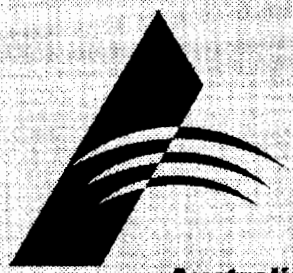

Australian Competition & Consumer Commission

Determination

Application for Authorisation

Inter-hospital arrangement between St Vincent's Private Hospital, Mater Misericordiae Private Hospital and Sydney Adventist Hospital

Date: 28 June 2000

Authorisation No:
A 90679

File No:
CA98/33

Commissioners:
Fels
Asher
Cousins
Shogren
[illegible]
Bhojani
King
Wilkinson

Summary

On 21 December 1998 an application for authorisation (No. A90679) was lodged with the Australian Competition and Consumer Commission (the Commission) by:

- St Vincent's Private Hospital;
- Mater Misericordiae Private Hospital Ltd.; and
- Sydney Adventist Hospital.

The application for authorisation was made under s. 88(1) of the *Trade Practices Act 1974* (Cth) (the Act). The Applicant Hospitals were seeking authorisation to enter into an arrangement, or to arrive at an understanding, under which they would act together in their discussions and negotiations with health insurance funds regarding reimbursement levels for health fund members (the Proposed Arrangement).

The Commission must, in considering whether to grant authorisation, apply the statutory test pursuant to s. 90(6) of the Act. Section 90(6) provides that in considering an application for authorisation the Commission shall not make a determination granting an authorisation unless it is satisfied that, in all the circumstances, the proposed conduct would result, or be likely to result, in a benefit to the public and that the benefit would outweigh the detriment to the public constituted by any resulting lessening of competition.

On 3 December 2000 the Commission released its Draft Determination proposing not authorise the proposed arrangement. Following the issue of the Draft Determination the Applicants amended their application so that their proposed common agent would represent the hospitals individually rather than jointly in negotiations with health funds. Features of the revised arrangement were an initial joint meeting between the Applicants and each fund, the sharing of current benefit level and non-fee information, and provisions for monitoring progress on negotiations. Collective boycotts were not allowed, nor any exchange on benefit levels sought.

The Applicants consider that the Proposed Arrangement would not have the effect of substantially lessening competition. They submitted that even if the proposed conduct is regarded by the ACCC as likely to substantially lessen competition, authorisation should be granted because the proposed conduct will result in, will be likely to result in, benefits to the public which will outweigh any detriment to the public constituted by any lessening of competition. The Applicants identified the following as public benefits deriving from the Proposed Arrangement:

- countervailing power to the substantial market power of the health insurance funds
- a continuation of community services
- a reduction in burden on public hospitals
- reductions in costs to hospitals
- other major cost savings.

The Commission believes that the Proposed Arrangement will inevitably see the Applicants achieve higher price levels in negotiations with health insurance funds, than they would otherwise have obtained, even if the same prices are not agreed for equivalent services. The Commission considers agreements or arrangements between competitors in relation to prices

to be amongst the most serious forms of anti-competitive conduct and highly likely to result in a lessening of competition.

The Commission has considered the effect of the proposed agreement on the hospital – patient market and the private hospital – health fund market.

The Commission is of the view that the Applicants compete for patients and that the Proposed Arrangement for negotiating with health funds, to the extent that it leads to "fixing, controlling or maintaining" prices, would ultimately lead to a lessening of competition in the hospitals services – patient market.

The Commission is also of the view that the proposed conduct would result in an anti-competitive detriment in the private hospital – health insurance market through the impact of agreements on prices and increases in prices. The detriment would in particular be reflected by:

- increased costs to health funds, potentially impacting on health insurance premiums and membership levels; and
- the easing of competitive pressures on the Applicants to improve the quality and efficiency of operations and services as a result of their being given an opportunity to pass on cost increases.

As to public benefits, the Applicants claimed that the Proposed Arrangement would give them countervailing power against the health funds. The Applicants are three of the four largest private hospitals in the Sydney metropolitan area and already receive the highest reimbursement payments from health funds in NSW and a disproportionate share of fund benefit payments. The Commission does not believe that the viability and service levels of the Applicants will be threatened, as claimed, unless they receive the higher reimbursement levels expected to flow from the Proposed Arrangement.

The Applicants also claimed that the viability of the hospitals was essential to minimise the burden on public hospitals and ensure the continuation of community services. As stated above the Commission is not convinced that their viability would be threatened in the absence of the Proposed Arrangement. That aside, the Commission was not persuaded that privately insured patients who were not able to be accepted for treatment by the Applicants would necessarily seek treatment in the public hospital system. Further, the Commission found no evidence that if patients did choose to enter the public hospital system, as either private or public patients, that there would be a detriment to the public health system.

The Commission also found that any reduction in costs accruing from collective negotiation was likely to be minimal given that three contracts would still need to be negotiated and that the combined spending of the Applicants on negotiations was a relatively small amount. The Commission notes that some of the other major savings would not require Commission endorsement and therefore do not have sufficient nexus with the Proposed Arrangement. Furthermore, the current Authorisation application could not necessarily be assumed to extend to all of the activities which the Applicants claim would result in other major savings.

For the reasons outlined above the Commission concluded that the proposed conduct would not result, or be likely to result, in a benefit to the public which would outweigh its anti-competitive effects. The Commission accordingly does not intend to authorise the conduct.

Contents

List of Abbreviations

Act	*Trade Practices Act 1974* (Cth)
AHSA	Australian Health Service Alliance Ltd
Applicants	St Vincent's Private Hospital, Mater Misericordiae Private Hospital Ltd. and Sydney Adventist Hospital
CMBS	Commonwealth Medical Benefits Scheme
Commission	The Australian Competition and Consumer Commission
MPPA	Medical Purchaser Provider Agreement
HPPA	Hospital Purchaser Provider Agreement
ARHG	Australian Regional Health Group Ltd
NHA	*National Health Act 1953* (Cth)

1. The Application

1.1. Introduction

On 21 December 1998 an application for authorisation (No. A90679) was lodged with the Australian Competition and Consumer Commission ('the Commission') by:

- St Vincent's Private Hospital;
- Mater Misericordiae Private Hospital Ltd; and
- Sydney Adventist Hospital.

The application was made under s. 88(1) of the *Trade Practices Act 1974* (Cth) (the Act). St Vincent's Private Hospital, Mater Misericordiae Private Hospital Ltd. and Sydney Adventist Hospital (the Applicants) were seeking authorisation to enter into an arrangement, or to arrive at an understanding, under which they will act together in their discussions and negotiations with health insurance funds regarding reimbursement levels for health fund members from health insurance funds (the Proposed Arrangement).

1.2. History of the Application

Application A90679, along with a supporting submission, was lodged with the Commission on 21 December 1998. In addition to the application the Commission received the following information from the Applicants:

- a letter of 17 June 1999 in response to submissions by third parties; and
- a letter of 27 June 1999 providing comments on the Commission's 2nd Draft Determination in response to the Application for Authorisation A50019 from five Queensland hospitals.

The Commission released its Draft Determination on 3 December 1999 proposing not to authorise the proposed arrangement. On 13 December 1999 the Applicants requested a pre-decision conference in relation to the Draft Determination. The pre-decision conference was convened on 10 January 2000 and, at the prior request of the Applicants, was immediately adjourned, to reconvene on 24 February 2000.

On 21 January 2000 the Applicants made a submission to the Commission responding to the Draft Determination and changing the conduct for which authorisation had been sought. This submission was circulated to interested parties prior to the conference.

The pre-decision conference was re-convened, in Sydney, on 24 February 2000. The minutes of the conference are at Attachment A. The conference was adjourned on the basis that a decision would be made whether there was a need to reconvene in the light of further submissions from the Applicants and interested parties.

The Commission sought further advice from the Applicants in a letter of 29 February 2000. The Applicants responded on 8 March 2000.

The Applicants also advised the Commission in a letter of 30 April 2000 that they did not agree with the final minutes of the pre-decision conference. The Applicants and other attending parties had been given an opportunity to comment on a draft of the minutes. Some suggestions for change made by the Applicants were not accepted by the Commission.

1.3. The Applicants

The Applicants are three private, not-for-profit hospitals located within the Sydney metropolitan area. They each provide a range of health care and community-based services. Although the hospitals are private hospitals, they do not have shareholders. The hospitals are administered by church organisations, and any surplus revenue is returned to the community.

Mater Misericordiae Private Hospital

The Mater Misericordiae Private Hospital is an Australian public company (Mater Misericordiae Hospital Limited), limited by guarantee and owned by the Trustees of the Sisters of Mercy. It is located at North Sydney, has 195 beds and offers major services including orthopaedics, obstetrics and gynaecology, general surgery and general medicine. The Mater Private was established in 1912 and new premises were opened in January 1991.

St Vincent's Private Hospital

Established in 1908, St Vincent's Private Hospital is an Australian public company, limited by guarantee and owned by the Sisters of Charity, a member of the National Sisters of Charity Health Service. The hospital has 245 beds, employs approximately 1,000 staff and undertakes all aspects of medical treatment and surgical intervention. St Vincent's hospital is located at Darlinghurst in central Sydney.

Sydney Adventist Hospital

The Sydney Adventist Hospital was established in 1903 and is located in the Northern Sydney suburb of Wahroonga. Sydney Adventist Hospital is a registered business name and the corporation carrying on business under this name is the Australasian Conference Association Ltd, an Australian public company, limited by guarantee. The hospital is owned by the Adventist Church of Australia and, with 324 beds, the hospital is the largest private hospital in NSW, offering a full range of medical services, with acute medical, surgical and obstetrics services including complex cardiac and orthopaedic procedures.

1.4. The Hospitals' Proposed Arrangement

Initially proposed conduct

The Applicants in their original application stated that they "seek authorisation to enter into an arrangement, or to arrive at an understanding, under which they will act together in their discussions and negotiations with health insurance funds regarding reimbursement levels for health funds members".

The stated purpose behind the Proposed Arrangement was to create countervailing power against the health funds which would enable the Applicants to negotiate better outcomes for health fund members.

The Proposed Arrangement was to involve a two step negotiation process. Firstly, representatives from each of the Applicant hospitals would meet with each other to discuss the approach to be taken in relation to contract terms and conditions and reimbursement level increases. The Applicants noted in the application that during these discussions prices for services provided by the hospitals would not be set. It was argued that each hospital would be seeking a different level of increase for different services due to different cost structures, financial and clinical goals of the hospital.

Once the approach was decided a 'lead negotiator' would be briefed. A representative from each of the Applicant hospitals and the 'lead negotiator' would be present during discussions with the health insurance funds.

Under the proposal any applicant hospital that did not wish to follow the uniform approach decided upon in the first step of the negotiation process, might 'opt-out' of the negotiations at any time.

Revised conduct

After the issue of the Commission's Draft Determination on 3 December 1999 proposing to refuse authorisation of the proposed conduct, the Applicants advised the Commission that they were revising the conduct for which authorisation was originally sought.

The Applicants advised that under the revised arrangements:

- No collective boycott will be permitted;
- An initial meeting will be held between the common agent, representatives of the Applicants and a health fund after which each hospital will progress negotiations represented only by the common agent and individual hospital employees;
- The Applicants may discuss a common approach to a forthcoming meeting with a health fund and progress of negotiations with that fund;
- No information related to any proposals for benefit level increases by individual hospitals will be shared; and
- Current level benefit information will be shared. The common agent will collate such information and provide members with averages across all members.

The Applicants provided a proposed Inter Hospital agreement (IHA) which contained the modified conduct. A copy of the IHA is at Attachment B.

The IHA states at Preamble C that the Applicants recognise that the cost of providing hospital and ancillary health cares 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 services.

Preamble D recognises as "the Principal Objective" that the Applicants wish to deal with those difficulties through:

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

The Applicants' application for authorisation has been restricted to arrangements relating to proposals for negotiations with health funds as described in the original application and as subsequently modified. Any authorisation decision by the Commission will therefore only extend to behaviour contained in the IHA relating to negotiations with health funds.

The proposals identified within the "Principle Objective" specified in the IHA will accordingly only be covered by the Commission's authorisation decision to the extent that they involve negotiations with heath funds. The authorisation decision would not be seen to extend for example to standardising systems, sharing resources or joint purchasing.

2. Conduct of the Inquiry

The Commission conducts inquiries in accordance with the requirements of the Act and with the procedures for authorisations as described in *Guide to Authorisations and Notifications, November 1995*. A chronology of the main stages of the Commission's inquiry is provided below.

Date	Description
21 December 1998	Application lodged
7 January 1999	Letter sent to interested parties inviting submissions
12 February 1999	Closing date for submissions
8 March 1999	Letter sent to Applicants requesting more information
31 March 1999	Meeting with various interested parties
17 June 1999	Applicants' further submission in response to other submissions
27 June 1999	Applicants' further submission in response to Queensland Hospitals Second Draft Determination
3 December 1999	Release of Draft Determination.
3 December 1999	The Commission wrote to the Applicants and interested parties advising that it proposed to reject the authorisation application, providing a copy of the Draft Determination, and advising of their right to request a pre-decision conference.
13 December 1999	Applicants requested a pre-decision conference.
10 January 2000	Pre-decision conference convened and immediately adjourned.
21 January 2000	Applicants' response to Draft Determination, including modified conduct.
24 February 2000	Pre-decision conference reconvened.
8 March 2000	Applicants' response to Commission's letter of 29 February 2000.
11 April 2000	Final minutes of pre-decision conference circulated.
28 June 2000	Determination issued.

3. Background to the Application

3.1. Recent reforms in the health industry

Over the last four years, there have been significant reforms within the health industry. An appreciation of these changes is important to understanding the environment in which the Application has been lodged. The nature of significant legislative reforms introduced in 1995 is discussed below. A brief history of the position prior to 1995 appears in Determination A50019.

Hospitals and health funds were entering into contracts for payments for hospital services prior to the 1995 legislative reforms. The effect of the reforms was to establish a legislative framework in which the contracting process could take place.

Among other things, the legislation provides that if a health fund does not have a Hospital Purchaser Provider Agreement (HPPA) with a hospital, it is required to pay the hospital a minimum amount, which is specified in the default table of the *National Health Act 1953* (1st tier). If the hospital is able to meet certain criteria, such as quality accreditation and simplified billing, it may qualify for a higher benefit even though it does not have a HPPA (2nd tier benefit). The 2nd tier benefit is set at 85 per cent of the average amount paid by that fund to similar hospitals for similar services. Where an HPPA exists the fund and hospital have been able to agree on a mutually acceptable rate.

The effect of the 1995 reforms on payment for medical services was that they allowed health funds to pay their members higher benefits than those specified in the Commonwealth Medical Benefit Schedule (CMBS) for medical services, provided the health fund had a Medical Purchaser Provider Agreement (MPPA) with the treating doctor. If not, the health fund could only pay the difference between the Medicare rebate and the CMBS fee. Following more recent legislative changes, a health fund may now also pay above the CMBS level if the doctor concerned has a Practitioner Agreement with a hospital which in turn has a HPPA with the health fund.

It should be noted that health fund members may still go to the hospital of their choice but if they choose a non-HPPA hospital they will receive a lower benefit. In some cases, health funds have negotiated HPPAs with hospitals which result in the patient having no out of pocket expenses.

3.2. Health insurance funds

As at 30 June 1999, there were 44 registered health insurance funds in Australia of which 29 were available to the public generally and 15 were operated as restricted membership organisations. The open funds accounted for 94 per cent of memberships and the restricted funds the balance. There are nine major providers of health insurance in the Australian market. They are Medibank Private, MBF, AXA Australia (previously National Mutual), HBF, HCF, NIB, Australian Health Management and two alliances, Australian Health Service Alliance (AHSA) and Australian Regional Health Group (ARHG).

Medibank Private, MBF, National Mutual, HBF and HCF are the top 5 health funds based on market share. Collectively these top five funds provide a 79.8% coverage of the Australian market (see Table 3.1 below).

Table 3.1. Health funds: membership and coverage as at 30 June 1999

Health fund	Members		Coverage (1)	
	No	%	No	%
Medibank Private	945,159	28.7	1,962,129	28.7
MBF	635,041	19.3	1,298, 626	19.0
HBF	386,498	11.7	790,766	11.5
National Mutual (2)	370,794	11.2	769,556	11.2
HCF	298,349	9.0	646,546	9.4
NIB	165,263	5.0	349,102	5.1
Australian Unity	95,958	2.9	178,707	2.6
Aust Health Mgmt.	84,837	2.6	197,144	2.9
SGIO	44,918	1.4	102,451	1.5
Other	270,502	8.2	588,799	8.6
Total	*3,297,319*	*100.0*	*6,883,826*	*100.0*

(1) A membership may cover more than one person. (2) Now AXA Australia.
Source: PHIAC Annual Report, 1998-99

As can be seen from Table 3.2, the individual market share of hospital contributions of the top five funds varies significantly between the States and Territories, but their aggregate market share is at least 67.5% in each State or Territory. New South Wales is the State in which the top five health funds collectively hold the least market share, with an aggregate 67.5% of the market.

Table 3.2. Health funds market share (%), by State, as at 30 June 1999 (1)

Fund	NSW	Vic	Qld	SA	WA	Tas	NT	Aust
Medibank Private	21.7	41.4	31.3	17.9	15.0	25.8	46.7	28.7
MBF	22.4	3.9	41.9	5.4	0.7	44.4	28.3	19.0
HBF	..	0.2	0.2	..	74.6	..	..	11.5
National Mutual (2)	0.9	24.1	3.2	46.1	1.0	0.5	17.5	11.2
HCF	22.5	0.9	1.7	..	0.1	..	..	9.4
NIB	11.5	0.9	1.7	0.5	0.2	..	..	5.1
Australian Unity	0.2	10.1	1.5	0.8	0.2	..	..	2.6
Aust Health Mgmt.	4.5	1.1	2.6	1.5	0.4	6.2	2.1	2.9
SGIO	..	..	..	12.9	1.6	..	..	1.5
Other	16.3	17.4	17.6	14.9	6.2	23.1	5.4	8.6
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(1) Based on members in each State/Territory. (2) Now AXA Australia.
Source: PHIAC annual report, 1998-99.

The following points can be noted from the information contained in the above Table:

- HCF has the highest market share in NSW with 22.5%
- The market share leaders in each of the States and Territories hold a market share between 22.5% (HCF in NSW) and 74.6% (HBF in WA).
- HBF, although having the highest market share in WA (74.6% market share), does not hold a significant market share in any other State; and
- Medibank Private is the only health fund which attains a significant market share in all States, with more than 15% in each State.

It is clear from the figures in Table 3.2 that the major health funds control substantial amounts of business. Accordingly, the failure of a private hospital to negotiate a HPPA with a leading health fund may affect a significant portion of its business. The State with the highest level of competition between funds is NSW where the highest market share of any fund is 22.5%.

The Minister stated when introducing the 1995 legislative reforms that they were designed to engender greater competition between private hospitals. The actions of health funds in trying to negotiate the lowest possible price for their members is consistent with that objective.

The legislation does not make it mandatory for health funds to have a HPPA with every hospital. As a result the health funds are able to compare prices between hospitals and contract with hospitals on a value for money basis.

3.3. Financial performance of the private health care industry

Both the private hospital and private health insurance industries have experienced difficult times in recent years. The declining participation rate in private health insurance and the increasing cost of providing health care has placed considerable pressure on health funds and hospitals.

Financial performance of health funds

Information obtained from the Private Health Insurance Administrative Council (PHIAC) shows that the private health insurance industry incurred substantial losses in the three years before 1998-99 (see Table 3.3 below). Most of the major funds incurred losses in 1995-96 and 1996-97, while in 1997-98 several made small profits and several losses. Overall, the industry lost $83 million in 1995-96, $127 million in 1996-97 and $33 million in 1997-98. Even where funds recorded a profit, the margin on operations was very small. In 1998-99 funds experienced net profits for the first time in some years with an overall profit of $101 million.

The financial losses were recorded despite significant increases in revenue. Revenue from contributions rose by 6 per cent in 1996-97 and 7 percent in 1997-98 due largely to increased premiums. However, these increases were not enough to offset increases in benefits paid out to members and "other expenses", including administrative overheads. These "other

expenses" increased by 7 per cent and 12 per cent respectively and, in 1997-98, accounted for 13 per cent of total expenses (up from 12 per cent in 1995-96).

Table 3.3. Financial performance of health funds, 1995/96 to 1997/98

	Contribution income	Total income	Cost of Benefits	Total expenses	Operating profit	Net profit (1)
			($'million)			
1995-96	3,829.7	4,004.0	3,606.3	4,080.8	(78.8)	(83.5)
1996-97	4,066.2	4,290.0	3,877.5	4,385.4	(95.5)	(127.4)
1997-98	4,345.6	4,472.5	3,852.4	4,419.1	53.4	(33.0)
1998-99	4,552.3	4,686.7	3,923.9	4,536.6	150.1	101.2

(1) After extraordinaries.

In 1998-99 contribution revenue rose 4.8% while benefit costs rose by 1.9% and other expenses by 8.1%.

It should be noted that interpretation of the financial performance of health funds needs to take into account activities undertaken by funds peripheral to health insurance. For example, the industry's performance overall in 1997/98 was heavily impacted by a net operating loss of $59.1m made by MBF which included an abnormal loss of $48.8m from a reduction in the value of hospital premises.

Most of the major funds traded profitably in 1998-99:

- MBF went from an operating loss of $132.2m in 1997-98 to a profit of $5.8m in 1998-99, and from a net operating loss of $57.9m in 1997-98 to a profit of $2.5m in 1998-99;
- Medibank Private went from an operating profit of $4.9m in 1997-98 to a profit of $57.3m in 1998-99, with no abnormals;
- SGIO went from an operating profit of $3.2m in 1997-98 to a profit of $1.4m in 1998-99 which reduced to $0.9m after the payment of income tax; and
- AXA (National Mutual) went from an operating profit of $24.8m in 1997-98 to a profit of $35.3m in 1998-99 which resulted in a net profit of $1.4m after abnormals.
- HCF went from an operating loss of $7.1m in 1997-98 to a profit of $1.6m in 1998-99.

A review of the private health insurance industry conducted by the Industry Commission in 1996-97 found that many of the cost increases incurred by health funds at that time were beyond the control of the funds. The Industry Commission found that between 1989-90 and 1995-96 health insurance premiums increased by 46 per cent in real terms. The major contributors to this increase were a shift by members to obtaining treatment in (non-subsidised) private hospitals rather than public hospitals, increases in benefits paid per bed day (including longer average length of stay), day hospital charges, increased utilisation rates and increased management expenses. Increased utilisation rates were largely a result of the ageing contributor base and adverse selection base of health funds. That is, as healthier

people opted out of health insurance the funds were left with higher risk members which, in turn, increased the utilisation rate.

The percentage of the population with private health insurance has been steadily declining for some years now. As at 30 June 1998, 30.5% of the population had private health insurance, compared to 43.7% in 1991 and 50% in 1984.

The Federal Government introduced a number of incentives designed to encourage participation in private health insurance, including from 1 January 1999 a 30% rebate on the premium for an appropriate private health insurance policy. For taxpayers without private patient hospital cover, a Medicare surcharge levy applies for single taxpayers with taxable income in excess of $50,000 and for families with taxable income in excess of $100,000. The surcharge levy adds 1% to the standard 1.5% Medicare levy. For taxpayers liable for the surcharge there is a strong incentive to take out private health insurance.

The government has subsequently introduced a scheme entitled Lifetime Health Cover which takes effect from 1 July 2000. The scheme recognises the length of times a person has had private hospital cover and rewards that loyalty through lower premiums. People who join funds early in life will be charged lower premiums throughout their life than people who join after 30 years of age.

The introduction of the above incentives has seen the decline in health fund membership arrested. Private health insurance coverage of the Australian population has steadily increased as follows:

30.1% at 31 December 1998
30.3% at 31 March 1999
30.5% at 30 June 1999
30.9% at 30 September 1999
31.2% at 31 December 1999 and
32.2% at 31 March 2000.

The increase in coverage equates to around 480,000 persons since December 1998.

Financial performance of private hospitals

Private hospitals provide approximately a quarter of all days of hospitalisation and one fifth of the recurrent expenditure by all (public and private) hospitals in Australia. Expenditure incurred by private hospitals in 1997-98 was $3,757m, representing 8% of expenditure for the entire health sector in Australia and 0.7% of gross domestic product. As at 30 June 1998, there were 317 private hospitals in Australia providing 23,091 beds. Of these beds 53% were in private hospitals designated as for-profit and 47% in not-for-profit hospitals.

In 1997-98, private hospitals treated 1.9 million patients and had an occupancy rate of approximately 70 per cent. This activity represented approximately 25 per cent of all public and private hospital admissions for 1997-98.

Similar to health funds, private hospitals have also experienced difficult operating conditions. However, unlike the health insurance industry, private hospitals have remained profitable. As Table 3.4 above shows, while annual profits for the industry have increased slightly between 1993-94 and 1997-98, operating margins have declined from 12% to 8% as costs per bed day

have increased. Recurrent expenditure for 1997-98 appearing in Table 3.4 does not include $403 million expenditure on buildings and other capital assets.

Table 3.4. Financial performance of private hospitals (1), 1993-94 to 1997-98

	1993-94	1994-95	1995-96	1996-97	1997-98
Hospitals (No)	329	328	323	319	317
Beds (No)	21,241	22,370	22,757	22,966	23,091
Separations ('000)	1,250.7	1,346.7	1,452.3	1,539.4	1,585.3
Bed days ('000)	5,172.4	5,421.9	5,844.2	5,853.6	5,858.8
Average length of stay (days)	4.1	4.0	4.0	3.8	3.7
Occupancy rate	66.7%	66.4%	70.4%	69.8%	69.5%
Revenue ($m)	2,491.7	2,763.2	3,083.9	3,374.3	3,517.0
Recurrent expenditure ($m)	2,225.9	2,503.1	2,823.8	3,087.7	3,231.5
Gross operating profit ($m)	265.8	260.1	260.1	286.6	285.5
Gross operating margin	11.9%	10.4%	9.2%	9.3%	8.8%
Expenditure per bed day	$430	$462	$483	$527	$552

(1) Excludes free standing day hospitals. Includes acute and psychiatric hospitals.
Source: ABS Catalogue No 4390.0

Table 3.5 below shows the relative performance of private hospitals by State. NSW can be seen to be one of the stronger performing States in terms of operating margins.

Table 3.5. Performance of private hospitals (1) by State, 1997-98

	Hospitals (No)	Revenue ($m)	Recurrent expenditure ($m)	Gross operating margin	Expenditure per bed day
NSW/ACT	91	1,037.5	950.0	9.2%	$597
Victoria	97	1,008.7	927.9	8.7%	$570
Queensland	51	728.5	652.9	11.6%	$488
SA/NT	41	277.1	267.3	3.7%	$478
WA	26	344.5	316.4	8.9%	$574
Tasmania	11	120.9	117.2	3.2%	$622
Australia	*317*	*3,517.0*	*3,231.5*	*8.8%*	*$552*

(2) Excludes free standing day hospitals. Includes acute and psychiatric hospitals.
Source: ABS Catalogue No 4390.0

There is only a limited amount of information available publicly on the performance of private hospitals in 1998-99. The major 'for profit' hospital groups Health Care of Australia

and Ramsay Health Care have released annual reports which provide some insight into their experience in the private hospitals sector in 1998-99. The 'not for profit' private hospitals do not as a rule release detailed public financial statements.

Health Care of Australia reported an increase in revenue from hospitals by 21% to $767m while earnings fell 30% to $59m. Margins were described as being under pressure because of increased labour costs and minimal price increases from health funds. Hospital bed numbers increased from 3,585 to 4,648 over the year, but despite this increase, occupancy levels were maintained with a small increase from 69% to 71%.

Ramsay Health Care reported an operating profit in 1998-99 before tax and abnormals of $12.8m, down $6.3m on the previous year. The report refers to a tough private health care environment noting that rates of return are being impacted by pressure on prices from health funds.

4. Submissions

A copy of each submission is held on the Public Register, pursuant to s. 89 of the Act. A list appears below of organisations from whom the Commission received submissions.

Submissions in relation to the original application of the Applicants were received from:

- Australian Catholic Health Care Association
- Australian Health Insurance Association Ltd (AHIA)
- Australian Health Service Alliance Ltd
- Australian Private Hospitals Association Ltd (APHA)
- Australian Regional Health Group Ltd
- Department of Health and Aged Care (Cth)
- Health Care of Australia (HCoA)
- Health Insurance Restricted Membership Association of Australia (HIRMAA)
- Hospitals Contribution Fund of Australia Ltd (HCF)
- Hunter Valley Private Hospitals
- Manchester Unity Friendly Society in NSW Ltd
- Medibank Private Ltd
- Medical Benefits Fund of Australia Ltd (MBF)
- National Mutual Health Insurance
- Naval Health Benefits Society
- NIB Health Fund
- NSW Health Department
- NSW Health Funds Association
- Ramsay Health Care Group
- SGIO Health Pty Ltd
- St. Luke's Hospital Complex
- St Vincent's Hospital, Lismore

Submissions in relation to the revised conduct proposed by the Applicants were received from:

- Australian Health Service Alliance Ltd
- Department of Health and Aged Care (Cth)
- Hospitals Contribution Fund of Australia Ltd (HCF)

- Medibank Private Ltd
- Medical Benefits Fund of Australia Ltd (MBF)
- AXA Australia (previously National Mutual Health Insurance)
- Private Hospitals Association of NSW (PHANSW)
- NRMA Health Pty Ltd (previously SGIO Health Pty Ltd)
- St. Luke's Hospital Complex

4.1 Applicants' submissions

Prior to the Draft Determination

The applicants sought authorisation to enter into an agreement, or to arrive at an understanding, under which they would act together in their discussions and negotiations with health insurance funds regarding reimbursement levels for health fund members.

The Applicants submitted that authorisation of the proposed arrangement would not result in a substantial lessening of competition in any relevant market and, if there was any lessening of competition in such a market, that the public benefits arising from the conduct would outweigh the detriment to the public from the lessening of competition. It was submitted that the public benefits are to: create a countervailing power to the market power of the health insurance funds; ensure the continuation of funding for community services; and ensure the viability of the Applicants' hospitals thereby offering benefits to privately insured patients and limiting the potential burden on public hospitals.

The Applicants' submissions in relation to each of these points and other issues raised are outlined below.

Relevant market for hospital services

The applicants did not directly compete with one another for patients as geographic factors and doctor referrals determined where a patient is treated. Price was not believed to be a major determinant in choice of hospital. The Applicants originally submitted the relevant market was public and private hospitals within the greater Sydney metropolitan area. In subsequent submissions the Applicants acknowledged there was some differentiation between public and private hospitals, and that psychiatric and rehabilitation hospitals can be excluded from the relevant market. Consistent with this view the Applicants stated that the most accurate definition of the relevant market is: (a) for general medical and surgical services, all private hospitals other than psychiatric and rehabilitation private hospitals in the Sydney metropolitan area; and (b) for super-specialty services, all private and public hospitals with the appropriate capability in the State.

Countervailing power

The Applicants argued that the need to provide a range of hospitals across the State of NSW geographically has resulted in a private hospital industry characterised by a large number of relatively small, widely dispersed providers. On the other hand while there are over 20 registered health funds in NSW, the industry in that State is dominated by five major funds which together account for around 96% of the market. The size and dominance of the major health insurers renders the relative bargaining positions of individual health funds and individual private hospitals unequal.

The inequality in market power between private hospitals and health funds has resulted in some hospitals being pressured into accepting contract terms and conditions and reimbursement levels insufficient to cover even unavoidable cost increases. The proposed arrangement between the Applicants would redress the power imbalance and lead to increased competitiveness in the health industry as a whole by providing a countervailing market force.

Efficiency of hospitals

The Applicants acknowledged that the objective of the 1995 Lawrence reforms was to improve the efficiency of private hospitals. Despite this the Applicants claim that they are not inefficient operators. Efficiency should not be assessed solely by financial measures. Clinical indicator reports show that the Applicants perform well relative to their peers on other benchmarks.

Collective negotiation

In the *Job Futures Limited* (1998) ATPR (Com) 50-261 decision, the ACCC recognised the benefit of a group of not-for-profit organisations acting together and combining their resources to tender with a government department. The ability of the Hospitals to collectively negotiate would provide similar benefits as those in *Job Futures Limited.* Economies of scale would be derived from using one negotiator thereby making increased funds available to be returned to the community.

Hospitals' viability

The Applicants claimed that as the Hospitals are run by church organisations and are not-for-profit , they need to have contracts with the major health insurance funds to remain viable. The power of the health funds in negotiations can result in a hospital having an unfavourable contract, or no contract, leading in turn to fewer profits being returned to the community or even the bankruptcy of the hospital.

Continuation of community services

The Applicants submitted there have been substantial reductions in the average length of stay by patients in hospitals in the interests of increasing efficiency and reducing costs. This results in a much greater load on community based services. The Hospitals contribute in excess of $5 million per annum on the provision of community welfare and other services.

The Applicants submit that if they were forced to sell to a public company oriented towards making profits for shareholders, many if not all of their community services funded by the Hospitals would cease. This is not in the public interest.

In relation to the proposed arrangements, the lower costs of negotiations would result in increased funds being made available to the community. Conversely harsher contracts with health funds would result in lower profits being returned to the community.

Reduction of burden on public hospitals

The Applicants submitted that there is an inherent public benefit in the existence of the services provided by private hospitals in the NSW health system. The existence of private hospitals, offering a full range of services, is a vital part of the Australian hospital system.

The Applicants argued that ensuring the viability of the private health sector and the maintenance of quality treatment offered direct benefits not only to privately insured patients, but also to public patients by relieving the burden on the public hospital system and ensuring hospital services are available in areas where, based on pure cost considerations, they may not otherwise be provided.

If the Applicants are unable to negotiate satisfactory contracts with the health insurance funds fewer patients may be able to be treated by the Applicants or, one or more of the Applicants might be forced to close. Such developments would place local public hospitals, already stretched to the limit, under even greater pressure.

Reduction in costs to hospitals

The Applicants estimated they collectively spent almost $1 million per year on contract negotiations. Negotiating together would enable them to save much of this expenditure.

Other major savings

The Applicants suggested that if the proposed arrangements were approved major savings might also be achievable, from common administrative procedures group purchasing, common or compatible computer systems, a common linen service, the rationalisation of some medical services, and access to capital.

After the Draft Determination

The Applicants submitted that the Commission's reasons for the proposed rejection of the authorisation were flawed and the application should be approved.

Price fixing

The Applicants disputed the Commission's belief that the proposed arrangements would inevitably see agreement between the Applicants on price levels.

They stated that it was questionable whether simply because the NSW hospitals might be aware of the level of reimbursement increases sought by each other that this will have the effect of fixing or controlling the prices charged by each hospital for its services. The NSW hospitals have expressly stated that they will not engage in discussions in relation to the prices for services provided by them which would result in agreement on those prices.

The Applicants stated that in order to allay the concerns of the Commission they proposed to make significant changes to their application and the conduct for which authorisation was sought. Under the revised conduct:

- No collective boycott will be permitted;
- An initial meeting will be held between the common agent, representatives of the Applicants and a health fund after which each hospital will progress negotiations represented only by the common agent and individual hospital employees;
- The Applicants may discuss a common approach to a forthcoming meeting with a health fund and progress of negotiations with that fund;
- No information related to any proposals for benefit level increases by individual hospitals will be shared; and
- Current level benefit information will be shared. The common agent will collate such information and provide members with averages across all members.

The modified conduct was contained in a proposed Inter Hospital agreement (IHA) a copy of which was supplied to the Commission and appears at Attachment B.

Inconsistencies between the Queensland Hospitals Authorisation and the NSW Hospitals Determination.

The Applicants considered that there were a number of areas of the Commission's assessment of their application where the Commission's deliberations were not consistent with the Commission's views as expressed in the Queensland Hospitals authorisation (Determination A50019). The areas of inconsistency nominated by the Applicants were:

- public benefits through improved efficiencies and reductions in costs;
- public benefits from an adjustment to an imbalance of negotiating power;
- public benefits from the use of a common agent in negotiations; and
- lessening of competition.

Other "faults" in the determination

The Applicants identified what they regarded as a number of other "faults" in the Draft Determination as follows:

(i) The ACCC has taken the view that the NSW hospitals have a cost plus mentality. There is nothing in the application to suggest that the purpose of the proposed arrangement is to obtain increases in reimbursements over and above unavoidable costs.

(ii) The ACCC stated that the primary objective of the conduct would appear to be to facilitate increases in reimbursement levels for all three hospitals at levels that would be higher than could be achieved on an individual basis.

A more appropriate assessment is that one of the objectives of the proposed arrangement is to enable the NSW hospitals to negotiate reimbursement levels

which, at minimum, cover unavoidable cost increases, thus ensuring the continued viability of their operations.

(iii) The Commission has made a number of assumptions which are not supported by evidence in the Draft Determination, including:

- The NSW hospitals will engage in price fixing.
- There is a market for private and public hospitals in the Northern Sydney, South Eastern Sydney and Central Sydney health services area.
- The fact that current contracts continue until new contracts expire means failure to renegotiate does not have a severe consequence.
- It is unlikely that the NSW hospitals negotiating individually would fail to reach contracts with health funds.
- Higher reimbursement levels achieved by collective means would not be justified and result in the hospitals becoming less efficient.
- The proposed arrangement would result in reimbursement levels which would ensure that the hospitals always make profits.
- As the NSW hospitals receive higher levels of reimbursement than other hospitals, further increases in reimbursement would be unjustified.
- The proposed arrangement would potentially support inefficient operating behaviour by the NSW hospitals,

The Applicants provided a further submission after the pre-decision conference, elaborating on the revised conduct and associated public benefits.

4.2 Submissions in favour of authorisation

Prior to the Draft Determination

Supporting submissions were received from organisations representing private hospitals and from a small number of private hospitals.

All submissions supported private hospital negotiating alliances as a means of offsetting perceived excessive market power wielded by health funds. Private hospitals were seen as being disadvantaged by the high concentration of the health insurance industry, relative to the private hospital industry, under circumstances where there was a strong incentive provided by health legislation for hospitals to enter into contracts with all health funds.

After the Draft Determination

A supporting submission was received from a State private hospital association which claimed an imbalance of power between individual hospitals and health funds and asserted that the failure of NSW funds to recognise the underlying cost of health care through sustainable benefit levels threatens the viability of the private hospital sector.

4.3 Submissions opposing authorisation

Prior to the Draft Determination

Submissions opposing the application for authorisation fell into two categories, those submitted by health funds and their representative bodies, and those submitted by other private hospitals.

Health funds submissions

Key issues raised in submissions made by, or on behalf of, health funds included the following:

Collective bargaining

The Applicants were seen as substantial hospitals in their own right which already have significant bargaining power due to their size, reputation and specialisation and which are perceived as essential members of any health fund's network of hospitals. Allowing the Applicants to bargain collectively with health funds would potentially allow them to fix prices and engage in boycott activity. This could see increases in prices to funds in excess of what normal competitive forces would deliver, resulting in increased insurance premiums and thereby impacting on fund membership. Authorisation would also ease pressure on the Applicants to achieve efficiency gains, reduce competition between hospitals (adversely affecting smaller hospitals), and disadvantage smaller funds in bargaining.

Relevant market for hospital services

Many health funds' submissions considered that private hospitals did not compete with public hospitals for reasons including the extent of public hospital waiting lists, quality of service and choice of doctor. The market should also exclude psychiatric, rehabilitation and non – surgical hospitals. Hospital size and reputation were also cited as relevant to market delineation.

It was also suggested that in analysing markets for hospital services the number of hospitals was not relevant. The important measures were the number of private hospital beds and the share of benefits paid by health funds to individual private hospitals.

It was considered that the geographic location of a hospital was less of a factor in super speciality services than routine services. For general and common specialist services the relevant geographic area was at least the greater metropolitan areas of Sydney and could embrace narrower regions. It was acknowledged that doctor referrals currently play a role in choice of hospital, but this role could diminish in the longer term in response to differences between hospitals in price and their coverage by individual funds as HPPAs develop.

The submissions claimed that the Applicants were well known hospitals possessing substantial shares in most speciality markets and competed directly with one another on reputation and service. The Applicants were regarded as competing in the same geographic areas, especially Mater Misericordiae and Sydney Adventist

Public benefits

The health funds have claimed that the benefits associated with the proposed arrangements are purely private, accruing to the Applicants only. Generally, the health funds believe the proposed agreement will result in the Applicants receiving more money for existing services. The Applicants will be able to negotiate a better outcome for themselves which will lead to increased costs for health funds and higher premiums for fund members.

The funds have also claimed that the public benefits purported to arise from the proposed arrangement are questionable and that there do not appear to be any real efficiency gains.

Furthermore, it was suggested that the Proposed Agreement would undermine the public benefits sought by the enactment of the HPPA provisions in the *NHA* and the recent industry reforms.

Countervailing power

The opposing submissions from the health funds suggested the health funds do not have a market power advantage over the Applicant hospitals. Health funds need to maintain an adequate clinical and geographic coverage of private hospitals. The four major health funds in NSW each have a balanced share of the market and their lack of market power is illustrated by their low profitability.

In the Sydney metropolitan area the balance of market power is in favour of the hospitals. All health funds need HPPAs with the Applicants. The Applicants already individually exercise considerable market power as evidenced by their high reimbursement levels (even with their tax exempt status) relative to other hospitals. There is no evidence that the Applicants are disadvantaged by the current process.

There would be a further shift in the balance of power if the authorisation was granted as the Proposed Arrangement would give the Applicants a competitive advantage over smaller hospitals and also give them a bargaining advantage over smaller health funds.

Continuation of community services

Health funds suggested that they should not be subsidising charity work or community services. This is effectively a levy which interferes with the market process and has the potential to lead to a situation where inefficient service providers are supported. If the Applicants' charity or community work is worthwhile, but not self sustaining, it can and should be supported by more transparent means.

Whilst it was agreed that the Applicants could distribute any surpluses as they see fit, excessive profits received from uneconomic pricing levels could not be justified simply because the Applicants are not-for-profit organisations which distribute surpluses into community services.

It was claimed that the Applicants had not quantified any potential reduction in potential negotiation costs and any likely savings would be minimal and outweighed by increased health care costs and decreased competition.

Furthermore, it was submitted that arguments based on the Applicants' charitable status are of limited significance given that many health funds are also not-for-profit organisations.

Reduced burden on public hospitals

The Applicants claimed that if they are unable to negotiate satisfactory contracts with funds they will be forced to reduce services or close. Either outcome would place increased pressure on public hospitals. The funds state that there is little evidence to suggest that the Applicants are experiencing financial difficulties, and their financial position as indicated in their Annual Reports, is such that they are unlikely to be forced to close.

Moreover the proposed arrangements would encourage inefficiency in private hospitals by allowing cooperative price setting and ultimately result in higher premiums. Higher premiums in turn will mean fewer people will privately insure, thereby increasing the number of people relying on the public hospital system for their health care needs.

Reduction in costs to Applicants and other major savings

With respect to the Applicants' proposed future common activities to create major savings, opposing submissions suggested the activities are not consistent with the institutions competing against one another.

It was further submitted that any decrease in costs from collective negotiation would be minimal, and insignificant compared to the substantial anti-competitive detriment arising from the proposed conduct. It was noted that the Applicants would still have to negotiate three separate HPPAs.

Focus on efficiency

Generally the funds argued there is a need for greater efficiency in the private hospital market. The Applicants referred to efficiency to describe quality of care but not efficiency per se. It was argued the focus should be on increasing efficiency instead of merely attempting to increase revenue.

Hospital submissions

Collective bargaining

Opposing hospitals claim that each of the Applicants is a substantial organisation capable of independent negotiation in its own right and if the authorisation was granted other private hospitals would have to look to similar arrangements to offset the collective power of the applicants.

It is also claimed that the proposed arrangements would not serve any useful purpose unless negotiations by any of the Applicants were conditional upon agreeing reimbursement levels with all of the Applicants.

There is general concern at the competitive advantage the proposed arrangement would give the Applicants over other private hospitals. There is particular concern that if health funds, in the face of the combined strength of the Applicants, concede significant increases in reimbursement levels, the funds may decide as a means of containing costs not to offer contracts to other hospitals which may subsequently be forced to close.

Relative market for hospital services

It is suggested that each of the applicants is a leading provider of private hospital services in their relative catchment areas and that their market share on a bed basis belies their market power, even at the Sydney metropolitan area level. The prestige and traditions of the Applicants are seen as features which contribute significantly to their bargaining power.

Public benefits

In the context of the Applicants' *countervailing power* submissions it is noted that competition between health funds is intense and that a fund would be at a significant competitive disadvantage if it could not secure arrangements with hospitals such as the Applicants. None of the individual health funds is regarded as possessing market power sufficient to justify the conduct proposed by the Applicants.

It is not considered a public benefit for the private health insurance system to fund in a non-transparent way the *community services* of some private hospitals. After taking into account the apparent high reimbursement levels paid to the Applicants and their 12-15% cost advantage over other hospitals because of tax exemptions, a substantial portion of the Applicants' current operating costs could be devoted to *community services* if they were run as *efficiently* as other private hospitals.

The suggestion that any of the Applicant hospitals could be forced to close if satisfactory contracts are not agreed with health funds is seen as misleading as hospitals have the ability to raise prices to a level that satisfies them. All private hospitals are at liberty to choose not to have 100% cover with a fund and to charge a co-payment to patients utilising the hospital.

After the Draft Determination

Health funds submissions

Health funds consider that the Applicants do compete against each other in the areas of basic hospital services and super speciality services and that the modified conduct of the Applicants will still lead to a lessening of competition which is not offset by public benefits.

The funds have suggested that the modified negotiation process is not fully independent across the hospitals. The use of an initial meeting to decide strategies and terms to be sought when negotiating with funds combined with the joint monitoring of the progress of negotiations and a common negotiator will led to price fixing and higher reimbursement levels. It is also suggested that the common negotiator while not acting jointly for the hospitals will have the benefit of knowledge of prior negotiations. The sharing of information on price levels will lead at the least to the average price being the floor for negotiations.

The funds consider that the size and status of the Applicants individually is such that they do not need countervailing power with their negotiating position being demonstrated by their reimbursement levels which are among the highest in NSW.

Funds have also pointed to differences in the conduct proposed by the Applicants to that authorised by the Commission for Queensland hospitals in Determination A50019.

Hospital submissions

A smaller competing hospital has stated that the principal objective of the revised conduct continues to be better pricing through the use of the combined market power of the Applicants. It is suggested that it would be difficult for health funds not to have a contract with the Applicants and funds are likely to compensate for reimbursement increases with no increases for smaller hospitals operating near the Applicants, regardless of the relative efficiency of those smaller hospitals.

5. Statutory Criteria

Application A90679 was made under s. 88(1) of the Act and seeks authorisation for the Applicants to make, and give effect to, an arrangement or agreement which may have the effect of substantially lessening competition. In particular the Proposed Arrangement involves the three Applicant hospitals collectively negotiating reimbursement levels in HPPAs with health funds.

Section 88(1) of the Act enables the Commission to grant authorisation for agreements which would have, or might have, the effect of substantially lessening competition.

The statutory test which the Commission must apply in considering whether or not to grant authorisation to the Proposed Arrangement is set out in s. 90(6) of the Act. Section 90(6) provides that in considering an application for authorisation in relation to an agreement, including an agreement containing price fixing provisions, the Commission shall not make a determination granting an authorisation unless it is satisfied, in all the circumstances, that the proposed conduct would result, or be likely to result, in a benefit to the public and that the benefit would outweigh the detriment to the public constituted by any lessening of competition that would result. Section 4G of the Act states that for the purposes of this Act, references to the lessening of competition shall be read as including references to preventing or hindering competition.

It should be noted that, as a matter of law, the fact that a price fixing agreement would be deemed under s.45A of the Act to substantially lessen competition for the purposes of s.45 of the Act does not mean that any similar deeming provision or legal presumption about the effect of the agreement carries over to s.90(6). However, the fact that price fixing agreements are deemed to substantially lessen competition, recognises that such agreements normally have an adverse effect on competition.

In deciding whether to grant authorisation the Commission must:

- examine the anti-competitive detriment of the conduct and the benefit to the public arising from the conduct; and
- weigh the anti-competitive detriment against the benefit to the public to determine which is greater.

Should the benefit to the public (or expected benefit to the public) outweigh the anti-competitive aspects, the Commission may grant authorisation or grant authorisation subject to conditions.

If that is not the case, the Commission may refuse authorisation or alternatively, in refusing authorisation, indicate to the applicants how the application could be restructured to change the balance of detriment and public benefit so that authorisation may be granted.

6. Draft Determination

On 3 December 1999 the Commission issued a Draft Determination proposing to refuse authorisation of the proposed arrangement. Interested parties were invited to comment on the Draft Determination and also offered the opportunity to request a pre-decision conference pursuant to s.90A of the Act.

On 13 December 1999 the Commission received a request for a pre-decision conference from the Applicants. A conference was duly held on 24 February 2000, after being adjourned from 10 January 2000 at the Applicants' request. The minutes of the conference, including a list of participants, appear at Attachment B.

Prior to the conference being held, the Applicants provided the Commission with a submission responding to the Draft Determination which included changes to their proposed conduct. Copies of this submission were provided to interested parties prior to the pre-decision conference being held.

Interested parties were also given the opportunity to provide the Commission with further submissions after the pre-decision conference.

7. Commission Assessment – Competitive Effects of the Proposed Agreement

7.1. Market definition

The first step in assessing the competitive effects and the public benefit/detriment of the conduct for which authorisation is sought is to consider the relevant market(s) in which that conduct occurs.

Markets generally

Section 4E of the Trade Practices Act states that a market for goods or services includes other goods or services that are substitutable for, or otherwise competitive with, the first goods or services[1]. The courts have established that both demand and supply side substitution must be taken into account in determining the relevant market. *QCMA*[2] is often cited when seeking to explain how markets are defined:

> A market is the area of close competition between firms or, putting it a little differently, the field of rivalry between them... Within the bounds of a market there is substitution between one product and another and between one source of supply and another, in response to changing prices. So a market is the field of actual and potential transactions between buyers and sellers amongst whom there can be strong substitution, at least in the long run, if given a sufficient price incentive... Whether such substitution is feasible or likely depends ultimately on customer attitudes, technology, distance and cost and price incentives.
>
> It is the possibilities of such substitution which set the limits upon a firm's ability to 'give less and charge more'. Accordingly, in determining the outer boundaries of the market we ask a quite simple but fundamental question: If the firm were to 'give less and charge more' would there be, to put the matter colloquially, much of a reaction?

In establishing the market boundaries, the Commission seeks to include all those sources of closely substitutable products, to which consumers would turn in the event that the firm attempted to exercise market power. The Commission looks at both the demand and supply side of the market and defines up to four different dimensions:

- geographic market - which may be local, state, national or international depending on where trade occurs;
- product market - based on whether products are close substitutes for one another;
- functional market - defines at what level the conduct in question occurs, eg retail or wholesale;
- temporal market, ie - what period of time does the analysis apply to? The next two years? The next ten?

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[1] The Commission identifies the relevant market by determining the smallest area over which a profit maximising monopolist would impose a "small but significant and non-transitory increase in price" (SSNIP), or equivalent exercise of market power. By including all substitution possibilities, the process of market definition identifies all the sources of competition that effectively constrain the price and output decisions of the relevant entities. Market definition is not an end in itself but rather a tool of analysis. The market must be defined only to the extent necessary to determine the effect of the proposed conduct on competition.

[2] *Re Queensland Co-op Milling Association Ltd & Defiance Holdings Ltd* (1976) ATPR 40-012.

If market boundaries are too narrow so that actual or potential sources of competition are excluded then the proposed conduct will appear to have greater anti-competitive effect than is actually the case. On the other hand, the market may be defined too widely to include products or geographic areas that are not close substitutes. In such circumstances the anti-competitive effects of the proposed conduct will appear to be weaker than they actually are.

7.2. The Commission's general view of health sector markets

Product market

The Commission has previously reached the view (see Determination A50019) that the health sector involves five principal groups: public hospitals, private hospitals, doctors, patients and health funds. All the groups are inter-related and to varying degrees are mutually dependent. The task of defining the relevant market or markets in such circumstances is difficult as the boundaries between them are often unclear or overlap and there may be flow on effects from one market to another.

The Commission considered it important to remember that an individual or firm could participate in more than one market. An individual, for example, participates in the market for food, the market for clothing, the market for transportation, etc. In the case of the health sector, private hospitals compete in numerous markets which encompass doctors, patients and health funds. The Commission reached the view that there are six main markets as follows:

- the provision of hospital services to patients;
- the provision of hospital facilities and services to doctors;
- the provision of medical services to patients by doctors
- the provision of health insurance services to the general public;
- the sale of private hospital services to health insurers (HPPAs); and
- the sale of private medical services to health insurers (MPPAs).

Further detail of the Commission's views on how these markets operate is available in Determination A50019

Geographic area market

The Commission considered that the geographic area for the markets listed above varies. Where hospitals are involved the area is likely to be relatively limited because patients prefer to enter a hospital close to home where they can be near family, friends, known medical practitioners and follow up care if needed. For medical services, the geographic area can range from local to state-wide, depending on the service required. For example, simple surgery and uncomplicated obstetrics are likely to be available locally and patients will tend to use the local medical practitioners, but where highly specialised services such as cardiac surgery are involved they may only be available in metropolitan areas and patients must travel. The health insurance market is, in general, much wider and in the case of larger funds is national.

7.3. Effect on competition

The proposed conduct

Initially proposed conduct

The arrangement originally proposed by the Applicants would have seen the three hospitals acting together in their discussions and negotiations with health insurance funds in relation to the level of increases in reimbursement levels that would be sought from the health insurance funds.

The negotiation procedure was to involve a lead negotiator and a representative from each hospital as follows:

- the hospital representatives would meet in advance to discuss the approach to be taken in relation to contract terms and conditions and reimbursements levels;
- these discussions would not set prices for the services provided by them;
- once an approach to the negotiations was agreed between the hospitals they would brief the lead negotiator; and
- any hospital not agreeing with the uniform approach could opt out of the negotiations at any time.

The application for authorisation also referred to forms of cooperation between the Applicants including a common linen service, group purchasing and common or compatible computer systems

Opposing submissions claimed that the proposed arrangements would allow the Applicants to fix prices and engage in boycott activity as part of their negotiations with health funds. It was also claimed that the proposed arrangements would not serve any useful purpose unless negotiations by any of the Applicants were conditional upon agreeing reimbursement levels with all of the Applicants.

There was also concern at the competitive advantage the proposed arrangement would give the Applicants over other private hospitals. In particular, if health funds, in the face of the combined strength of the Applicants, conceded significant increases in reimbursement levels, the funds might decide as a means of containing costs not to offer contracts to other hospitals which may subsequently be forced to close.

The Commission stated in its Draft Determination that it was difficult to see any circumstances under which the proposed arrangements could be seen to coexist with effective competition between the Applicants in their dealings with health insurance funds. As the primary objective of the arrangement appeared to be to facilitate increases in reimbursement levels for all three hospitals, the Proposed Arrangement was likely to have the effect of fixing or controlling prices for the purposes of section 45A of the Act.

While the collective negotiation process proposed did not necessarily imply that each health fund would have to reach an agreement with each hospital in the group, the Commission considered that there was an opportunity and incentive under the arrangement for the hospitals to negotiate on an "all or none" basis.

The Commission also expressed concerns with the concept of an arrangement which had at its core the objective of achieving increased reimbursement levels. Such a proposal was seen as symptomatic of a "cost plus" approach to price setting rather than having prices evolve in a competitive market where pressures on costs and efficiency are also factors in price determination.

The Applicants in their response to the Draft Determination have stated that they do not agree with the views of the Commission for a number of reasons. The Commission would ordinarily examine these claims in detail. However, as the Applicants have modified their conduct, such an exercise would serve no useful purpose and the Commission will accordingly proceed to examine the revised conduct proposed.

Some of the Applicants' criticisms of the Commission's views of the original conduct referred to the contents of a draft Inter Hospital Agreement (IHA) claimed to be forwarded to the Commission by email on 2 July 1999, some six months after the original Application was lodged. The Commission has no record of this IHA nor consequently does a copy appear on the Commission's Public Register. To the extent that this draft IHA has been replaced by a revised draft IHA reflecting the revised conduct, the Commission does not see any need to examine it further.

Revised conduct

The Applicants have stated that in order to allay the concerns of the Commission they propose to make significant changes to their application and the conduct for which authorisation was sought. Under the revised conduct:

- No collective boycott will be permitted;
- An initial meeting will be held between the common agent, representatives of the Applicants and a health fund after which each hospital will progress negotiations represented only by the common agent and individual hospital employees;
- The Applicants may discuss a common approach to a forthcoming meeting with a health fund and progress of negotiations with that fund;
- No information related to any proposals for benefit level increases by individual hospitals will be shared; and
- Current level benefit information will be shared. The common agent will collate such information and provide members with averages across all members.

The modified conduct is contained in a proposed Inter Hospital agreement (IHA) a copy of which was supplied to the Commission and appears at Attachment B.

Parties opposing the Applicants' request for authorisation have raised a number of reservations about the proposed revised conduct as represented in the draft IHA. It is suggested that when these reservations are taken together, even though the Applicants are not explicitly undertaking joint negotiations with health funds, the effect is as if they were. It is claimed that the end result of such behaviour will be increases in reimbursement levels higher than would have been achieved by the Applicants negotiating independently, leading to increased costs to funds and their members. Achievement of higher reimbursement levels would also delay or stall initiatives to improve the efficiency of the private hospital industry.

The opposing parties suggest that the proposed behaviour, after taking into account the premium prices already commanded by the Applicants would enable them to price fix, at a level significantly above the competitive market levels.

The reservations raised in the opposing submissions are that:

The *initial joint meeting* allows the Applicants to lay down jointly their expectations of terms and conditions, including basis of payment, even if not specific prices. As the Applicants have access to shared price information there will be a tendency for the average price to become at least the price floor for negotiations. Even if not discussing prices the Applicants would be able to discuss their perceptions of "unavoidable cost increases", an acknowledged factor in determining benefit levels to be sought.

The IHA provides for the Applicants to collectively *monitor the negotiation process*. Even though the Applicants may not be aware of specific prices being sought by each other when monitoring progress, their common agent is able to advise the Applicants on how negotiations should proceed in their interests. MBF made the following comment in this respect:

> *Although individual meetings will be held between Funds and Facilities or the appointed agent, all information gained from these meetings will be shared on a group basis. Thus, in effect, the hospitals will be negotiating as one group.*

It is suggested by AHSA that even if the *"agent is an honourable person who would not divulge price arrangements negotiated for one hospital to the other hospitals .....the mere fact that this person is holding such information places them in a much stronger negotiation position"*. The agent would know, for example, when to stand firm rather than to waiver.

Medibank claimed that it was beyond the ability of the agent not to be influenced by knowledge from the initial meeting and acquired during the negotiation process. HCF suggested that it was hard to believe that the common agent could "erect Chinese Walls" in his own brain.

It is also suggested by HCF that there is information available publicly which could better serve the purposes of the Applicants for the benchmarking of revenue and costs than the exchange of information envisaged under the proposed conduct. HCF refers specifically to the Hospital Case Mix Protocol (HCP) Data Set and associated statistical package administered by the Department of Health and Aged Care (DHAC).

DHAC has advised that the above package, distributed at no cost to hospitals, enables a hospital or health fund to compare itself with others in its State or nationally for benchmarking purposes down to the DRG level for a range of measures including:- average length of stay, average hospital charge, average accommodation charge, average bed day charge, average theatre charge and average total hospital and medical gaps. This package became available to hospitals for the first time in September 1999. Data for 1998-99 was to be available in April this year.

The Applicants state that they have amended their original application to remove any possibility of price fixing or anti-competitive collective boycott action. They claim that the IHA will not lead to price fixing or collusion between the Applicants. They seek to enter the

IHA because *"the cost of providing hospital and ancillary health care services has continued to rise, with the result that it is difficult for the Applicants to maintain and improve the quality and scope of the services they provide"*. They state that the imbalance of negotiating power between health funds and the Applicants as individual hospitals exacerbates this situation and they wish to address these difficulties through cost reduction strategies, benchmarking of revenues and costs, improved efficiencies in service delivery and improved contract negotiation processes.

The Applicants state that the IHA will be progressed through a Cooperative Committee whose role is to facilitate the collection of fee and non-fee related information, examine opportunities for cost reductions and improved efficiency, and to meet with each health fund at an initial meeting prior to negotiations beginning between a hospital and a health fund.

Under the IHA the Committee will not enter into a contract with a fund, advise on the appropriateness of a health fund offer, allow a collective boycott, or discuss proposed increases in benefit levels sought by an Applicant hospital.

It is the Commission's belief that the primary objective of the proposed conduct is for the Applicants to achieve higher reimbursement levels than would otherwise have been obtainable. This is quite clear from the Applicants' initial application and subsequently from the Applicants' response to the Draft Determination.

In their original application the Applicants stated:

Para 1.1 *"In particular the Hospitals seek authorisation to enter into an arrangement or to arrive at an understanding under which they will act together in their discussions and negotiations with health funds regarding reimbursement levels for health fund members."*

Para 2.3 *"The Hospitals submit, that in the absence of the proposed conduct, the degree and effectiveness of competition in the greater Sydney health services market will be diminished because of the inability of each hospital, acting alone, to negotiate reasonable increases in reimbursement levels for health fund members effectively with the health insurance funds which will impact on their ability to attract patients to these hospitals."*

In their response to the Draft Determination the Applicants state at page 12:

> *"There is nothing in the Application to suggest that the purpose of the proposed arrangement is to obtain increases in reimbursement over and above unavoidable costs."*

It is also clear that the Applicants believe that the proposed conduct, as revised, will result in higher reimbursement levels than would otherwise have been achieved. The Applicants have claimed countervailing power benefits from the conduct for which authorisation has been sought. In this case there would be no countervailing power benefit in terms of that specific conduct unless the Applicants could achieve higher reimbursement levels than they could absent the conduct.

The Commission does not consider that the Applicants would be in effect negotiating truly independently with health funds. The Commission does not believe that the common agent

can be regarded as negotiating separately for each of the Applicants under circumstances when they:

- have entered an agreement with each other for negotiation purposes;
- can meet together with a fund, even if only initially, as part of the negotiation process; and
- can, as a group, monitor the progress of negotiations.

The Commission agrees with the view put by MBF that the Applicants would in effect be negotiating as a block. The issue for the Commission now is to determine for the relevant markets whether the Applicants' conduct would result in the lessening of competition and the extent of any associated detriment.

In its Draft Determination the Commission stated that it considered that the joint negotiation conduct proposed at the time would be likely to have the effect of fixing or controlling prices for the purposes of section 45A of the Act. In their response to the Draft Determination the Applicants expressed the view that Commission was in error in forming this conclusion because the hospitals expressly stated that they would not engage in discussions which would result in agreement on prices for services provided by them.

For the purposes of section 45A it does not matter whether the hospitals were engaged in such discussions for such purpose. Section 45A is concerned if an arrangement has the purpose or has, or is likely to have, the effect of fixing, controlling or maintaining prices.

The question of whether the latest proposed conduct would be deemed under s.45A of the Act to substantially lessen competition for the purposes of s.45 of the Act would ultimately be a matter for the courts to decide. However, there is an intent and expectation by the Applicants that the proposed conduct will result in higher prices than would otherwise have been achieved. Under these circumstances it would be difficult for the Commission not to draw the conclusion that the conduct has the effect, or likely effect, of "fixing, controlling or maintaining" prices.

It remains to examine the markets involved and to determine the extent of any detriment from the lessening of competition.

The hospital – patient market

In Determination A50019 the Commission stated that it considered public and private hospital services to be substitutable products for the reasons that declining health fund memberships implied acceptance that public hospitals could substitute for private hospitals, some privately insured patients use public hospital services as private patients, and some privately insured patients enter public hospital as public patients.

In this case the Applicants have suggested that, in broad terms, the relevant market includes both public and private hospitals. Health funds have suggested that private hospitals do not necessarily compete with public hospitals. The differentiation between public hospitals and private hospitals was premised on public hospital waiting lists, quality of service and choice of doctor.

While there is certainly substitutability between public and private hospitals there may well be differences in the degrees and directions in which such substitution occurs. For example,

avoidance of costs associated with gaps can provide an incentive for privately insured patients to enter the public hospital system. Against this those patients would have to enter the queues for elective surgery with uninsured patients. Government policies directed towards achieving no-gap or known gap outcomes in hospital/health fund contracts by the end of June 2000 could ameliorate the gap factor in the decision for insured patients. For patients seeking highly specialised services only available in public hospitals there is no choice to make.

The Productivity Commission's December 1999 report noted that the public sector's share of the private patient market has been steadily declining, from 36% of insured separations in 1993-94 to 19% in 1997-98. It is also suggested that a significant portion of these patients comprises emergency patients or patients receiving treatments not available in nearby private facilities. Overall the impression appears to be that competition to private hospitals from public hospitals is in decline. This decline could be expected to accelerate in the face of growth in health fund membership.

Health fund membership for any individual is probably a function of premium cost, the size of any gap, services covered and the perceived risk of hospital admission. It is apparent that the declining financial performance of the funds in the late 1990's was in general due to the members leaving the funds having a lower risk profile than members remaining with the funds. The fact that higher risk profile members remained with funds also suggests that there may be a difference in perception of services provided between public and private hospitals.

As discussed earlier, recent figures from Australian Health Insurance Association Ltd show that the decline in health fund membership has been arrested since the introduction of the Medicare surcharge levy, the 30% tax rebate on health insurance premiums and the new 'cover for life' program. These developments suggest that premium cost is now less of a factor, especially for patients who would otherwise have to pay the Medicare surcharge levy.

While public hospitals draw their patients from both the uninsured and the insured, the latter as both private and public patients, private hospitals draw their patients from a narrower group. According to the Productivity Commission 76% of private hospital patients are privately insured, 9% are Department of Veterans Affairs patients, 9% are self-paying, 5% are compensable patients and 2% are eligible public patients. Some uninsured persons are effectively self insured and can afford private hospital treatment. Most cannot. A substantial proportion of insured patients will always look to private hospitals for treatment in recognition of factors identified in submissions, ie to avoid waiting lists, to obtain doctor of choice, or for perceived quality of service reasons.

From the Commission's perspective it appears relevant to look at the competition impact of the proposed conduct on both the market between patients and public and private hospitals and the market between insured patients and private hospitals.

Geographic markets

The Commission considers that the geographic market in which the Applicants compete is *at most* the Sydney metropolitan area. The Applicants would only compete with hospitals at, say, the State level in areas of super specialist services which generally account for a minority of a hospital's business. A number of submissions have suggested that a narrower region can be used for market analysis. Narrower regions are examined further below. Table 6.1 below

shows that in the population of all hospitals, public and private, in the Sydney metropolitan area, the Applicants have a combined estimated market share of 5.8%.

Table 6.1: Public and private hospitals in Sydney (1)

Hospital	Number	Beds (No.)	Beds (%)
Private hospitals:			
Mater Misericordiae	1	185	1.5%
Sydney Adventist	1	329	2.6%
St Vincents	1	230	1.8%
Total	*3*	*744*	5.8%
Other private hospitals	38	2,547	20.0%
Public hospitals	34	9,465	74.2%
All hospitals	*75*	*12,756*	*100.0%*

(1) Excludes psychiatric and rehabilitation hospitals, day surgeries and nursing homes.
Source: NSW Health; Hospital and Health Services Yearbook, 1998.

In terms of their competitive position with other private hospitals Table 6.2 below shows that the Applicants have a market share of around 23% at the Sydney metropolitan area level. The Applicants in conjunction with the three other largest hospital groups account for 54% of the Sydney private hospital market.

The Applicants have submitted that the proposed arrangement will not substantially lessen competition in the relevant market because the Applicants do not compete with each other for patients. Geographic factors and doctor referrals are seen as the key factors in determining where a patient is treated. The Applicants assert, on the basis of an analysis of postcodes of patients' residences, that there is virtually no overlap in the geographic areas of patient residence amongst the hospitals and the relevant geographic market is the greater Sydney metropolitan area in terms of hospital beds. The Applicants assert that even if the proposed arrangement were to have the effect of lessening competition, the effect of lessening competition would not be substantial.

Table 6.2: Private hospitals (1), Sydney

Hospitals	Number	Beds (No)	Beds (%)
Applicants	3	744	22.6%
Health Care of Australia	5	605	18.4%
Alpha Healthcare Ltd	4	264	8.0%
Ramsay Health Care	1	164	5.0%
Other private	28	1,514	46.0%
Total	41	3,291	100.0%

(1) Excludes psychiatric and rehabilitation hospitals, day surgeries and nursing homes.
Source: NSW Health; Hospital and Health Services Yearbook, 1998.

Opposing submissions claimed that the Applicants are in fact in competition as indicated by the health services they provide and their reputation in the health industry.

It was further suggested that, in defining the geographic market in which the Applicants operate, a pure postcode analysis would be insufficient. It was submitted that patient catchment is not based solely on postcode location, but rather it includes specialisation, reputation, hospital size and doctor referral. A patient's choice of hospital was seen as being determined in the majority of cases by the following influences:

- the patients' choice of their doctor;
- the cost or price of the service to the patient;
- degree, if any, of Medicare coverage for the health services; and
- if the patient is privately insured, whether the hospital is covered by a HPPA under their policy.

An opposing submission from a health fund provided postcode data on its members' hospital choices in support of the claim that there is overlap in patient demand across the Applicant hospitals from individual postcodes.

The Commission stated in its Draft Determination that, regardless of the postcode analysis presented by the Applicants, it would be difficult to conclude from Table 6.3 below that the Sydney Adventist and Mater Misericordiae hospitals are not competing with each other in the Northern Sydney region.

In their response to the Draft Determination the Applicants challenged this view on the basis that:

> *"it is not clear what suburbs are included in the various areas in order to assess if they are appropriate to the case at hand;*
>
> *the ACCC itself has recognised in Table 6.3 (at page 31 of the [draft] determination) that over 20% of Sydney Adventist patients, 17% of Mater Misericordiae patients and 36% of St Vincents patients do not even come from North, South Eastern or Central Sydney;*
>
> *it is unclear why patients from Western Sydney have not been included, as the NSW hospitals suggested in their authorisation submission, when in total they provide a higher percentage of patients than Central Sydney."*

The Commission does not see that these comments raise any issues which would cause it to resile from its stated view. The areas used are NSW health service areas as stated in the Draft Determination. The health service area classification is a classification used by the NSW Government and in common use in the health industry. It is not relevant that minor percentages of the Applicants' patients do not come from the nominated health service areas. If the Commission is satisfied that the hospitals are competing for patients in the nominated three health service areas, that would be sufficient to establish that they are competing with each other.

The incidence of patients from Western Sydney would similarly not necessarily be of relevance. The Commission does note however a comment made by the Applicants in

response to a suggestion made by the Commission in the Draft Determination that patients in Liverpool are unlikely to opt for an Eastern suburbs hospital and vice versa. The Applicants indicated that patients from the Liverpool area are in the top 50 postcodes for two of the Applicants (Sydney Adventist and Mater) and over 200 attended St Vincent's Private Hospital in last 12 months. This comment would suggest that the three hospitals are competing even for more distant patients.

In claiming that they are not competing against each other the Applicants suggested in their application that the main factor affecting a patient's choice of private hospitals is the existing relationship between the patient and a doctor aligned with a particular hospital. In support they point to data showing that doctors are aligned with individual hospitals and do not operate across hospitals. MBF has submitted that according to its records there are at least thirty-two visiting medical officers who are credentialled at all three facilities.

In its Draft Determination the Commission stated that the above claim by the Applicants did not take into account the role of the general practitioner doctor (GP) in hospital choice. It is the GP who refers the patient to a specialist. The GP is able assist the patient to choose from a range of specialists (and aligned hospitals). In helping the patient to make a selection he is able to take into account the patient's requirements in terms of hospital location and the net costs to the patient of treatment. As HPPAs evolve it is likely that net costs will become more of a factor in this selection process.

The Applicants have acknowledged that the GP does have a role in specialist referral but suggest that this should not be overemphasised because there is no certainty that a hospital admission will follow a referral and the hospital at which the specialist has visiting rights is probably not discussed. The Applicants also suggest that as individual funds benefits are standardised across hospitals, medical costs rather than hospital costs are more likely to be an issue in specialist selection.

Table 6.3: Hospital admissions 1997/98

Health Service Area	Admissions by hospital(%)		
	Sydney Adventist	Mater Misericordiae	St Vincents
Northern Sydney	75.5	71.1	14.1
South Eastern Sydney	0.6	5.8	42.9
Central Sydney	1.0	5.8	6.3
Western Sydney	11.4	2.0	1.5
South Western Sydney	0.6	2.1	3.3
Other	10.9	13.2	31.9
Total	*100.0*	*100.0*	*100.0*

Source: Derived by the ACCC from information supplied by the Applicants

The Commission considers that there is merit in looking at a narrower geographic region than the Sydney metropolitan area in the hospital-patient market. The very size and spread of the Sydney metropolitan area is such that for common and general hospital services location can be an important factor for patients in hospital choice.

Table 6.4 below examines the market for private and public hospitals in the Northern Sydney, South Eastern Sydney and Central Sydney health service areas. These areas were chosen on

the basis that they embrace the locations and principal catchment areas of the Applicants and cover a population of in excess of 500,000 persons, being around 40% of the population of greater Sydney.

Table 6.4: Public and private hospitals (1), selected Health Service Areas.

	Northern Sydney	South Eastern Sydney	Central Sydney	Total
Applicants (beds)	514	230		744
Total private hospitals	1,312	998	347	2,657
Total public hospitals	1,747	2,283	1,866	5,896
All hospitals	3,059	3,281	2,213	8,553
Applicants' share of:				
- all private hospitals	39.2%	23.0%	0%	28.0%
- all hospitals	16.8%	7.0%		8.7%

(1) Excludes psychiatric and rehabilitation hospitals, day surgeries and nursing homes.
Source: *NSW Health; Hospital and Health Services Yearbook, 1998.*

One health fund, HCF, has noted that private hospitals operating in the Northern Sydney and South Eastern Sydney areas account for 71% of its private hospital patient services in Sydney and 58% in NSW. This was explained by the areas' having the largest concentration of health insurance members.

Other market issues

A number of submissions have referred to the large size of the Applicants relative to other private hospitals. It has been suggested that not only day hospitals, but also smaller private hospitals of up to 100 beds without accident/emergency or specialist cardiac services should be excluded from any market assessment.

Table 6.5 below shows the size distribution of private hospitals in the Sydney metropolitan area. The skewness of the distribution is such that for the large hospitals market share may not necessarily be a good guide to their position in the market. The largest seven hospitals for example, account for 17% of the number of hospitals but 44% of the beds. At the other end the 31 smallest hospitals account for 76% of the hospitals but only 46% of the beds. The three hospitals of the Applicants are in the top four hospitals by size.

A number of submissions have claimed that the market share of the hospitals in terms of number of beds is belied by the business they attract as a result of their reputations as large established prestige hospitals. While this may well be a factor for some patients and for super speciality services, the figures for catchment areas of patients' residences for the hospitals, with the possible exception of St Vincents Hospital, tend not to support the claim.

Table 6.5: Sydney private hospitals (1) by size and bed numbers.

Hospital size (number of beds)	Number of hospitals	Aggregate number of beds
0-50	19	674
51-100	12	831
101-150	3	329
151-200	4	692
201-300	2	436
301-600	1	329

(1) Excludes psychiatric and rehabilitation hospitals, day surgeries and nursing homes.
Source: Compiled by ACCC

St Luke's, a small private hospital in direct competition with St Vincent's, has submitted at the pre-decision conference and in a written submission that the proposed conduct will result in reimbursement increases for the Applicants. Such increases it claims could place it in a "position of decreasing service or cease providing health care services".

The basis for this claim is that, if health funds are unable to pass on such increases in the form of higher premiums, then "it is entirely logical" that they would attempt to counter this by negotiating nil increases or even decreases with other smaller hospitals operating within the same or near markets to the Applicants. Such an outcome would lessen competition, and reduce the number of services, their availability and choice. St Luke's contends that it would be extremely difficult and undesirable for health funds not to have a contract with the Applicants because of their size, reputation and market power. St Luke's would be penalised regardless of its efficiency relative to the Applicant hospitals.

The Commission's view

The Commission is of the view that the Applicants do compete for patients and that the proposed conduct for negotiating with health funds would be likely to lead to a lessening of competition in the hospitals – patient market. Flowing from the lessening of competition would be increases in reimbursements (higher than would otherwise be achieved) giving rise to either increased health fund premiums or reductions in the provisions of services by other private hospitals.

The Applicants stated in their response to the Draft Determination that such a conclusion was not consistent with the September 1999 authorisation for Queensland private hospitals which had a metropolitan Brisbane market share for public and private hospitals of less than 11%. In the Queensland case the Commission concluded that the proposed agreement would not lead to a substantial lessening of competition in the hospital – patient market.

In terms of the statutory criteria for authorisations, as detailed earlier, the Commission is required to weigh benefits of any proposed conduct against the detriment to the public constituted by any lessening of competition that would result from that conduct. The

Commission does not have to conclude that there is a substantial lessening of competition as part of the assessment process.

The private hospital – health insurance fund market

The Commission considers that the market between private hospitals and health insurers is the market most relevant to this application and that the proposed conduct will impact on this market.

The Applicants submitted in their original application that due to the need to provide a wide range of hospital services at geographical locations within NSW, the private hospital industry is characterised by a large number of relatively small, widely dispersed providers. In contrast, the NSW health fund industry is dominated by five major funds. The significant market power of the health funds means that some private hospitals are pressured into accepting contract terms and conditions as well as reimbursement levels which are not sufficient to cover even unavoidable costs.

The opposing submissions state that the Applicants already command higher levels of remuneration from health funds than other hospitals. Agreements reached with funds as a result of collective negotiations involving the three Applicants are likely to result in higher reimbursement levels. There is a chance that some funds may be unable to reach an agreement with any of the Applicants when the Applicants negotiate as a block. These funds are unlikely to be able to compete with other funds given the importance of the Applicants to hospital networks. The portable nature of fund membership could see funds successful in reaching an agreement with the Applicants increasing their market share.

While the Applicant's referred to the considerable "market power" of the health funds, the Commission noted in its Draft Determination that on the basis of market share, competition between funds is stronger in NSW, as shown in Table 3.2, than in any other Australian State. Regardless of whether or not smaller private hospitals are at a disadvantage in dealing with health funds, as suggested by the Applicants, the Applicants do not fall into this category of hospital.

The Commission considered that the Applicants are hospitals of substance in the private hospital market located in areas which have high concentrations of consumers insured with health funds. It was also noted that information provided by health funds shows that the Applicants' share of the total reimbursables or benefits paid out by the funds tends to be significantly higher than their share of the private hospital market measured in terms of number of beds.

The Commission stated in the Draft Determination that it believed that the originally proposed arrangement, while not necessarily resulting in the Applicants agreeing the same prices for equivalent services, would inevitably see agreement between the Applicants on price levels to be sought in negotiations with health insurance funds. It has stated above that it believes that the latest proposed conduct as embodied in the IHA will likely result in increases in reimbursement levels above those that would be achieved in the absence of the conduct.

The Commission considers agreements or arrangements between competitors that have an effect on prices to be amongst the most serious forms of anti-competitive conduct and highly likely to result in a lessening of competition.

The Commission accepts that the health funds are sincere in their belief that the Applicant hospitals are essential to their network of hospitals to maintain market share. The risk of not securing an agreement with any of the hospitals as a result of the collective negotiation process could lead funds to agree to increases in the reimbursables obtained by the Applicants from health funds.

The Commission's views

The Commission is of the view that the proposed conduct would result in an anti-competitive detriment in the private hospital – health insurance market through the impact of agreements on prices and increases in prices. The detriment would in particular be reflected by:

- increased costs to health funds, potentially impacting on health insurance premiums and membership levels; and
- the easing of competitive pressures on the Applicants to improve the quality and efficiency of operations and services as a result of their being given an opportunity to pass on cost increases.

The Draft Determination – The Applicants' response

In their response to this section of the Draft Determination the Applicants have stated that they do not believe that it is correct [for the Commission] to state that simply because the four major funds in NSW each have market shares of around 20% they do not have market power, but that the two major funds in Queensland having 30% and 50% market share each do have such power. It is argued that that the Commission has not used a valuable test proposed by the Applicants and cited in the Queensland hospitals determination 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%).

They also state that the Commission concluded that the proposed conduct would result in anti-competitive detriment in the private hospital – health insurer market but did not state whether this amounted to a substantial lessening of competition.

In relation to costs and efficiency the Applicants suggest that the Commission does not appear to distinguish between cost increases that are unavoidable and those which the NSW hospitals would be forced to reduce or avoid through competitive pressures. They only seek to obtain increases in reimbursements in relation to unavoidable costs.

In this part of its assessment the Commission's task is to determine whether or not there is a lessening of competition in the private hospitals – health insurers market as a result of the proposed conduct, and the extent of any associated detriment. It is quite clear to the Commission that there would be a lessening of competition. Otherwise the Applicants would not obtain the higher reimbursement levels which the proposed conduct is designed, intended and expected to deliver.

It would seem to the Commission that the main comments of the Applicants, in relation to bargaining position and the implications of a failure to negotiate a contract, relate more to the countervailing power public benefit claimed by the Applicants than a lessening of competition. It is in the examination of countervailing power that the position of the Applicants in the absence of the proposed conduct is relevant. If the inability of the Applicants to receive the higher reimbursement levels expected from the proposed conduct resulted in their viability being threatened, for example, it would be arguable that there was a public benefit from the proposed conduct of maintaining hospital viability.

As to the other comments of the Applicants, in the first instance, the Commission does not need to find a substantial lessening of competition in order to reject an authorisation. The Commission only has to find that the detriment associated with a lessening of competition (substantial or not) does not exceed public benefit.

As to costs, it seems to the Commission that the concept of unavoidable costs and efficiency are intrinsically linked. Any proposition that costs should be recognised as needing to be passed on because they are unavoidable runs contrary to the premise that prices should be market driven rather than derived from aggregate costs plus a return. The Productivity Commission recognised this in its 1999 report when stating:

> *"More generally, a negotiating framework that allowed hospitals to readily pass on any cost increases to health funds and their members would not be in the interests of the community."* [Summary, page xvii]

In a private hospital industry subject to strong competitive pressures and universally operating at optimal efficiency, the failure of health funds to recognise changes in hospital cost structures could lead to reductions in hospital services and/or hospital failures. This would hardly seem in the interests of the health funds.

In a private hospital industry that is not operating efficiently there is a danger that conduct such as that proposed by the Applicants which recognises and pursues compensation for unavoidable costs, can lead to a reduction in pressures to achieve efficiency and an inefficient allocation of health insurance fund resources.

While the Commission examines the financial performance of private hospitals more closely when examining the Applicants public benefit claims, there is merit in briefly mentioning the findings of the recent Productivity Commission report in this area. While not drawing any conclusions about their efficiency, the Productivity Commission noted in relation to religious/charitable not-for-profit private hospitals, the group to which the Applicants belong, that they have unit costs around 23% higher than the next highest private hospital group.

The health insurance fund – patient market

The Commission believes that the proposed arrangement would tend to result in the Applicants all obtaining optimal prices in negotiations with health funds. Given the major role the Applicants play in benefits payable in the Sydney metropolitan area this could see reduced premium price 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.

For the above reasons there would be a detriment in the health fund - patient market from the proposed conduct.

In its response to the Draft Determination the Applicants state that they have provided evidence to the Commission that any increase in premiums resulting from increases in reimbursements to the hospitals would be minuscule. The Applicants state the belief that the Commission vastly overestimated the effects of any reimbursement increases.

The evidence provided to the Commission by the Applicants was an estimate of premium increases. The Applicants estimated that a 0.0015% increase in premiums would be required to give them a 1% increase in reimbursements and that this would require a 7.2 cents per week increase in insurance premiums. Following comments from HCF on their methodology the Applicants revised this estimate to 8.8 cents (prior to the 30% rebate).

HCF also supplied estimates, based on the Applicants obtaining a 4% increase in reimbursements and some flow on to other funds. The 4% is the portion of unavoidable cost increases identified by the Applicants in their application not covered by negotiation outcomes at the time. The HCF approach results in a 2.1% increase in premiums, amounting to $0.74 per week for family policies.

The Commission has examined both methodologies and believes that the HCF estimate is closer to a likely outcome than the Applicants' estimate. The Commission considers that an increase in premiums approaching $1 per week would constitute a significant detriment arising from the lessening of competition associated with the proposed conduct. From the Commission's perspective it also has to take into account all increases in reimbursements arising from future negotiations involving the proposed conduct.

The hospital – ancillary service market

The Applicants have stated in their application, when claiming reductions in costs to hospitals as a public benefit, that *if this Application is approved, other major savings may achievable* in areas such as common administrative procedures, group purchasing, common or compatible computer systems, common linen service, the rationalisation of some medical services and access to capital.

The Applicants are not by this comment seeking authorisations of such activities in this application but are observing that if the Commission authorises joint negotiations with health funds then they perceive that the ability of the Applicants to share information would allow them to act together for other purposes. This matter is discussed below under the analysis of claimed public benefits.

7.4. Barriers to entry

The Commission stated in Determination A50019 that there were significant barriers to entry such as the extent of capital required, Government approvals and the need to attract doctors. While these barriers, as the Commission stated, are not in themselves insurmountable, they are still substantial. Moreover, the current financial performance of the hospital industry, relative to other sectors of the economy, may not be conducive to attracting investment at the levels required to establish facilities which would be competitive with the Applicants. There are also long lead times in bringing a new private hospital to full operating status.

7.5. Conclusion on competition

The Commission is of the view that the Applicants do compete for patients and the Proposed Arrangement for negotiation with health funds would be likely to lead to a lessening of competition in the hospital – patient market. This lessening of competition 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 reimbursement levels. The detriment would be reflected in increased costs to health funds, potentially impacting on premiums and membership, and the easing of pressure on the Applicants to improve the quality and efficiency of their services.

The Proposed Arrangement would tend to result in the Applicants all obtaining optimal prices in negotiations with health funds. Given the major role the Applicants play in benefits payable in the Sydney metropolitan area this could see reduced premium price 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. For the above reasons there could be a detriment in the health fund - patient market from the Proposed Arrangement.