8. Commission Assessment – Public Benefits arising from the Proposed Arrangement

The Commission must be satisfied that the Proposed Arrangement results in a benefit to the public that outweighs any detriment arising from anti-competitive conduct. The Commission must also consider whether the claimed benefits represent public or private benefits and whether they arise as a direct result of the Proposed Arrangement.

In order for the Commission to include claimed public benefits in its consideration , it must be satisfied that there is a nexus between the claimed public benefits and the conduct for which the authorisation is sought. If there are public benefits which occur, or may occur, irrespective of the authorisation, the Commission need not include them in its assessment.

8.1. Public benefits claimed by the Applicants

The Applicants identified 5 public benefits which are claimed to result if the Proposed Arrangement is authorised. It is claimed the Proposed Arrangement would:(1) provide countervailing power against large health funds; (2) see the continuation of community services; (3) reduce the burden on public hospitals; (4) reduce costs to the Applicants; and (5) achieve other major savings. These public benefits are discussed in detail below.

Countervailing power

Original claims made by the Applicants

The Applicants submitted in their original application that one of the public benefits arising from the Proposed Arrangement and the associated collective bargaining would be to give the Applicants countervailing power against the large health funds.

The Applicants submitted the significant imbalance which arises when a hospital negotiates individually with a health insurance fund, means it is in the public interest to allow the Applicants to conduct joint negotiations. The imbalance in market power between private hospitals and health funds was claimed to result in the hospitals being forced to accept unfavourable contracts and reimbursement levels insufficient to cover increases in costs.

The Applicants argued that the public benefits arising from the ability to collectively negotiate, would be similar to the benefits identified in *Job Futures Limited* (1998) ATPR (Com) 50-561. In this matter, the Commission granted authorisation to Job Futures Limited in relation to arrangements for tendering with the Department of Employment Education Training and Youth Affairs for the provision of employment services. The Applicants also submitted that in *Re Motor Traders Association of New South Wales* (1983) ATPR (Com) 50-063, the Commission's predecessor (the Trade Practices Commission) allowed New South Wales and the Australian Capital Territory panel beaters to negotiate collectively with insurers, provided prices were not agreed to by the panel beaters.

Draft Determination and the Applicants' Response

The Draft Determination

In its Draft Determination the Commission concluded that Applicants had sought countervailing power through collective negotiations by the Applicants in order to achieve higher reimbursement levels from health funds. The Commission stated that higher reimbursement levels in themselves did not constitute a public benefit and the Commission was not satisfied on the basis of its examination of the claims of the Applicants that any public benefits of note would arise from higher reimbursement levels.

Under these circumstances the Commission did not consider there was a need to assess countervailing power as a benefit. The Commission noted in passing that health fund market shares in NSW are reasonably balanced across a number of funds making NSW the State with the highest level of competition between funds.

The Commission stated that while it was not necessary on this occasion for the Commission to determine whether there was an imbalance in negotiating power between the Applicants and health funds, it should be noted that any attempt to conduct such an analysis can be a complex and not always conclusive exercise. An analysis of countervailing power would necessarily require an assessment of the quantum of countervailing power required for a benefit to the public to result. Additionally, any move to increase the bargaining power of one sub group of the private hospital industry may impact on the dynamics between the private hospital industry and health funds in NSW as a whole. For example, if the Applicants were able to negotiate as a group, this could decrease the negotiating power of both smaller hospitals and smaller health funds.

The Applicants' response

Firstly, the Applicants are critical of the Commission for not taking the same approach as in Determination A50019. It is claimed that in Determination A50019 the Commission did not link the ultimate aim of the authorisation with the need for equality of bargaining power and the Commission acknowledged that differences in bargaining power may led to health funds adopting a "take it or leave it" approach, and a misallocation of resources. In the Draft Determination the Commission focussed on the perceived object of the authorisation application and not the same prospect of health funds adopting a take it or leave it approach to negotiations.

Secondly the Commission stated that higher reimbursements levels do not in themselves constitute a public benefit. The Applicants considered that if higher reimbursement levels are necessary to cover increases in unavoidable costs, then a failure to obtain a higher reimbursement will ultimately lead to reduced services or declining standards in hospitals. This reduction would not be in the public interest. The aim of obtaining higher reimbursements is not to avoid the need to improve efficiency, but rather is to avoid a situation where increases in unavoidable costs outstrip increases in reimbursements.

The Applicants do not believe that it is correct to state that simply because the four major funds in NSW each have market share of around 20% that they do not have market power, but that the two major funds in Queensland, having 30% and 50% market share, do have market power. It is argued that that the Commission has not used a valuable test proposed by the Applicants and cited in the Determination A50019 to the effect that:

"If to accept a contract price or to reject a contract price would place an organisation's future in jeopardy then the person offering the price has market power."

The Applicants state that they have presented evidence to the ACCC to indicate:

- the disparity of bargaining position between themselves and the health funds;
- the minimal effect on a health fund of not contracting with a hospital but the major effect on a hospital of the same situation; and
- the severe financial effects of a failure to negotiate with any health fund with a significant market share (exceeding 15%).

The Applicants have also stated that even given the most narrow market definition, the market shares of the Applicants are similar to those of the Brisbane hospitals in Determination A50019. The market shares of at least four health funds (or groups of health funds who negotiate as one) in NSW are significant. The Applicants therefore believe that their situation is similar to that in Determination A50019 and that rectification of the imbalance of negotiation power between each individual Applicant and the health fund represents a public benefit. They further claim that the amendments made to the authorisation application have not removed the public benefits that will result from bringing balance to the negotiating positions of the Applicants and health funds.

The Applicants state that they believe that the actual market share held by each fund is less important once a critical market share is held. The crucial issue is the effect on the hospital's business if a suitable contract cannot be negotiated. Because of the relatively small number of significant purchasers of hospitals' services no hospital can afford to be without a contract with any purchaser that has 15% of the relevant geographic market. While stating that they seek authorisation to enter the IHA in respect of all health funds, the Applicants submit that at a minimum it is necessary for authorisation to extend to those health funds (or groups of funds who negotiate as one) with market shares over 15% in the Sydney metropolitan area.

Commission consideration

From the Commission's perspective there are two issues:

- whether there is an imbalance of power between the Applicants and health funds which would be redressed by the proposed arrangements; and
- whether any such changes to the balance of power would result in benefits to the public.

Is there an imbalance of power?

The Commission notes there is a wide disparity of views on the issue of the negotiating power between the health funds and the hospitals generally. The Applicants submitted that they have limited negotiating power with respect to the health funds. On the other hand submissions by health funds stated that the Applicants hold a considerable degree of negotiating power over the health funds, as evidenced by their reimbursement levels which are already higher than those obtained by other private hospitals. Opposing submissions from

other private hospitals suggested that each of the Applicants was capable of independent negotiation in its own right.

To the Commission the relationship between health funds and hospitals appears to be one of mutual dependence. To provide an appropriate level and range of services, health funds need to have HPPAs with the major hospitals or risk losing market share. On the other hand, hospitals need to have HPPAs with the health funds or risk a significant reduction in their potential patient market.

The Applicants acknowledge this interdependence in par.66 of their submission of 17 June 1999:

> *Every hospital operator in Australia is aware of the potential catastrophe that this* [failure to negotiate a contract with a particular health fund] *would cause and knows that contract negotiations with health funds have to be successful. The Applicants maintain that the pressure to maintain a valid contract with all major health funds is paramount for ultimate survival.*

Similarly Manchester Unity states that:

> *A Sydney based health fund which did not include one or more of these hospitals* [the Applicants] *on its advertised list of contracted hospitals could expect to suffer a loss of market share.*

For these reasons the Commission is of the belief that both the Applicants and the funds hold a degree of negotiating power. The Commission did not consider it necessary to express a view in its Draft Determination as to where the balance of negotiating power lays, because it was not convinced that any change to the balance of power would result in public benefit.

While not resiling from this position the Commission will state that it would find it hard to believe that there is an imbalance of power to the disadvantage of the Applicants when it is clear on the basis of submissions from funds, supported by hard data, that the Applicants receive substantially higher reimbursement levels than other NSW private hospitals.

HCF has provided data for its top DRGs (diagnostic related groupings) showing that the Applicants receive significantly higher reimbursement levels than other private hospitals and that their average length or patient stay is significantly longer. AHSA has stated that the Applicants are the top three hospitals in terms of benefits paid by AHSA funds in NSW. MBF has stated, with supporting data, that the Applicants have the highest rates paid by MBF in NSW. Manchester Unity has submitted that charges at the Applicants hospitals are generally higher than for other major surgical hospitals in Sydney – 7% more for bed charges, 9% more for labour ward, 1.6% more for ICU and 1.4% less for theatre charges.

The Applicants have stated in response to the Draft Determination that *"even if the previous levels of reimbursement received by the NSW hospitals are higher than other hospitals, they may still be inadequate, and in need of improvement"*.

The Commission's point in identifying that the Applicants receive higher reimbursement levels than other hospitals is that the Applicants have more negotiating power than other NSW private hospitals. To accept the Applicants' view that such levels are inadequate would be to raise serious question about either the efficiency of the Applicants or the viability of the

private hospital industry in NSW (given the lower reimbursement levels obtained by the other hospitals).

The Applicants have suggested that the Commission should have applied the following test in relation to the Applicants.

> *"If to accept a contract price or to reject a contract price would place an organisation's future in jeopardy then the person offering the price has market power."*

While the Commission examines below the relationship between the failure of the Applicants to obtain higher reimbursement levels and profitability/viability, the Commission can state now that is has seen no evidence which suggests that the Applicants' viability is in jeopardy.

Indeed if the Applicants' future was in jeopardy it would be expected that the financial position of other NSW private hospitals would be at the extreme given the differences in reimbursement levels. The only claim of industry wide difficulties made to the Commission appeared in the Private Hospitals Association of NSW submission to the Commission's pre-decision conference of 23 February 2000. This submission said:

> *The Association's general position of support is based on the current imbalance of power between individual hospitals and health funds in one on one contracting. The failure by NSW health funds to recognise and address the real underlying cost of healthcare services through the provision of sustainable benefit levels threatens the viability of the private hospital sector. The prospect of collapse is quite real and would have significant adverse impacts in public interest terms, including unmanageable impacts on the stressed NSW public hospital system.*

The Commission finds it curious that if the position is so bad, no other private hospitals have made submissions detailing their dire financial positions. It is also curious that if the situation is as critical as described by the Association, it waited until the pre-decision conference to make its initial submission.

It seems hardly in the interest of the health fund industry to allow the private hospital industry to collapse or the quality of service to erode to levels below members' expectations. This point was made by NRMA Health at the pre-decision conference:

> *The hospitals seem to be saying that hospitals only fail because of health funds. Often they fail because of poor management. The letter [from PHANSW] suggests health funds are either stupid or suicidal. Heath funds would not survive without the hospitals.*

It may well be that the hospital – health fund negotiation process, the major source of competition tension faced by hospitals, is putting the financial position of some hospitals under pressure. The Productivity Commission said in relation to this process that: *"Some would argue that threatening a hospital's existence is a clear misuse of market power. But is it necessarily misuse of market power to force an inefficient hospital to improve its performance or exit the industry?"* There is a difference between this and taking the industry as a whole to the brink of collapse.

A similar point was made by NRMA Heath in the context of unavoidable cost claims as to how hospitals might respond to financial pressures.

> *The applicant hospitals have choices whether and how they provide their service to patients. If the applicant hospitals are not receiving a reasonable rate of return on their assets – pressures that all businesses are expected to face – they may need to reallocate these resources. Ultimately, it is competitive forces which should influence applicant hospitals whether and on what terms they continue to provide particular services.*

Would changes to the balance of power result in public benefit?

Apart from the current balance of negotiating power position there is the question of whether the Proposed Arrangement would result in a change to the balance of power and the extent of any associated public benefits. The Commission is of the view, as described in its earlier assessment of the competitive effects of the Proposed Arrangement, that it will likely lead to a lessening of competition in a number of markets and increases in reimbursement levels. The Applicants have claimed public benefits from the negotiation process itself. However, the key question is probably whether or not the outcome of the negotiations, the securing of higher reimbursement levels by the Applicants, results in a public benefit.

The Applicants are claiming that their "profitability" and ultimately their viability is threatened if higher reimbursement levels are not obtained. They state in their application that:

> *.....the power of the funds in negotiations can mean that a hospital can be sent bankrupt with an unfavourable contract or with no contract. If contracts are made harsher, fewer profits will be returned to the community.*

In para 69 of their submission of 17 June 1999 the Applicants say that:

> *Hospital operators have very large investments in capital and human assets to protect. If they are placed in the horns of dilemma, they will have to opt for the least painful option. For example, if prices offered by a major payor* [sic] *are such that, if accepted, the hospital will lose money, the operator must consider the alternative – that if the contract price is not accepted the hospital will receive little or no money from that payor. Because of the no win situation, the operator will probably accept a loss making arrangement in the hope that at some time in the future, the situation will improve.*

The Applicants maintain that while unavoidable cost increases of the order 4%-5% per annum are being incurred by hospitals, the increase in benefit levels being offered by health funds over 1996 and 1997 was around 2% and the starting position for 1998 negotiations was no change. The Applicants state that they have seen decreases in profit margins of between 10% and 35% in the last few years, inclusive of significant efforts to reduce costs. The major cost increases are in labour and medical supplies which account for over 75% of all hospital cost charges.

Any analysis of the financial position of the Applicants is impeded by the lack of published financial accounts. The for-profit hospitals, by comparison, release their accounts into the public arena. The Commission must therefore draw upon statistics published annually by the

ABS on private hospitals. The latest statistics are for 1997/98 and show that for Australia, for private and acute psychiatric hospitals:

- recurrent expenditure per patient increased by 38% between 1991/92 and 1997/98 with an average increase of around 6% per year and a 4.7% increase from 1996/97 to 1997/97;

- the ratio of revenue to recurrent expenditure increased from 89.8% in 1991/92 to 91.8% in 1997/98, with a decrease in margins from 11.1% to 8.8%;

- in 1997/98 average expenditure per patient day in religious or charitable hospitals was 29% higher than in for profit hospitals (compared to 24% higher in 1996/97); and

- in 1997/98 labour costs accounted for 57.7% of the total recurrent expenditure for religious or charitable hospitals and 59.8% for for-profit hospitals.

Opposing submissions have included a number of representations relevant to the financial performance of the Applicants generally, as well as relative to other hospitals.

- HCF states that:

  - over the four year period since 1994 the average charge per day paid by HCF to the Applicants has increased by 28.8% for same day patients and 26.7% for overnight patients;

  - religious/charitable hospitals have a tax advantage of 15-20% over for-profit hospitals and should be making at least equivalent surpluses

  - leading for-profit hospitals continue to report increasing turnover and EBIT margins of around 13%;

- Medibank Private states that each of the Applicants receives a disproportionate amount of Medibank Private funding through member benefits and the Applicants have a 10% cost advantage over their direct competitors by virtue of their exemption from taxation.

- MBF state that the Applicants have not suffered from their alleged inability to negotiate and are among the fund's highest paid contracted facilities. MBF goes on to say that ensuring the viability of the private health sector requires all hospitals to compete based on their ability to provide quality and value at an affordable price, not to be subsidised because of their reputation, charitable activities or tax exempt status.

Information submitted to the Commission, including the Applicants' Annual Reviews, suggests that the Applicant's have a long term strategic focus involving substantial levels of capital expenditure:

- The Mater Misericordiae has undertaken development of an intensive care unit, day surgery unit, special care nursery for frail and newborn babies, new angiography suite and chemotherapy cottage.

- St Vincent's Private Hospital Board approved a $15m development to increase theatre capacity and provide additional single rooms. The hospital was also jointly funding a new $150m building to link the public and private hospitals.

- The Sydney Adventist Hospital completed a major expansion and refurbishment program (debt free) and is undertaking construction of a 3 level multi-story car park.

From the Commission's perspective there is no evidence to suggest that a failure to obtain increased reimbursable levels over and above those which could be achieved by the Applicants individually in negotiations would pose a threat to the viability of the Applicants.

Official statistics show that private hospitals as an industry are achieving margins which have diminished slightly over the past six years. Importantly they also show that the industry as a whole is still operating with income running well in advance of recurrent expenditure. More recent figures for for-profit hospitals show reductions in profitability.

The official statistics include figures for patient day costs by type of hospital. These figures show that the not-for-profit hospitals impose charges for services which are substantially ahead of those of the for profit hospitals, with the gap increasing. Such figures are consistent with claims made by health funds that the reimbursements they make to the Applicants for services are generally higher those made to other hospitals.

If the private hospital industry as whole is viable and the Applicants are receiving payments from health funds above the norm, while at the same time enjoying tax exemption advantages over a majority of private hospitals, it would difficult for the Commission to conclude that the increased remibursables sought from collective negotiations are essential to maintain their viability. This view is reinforced by the Applicants' strong capital works programs.

If the operating margins being experienced by the Applicants are low relative to the rest of the industry, despite their obvious advantages, it would be reasonable to question their operational efficiency. To assist the procurement of the increased reimbursables sought through approving the Proposed Arrangement would be to potentially support inefficient behaviour. Any such inefficiency would also raise questions over the extent to which the Applicants are currently subject to competitive pressures and the appropriateness of any move to strengthen their competitive position.

Any examination of the shift in the balance of power would be complicated by the portability rights of health fund members pursuant to the *Health Insurance Act 1973*. Increases in bargaining power to hospitals could disproportionately affect funds because their members can readily change funds to align with the hospitals of their choice. In other words, while the Applicants' Proposed Arrangement is designed to strengthen their negotiating power, it is possible it could also strengthen the market position of those health funds successful in negotiations with the Applicants relative to those funds which do not agree such contracts.

That said, the negotiating power held by the Applicants under the Proposed Arrangement would clearly be in excess of that held by smaller health funds in NSW. This was acknowledged by the Applicants in their submission of 8 March 2000 when offering to limit authorisation to negotiations with health funds with market shares exceeding 15% in the Sydney metropolitan area. The Proposed Arrangement could also be to the disadvantage of smaller hospitals, as submitted by St Luke's, who would be unable to match the negotiating power of the Applicants or achieve the reimbursement levels that they attain.

The Applicants have cited a number of prior Commission decisions in support of their countervailing power arguments. These are examined below.

The Application for Authorisation lodged by *Job Futures Limited (1998) ATPR (Com) 50-561* (Job Futures) involved a proposal by Job Futures to tender with DEETYA for a contract to supply employment services in areas where the members of Job Futures are located. Any work that had been successfully tendered for by Job Futures would be sub-contracted to members. Like the Applicants members of Job Futures were non-profit organisations.

The Application did not involve any arrangement to negotiate on price. The Commission assessed the anti-competitive detriments arising from the arrangement to be low. Furthermore, the members of Job Futures operated at different locations throughout Australia. The current application differs from Job Futures insofar as it involves three substantial businesses operating within close proximity of each other negotiating on reimbursement levels.

The Applicants also referred to the Commission's decision in *Re Motor Traders Association of New South Wales (1983) ATPR (Com) 50-063* (Motor Traders). In this application the Motor Traders Association (MTA) wished to negotiate on behalf of motor body repairers with insurance companies for the purpose of agreeing on hourly rates payable by insurance companies.

This current application can be distinguished from Motor Traders in two respects. In its final determination the Commission noted that motor body repairers are mostly one or two proprietor businesses employing few staff and operating with little or no managerial or bookkeeping assistance. The Applicants, on the other hand are substantial businesses with significant commercial experience and expertise. The Commission also found that prior to the application made by the MTA there was no real bargaining between motor body repairers and insurance companies on the actual hourly rate on which quotations were based. The Commission found that the particular market operates in a way that is not conducive to individual negotiation. In the current application reimbursment levels are the subject of extensive negotiations between the Applicants and the health funds.

As to the comments of the Applicants that they are forced to accept unfavourable contracts and low reimbursement levels, the Commission accepts that health funds are hard negotiators who seek the best possible deal for their customers. If they did not, they would not be able to offer attractively priced packages and would lose business to other funds. The 1995 legislative reforms actively promote such behaviour. There is a difference between hard negotiation and unconscionable conduct. The latter would be a matter of concern for the Commission.

The Queensland decision

The Applicants state in relation to Determination A50019:

> *Even given the most narrow market definition, the market shares of the Applicants are similar to those of the Brisbane hospitals in the Queensland authorisation. The market shares of at least four health funds (or groups of health funds who negotiate as one) in NSW are significant. The Applicants therefore believe that their situation is similar to that in the Queensland authorisation, and that a rectification of the*

imbalance of negotiating power between each individual Applicant and the health funds represents a public benefit.

In the Determination A50019 the Commission expressed the view that:

> *"..... the balance of negotiating power rests with the large health funds (MBF, Medibank Private) in respect of the three regional hospitals but that a more equal position exists in respect of the two Brisbane hospitals, although it is still likely to reside with the large health funds".*

In relation to the two Brisbane private hospitals the Commission said:

> *The dominant health funds in Queensland (MBF and Medibank Private) control substantial volumes of business and no private hospital could reasonably expect to operate profitably without their patronage.*
>
> *The major private hospitals have some countervailing power in that the funds will be expected by their members to contract with the premier private hospitals. If MBF and Medibank Private were not to have contracts with St Andrew's War Memorial and the Wesley hospitals it is possible that they would lose members to funds that do have those hospitals under contract. However the financial consequences of not having a contract are more likely to be felt more immediately by the hospitals than the funds and so the extent of any countervailing power is limited.*

Even if the market shares of the Sydney and Brisbane hospitals were considered to be comparable it is not clear that the Commission's views in Determination A50019 can be used to support the countervailing power benefit claim in the case of the Applicants.

In the first instance while the Commission found a countervailing power benefit for the five Queensland hospitals (two metropolitan and three regional) an important ingredient was the poor negotiating position of the three regional hospitals. There are no equivalent hospitals covered by this application.

Secondly there is more competition on the health fund supply side in the NSW case than there was in the Queensland case. If a NSW fund does not have a contract with the Applicants it could readily lose members to other funds that do have a contract. With two funds dominating in Queensland there is a limited choice of alternate funds. The financial consequences to a hospital of not having a contract with a major fund are also more severe in Queensland than NSW.

Commission conclusion on countervailing power

The Applicants have sought countervailing power through the Proposed Arrangement essentially in order to achieve higher reimbursement levels from health funds. The Applicants maintain that such higher benefit levels are the means of maintaining both quality of service and viability.

The Commission is not convinced that the viability and service quality of the Applicants will be threatened unless they obtain the increases in benefit levels claimed to arise from the Proposed Arrangement. The Applicants are three of the four largest private hospitals in the Sydney metropolitan areas and are described by the NSW Health Department as playing *"a*

major role in the provision of private health care" in that area. Their individual market power is well demonstrated by the high reimbursement levels they already receive from health funds.

The status, reputation and size of the Applicant hospitals, is also evidenced by their disproportionate share of fund benefit payments. For example the Applicants are claimed to account for 40% of NSW private hospital ICU bed days for Medibank Private and 40% of benefits payable by Manchester Unity to comparable private hospitals in metropolitan Sydney. It is likely that a failure by the Applicants to secure a contract with major fund could impact their financial performance. It is also the case that the major funds need the Applicants as contracted hospitals.

Accordingly the Commission does not believe that there is an imbalance of power between the Applicants and health funds or that any changes to the balance of power would result in a benefit to the public. Differences between the health fund markets in NSW and Queensland and between the hospitals covered by the two Applications limit the relevance of the Commission's assessment of countervailing power benefit in Determination A50019 to this application.

Continuation of community services

Claims made by the Applicants

In general, there is an increasing need for community services. Industry statistics show there has been a substantial reduction in the average length of stay by patients in hospital, which has the effect of increasing demand for community based services. Collectively, the Applicants contribute over $5 million per annum towards community services which include a range of charitable, welfare and support services.

The Applicants argue that the Proposed Arrangement will ensure the continued provision of funds for such community services. The Applicants assert that if they are unable to negotiate higher reimbursement levels with the health funds then one or more of them may be forced to close or sell out to a public company. A consequence of such actions would be the cessation of the currently provided community services.

Commission consideration

The opposing submissions have argued that whilst the Applicants are entitled to distribute any surplus arising from their participation in a competitive market as they see fit, it is not appropriate to authorise collective behaviour simply because the Applicants distribute any surplus revenue through community services.

For the Commission there is an issue as to whether the continuation of the provision of community services is a realistic objective and appropriate public benefit associated with the proposed collective negotiation process.

The Applicants compete for patients with for-profit hospitals. Those for-profit hospitals are run as commercial businesses and over their economic life will experience performance fluctuations, making profits in some years and losses in others. The question of how those profits are utilised is a matter for those businesses in their commercial judgement.

The Commission similarly considers that the way not-for-profit hospitals, such as the Applicants, dispose of their "profits" is a matter for their discretion. However the Commission also believes that the financial performance of the not-for-profit hospitals should be subject to the same vagaries of markets as the for-profit hospitals with whom they compete, and accordingly there will be years when profits (and monies available for community services) will be lower. The Commission willingly accepts that there is a public benefit arising from the provision of community services by the Applicants. However, it does not accept that there would be a public benefit for the purpose of this assessment when those services are a product of a collective negotiation process which results in the Applicants being given a means of guaranteeing reimbursements at levels which would ensure they always remain profitable. Such a process distorts the market and gives the Applicants an unfair advantage over not just for-profit hospitals but also other not-for-profit hospitals.

In their response to the Draft Determination the Applicants stated:

> *These community services represent an important public benefit. This is not a public benefit secured by a transfer of wealth from the health funds to the public by means of negotiating reimbursements levels with a built in profit level that will be passed on in the form of community services. They are public benefits secured through the increase in efficiency, cost reductions and balance to negotiating power that will come as a result of the proposed conduct.*

It is the view of the Commission that increased reimbursement levels are the focus of the proposed conduct for which authorisation is sought and a prime contributor to financial outcomes and the financial surpluses from which community services are funded. Statements made by the hospitals in their application tend to support this view.

> *Over the years, the relevant branches of the church have contributed substantial sums of money to keep the Hospitals in a position where they can continue to provide community services. Because of the sums involved, this is no longer possible.*
>
> *While the community services offered by the Hospitals may be considered of a significant public benefit, there may be a question raised as to why the health funds (and other payers) should, in effect, pay for these public benefits by paying higher prices to the Hospitals.*

There appears to be an acknowledgment that traditional sources of funds for community services are drying up and that the Applicants are looking to health fund reimbursements to cover the cost of such services.

Increased efficiency and cost reductions can assist the Applicants to the extent that they contribute to the generation of surpluses, but there is a question as to the extent to which savings from these factors can be attributed to the conduct for which authorisation has been sought.

Commission conclusion on continuation of community services

The Applicants' contribution to community services, as acknowledged earlier, is a genuine and valuable public benefit, but it is derived from the Applicants' operating surpluses. It would be expected accordingly that the amount of funds available from year to year will vary with the trading performance of the hospitals. That said, would the Applicants reasonably

expect the proposed conduct to be able to be justified on the basis of ensuring increased reimbursables to allow a constant stream of funds for community services, regardless of the financial performance and efficiency of their hospitals.

The Commission suggests that if the reimbursement payments received by the Applicants from health funds include a component earmarked for use in community services this should be public knowledge so that all interested parties, including health fund contributors, are aware of this practice.

The Commission accepts that a flow of funding for worthwhile community purposes would cease in the event that the applicants became non-viable and as a result entered bankruptcy or were sold off to commercial interests. However, as stated earlier, the Commission is not convinced the negotiation arrangement for which authorisation has been sought is essential to the Applicants' viability and therefore to the continuation of community services. The Commission therefore concludes that there is no public benefit arising from the proposed conduct in relation to the continuation of community services.

Reduction of burden on public hospitals

Claims made by the Applicants

The Applicants submitted that there is an inherent benefit in the existence of services provided by private hospitals in the NSW health system, noting that in 1997/98 private hospitals provided treatment for 33% of all admissions to Australian hospitals. Ensuring the viability of private hospitals and the maintenance of quality treatment offers direct benefits not only to privately insured patients, but also to public patients. It relieves the burden on the public hospital system and ensures that hospital services are available in areas where, based on pure cost considerations, they might not otherwise be provided.

The Applicants claim that:

> *If due to an inability to negotiate satisfactory contracts with health insurance funds fewer patients are able to be treated by the Hospitals, or, one or more is forced to close, the local public hospitals, which are already stretched to the limit, will be under even greater pressure.*

Commission consideration

In the event that any of Applicants were, for whatever reason, not able to accept private patients, those patients would have the option of seeking treatment in public hospitals (as private or public patients) or in other private hospitals. The Applicants have provided no material or arguments in support of their claim that a significant portion of these patients would choose to enter the public hospital system. The Commission has previously noted (Determination A50019) that there has been a trend for privately insured patients to increasingly seek treatment in private hospitals in recent years.

The indications are that the private hospital market could accommodate patients unable to be accepted by the Applicants. The Applicants have stated at paragraph 22 of their submission of 22 June 1999 that they have a combined 21.7 % share of the Sydney metropolitan area market for relevant hospitals, and 26% of the narrower regional market. They submit that this could hardly be called a dominant market position.

ABS statistics show that private hospitals in NSW experienced bed occupancy rates of 64% in 1997/98. Private hospitals in the Sydney metropolitan area account for around 3,300 beds which constitutes around two thirds of all private hospital beds n NSW. The applicants in total have 744 beds.

The Applicants have stated that Federal Government health policy encourages the public to use the private health system. That said, it would be expected that public health authorities would respond to claims made by the Applicants that an inability to negotiate collectively would impinge substantially on public hospitals to their [implied] detriment. The only such authority which made a submission was NSW Health. The Director General of NSW Health stated in relation to this claim that:

> *I would also have difficulty in accepting that there is an automatic connection between the hospitals concerned achieving a higher reimbursement rate from the health insurance funds and a direct benefit to the public hospital system. While for some types of hospital services the private hospitals are substitutes for public hospitals, the general trend is that an increase in activity in the private hospital system in NSW does not reduce the demand on the public hospital system.*

NSW Health also says privately insured patients can make an effective contribution to the public health system.

> *I would also point out that contrary to the impression that you might have gained from the submission, the continued decline in the level of coverage of private health insurance has significantly reduced the revenue to the NSW public hospital system. Since 1990/91 the number of chargeable bed days in the NSW public hospital system has fallen by over 800,000. This has led to a reduction in revenue of over $170M over this period.*

The Commission has previously expressed the view in its consideration of community service benefits above that an inability to collectively negotiate would not threaten the viability of the Applicants.

Commission conclusion on reduction of burden on public hospitals

The Commission is not persuaded that privately insured patients who, for any reason, were not able to be accepted for treatment by the Applicants would necessarily seek treatment in the public hospital system. Nor is there any evidence to suggest that if any such patients did as a consequence choose to enter the public hospital system, as either private or public patients, that there would be a detriment to the public health system. A submission from NSW Health suggests that if those patients enter as insured, rather than uninsured, patients then there would be a revenue benefit to the public hospital system.

Accordingly, regardless of whether or not an inability by the Applicants to collectively negotiate with health insurance funds would result in patients being unable to be treated by the Applicants, the Commission cannot conclude that the proposed conduct would result in a public benefit associated with a reduction of burden on public hospitals.

An increased burden on public hospitals is more likely to come from the proposed conduct should it result in increases in private insurance premiums and deter the public from taking out private insurance.

The Applicants made no comment on the Commission's views on this claimed public benefit as they appeared in the Draft Determination.

Reduction in contract negotiation costs

Claims made by the Applicants

The Applicants claim that collectively, they spend almost $1 million per annum on contract negotiations. This amount includes expenditure on data collection and analysis, changing computer systems, monitoring and reporting on contract compliance and obtaining legal advice and expert negotiating advice. The Applicants submit that much of this expenditure would be saved through the proposed negotiation arrangement.

Commission consideration

The opposing submissions challenged the level of savings which would be achieved through the originally proposed negotiation arrangements suggesting it would be minimal. It was also observed that three separate HPPA's would have to be negotiated with each fund. It was suggested furthermore that negotiation through a third party could raise the potential for misunderstandings which would add to the costs of negotiation.

No details of the specific savings that could be achieved through collective negotiation were provided to the Commission in the Applicants' application or their submission of 17 June 1999. While cost savings amounting to $2.7 million were identified in the Applicants' submissions of 27 June 1999 and 21 January 2000 these included savings both from negotiations and from a rationalisation of other activities including ancillary services and conduct for which authorisation had not been sought.

The Applicants accept that the modification to their authorisation application means that the level of savings may differ from the original estimate, since after the initial meeting negotiations will be held on an individual basis.

Commission conclusion on reduction in contract negotiations costs

The Commission notes that given the total costs of negotiation for the Applicants is estimated at only $1 million any savings will be minor in the context of the overall operating costs of the Applicants, even before the costs of engaging a lead negotiator are taken into account.

The Commission is of the view that the use of a common agent may produce some minor efficiency gains for the Applicants.

Accordingly, while the Commission is able to conclude that there is a public benefit arising from reductions in negotiation costs associated with the Proposed Arrangement, it would be relatively minor.

Other cost savings

Claims made by the Applicants

The Applicants put forward that the proposed arrangement may result in other cost savings being achieved, including from:

- common administrative procedures;
- group purchasing;
- common or compatible computer systems;
- common linen service;
- rationalisation of some medical services; and
- access to capital.

In a submission dated 21 January 2000 the Applicants stated they had estimated that savings of around $2.7 million could be made in the areas of software development and purchasing, purchasing generally, contract administration, EDI initiatives, simplified billing initiatives, negotiations with rehabilitation/aged care providers, implementation of best practice processes and health fund negotiations.

In a later submission the Applicants state that the likely cost savings to be gained from these other areas of collaboration will not be affected by amendments to their Application and will not be realised if the Application is rejected.

Commission consideration

The Applicants have stated in their application, when claiming reductions in cost to hospitals as a public benefit, that *"if this Application is approved, other major savings may be achievable"* in the areas identified above.

As stated earlier, and in its Draft Determination, it is the Commission's view that the Applicants were not by this comment seeking authorisation of such activities but were observing that if the Commission authorised joint negotiations with health funds then they perceived that they would be able to act together for other purposes. The Applicants have not responded to this view.

Most of the savings identified above would accrue from activities not associated with the negotiating conduct for which Authorisation was sought. The Applicants state in their application, for example:

> *The purpose of the Hospitals in seeking this authorisation is to allow them to coordinate their activities in relation to discussions and negotiations with health insurance funds regarding contract terms and conditions and reimbursement levels for health fund members.*

Under these circumstances the Commissions could hardly conclude that costs savings arising from negotiations with aged care providers, for example, should be regarded as a public benefit arising from the conduct for which authorisation was sought.

The logic of the Applicants appears to be that if the proposed behaviour with health funds is approved, than any less anti-competitive behaviour (in their view) would also be allowable.

The only reference to such activities in the IHA comes in the Preamble which contains a statement that *"the Hospitals wish to deal with those* [escalating cost] *difficulties through:*

- *The wider dissemination of cost reduction strategies;*
- *The benchmarking of revenues and costs;*

- *The development of greater efficiencies in the delivery of services;*
- *Improved contracting processes that will produce more efficient outcomes".*

This reference appears to be more a statement of a framework into which the proposed health fund negotiations arrangements (the focus of the IHA) fall, rather than a schedule of specific activities for which authorisation may be sought.

Some of the nominated activities, such as joint purchasing, may not require Commission endorsement. On the other hand other activities, eg rationalisation of medical services and common computer systems, to the extent that they touch upon other health markets or result in more detailed information sharing could require closer examination by the Commission. Yet other activities involve negotiations with parties other than health funds. Authorisation of the proposed conduct could not be assumed to extend to any of these activities.

Commission conclusion on other cost savings

The Commission does not consider that any potential cost savings from the above activities can be recognised as public benefits arising from the Proposed Arrangement for which authorisation has been sought.

Exchange of information

Claims made by the Applicants

In their submission of 21 January 2000 the Applicants for the first time claimed a specific public benefit from the exchange of information. The Applicants stated:

> *In addition to the enhanced bargaining position that the exchange of information would provide, the greater dissemination of information would allow each Applicant to benchmark their operations against an average standard, and thus identify areas of operation in which improvement is necessary or possible. This would enable comparisons in areas such as employee remuneration, 'hotel service' costs, cost of medical equipment and supplies, information technology costs, and the competitive pricing of hospital services provided by each applicant. The information will occur via an agent, in accordance with the "messenger model".*

The Applicants did not propose this broad information sharing in the original conduct for which they sought authorisation. It was first mentioned in a submission made to the Commission on 27 June 1999 on its second draft determination on the Queensland Hospitals application for authorisation No A50019 when commenting on public benefits.

The Applicants stated that an important aspect of the sharing of information would be the ability of the Applicants to act together for other purposes, eg development of joint purchasing, joint computer and administration systems, and joint payment models.

The IHA submitted on 21 January 2000 included provisions for:

> *4.2.6 facilitating the collection of necessary information by the appointed agents to enable the sharing of average fee related information by the hospitals;*

4.2.7 facilitating the collection of non-fee related information and the provision of that information by the agent to Funds;

Commission consideration

From the Commission's perspective there was no explicit request for the sharing of information between the hospitals to be covered by the authorisation application. However, to the extent that the proposed conduct involved the Applicants acting together in their discussions and negotiations with health insurance funds regarding reimbursement levels, contract terms and conditions the Commission accepts that it was implicit that information sharing relative to the negotiations would invariably have occurred.

When the Applicants advised a modification to their conduct on 21 January 2000, it was therefore necessary to specifically provide for information sharing, which they did. The Applicants proposed that:

> *No information related to any proposal for benefit level increases by individual hospitals will be shared.*
>
> *Current benefit level information will be shared. The common agent will collect and collate such information and provide members with averages across all members.*

These intentions were reflected in the provisions of the IHA referred to above. There was however no specific provisions in the IHA for the sharing of non –fee information between hospitals outside of the negotiation process. The only reference was in the broad framework statement in the preamble to the IHA which included as an objective "the benchmarking of revenues and costs".

It appears to the Commission that the exchange of *non-fee information* has not been included in the conduct for which authorisation has been sought and therefore any benefits accruing from such exchanges could hardly be considered as offsetting benefits of that conduct

Even if the *non-fee information* exchanges had been included in the specified conduct, there is a question as to whether such benefits could be obtained independent of the negotiation process. This view is consistent with the Commission's findings in Determination A50019.

> *The Commission is of the view that because it is likely any efficiency gains that may result from the exchange of non-fee information could be achieved without authorisation, the benefits claimed to arise from such activity need to be discounted from the Commission's consideration.*

In regard to the exchange of fee information the Commission agrees that access to price information can result in more informed decision making and increased efficiency. The Commission also notes the that the US Federal Trade Commission and Department of Justice stated in relation to the "messenger model" that:

> *Without appropriate safeguards , however, information exchanges among competitive providers may facilitate collusion or otherwise reduce competition on prices or compensation, resulting in increased prices, or reduced quality and availability of health care services.....*

The conduct considered by the Commission in Determination A50019 included safeguards such as:

- at least 5 hospitals reporting data upon which each disseminated statistic was based;
- no individual hospital's data would represent more than 30% on a weighted basis of that statistic; and
- Information disseminated will be sufficiently aggregated such that it would not allow Network members to identify the prices charged by any individual hospital.

There are no similar safeguard provisions in the IHA forwarded by the Applicants. The potential for inadvertent release of individual hospital data is also greater when there are only three hospitals in the survey, compared to the five in Queensland.

Opposing submissions have suggested that alternative fee information is available from a range of other sources. Particular mention has been made of improved systems for accessing the Hospital Casemix Protocol (HCP) data held by the Commonwealth Department of Health and Aged Care which became available late in 1999. A submission from the Department describes these improvements.

The Department has developed a statistical and benchmarking reporting package which has been distributed at no cost to all private hospitals and health funds, together with instructions for its use. The package allows a hospital or health fund to prepare customised statistical reports down to DRG or CMBS item level enabling it to compare itself with others in its State, or nationally, for a rang of measures including:

- average length of stay
- average hospital charge
- average accommodation charge
- average bed day charge
- average theatre charge
- average total, hospital and medical gaps.

The Department notes that data is available in a timely fashion, around nine months after the end of a financial year to which it relates, and the package can be modified to allow analysis based on hospital size.

On face value this new package, which postdates the Hospitals' authorisation application, would appear to provide an extremely useful tool for fee benchmarking purposes. Certainly only benefits from information available from the Applicants proposed fee information exchange over and above that available from the HCP data base should be considered by the Commission for the purpose of authorisation application.

In Determination A50019 the Commission, while concluding that the exchange of fee related information could not occur without authorisation, considered that any resultant public benefit was "*relatively minor*". Estimated savings were a factor in this assessment. On the basis of estimates provide to the Commission by the Applicants, and given the comprehensiveness of alternative data available it would also be difficult for the Commission to conclude that the benefits in this case were more than minor.

Commission conclusion on exchange of information

The Commission concludes that there is no non-fee information exchange benefit associated with the Proposed Arrangement and a minor benefit from the exchange of fee information.

8.2. Conclusion on public benefits

In their application the Applicants identified various public benefits deriving from the Proposed Arrangement for negotiating with health insurance funds. After an examination of the claims of both the Applicants and other parties, the Commission recognises minor benefits associated with savings on negotiation costs and the exchange of fee information. The Commission does not recognise benefits claimed to arise in the form of countervailing power, community services, reduction in burdens in public hospitals, other cost savings and the exchange of non-fee information.

9. Commission assessment – whether public benefits outweigh anti- competitive effects

The Commission is of the view that the Proposed Arrangement for negotiation with health funds would be likely to lead to a lessening of competition in the hospital – patient market which would be reflected in higher increases in reimbursements than would otherwise be achieved and potential reductions in services by other private hospitals.

The Commission also believes that the Proposed Arrangement would result in an anti-competitive detriment in the private hospital - health insurance market through the impact of agreements on prices and through increases in prices. The detriment would be reflected in increased costs to health funds, potentially impacting on premiums and membership, and the easing of pressure on the Applicant to improve the quality and efficiency of services.

The Proposed Arrangement could also give rise to a detriment in the health fund - patient market through reduced competition between the funds on premiums for services provided by the Applicants. Health funds could also be affected if price increases result in premiums being increased to the extent that membership levels are impacted

The Commission has identified some public benefits arising from the Proposed Arrangement but these are only relatively minor. Accordingly the Commission has reached the view that the public benefits arising from the Proposed Arrangement are unlikely to outweigh its anti-competitive effects.

10. Determination

The Commission concludes that the Proposed Arrangement will not result, or be likely to result, in a benefit to the public which will outweigh its anti-competitive effects. For the reasons outlined above, the Commission does not intend to authorise the conduct.

This determination is made on 28 June 2000. If no application for review of this determination is made to the Australian Competition Tribunal in accordance with s.101 of the Act, this determination will come into force on 19 July 2000.

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

(a) on the day on which the Tribunal makes a determination on the review; or

(b) where the application for review is withdrawn – on the day on which the application is withdrawn.

ATTACHMENT A

MINUTES OF PRE-DECISION CONFERENCE

A pre-decision conference in relation to ACCC Draft Determination No. A90679 of 3 December 1999, responding to an application from the Mater Misericordiae, St Vincent and Sydney Adventist Private Hospitals for authorisation of an Inter-Hospital Agreement, was requested by the Applicants.

The pre-decision conference was convened at 3.40pm on 10 January 2000 and was immediately adjourned until 9.00am 24 February 2000.

The conference commenced at 9:05am on Thursday, 24 February 2000 at the Corinthian Room, the Masonic Centre, 279 Castlereagh Street, Sydney.

Attendees

Chair: Commissioner Sitesh Bhojani

ACCC Staff:

John O'Neill - General Manager, Adjudication
Greg Outzen - Director, Adjudication
Bronwyn Gallacher - Graduate Administrative Assistant
Cecily Wills - Administrative Officer

Applicants:

Greg Herring - Herring Health & Management Services (Herring)
David Brewster - Arthur Robinson & Hedderwicks
Rex Goldring - Sydney Adventist Hospital
Steven Rubic - St Vincent's Private Hospital (St Vincents)
Alice Killen - Mater Misericordiae Private Hospital

Interested parties:

David Adler - Prime Health Management (Prime)
John Tucker - Private Hospitals Association of NSW (PHANSW)
Rosemary Townsend - Australian Private Hospital Association (APHA)
Perry Sperling - Commonwealth Department of Health & Aged Care (DHAC)
George Toemoe - St Luke's Hospital Complex (St Luke's)
Paul Collins, - Private Health Insurance Administrative Council (PHIAC)
Frances Cunningham - NSW Health Funds Association (NSWHFA)
Lynn McDonald-Duke - Australian Health Service Alliance (AHSA)
Margaret Chibinall - Manchester Unity (MU)
Marc Mowbray-d'Arbela - Department of Veterans Affairs (DVA
Lisa Halliday - Medibank Private (Medibank)
John Masters - Medibank Private (Medibank)
Alan Skeates - Medibank Private (Medibank)

David Cooper - Medibank Private (Medibank)
Ian Stone - NRMA Health (NRMA)
Russell Schneider - Australian Health Insurance Association (AHIA)
James Morley - Australian Medical Association NSW (AMA)
Alan Kinkade - HCF
Susan Hamilton - HCF
Suellen Moore - MBF
Yvonne Mott - MBF
Chris Bertinshaw - CBHS Friendly Society (CBHS)
Angus Norris - AXA Health Insurance (AXA)
Gerry Carton - AXA Health Insurance (AXA)
Dina Gounis - NIB Health Funds (NIB)
Laurel Mitchell - NIB Health Funds (NIB)

The Chairman welcomed the attending parties to the pre-decision conference and advised the general procedures to be followed.

CBHS suggested the applicants should submit a new application for authorisation to the Commission, since the amendments to the original application were major changes. The Chairman asked the applicants if they were amending their application. The applicants confirmed this was the case and the **Chairman** advised attending parties that it was the amended application that was being addressed at the pre-decision conference. The **Chairman** stated that he did not consider it necessary to submit a new application for authorisation and called upon the applicants to discuss the proposed amendments to their application.

Herring described the changes to the applicants' proposed conduct, namely:

- collective boycotts would not be allowed as part of the negotiation process between the NSW private hospitals and the health funds;
- the only meeting at which all the hospitals and their common agent would be present was an initial meeting aimed at briefing the funds on the hospitals' objectives in relation to terms and conditions; and
- the applicants would refrain from discussing sought pricing changes between themselves during the negotiation process.

The applicants considered that the major issue in the case was price fixing, with the Commission concluding that it would occur. The major differences between the conduct authorised for the Queensland hospitals and that proposed by the applicants were assurances against boycotting and separate as against joint negotiation.

For the conduct for which approval was sought to constitute price fixing, there must be an arrangement of some sort between the applicants. They were not in agreement on prices. They were not in competition with each other. There were no price fixing provisions in the Inter Hospitals Agreement (IHA). The applicants did not set prices but sought changes within their price contracts. There were different outcomes for different hospitals. If the end result was fixed by the funds how could it be influenced by the hospitals. The IHA excluded boycotts against funds. There could be no assumption of price fixing, control or maintenance. The applicants were prepared to modify their IHA to remove any chance of price fixing being seen to occur and had amended the IHA for this purpose.

The applicants considered there were inconsistencies between the Commission's assessments of the Queensland hospitals' application and that of the Sydney hospitals. In the Queensland case the Commission did not question the Applicants' estimates of savings which would be derived from the proposed behaviour. In this case the Commission has questioned the level of savings and how they would be passed on. The Commission has also ignored the countervailing power benefit and the take it or leave it approach of health funds.

The applicants have tried to show that the hospitals must have a contract with all major health funds. The converse is not true for health funds. The funds can cause extensive delays in negotiations, which are costly for hospitals, by changing payment structures and offering decreases in funding. For example two of the applicants have been dealing with MBF for 18 to 20 months trying to renegotiate an HPPA. Increases in benefits obtained are generally less than the increased unavoidable costs of running a hospital. Hospitals are price takers not setters. There should be a further examination of relative power by the Commission.

In the Queensland case the Commission considered that private and public hospitals competed with one another. A different view was expressed in the current case. If public hospitals are substitutable for private in Queensland, then they are even more so in NSW based on admission figures.

The Queensland hospitals had less than 11% of the combined public and private acute hospitals beds in Brisbane. The equivalent figure for the applicants in Sydney is less than 5.8%. The Commission has arbitrarily reduced the relevant geographic market from the Sydney metropolitan area to three health areas. Even after removing public hospitals and reducing the geographic area the applicants still only have 28% of private acute beds in the ACCC defined area compared to the equivalent 26% for the Queensland hospitals in the Brisbane metropolitan area.

The applicants are not competing with one another. They are in separate markets and derive their patients from different suburbs in Sydney, as indicated by lack of overlap between patient postcodes. They also do not share doctors. The GP's influence is less than that stated by the Commission. A GP does not often refer a patient to a hospital but rather to a specialist. It is the specialist who decides which hospital the patient will be admitted too. A doctor will suggest a hospital for a patient to attend based upon a fellow doctor's accreditation, not upon what hospital he or she works for. The applicants only compete with other local public and private hospitals and not with one another.

Herring then addressed the Commission's view of a cost plus mentality by the applicants. The hospitals' gross margins in NSW were estimated by the Commission to be 9.2%. This low figure indicates either that the funds exert an influence over the hospitals' prices to force down profits or merely that the hospitals are unprofitable. The increases sought by hospitals in the latest year do not reflect increases in costs of the order of 14.5%. Actual increases obtained from funds were in the order of 1% to 2%. The applicants have improved their efficiency as evidenced by reduced length of hospital stays. They only seek to increase reimbursement levels for unavoidable costs. It is true that the applicants receive higher reimbursements than other hospitals but this only reflects that they are tertiary, high technology hospitals.

The applicants submit that the authorisation will give the hospitals an opportunity to increase their overall efficiency. It will also help them address increasing costs in the form of administration and information technology overheads, which are involved in the negotiation process with health funds.

Medibank (Masters) questioned Herring's entitlement to speak on behalf of the applicants, citing s90 and 90A of the *Trade Practices Act.* **The Chairman** ruled in the exercise of his discretion that Herring was allowed to speak at the conference as he represented the applicants and asked the applicants if any of them wished to add to Herring's submission.

St Vincents affirmed Herring's concerns that hospital administration costs were significantly increasing due to the costs associated with the many different models of payment imposed by the health funds. This position is not helped by the funds having five or six different types of contracts, and there is extensive debate on the need for common standards.

CBHS repeated that the applicants should make a fresh application to the Commission. Concern was raised that the authorisation process was being manipulated, as the amendments aimed at preventing price fixing arrangements were major modifications. Interested parties had not had adequate time to consider these amendments, as copies of the submission were only made available today.

The Chairman considered that a new Draft Determination was unnecessary and would represent an overly bureaucratic approach. The applicant's amended submission minimised costs for all attendees. CBHS was also advised that all interested parties had been sent copies of the amendments. If CBHS had not received a copy, the Commission could grant an extension of time for CBHS to respond to material. The Chairman asked attendees to respond in turn to Herring's submission.

Prime supported the application and the proposed amendments. An examination had been undertaken of costs at the (now defunct) Kensington Private Hospital. Administrative costs associated with a Hospital Purchaser Provider Agreement (HPPA) involved areas such as information technology, hardware and software, payment structures of the HPPA, record keeping practices, certification and the time of nurses and staff. These costs amounted to 3% of the hospital's gross revenue. Prime advocated that hospitals were getting together on HPPA. A Senate Committee Inquiry into the health industry had recognised the benefits of such alliances.

St Luke's opposed the application. The applicants had glossed over smaller hospitals competing in the same market. 40% of post codes for the applicants were for patients from the South East Sydney area where St Luke's operated. It was unlikely any fund would walk away from the applicant hospitals. St Luke's has cut costs without compromising quality or risk of service and should not be disadvantaged. If the applicants get price increases, smaller hospitals will get quid pro quo cuts, which will threaten their viability and lead to a lessening of competition.

NSWHFA reaffirmed its original submission. The implications of the revised IHA could not be fully considered until full details were available about the new measures.

AHSA noted that the applicants are substantial stand-alone entities and have a market share larger than other hospitals in the market. Funds cannot walk away from any of the applicants.

Smaller health funds would be substantially disadvantaged by the proposed IHA as the Applicants would have an unfair advantage if conjoined in the bargaining process.

DVA buys health services but was not affected by the Commission's decision. DVA was worried about the potential for a conflict of interest by the agent. Would the agent be effectively monitored to ensure that confidential information is not revealed to other parties. The agent's conduct and confidentiality were issues that needed to be addressed by the IHA. The role of the agent is critical. What is the obligation of the agent to pass information on to the applicants. How would parties ensure the agent did not act anti-competitively.

Medibank (Cooper) questioned whether any public benefits existed. If there were none, the application was difficult to approve. Medibank endorsed the draft determination. There were significant detriments to heath funds and their members from increases in reimbursables and the public benefit does not outweigh the detriment. The key question is whether there is a reduction in price competition. If price increases are not the effect of the IHA what is it trying to achieve. Health funds and private hospitals operate in a market where there are very few price signals. Negotiations constitute one of the few areas of such activity. Any joint process will undermine that activity.

Medibank (Masters) noted that s.45 of the Act looks at arrangements not just contracts. It is therefore relevant to look at the IHA in terms of the arrangement with the agent. There is nothing in the IHA to ensure that it is effectively monitored and enforced. The disclosure of average prices by the agent to the hospitals would effectively eliminate the lowest price paid by the health funds to one of the three hospitals.

The applicants' latest submission states at (a) on page 4 that because no hospital would be discussing its individual pricing requirements at the initial meeting, the other hospitals would be unaware of those requirements. However the agent, who represents all the hospitals in the negotiations will be aware of their individual pricing requirements. Medibank is very sceptical of any suggestion that the IHA provides for individual negotiations. The applicants either in the IHA or in Herring's submission to the conference have not raised the issue of "Chinese walls" on the agent's part. The substance of the IHA, if not the form, is that it will eliminate individual negotiations on the part of the hospitals. There were opportunities for the hospitals to engage in boycott tactics, despite the existence of the anti-boycott clause in the IHA.

NRMA said the market is competitive and questioned the need for collective action. The latest submission does not lead to any change in the position of the application. The objective is still for higher benefits, which will flow on to premiums. The applicants will be involved in collective behaviour, which would inevitably lead to price fixing, if it did not they would not apply for authorisation.

The public benefits are at best unclear. Efficiency gains have not been defined. Any cost savings are minor. It is wrong to suggest that health funds have market power in NSW. Five health funds compete to gain hospital agreements. NRMA (previously SGIO) has only 18% of the market which is less than that of the three applicants. The IHA would lead to market imbalance. There is a mutuality of interest between private hospitals and health funds. A health fund, which does not have one of the hospitals on its agreement list, risks losing members with fund membership portability.

The private hospitals say that adjusting bargaining power will assist them to obtain higher benefit levels to meet unavoidable costs. It is the health funds' view that not all costs are unavoidable. Competitive market forces should determine which services are provided by hospitals. The applicants should not rely on the Queensland hospital authorisation to further their application. There is a different market in health funds in Queensland.

The three Sydney hospitals assert that they do not compete against each other. If this is the case then the relevant geographic markets are much smaller than the whole of NSW or the Sydney metropolitan area.

Morning Tea Break (20 minutes)

AHIA said that hospitals compete with hospitals not with health funds. The application strengthens the position of the three hospitals to compete with other hospitals. The applicants have referred to costs associated with IT. IT should be viewed as an investment, rather than a cost, which leads to better management practices. Common payment systems are being developed with Commonwealth support. Consumer interests would be served best if price information were available in the public arena and not just between the three hospitals.

HCF (Kinkade) supported the ACCC draft determination and did not believe the applicants' latest submission changed the position. The applicants currently receive the highest benefit levels and the IHA will lead to even higher levels. The new proposal still amounts to price fixing – the applicants are still discussing current benefit levels and terms and conditions and using a sole agent. It is believed that there would be a negative impact on small hospitals and little public benefit.

Current negotiation costs are stated to be $1m. Even if joint negotiation gave a 50% saving the costs savings would only be $0.5m, on a revenue base of $250m. Even these saving would disappear under the amended conduct. There is uncertainty about just what efficiency benefits would accrue or why the proposed conduct is necessary.

The need for countervailing power is not proven. If the applicants already contract the highest benefit levels with health funds why do they need countervailing power. Increased power would increase health fund costs and impact on other hospitals or premiums. There would be less choice for consumers if inefficient hospitals put efficient hospitals out of business.

Profitability is a function of price and cost. The applicants have the highest prices and occupancies. Therefore if profitability is an issue for them their cost structures must be assessed. These are not publicly available. On the basis of the limited data available the applicants cost structures are higher than for other not for profit and for profit private hospitals.

There is ample benchmarking information available publicly for the applicants to assess relative efficiency without the need for behaviour requiring authorisation. There have been developments in data availability since the initial application was lodged there has been industry developments in the areas of contract standardisation, agreed minimal data sets and a joint expression of interest to improve the industry's billing and payment systems. These recent developments need to be taken into consideration in that they address some of the issues the applicants have identified in their application.

Any attempt to build a 'Chinese wall' between the hospitals and the common agent for the purposes of negotiations would be ineffective.

MBF stood by their original submission. The use of external consultants would contribute to delays in negotiations. Their time is not fully dedicated to the negotiating process. The applicants should view information technology as an investment and not a cost.

CBHS said the applicants' aim was to seek approval for illegal conduct. [The **Chairman** responded that the legality of the proposed conduct was not an issue. That was a matter for the courts to determine, if necessary]. The IHA would decrease competition and public benefits would not result when viewed from the perspective of the community at large.

AXA (Norris) considered that substantive elements of the application were the collective bargaining and anti-boycott provisions. Any hospitals can discuss benchmarking, share information, etc. The essence of the conduct is to achieve higher benefits. AXA could not walk away from the three Sydney hospitals concerned without significant risk. Since AXA has limited funds for health spending, the IHA would leave it with no choice but to divert funds from small hospitals, such as St Luke's. All hospitals want to make reasonable profits. There are not enough people insured for this to occur.

Nothing in the application relates to efficiency. Increases in benefits should relate to efficiency and not the size of a hospital or how sick its patients are. Case complexity can be an issue but can be benchmarked. That said, AXA does not have the market power to walk away from major providers.

NIB did not support the application in the absence of a demonstrable public benefit. The changes proposed to the conduct do not dispel the potential for price fixing. NIB would not be able to bear the burden of increased prices.

PHANSW referred to the letter it provided to the Commission that day, which supported the application, based on the imbalance of power between the hospitals and the health funds and health funds' inability to recognise hospitals' cost structures. A shortage of nurses and a strong nurses' industry association had resulted in substantial wage increases in recent years. Wages constitute 60% of a hospital's expenditure. The Premier has announced a 16% wage increase over the next three years for nurses in the public sector. This would flow on to private hospitals. How was such an unavoidable cost to be accommodated. The cost savings from the IHA would balance out the recent cost increases to the hospital industry, in the form of increased wages and more expensive surgical supplies and equipment. There was a real prospect of a collapse of the private hospital sector otherwise.

Herring noted that the role and duties of the common agent are discussed on page 4 of the latest submission. The normal ethical duties of a party in this position would attach to the common agent and the position was no different to say a solicitor in a small town. AXA's comment about diverting funds from smaller hospitals was demonstrative of health funds' attitude of non–negotiation, especially coming from a fund with only 3% of the NSW market. The **Chairman** asked if every fund had greater power than the Applicants. **Herring** replied 'no". He went on to say that the conduct of some funds was fair and reasonable.

AXA (Norris) stressed that since the health funds have a limited capacity to pay, they would have only two choices if the IHA were to be approved, to increase premiums, or divert funds from smaller hospitals to the applicants.

AHSA commented that if the new conduct gave no joint power what is the benefit to the applicants from it? **Herring** agreed that some postulated savings were lessened and that some activities proposed did not require authorisation. The problem was that whenever the applicants sat down to discuss prices etc. the spectre of *The Act* was raised. The position would not be as satisfactory with the more limited conduct, but it would at least allow the hospitals to sit down together to discuss a range of issues.

AHSA said that if they knew what other health funds were paying hospitals, its negotiation position would be strengthened, for example knowing when to stand firm rather than to waiver. The common agent's position could be likened to this.

Medibank (Masters) queried whether the applicants agreed with the letter from **PHANSW. Herring** confirmed that the applicants' representatives do agree with the letter, with one of the applicants providing the President of **PHANSW** and the other two being on the Board. **Medibank (Masters)** noted that the **PHANSW** letter stated that the aim of the applicants' conduct was to achieve higher reimbursement levels.

NRMA challenged the **PHANSW** comment that the private hospital sector would collapse under the burden of increased costs. The hospitals seem to be saying that hospitals only fail because of health funds. Often they fail because of poor management. The letter suggests health funds are either stupid or suicidal. Health funds would not survive without the hospitals.

HCF (Kinkade) noted that the applicants, while admitting that public benefit savings had been reduced had not quantified them. The **Chairman** asked **Herring** to articulate the changes to public benefit arising from the new conduct in a submission.
The Chairman asked **Herring** if countervailing power benefits were still being claimed given joint negotiations were no longer being conducted. **Herring** said he would come back to the Commission on this matter.

HCF (Kinkade) questioned the extent of the impact of wage increases cited by PHANSW, given the 16% wage increase at issue applied only to public hospitals. PHANSW replied that the increase was a 90% reality since the nurses' association had already lodged a claim. HCF stated that the increase did not apply to the private health system yet and there was an industrial relations dimension to be handled. A 16% increase was not necessarily unavoidable. PHANSW said the flow-on effect to the private sector was unquestionable, not just for nurses but for other workers as well. HCF considered that a public sector award increase of 16% may not totally flow on to the private hospital system. The extent of any flow on would be subject to many variables including:

- whether the same increase was granted to the workers in the private hospital industry;
- whether private hospital management took any steps to address their staffing profile and levels which may reduce the impact of the flow on; and
- whether there were any other efficiency savings, capital or technological investments that private hospital management could introduce to reduce the impact of the potential award increase.

AXA (Norris) asked the applicants what the initial meeting, the only all party meeting, would address. **St Vincents** responded that the applicants would come back to the Commission with these details.

AHIA asked whether it was an aim of PHANSW to achieve viability for all private hospitals. PHANSW replied that rationalisation was inevitable.

DHAC asked AXA (Norris) if it was inevitable that smaller hospitals would have to be satisfied with 2nd tier benefits. AXA replied that there is no set strategy to "get little hospitals". AXA considered that some little hospitals were very efficient and some big hospitals very inefficient. That aside, there were hospitals that had risk management relevance to AXA in terms of market power. The concept of every health fund offering 100% coverage at every hospital was not sustainable.

CBHS noted that closed funds want to contract with as many hospitals as possible.

AHIA stated that increased leverage for the applicants would result in either increased premiums or less money for other hospitals.

HCF (Kinkade) said quality and choice is the main aim of health funds. If the authorisation occurred it would lead to higher price benchmarks resulting in higher premiums and/or smaller hospitals losing business. A reduction in health fund membership as a result of premium increases would in turn increase the burden on the public health system. The 0.015% increase in premiums estimated by the applicants was out by 100 fold, as will be addressed in the HCF submission.

Medibank (Skeates) raised the question of why specialists do not compete with one another across the three Sydney hospitals. Medibank also said that in terms of the negotiations it was not a question of who conducts the negotiations, it is what information the negotiator has that is important.

HCF (Kinkade) stated it was inconsistent for the applicants to say that they can obtain different (higher) prices because they offer different services and yet at the same time claim they compete with one another. Herring pointed to factors such as tertiary facilities, stand-by capacity, accident and emergency, on call specialists and specialised equipment. HCF claimed that only one of the hospitals has accident and emergency facilities.

DVA asked to what extent the Commission would stand by the Queensland hospitals decisions. The **Chairman** replied that the Commission would be consistent on points of principle. The relevance of the facts of each case may differ however.

The Chairman asked MBF whether they would tender on set criteria to meet their needs. **MBF (Moore)** advised that MBF would be tendering for services on set criteria and purchasing as much as is necessary to service its members.

NSWHFA expressed concern that there was no ACCC appraisal of the applicants' amended conduct available.

Herring stated that whether the hospitals' market power is 28% or 6%, their power is insignificant compared to the power of the health funds. One health fund had dropped the biggest hospital in one State. **AXA (Norris)** commented that AXA was the health fund concerned and it had been a brave decision. This was not to say AXA could not drop one of the three applicant hospitals, but to do so would be detrimental to its members.

The Chairman adjourned the conference at 12.40pm to a date to be fixed. He advised the participants that the Commission would distribute the minutes of the conference as well as further details on behalf of the applicants on the nature and extent of the claimed public benefits in the light of the amended application. The ACCC would notify the parties by letter of a suitable time frame in which they could make responses to the draft determination, the amended application or issues arising in the pre-decision conference. A decision would be made whether there was a need to reconvene the conference in the light of further submissions from the applicants and interested parties.

INTER HOSPITAL AGREEMENT

BETWEEN

ST VINCENT'S PRIVATE HOSPITAL, DARLINGHURST

MATER MISERICORDIAE PRIVATE HOSPITAL, CROWS NEST

THE SYDNEY ADVENTIST PRIVATE HOSPITAL, WAHROONGA

("the Hospitals")

PREAMBLE

A. Each of the Hospitals is a religious hospital, which provides a wide range of hospital and ancillary health care services;

B. From time to time, each of the Hospitals requires to enter into contracts with Health Benefits Organisations ("Funds") to provide services to Fund Members at agreed rates of contribution from the Funds ("Purchaser Provider Contracts");

C. The Hospitals recognise that the cost of providing hospital and ancillary health care services in the private sector has continued to rise. This has meant that it has become increasingly difficult to maintain and improve the quality and scope of hospital and ancillary health care services.

D. The Hospitals wish to deal with those difficulties through -

- the wider dissemination of cost reduction strategies;
- the benchmarking of revenues and costs;
- the development of greater efficiencies in the delivery of services;
- improved contracting processes that will produce more efficient outcomes.

("the Principal Objective")

E. The Hospitals wish to make and give effect to this agreement in pursuit of the Principal Objective and subject to authorisation being obtained from the Australian Competition and Consumer Commission ("the ACCC").

OPERATIVE

Definitions

ACCC	Australian Competition & Consumer Commission
Average Fee Related Information	The average of benefits paid by Funds in current contracts across the Hospitals
Funds	Health Benefits Organisations
Governing Authorisation	The Authorisation from the ACCC or the Australian Competition Tribunal to make and give effect to this Agreement
Hospitals	St Vincent's Private Hospital, Darlinghurst Mater Misericordiae Private Hospital, Crows Nest The Sydney Adventist Hospital, Wahroonga
Initial Meeting	An initial meeting held between representatives of the Hospitals, their agent and a Fund when negotiating or varying a PPC with that Fund
Principal Objective	The objective set out in paragraph D of the Preamble to this Agreement
Purchaser Provider Contracts (PPC)	Contracts between Hospitals and Funds by which Hospitals agree to provide services to Fund members at agreed rates of contribution from the Funds
The Cooperative	The Sydney Religious Hospitals' Cooperative established pursuant to Clause 3.1 of this Agreement
The Cooperative Committee	The Committee established pursuant to Clause 4.1 of this Agreement
TPA	Trade Practices Act 1974

1 Subject to Authorisation

1.1 This Agreement is subject to the Governing Authorisation being obtained and the performance of this Agreement is subject to the conditions of the Governing Authorisation.

1.2 If any provision of this Agreement is or becomes inconsistent with the conditions of the Governing Authorisation and the Parties do not exercise any right of review or appeal with respect to the Governing Authorisation the Parties will -

1.2.1 amend that provision to accord with the conditions of the Governing Authorisation; or if that cannot be done without materially and adversely affecting the Principal Objective;

1.2.2 delete that provision from the Agreement; or if that cannot be done without materially and adversely affecting the Principal Objective;

1.2.3 terminate this Agreement.

2 Agreement to cooperate in pursuit of Principal Objective

2.1 The Parties agree to establish cooperation between the Hospitals in the manner set out in this Agreement and in pursuit of the Principal Objective.

3 Sydney Religious Hospitals Cooperative

3.1 The Hospitals will form a network to be known as the Sydney Religious Hospitals' Cooperative ("the Cooperative").

3.2 Until otherwise determined by the Cooperative Committee, the requirements for membership of the Cooperative are -

3.2.1 that members be religious, charitable or community based;

3.2.2 that members hold Australian Council on Healthcare Standards accreditation or other equivalent accreditation acceptable to the Cooperative Committee;

3.2.3 that members have in place a Trade Practices compliance programme of a standard acceptable to the Cooperative Committee;

3.2.4 that members abide by the conditions of the Governing Authorisation;

3.2.5 that members operate a hospital or undertake activities with a predominant focus on providing accommodation and health care services for the sick or infirm.

3.3 Until otherwise determined by the Cooperative Committee, a Hospital's membership of the Cooperative may be terminated by a decision of the Cooperative Committee if -

3.3.1 the Hospital fails to continue to satisfy the requirements for membership;

3.3.2 the Hospital enters into liquidation for a purpose other than a restructuring of the operation of the Hospital;

3.3.3 the Hospital's continued membership brings about a material change in circumstances such as may lead to issue by ACCC of a notice of intention to revoke the Governing Authorisation, or

3.3.4 the Hospital breaches a fundamental term of this Agreement.

3.4 A Hospital may resign from the Cooperative at any time upon giving notice in writing to that effect. However, it will remain liable to pay the amount of its contribution to the costs of the Cooperative up to and including the date of its resignation.

3.5 No other hospital(s) will be admitted to the Cooperative unless the ACCC has approved either a variation of the Governing Authorisation pursuant to section 91A of the TPA, or the substitution of the Governing Authorisation with a new authorisation pursuant to section 91C of the TPA, to reflect the addition of the new hospital(s) to the Cooperative.

4 Sydney Religious Hospitals' Cooperative to be administered by Committee

4.1 The Cooperative will be administered by a Committee to be known as the Sydney Religious Hospitals Cooperative Committee ("the Cooperative Committee").

4.2 The function of the Cooperative Committee will be to make decisions appropriate to the pursuit of the Principal Objective, including -

4.2.1 making rules and establishing procedures for the business of the Cooperative Committee;

4.2.2 selecting and appointing agents to negotiate PPCs on behalf of Cooperative members;

4.2.3 determining the scope of the agents' functions;

4.2.4 reviewing the effectiveness and performance of the agents;

4.2.5 providing a point of contact between the agents and the Hospitals;

4.2.6 facilitating the collection of necessary information by the appointed agents to enable the sharing of average fee related information by the Hospitals;

4.2.7 facilitating the collection of non-fee related information and provision of that information by the agent to Funds;

4.2.8 meeting with each Fund at an Initial Meeting prior to individual negotiations with that fund to discuss terms and conditions of PPCs;

4.2.9 monitoring the progress of negotiations with Funds;

4.2.10 budgeting and incurring costs in pursuit of the Principal Objective;

4.2.11 arranging the collection of each Hospital's contributions towards payment of the costs of operating the

Cooperative;

4.2.12 monitoring compliance with the conditions of the Governing Authorisation;

4.2.13 endeavouring to resolve by discussion any dispute between members of the Cooperative regarding this Agreement;

4.2.14 discussing general business and administration matters not related to negotiations with the Funds.

4.3 It is not a function of the Cooperative Committee -

4.3.1 to enter into a PPC on behalf of any member of the Cooperative;

4.3.2 to advise or make recommendations to any member of the Cooperative regarding the appropriateness of any offer of a PPC communicated by the agents;

4.3.3 to suggest, encourage or allow any collective boycott of any fund by Cooperative members;

4.3.4 to discuss any proposed increases in benefit levels which a member might request as part of a negotiation with a Fund.

4.4 Each Hospital participating in the Cooperative will appoint a member of its staff to the Cooperative Committee and will ensure that the person so appointed has appropriate delegations to enable that person to participate in the functions of the

Cooperative Committee.

5. PPC Negotiations with Funds

5.1 Members of the Cooperative Committee and any appointed agents may attend an initial meeting (the "Initial Meeting") with a Fund when negotiating or varying a PPC with that Fund.

5.2 The purpose of the Initial Meeting is to discuss the terms and conditions of the PPC (other than proposals for changes to benefit levels) to be entered into by each Hospital and the Fund.

5.3 All negotiations between a Hospital and a Fund following the Initial Meeting will be carried out on an individual basis.

5.4 The Hospitals will not engage in the collective boycott of any Fund.

6. Costs of Hospitals' Cooperative

6.1 Until otherwise decided by the Cooperative Committee, the Hospitals agree to share the costs incurred by the Cooperative Committee in pursuit of the Principal Objective equally.

6.2 The costs incurred by the Cooperative Committee will not include the costs charged by the agents in negotiating or advising on Purchaser Provider Contracts on behalf of members. Each Hospital will be separately liable for those costs.

7. Freedom of Choice

7.1 Each Hospital is at liberty to choose not to avail itself of the services of a particular agent.

7.2 Each Hospital is at liberty to adopt any other process for negotiating or concluding a PPC that it may choose.

7.3 No Hospital will be bound to contract with a particular Fund.

7.4 No Hospital will be bound to decline to contract with a particular Fund.

8. Confidentiality

8.1 The parties will ensure that the confidentiality of information communicated pursuant to this Agreement is maintained.

8.2 Without limiting the operation of Clause 8.1, the parties agree that confidential information, if communicated to them, will not be used for any purpose other than in pursuit of the Principal Objective.

9. Dispute Resolution

9.1 Unless a party to this Agreement has complied with the provisions of this Clause, that party may not commence Court Proceedings or arbitration relating to any dispute arising from this Agreement (except where that party seeks urgent interlocutory relief). Where a party to this Agreement fails to comply with the provisions of this clause, then any other party to the Agreement need not comply with this clause before referring the dispute to arbitration or commencing Court proceedings in

relation to that dispute.

9.2 Any party to this Agreement claiming that a dispute has arisen under the Agreement shall give written notice to the other party which shall designate the notifying party's representative in negotiations relating to the dispute who shall be a person with authority to settle the dispute. The party receiving the notice shall promptly give notice in writing to the notifying party designating as its or their representative in negotiations relating to the dispute a person with similar authority to settle the dispute.

9.3 If the dispute is not resolved within 21 days of the giving of the second notice referred to under Clause 8.2 (or such further period as the nominated representatives agree) the parties shall within a further 21 days (or such other period as the nominated representatives consider appropriate) enter into negotiations to agree on a process for resolving the whole or part of the dispute through means other than litigation or arbitration (such as further negotiations, mediation, conciliation, independent expert determination or mini trial) including such matters as:

9.3.1 the procedure and timetable for any exchange of documents and other information relating to the dispute;

9.3.2 procedural rules and timetable for the conduct of the selected process; and

9.3.3 a procedure for selecting and compensating any person whose services may be acquired as part of

the process.

9.4 The parties acknowledge and agree that the purpose of any exchange of information or documents or the making of any offer of settlement pursuant to this Clause is to attempt to settle the dispute between the parties and further acknowledge and agree that no party may use any information obtained through the dispute resolution process established by this Clause for any purpose (other than an attempt to settle any dispute between the parties) and, in particular, that such information or documents may not be used in any Court proceedings or arbitration without the consent in writing of the party who may have supplied such information or documents.

9.5 Following the expiration of the period specified or agreed to under Clause 8.3, either party which has complied with the provisions of Clauses 8.2 and 8.3 may terminate the dispute resolution process by giving notice in writing to the other party and then may proceed to enforce its right as it sees fit.

10 Relationship between Parties

10.1 The Parties enter into this Agreement as independent contractors.

10.2 It is the intention of the parties that nothing in this Agreement shall have the effect of creating any partnership, joint venture, agency or relationship between them other than as independent contractors.

11 Notices

11.1 All notices shall be in writing addressed to the address from time to time supplied by each Hospital to the Cooperative Committee.

12 Waiver

12.1 Any waiver or forbearance in regard to the performance of this Agreement shall operate only if in writing, shall apply only to the specified instance and shall not affect the existence and continued applicability of the terms of this Agreement.

13. Entire Agreement

13.1 This Agreement embodies all the terms between the parties and replaces all previous representations or proposals not embodied in this Agreement. All warranties made, other than those expressly stated in this Agreement are negated.

14. Applicable Law

14.1 This Agreement and the documents executed pursuant to this Agreement shall be governed by the laws in force in the State of New South Wales. The parties agree to submit to the non-exclusive jurisdiction of the Courts of competent jurisdiction in the State of New South Wales.

15. Amendments

15.1 This Agreement may not be varied except in writing, signed by the parties.

16. Severability

16.1 If any provision of this Agreement is held by a court to be unlawful, invalid, unenforceable or in conflict with any rule of law, statute, ordinance or regulation, the validity and enforceability of the remaining provisions shall not be affected and the offending provision shall be removed from this Agreement.

17. Stamp Duty and Costs

17.1 The parties shall be responsible for their own legal costs or and incidental to the preparation and signing of this Agreement, provided that any stamp duty payable on this Agreement or any documents executed pursuant to this Agreement shall be paid by the agent.

DATE:

PROVISION FOR SIGNATURE:

Executive Director,
St Vincent's Private Hospital Darlinghurst

Chief Executive Officer
Mater Misericordiae Hospital

Chief Executive Officer
The Sydney Adventist Hospital