the Repatriation Commission (through the Department of Veterans' Affairs);
- the Transport Accident Commission (for transport accident victims); and
- the Workcover Authority (for people injured in the workplace).

68. Industry participants indicated that private rehabilitation hospitals generally service any 'chargeable' patients, irrespective of their source of funding, provided they are equipped to meet an individual patient's rehabilitation requirements, and the patient's funding is sufficient to cover their anticipated period of rehabilitation. However, industry participants noted that some hospitals actively pursue referrals of patients with particular funding, such as TAC patients whose admissions are funded at higher rates and for longer periods of time than private health insurance typically provides.

69. Industry participants also indicated that private hospitals had regard to the limitations of a patient's funding before accepting the referral of a patient for rehabilitation. This particularly applies to patients whose third party funding source is private health insurance. For example, a number of market participants noted that most private health insurance policies have limits on the number of days of rehabilitation the fund will cover, commonly around four to five weeks. Further, the daily rate that a private hospital receives from the health fund for providing rehabilitation services to an inpatient is 'stepped-down' to a lower rate after around 14 days of treatment. As such, a number of industry participants submitted that private hospitals seek referrals of patients likely to require no

more than four weeks of rehabilitation and often aim to discharge patients within 14 days before their funding rate is 'stepped-down'.

Public hospitals

70. The ACCC notes there is overlap between rehabilitation services provided by private hospitals and those provided by the public system. A number of public hospitals in Melbourne, such as the Royal Melbourne Hospital and the Austin Hospital, have rehabilitation facilities providing both inpatient and outpatient services which can be accessed by patients with private health insurance. However, data provided by industry participants indicated that only a small percentage of 'chargeable' patients receive rehabilitation treatment at public hospitals.

71. The ACCC also had regard to data and information provided by a number of industry participants which illustrated that, on average, privately insured patients in public hospitals require significantly longer periods of rehabilitation than patients in private rehabilitation hospitals. This is linked to the fact that private hospitals target patients whose anticipated length of stay will be covered by their source of funding. Market inquiries indicated that patients whose rehabilitation requirements may exceed their available health insurance funding, such as patients who require more than four weeks of rehabilitation, will have difficulty in being accepted into a private rehabilitation hospital. As a result these patients often have to obtain rehabilitation services in a public hospital.

72. The ACCC found that public hospitals have a financial incentive to admit chargeable patients and do take steps to encourage these patients to be admitted as such, particularly the TAC, Repatriation Commission and Workcover patients. For example, some public hospitals waive out-of-pocket costs for patients who agree to use their private health insurance in the public rehabilitation facility.

73. However, public rehabilitation facilities typically face capacity constraints and there are often waiting lists for patients. As a result, market inquiries indicated that the primary consideration for discharge coordinators in acute public hospitals is to discharge eligible patients to private rehabilitation hospitals where possible. This enables public rehabilitation beds to be made available for non-chargeable patients, or for privately insured patients whose period of rehabilitation exceeds their funding. Discharge coordinators value the fact that private rehabilitation hospitals are often able to move patients out of the acute ward more quickly than the public facilities. Market inquiries indicated that where a public acute hospital was able to discharge a patient to a private rehabilitation hospital it would tend to do so, rather than seek to retain that patient in the public system.

74. Industry participants also indicated that public hospitals are limited in their ability to reserve single rather than shared rooms for private patients, and can only do so subject to the medical needs of other patients.

75. Market inquiries also indicated that public rehabilitation hospitals do not actively seek to admit patients from private acute hospitals, or from other public acute hospitals outside their geographic catchment area. Funding constraints also prevent the public hospitals from employing rehabilitation assessors to market their services in the way that private hospitals do. Accordingly, most privately insured patients are admitted to public rehabilitation facilities after having received acute care in the same hospital.

76. Having regard to the above factors, the ACCC considered that a significant proportion of patients with private health insurance who receive rehabilitation treatment in public hospitals are not contestable patients whom private hospitals seek to admit. Further, the ACCC considered that capacity and funding constraints limit the ability of public hospitals to compete for the contestable patients whom the private hospitals seek to admit.

77. The ACCC therefore considered that public hospitals are unlikely to provide a significant competitive constraint on private hospitals for the provision of rehabilitation services and should not be included in the relevant market. In any event, the ACCC's decision did not turn on the exclusion or inclusion of public hospitals in the market, because even if they were included in the market, they would provide a weaker competitive constraint for privately funded rehabilitation patients than other private hospitals.

Potential for supply-side substitution from acute private hospitals

78. The ACCC found there was insufficient supply side substitutability between private general medical or surgical hospital services and rehabilitation services to include private hospitals which do not currently provide rehabilitation services in the relevant market.

79. Industry participants submitted that a rehabilitation unit requires not only beds, but also facilities such as a gymnasium and a pool for hydrotherapy. Rehabilitation services also require significantly different medical staff compared to other medical services, so the conversion of general medical beds to rehabilitation beds requires the recruitment of a range of new staff including rehabilitation specialists and allied health professionals.

80. The ACCC also observed that for a private hospital not currently providing rehabilitation services to commence doing so would require the development of approved rehabilitation programs and negotiation with health funds for the inclusion of rehabilitation services into the hospital's HPPAs (contracts with health funds).

81. Information from industry participants indicated that the provision of acute surgical services and general medical services at private hospitals is generally considered to be a high-cost, but also high-revenue, activity relative to providing rehabilitation services. If a hospital has a profitable general medical and/or surgical service operating at close to capacity, it is unlikely that the hospital would have sufficient incentive to convert its beds to provide rehabilitation services, even in the event of a reduction in rehabilitation quality or capacity in the relevant local market.

82. Therefore, the ACCC considered there was insufficient supply-side substitutability to broaden the scope of the private rehabilitation market to include general medical or surgical private hospital beds.

Geographic scope of the market

83. The ACCC defined the geographic scope of the market having regard to a number of factors:

- The 'catchment area' of the target hospital, Brunswick Private, which was based on the places of residence of patients attending the Brunswick Private, and mostly consisted of suburbs in northern Melbourne;

- The potential for competitive constraint by rehabilitation hospitals which were located near a boundary of the Brunswick Private's catchment area;

- Information provided by industry participants which explained the process for determining which rehabilitation hospital a patient is referred to and which hospitals were considered to compete with Brunswick Private and Healthscope's Dorset and NERC hospitals;

- Information and documents which revealed that the Brunswick Private and Healthscope's Dorset and NERC hospitals were close competitors for the supply of rehabilitation services to patients in northern Melbourne.

84. The ACCC considered this information to assess the extent to which the potential for patient switching would be likely to deter the hospitals in the northern suburbs from providing a lower quality rehabilitation service. While there is no specific data which goes directly to this issue, the ACCC considered a range of materials to form a view about the actual and potential constraint from other hospitals on the merger parties. These included:

- market inquiries indicated the importance of location in a patient's choice of rehabilitation hospital;

- data on admission patterns for patients in the northern suburbs (based on current quality levels), provided an indication of the preferences of patients whose substitution possibilities are most relevant to the degree of competitive constraint on hospitals in the northern suburbs; and

- information from the merger parties about the hospitals they consider to be competitors of their rehabilitation hospitals in the northern suburbs.

85. Data and information from industry participants and the merger parties indicated that geographic proximity of a rehabilitation hospital to a patient's home or the home of their family or other carer is a key determinant of competition.[4]

86. Inpatients receiving rehabilitation services could spend a number of weeks or even months in hospital and as such, being a convenient distance from family is important. Similarly, a patient receiving ongoing rehabilitation as an outpatient would prefer to attend a rehabilitation facility close to their home to minimise travel time for the ongoing visits.

87. Market inquiries showed that while some patients from the northern suburbs of Melbourne would attend an acute private hospital to the east or south of the CBD (e.g. Richmond or East Melbourne) for elective surgical procedures, many of these patients would still generally be referred to a rehabilitation facility on the northern side of the CBD for the reasons outlined above. Nevertheless, market inquiries revealed information which suggested that the Epworth Richmond and St Vincent's would likely provide some constraint on the hospitals of the merger parties in the northern suburbs and therefore should be considered as substitutes to Healthscope in the event of a reduction in service quality post-acquisition.

[4] Subject to that rehabilitation hospital being able to offer a suitable rehabilitation program which meets the patient's requirements.

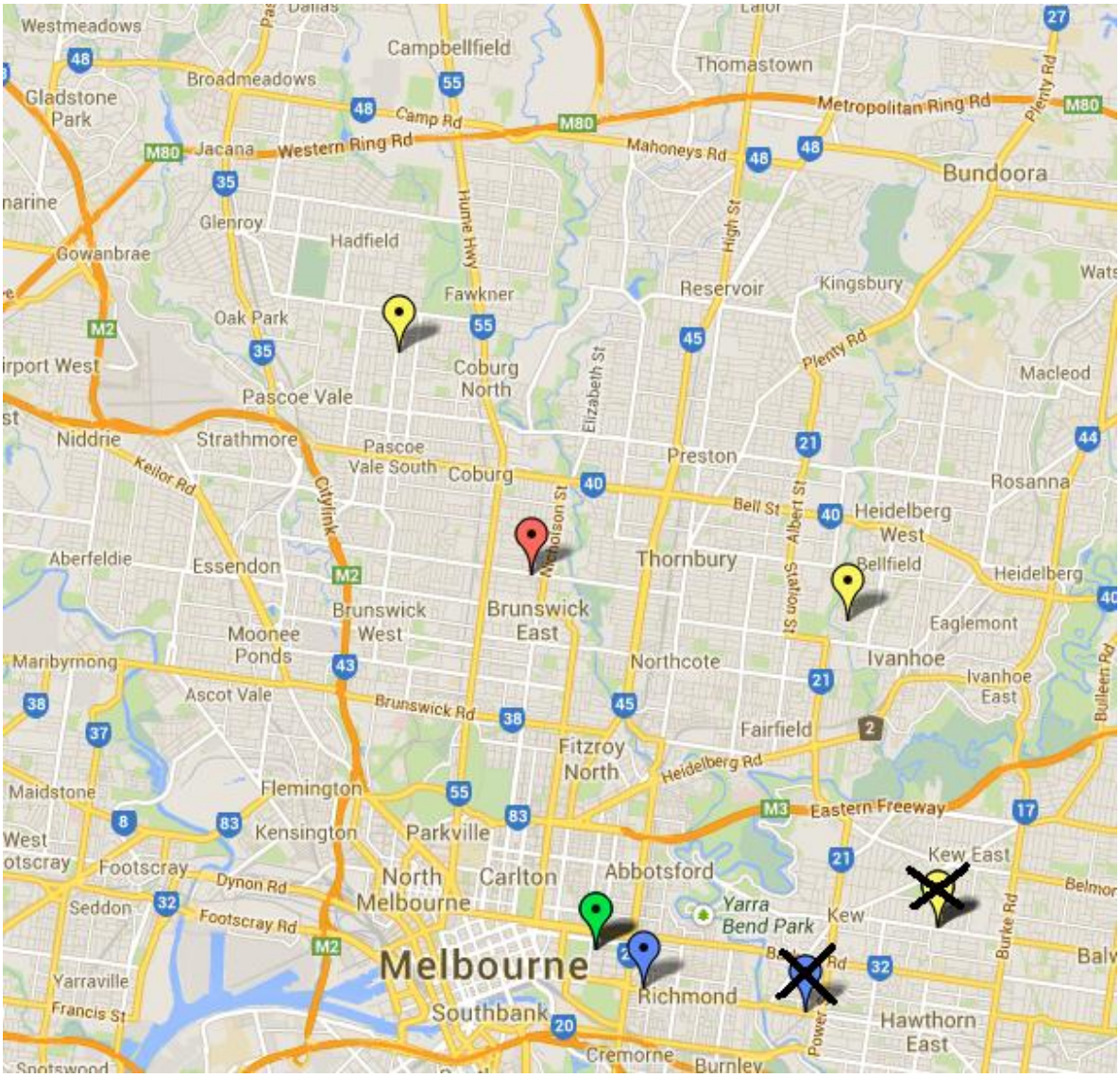
Conclusion on the geographic dimension

88. The ACCC concluded that the relevant market for the supply of rehabilitation services to patients from the northern suburbs of Melbourne comprised private rehabilitation hospitals located in the northern suburbs of Melbourne (Brunswick Private, Healthscope's Dorset and NERC hospitals) and Epworth Richmond and St Vincent's in East Melbourne.

89. The ACCC considered that the analysis of the proposed acquisition did not critically hinge on the precise geographic boundaries of the market. The ACCC considered that rehabilitation hospitals located further away from Brunswick Private were likely to be weaker competitive constraints than those closer to Brunswick Private and broadening the scope of the geographic market would not necessarily alter the ACCC's view of the likely effects of the proposed acquisition.

90. Figure 1 illustrates the locations of rehabilitation hospitals in northern Melbourne.

Figure 1. Map of northern Melbourne rehabilitation hospitals



Map legend

	Company	Locations and rehabilitation bed numbers
	Healthe Care	• Brunswick Private (Brunswick) – 98 beds
	Healthscope	• Dorset (Pascoe Vale) – 30 beds • North Eastern Rehab (Ivanhoe) – 46 beds • Cotham Private (Kew) (outside of relevant market**)**
	Epworth Healthcare	• Epworth Richmond (Richmond) – 61 beds • Epworth Hawthorn (Hawthorn) **(**outside of relevant market**)**
	St Vincent's	• St Vincent's Private (East Melbourne) – 17 beds

Competition between hospitals as a network

91. The ACCC also considered the extent to which hospitals compete as 'networks' and therefore whether private hospitals are competitively constrained by a regional network of hospitals, rather than by one or two local branches of a hospital network. In particular, the ACCC considered whether post-acquisition, the merged entity's rehabilitation hospitals in the northern suburbs of Melbourne would be constrained by the Epworth network of hospitals (with rehabilitation service offerings in Richmond, Hawthorn, Camberwell and Brighton) as distinct from facing competition only from one or two of the Epworth's hospitals.

92. The ACCC considered that a hospital network may have an incentive to attempt to refer post-acute or emergency patients to the hospital network's own rehabilitation beds, in order to maximise bed utilisation in the rehabilitation hospital network. In order to form a view on whether hospitals in Melbourne are competing against each other as 'networks', the ACCC considered a number of factors including:

    - market share data in relation to hospital catchment areas which indicated that a hospital's market shares appear to be closely correlated to its distance from the residential addresses of patients admitted to the hospital.

    - the insignificant market shares of hospitals in the southern and eastern suburbs of Melbourne for admissions of patients from the northern suburbs of Melbourne, irrespective of whether they were part of a larger network of hospitals;

    - the relative proportions of within-network versus outside-of-network transfers of patients from acute or emergency hospitals to rehabilitation hospitals; and

    - further qualitative information provided by industry participants.

93. Having regard to the above factors, the ACCC concluded that it was unlikely that Healthscope's rehabilitation service offering in the northern suburbs of Melbourne would be competitively constrained by the networks of hospitals operated in the Melbourne area by Epworth Health, St Vincent's Private or Ramsay Health Care.

Competition Assessment

94. As discussed at paragraphs 31-32, to a large extent, private rehabilitation hospitals compete for patient referrals through investments in facilities to attract doctors and improve services for patients.

95. The ACCC was concerned that the proposed acquisition would result in the removal of Healthscope's closest competitor in the market for the supply of private rehabilitation services to patients in northern Melbourne. The ACCC considered the proposed acquisition was likely to substantially lessen competition by reducing the incentives for Healthscope to continue to invest in staff, specialists, facilities and programs for the supply of rehabilitation services to patients in its northern Melbourne hospitals.

Competitive significance of Brunswick Private

96. A number of industry participants identified Brunswick Private as a vigorous and effective competitor for the supply of private rehabilitation services in northern Melbourne, having regard to the substantial investments in Brunswick Private made by Healthe to expand the size and quality of the rehabilitation offering to attract more patient referrals from private acute hospitals.

97. The ACCC noted that Brunswick Private's lack of large nearby 'feeder' hospitals owned by the same hospital group (in contrast to Healthscope's Dorset which has the John Fawkner Hospital as a feeder hospital) means that it cannot rely on 'internal' referrals within its own group. Healthe's La Trobe Private acute hospital at Bundoora was too small to provide a significant number of referrals to Brunswick Private. This has incentivised Brunswick Private to be highly active in seeking patient referrals from third party hospitals. Market inquiries indicated that Brunswick Private has been very successful in attracting patients and growing the number of patient referrals. Industry participants also identified the management of Brunswick Private as being closely engaged with its medical staff and providing an attractive work environment for medical professionals.

98. The ACCC considered that in the future absent the proposed acquisition, Healthe would continue to have an incentive to invest in improved services to attract patients to Brunswick Private and persist in being highly active in seeking patient referrals from third party hospitals.

99. The ACCC considered that regardless of the precise market definition adopted, Brunswick Private is the closest competitor of Healthscope in the relevant market, because:

- as explained in the market definition section above, most patients choose a rehabilitation hospital close to their home (or in some cases the home of a relative or friend with whom they will stay after the discharge from rehabilitation);
- Brunswick Private is the geographically closest private rehabilitation hospital to each of Dorset and NERC;
- internal documents and submissions from industry participants indicated that Brunswick Private is Dorset's closest competitor and one of NERC's closest competitors.

100. Information provided by industry participants indicated that the expansion of Brunswick Private had a significant impact on referrals to Healthscope's rehabilitation hospitals in northern Melbourne.

Insufficient competitive constraint from other hospitals

101. The ACCC considered that the other rehabilitation hospitals in the market would be unlikely to provide a sufficient constraint on Healthscope post-acquisition to prevent a substantial lessening of competition.

102. St Vincent's Private and the Epworth in Richmond would have a substantially smaller number of rehabilitation beds than Healthscope post-acquisition. The ACCC considered that given the locations of Epworth Richmond and St Vincent's Private (as well as other private hospitals outside the defined boundaries of the market), and as there are no private rehabilitation hospitals located to the north of Dorset, Healthscope would likely have a significant 'captive' market of patients in the northern suburbs post-acquisition such that a small but significant decrease in quality may not cause enough local patients to switch to other rehabilitation hospitals.

103. While Epworth HealthCare is a large and highly regarded private hospital group with a large number of rehabilitation beds in the southern and eastern suburbs of Melbourne, the ACCC considered that the Epworth in Richmond would provide only a limited competitive constraint on Healthscope for the supply of rehabilitation services to patients in the northern suburbs of Melbourne. The ACCC formed this view on the basis of market share data, internal documents from private hospitals and submissions from a range of industry participants. The ACCC found that the Epworth Richmond serviced a relatively small share of patients from Brunswick Private's catchment area and its location was identified as a primary factor for its lower market share.

104. The ACCC noted that St Vincent's is a major health provider in inner Melbourne, however its rehabilitation capacity is very small, and likely to only compete for a limited number of northern Melbourne patients and generally only where those patients had attended a St Vincent's acute hospital. It was considered unlikely it would compete actively for rehabilitation patients from other acute hospitals (including public hospitals such as the Royal Melbourne and The Austin).

Reduced incentive to accept slow-stream patients?

105. The *Statement of Issues* raised concerns that:

- Brunswick Private had focussed on providing services to slow-stream patients, in contrast to other private rehabilitation hospitals in the area which accept mainly fast-stream patients (as slow-stream patients tend to be less profitable) and had developed a rehabilitation model that was particularly suited to these patients; and

- had the proposed acquisition proceeded, Healthscope may have had less incentive to accept slow-stream rehabilitation patients and adjusted its rehabilitation model accordingly.

106. Further market inquiries following the *Statement of Issues* indicated that while some market participants might have had a perception that Brunswick Private focused on slow-stream patients, the empirical evidence on length of stay and frequency / intensity of treatment was not supportive of this theory. Further

market inquiries also indicated that the terms ‘slow stream’ and ‘fast stream’, whilst being common industry terminology, were imprecisely defined and subject to a significant degree of ambiguity. However, a number of industry participants identified Brunswick Private’s combined general medical and rehabilitation offering as a reason as to why it was considered to have a particularly high quality rehabilitation offering to geriatric patients who commonly require more extensive periods of rehabilitation.

Barriers to entry

107. The ACCC considered that there was unlikely to be any significant entry or expansion of capacity in the market within the next three years.

Barriers to entry and expansion

108. Industry participants generally identified long lead times involved with expansions or greenfield entry, including seeking board and council approval for a development and then constructing and outfitting a new facility. Industry participants submitted that the process for planning, developing and building a new private health facility would commonly take a minimum of three years and often take up to five years.

109. However, industry participants submitted that barriers to commence providing rehabilitation services are generally lower than barriers for the provision of some other medical services such as acute surgical procedures as the costs associated with establishing a facility for rehabilitation services are lower, and attracting and retaining qualified and quality rehabilitation staff is not as difficult as attracting surgeons to a new private facility.

110. Industry participants also identified that the need to renegotiate HPPAs (contracts) with health funds can present a barrier to a hospital group opening a new rehabilitation facility, as health funds generally will not automatically extend their contracts with the hospital group to cover new facilities. Rather, hospital groups typically need to demonstrate to the health funds that the new facility will cater for otherwise unmet needs in that area.

111. The ACCC conducted market inquiries with hospital groups throughout the greater Melbourne area and did not identify any plans for new entry or expansion into the relevant market that would be likely to constrain the merged firm post-acquisition. The ACCC took into account Epworth Health Care’s plans to expand its Richmond hospital, which would increase the number of rehabilitation beds. The ACCC concluded that the threat of new entry or expansion into the market would not be likely to constrain the merged firm in the foreseeable future.

Conclusion

112. The ACCC considered that the proposed acquisition would result in Healthscope acquiring its closest and most significant competitor for the provision of rehabilitation services in northern Melbourne.

113. Brunswick Private is a vigorous and effective competitor to Healthscope’s rehabilitation hospitals in northern Melbourne. Healthe Care has invested substantially in the capacity, facilities and services offered at Brunswick Private. This has resulted in increased referrals of patients to Brunswick Private and had a significant impact on referrals to Healthscope’s rehabilitation hospitals in northern Melbourne. The ACCC considered that, in the absence of the proposed

acquisition, Brunswick Private is likely to continue to place competitive pressure on Healthscope to upgrade its rehabilitation hospitals in northern Melbourne.

114. The ACCC considered that Healthscope would be unlikely to allow a deterioration of quality standards at its northern Melbourne rehabilitation hospitals to the point where it would damage the Healthscope brand. The ACCC also considered that the influence of doctors, governance procedures and regulatory standards were likely to create a 'floor' below which quality standards would not drop.

115. However, the ACCC considered that the proposed acquisition would be likely to substantially reduce the incentives for Healthscope to invest in staff, specialists, facilities and rehabilitation programs for the provision of services to patients in northern Melbourne, when compared to a future where it was competing directly with Brunswick Private to attract patients.

116. The ACCC considered that Healthscope may face some competition post-acquisition from other hospital groups, such as Epworth and to a lesser extent St Vincent's Private. However, given the importance that patients place on geographic location, the ACCC considered that the presence of these competitors would not provide a sufficient ongoing incentive for Healthscope to invest in and improve the services offered to patients and doctors at its northern suburbs hospitals post-acquisition.

117. The ACCC therefore concluded that the proposed acquisition would be likely to result in a substantial lessening of competition in the market for the supply of private rehabilitation services to patients in the northern suburbs of Melbourne, in contravention of section 50 of the Act.