**(Public Register)**

**Acute Public Hospitals (Beds) in Metropolitan Sydney**

| Name | Area Health Service | Average Available Beds |
|---|---|---|
| Concord Repatriation | Central | 568 |
| Liverpool District | SW Sydney | 499 |
| Penrith – Nepean | Wentworth | 382 |
| Prince of Wales/Prince Henry | SE Sydney | 598 |
| Royal North Shore | Northern Sydney | 628 |
| Royal Prince Alfred | Central Sydney | 799 |
| St George | SE Sydney | 542 |
| St Vincents Darlinghurst | SE Sydney | 336 |
| Westmead | Western Sydney | 707 |
| | | |
| Auburn District | Western Sydney | 153 |
| Bankstown/Lidcombe HS | SW Sydney | 404 |
| Blacktown | Western Sydney | 290 |
| Campbelltown | SW Sydney | 186 |
| Canterbury District | Central Sydney | 117 |
| Fairfield District | SW Sydney | 169 |
| Hornsby & Ku-Ring-Gai | Northern Sydney | 262 |
| Manly District | Northern Sydney | 189 |
| Mona Vale District | Northern Sydney | 158 |
| Mount Druitt | Western Sydney | 136 |
| Ryde | Northern Sydney | 150 |
| Sutherland | SE Sydney | 303 |
| | | |
| Sydney Childrens | SE Sydney | 136 |
| The New Childrens Hospital | | 243 |

| | | |
|---|---|---|
| Royal Hospital for Women | SE Sydney | 153 |
| Sydney/Sydney Eye | SE Sydney | 78 |
| Total for public acute | | 8186 |

Source: http://internal.healty.gov.au/isad/iad/yb9798/hospgrps.html

1997/98 Public Hospitals Comparison Data Book – Hospitals by Group & Area

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| | |
|---|---|
| Combined total for acute hospitals | Beds 11,851 |
| **Applicants' current share of:** | |
| Private acute in metro Sydney | Beds 8.4% |
| Combined acute in metro Sydney | Beds 2.6% |

**(Public Register)**

The estimate of the hospital services/patient market in the Great Lakes Shire Region is as follows:

| Description | No. of hospitals | Beds | Admissions |
|---|---|---|---|
| **Private acute hospitals in the Great Lakes Shire region** | | | |
| Cape Hawke Community Private Hospital | 1 | 42* | 3,058 |
| Other private acute | Nil | | |
| Total for the private acute | 1 | 42* | 3,058 |

* Plus 8 licensed day surgery beds + 21 licensed inpatient beds approved in principle (under construction).

| Description | No. of hospitals | Beds | Admissions |
|---|---|---|---|
| **Public acute hospitals in the Great Lakes Shire region** | | | |
| Buladellah District Hospital | 1 | 13 | |
| Total for other public acute | 1 | 13 | |
| Combined total for acute hospitals | 2 | 55 | |

**Applicants' current share of:**

| | |
|---|---|
| Private acute in the Great Lakes Shire region | Beds 100% * |
| Combined acute in the Great Lakes Shire region | Beds 76.4% * |

* NB: Cape Hawke Community Private Hospital will not under this Application share any information with another Applicant Hospital in the hospital/patient market in which it participates.

Some patients in this region also attend hospitals out of the region such as Newcastle, for particular specialties (no patients from Newcastle are treated in this region), Manning Base Hospital, particularly for obstetrics and Port Macquarie as a number of the specialists having accreditation at Cape Hawke also have accreditation at Port Macquarie (and on occasions surgery is undertaken at that hospital).

The estimate of the hospital services/patient market in the Manning Valley District as follows:

| Description | No. of hospitals | Beds | Admissions |
|---|---|---|---|
| **Private acute hospitals in the Manning Valley District** | | | |
| Taree Mayo Private Hospital | 1 | 39 | |
| Other private acute | Nil | | |
| Total for the private acute | 1 | 39 | |
| **Public acute hospitals in the Manning Darling District** | | | |
| Manning Base Hospital | 1 | 176 | |
| Gloucester Soldiers Memorial Hospital | 1 | 80 | |
| Wingham Hospital | 1 | 36 | |
| Total for other public acute | 4 | 292 | |
| Combined total for acute hospitals | 5 | 331 | |

**Applicants' current share of:**

Private acute in the Manning Darling District Beds 100% *

Combined acute in Manning Darling District Beds 10.8%

* Note: Mayo Private Hospital will not under this Application share any information with another Applicant Hospital in the hospital/patient market in which it participates.

The estimate of the hospital services/patient market in the Newcastle, Maitland and Port Stephens Regions is:

| Description | No. of hospitals | Beds | Admissions |
|---|---|---|---|
| **Private acute hospitals in the Newcastle, Maitland and Port Stephens region** | | | |
| Hunter Valley Private Hospital | 1 | 40 | 3365 |
| **Other Private Acute** | | | |
| Christo Road (HCOA) | 1 | 68 | |
| Lingard (HCOA) | 1 | 120 | |
| Warners Bay (HCOA) | 1 | 71 | |
| Toronto Private (Independent) | 1 | 72 | |
| Lake Macquarie Private (MBF) | 1 | 78 | |
| NIB Private (NIB) | 1 | 38 | |
| Total for the private acute | 7 | 487 | Not available individually |
| **Public acute hospitals in the Newcastle, Maitland and Port Stephens region** | | | |
| Belmont | 1 | 98 | 6613 |
| John Hunter | 1 | 630 | 52225 |
| Newcastle Mater | 1 | 166 | 10550 |
| Royal Newcastle | 1 | 120 | 7430 |
| Nester Bay Polyclaire | 1 | 14 | 786 |
| Cessnock Hospital | 1 | 84 | 5194 |
| Duryong Hospital | 1 | 15 | 3298 |
| Kurri Kurri Hospital | 1 | 40 | 10849 |
| Maitland Hospital | 1 | 155 | 11558 |
| Singleton Hospital | 1 | 169 | 14617 |
| Total for other public acute | 10 | 1491 | 123120 |

| | | |
|---|---|---|
| Combined total for acute hospitals | 17 | 1978 |

**Applicants' current share of:**

| | |
|---|---|
| Private acute in the Newcastle, Maitland and Port Stephens region | 8.2% of beds |
| Combined acute in the Newcastle, Maitland and Port Stephens region | 2% of beds |

The estimate of the hospital services/patient market in the Wagga and South Western New South Wales Region is:

| Description | No. of hospitals | Beds | Admissions |
|---|---|---|---|
| **Private acute hospitals in the Wagga and South Western NSW region** | | | |
| Calvary Hospital Wagga Wagga Inc | 1 | 90 | 5742 |
| **Other Acute Private** | | | |
| Albury Wodonga Private Hospital | 1 | | |
| Albury & Wagga Wagga Day Surgery | 1 | | |
| Wagga Wagga Endoscopy Centre | 1 | | |
| Mercy Hospital | 1 | | |
| Murray Valley Private Hospital | 1 | | |
| Total for the private acute | 6 | | |
| **Public acute hospitals in the Wagga and South Western NSW region** | | | |
| Wagga Wagga Base Hospital | | | |
| Albury Base Hospital | | | |
| Total for other public acute | | | |
| Combined total for acute hospitals | | | |

**Applicants' current share of:**

| | |
|---|---|
| Private acute in the Wagga and South Western NSW region | 61.5% of Private Hospital/Day Surgery Acute admissions* |
| Combined acute in the Wagga and South Western NSW region | 44.9% of Private admissions to both Private & Public Hospitals * |

* Figures for beds and admissions incomplete. Market share figures are provided by Market Assessment Survey in 1997.

**Note** Calvary Hospital will not under this Application share any information with another Applicant Hospital in the same hospital/patient market in which it participates.

**(Public Register)**

Set out below are the coverage and market shares of health funds in NSW and nationally.

**Table 1 Health funds: national membership coverage as at 30 June 1998**

| Health fund | Members | | Coverage (1) | |
|---|---|---|---|---|
| | No | % | No | % |
| Medibank Private | 937,372 | 28.9 | 1,971,025 | 29.1 |
| MBF | 628,361 | 19.4 | 1,284,728 | 19.0 |
| HBF | 392,489 | 12.1 | 787,866 | 11.6 |
| National Mutual (2) (AXA) | 361,390 | 11.2 | 749,367 | 11.1 |
| HCF | 288,797 | 8.9 | 620,780 | 9.2 |
| NIB | 159,839 | 4.9 | 340,388 | 5.0 |
| Australian Unity | 98,384 | 3.0 | 187,585 | 2.8 |
| SGIO | 42,914 | 1.3 | 98,429 | 1.5 |
| Other | 330,086 | 10.2 | 726,466 | 10.7 |
| *Total* | *3,239,632* | *100.0* | *6,766,634* | *100.0* |

**Table 2 Health funds market share (%), by State, as at 30 June 1998 (1)**

| Fund | NSW | VIC | QLD | SA | WA | TAS | NT | AUST |
|---|---|---|---|---|---|---|---|---|
| Medibank Private | 20.2 | 42.5 | 36.8 | 16.6 | 18.3 | 27.0 | .. | 28.9 |
| MBF | 26.4 | 3.0 | 54.0 | 4.6 | .. | 52.7 | 56.8 | 20.5 |
| HBF | .. | .. | .. | .. | 74.1 | .. | .. | 7.1 |
| National Mutual (2) (AXA) | 1.0 | 28.0 | 3.3 | 56.7 | 1.2 | 0.1 | 43.2 | 14.4 |
| HCF | 21.4 | .. | .. | .. | .. | .. | .. | 7.1 |
| NIB | 15.2 | 0.7 | 1.7 | 0.6 | 0.3 | 0.4 | .. | 5.6 |
| Australian Unity | .. | 14.5 | .. | .. | .. | .. | .. | 4.1 |
| SGIO | .. | .. | .. | 12.5 | 1.0 | .. | .. | 1.3 |
| Other | 15.9 | 11.2 | 4.2 | 8.9 | 5.0 | 19.7 | .. | 11.0 |
| | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Source of both Tables: PHIAC Annual Report 1997/98

## 4. Effect on competition

The Applicants propose to share non fee related as well as fee/cost/price related information.

In terms of the main markets affected by the conduct, the Applicants submit as follows:

(a) The private hospital/health fund market

On the basis that the relevant geographic boundary of the market is the State of New South Wales the combined market share of all of the Applicants is very small as compared with the total number and size of private hospitals in New South Wales

Further as will be set out below, the bargaining power of the Applicants as compared with, in particular the major health funds and the alliances of smaller health funds is heavily in favour of the health funds

(b) The private hospital/patient market

Leaving aside that private hospitals compete with public hospitals for private patients, it is clear from the above tables that where the Applicants are participating in the same geographic market they have low shares in the market. Where the Applicants have higher market shares in a market they are only sharing information with Applicant hospitals participating in separate geographic markets.

Accordingly, the effect of the proposed conduct on competition is likely to be negligible.

**Public benefits arising from the proposed Inter Hospital Agreement**

This application will refer initially to the public benefits and other circumstances necessitating the Application for Interim Authorisation of the proposed Inter Hospital Agreement referred to in paragraph 2(a) of the Application before setting out any further benefits associated with the other elements of the proposed Inter Hospital Agreement.

## 5. Application for Interim Authorisation

### (a) Appointment of common agent to facilitate the sharing of information.

The Applicants are proposing to appoint a common agent to facilitate in the sharing of information between the hospitals.

The Applicants have taken account of the ACCC's concerns in the Authorisation No. A50019 about the collection of information by the hospitals themselves. Accordingly, the proposed Inter Hospital Agreement will set out that, rather than the Applicants collecting the information themselves, an agent be appointed by the hospitals to collect the information on behalf of each of them.

(b) **The collection of fee/cost/price information and non-fee information by the agent on behalf of the Applicants.**

*Non-fee related Information*

The Applicants propose that the agent may collect data from Applicants about a particular procedure or procedures sought to be covered in a HPPAs, and other information pertaining primarily to quality/benchmarking issues such as:

- Clinical indicators;
- numbers of staff per hospital beds/admissions; and
- operational data.

The Applicants submit that such data:

(i) acts as a benchmark against which each hospital may measure itself in relation to standards of patient and hospital management;

(ii) provides Applicants with a view about the practices that are efficient and necessary and those that are more incidental - such data is vital as part of the negotiations/trade-offs as part of negotiation of the HPPAs.

(iii) allows for the transfer of innovations among the member Applicants;

(iv) inevitably leads to an overall increase in the quality systems and efficiencies referable to patient and hospital management. This may be translated into cost savings both in terms of the practices of individual hospitals and among members who may wish to take advantage of sharing training facilities, production of similar manuals etc (the likely convergence of systems is likely to lead to those cost saving opportunities); and

(v) the resulting improvements in quality are likely to result in an increased ability to attract highly qualified personnel.

In their Statements of Antitrust Enforcement Policy on Health Care the DOJ and FTC stated that:

> "the collective provision of non-fee related information by competing health care providers to a purchaser in an effort to influence the terms upon which the purchaser deals with the providers does not necessarily raise anti-trust concerns. Generally, providers' collective provision of certain types of information to a purchaser is likely either to raise little risk of anti-competitive effects or to provide pro-competitive benefits.......... and will not be challenged by the agencies, absent extraordinary circumstances..........
>
> However, the antitrust safety zone excludes any attempt by providers to coerce a purchaser's decision making by implying or threatening a boycott any plan that does not follow the providers' joint recommendation.........." (Page 17 of 63 internet version of these statements).

The proposed Inter Hospital Agreement will not provide for collective action in the way of boycott.

***Fee/cost/price related information***

The applicants submit that:

(i) sharing information about the costs can as with non-fee related information, provide benchmarks against which hospitals may measure themselves and aim to reduce costs. This is relevant to many areas within hospitals such as the cost of "meal per patient day", cost of and utilisation of staff, linen, salaries, diagnostics, medical and non medical consumables etc. This provides hospitals with information and scope for cost reductions.

The information merely serves to improve the quality of information available to hospitals in negotiating with suppliers of such goods or services. These negotiations take place between the individual hospital and the supplier of goods or services. The supply of many of these goods or services are to some extent in a similar position to the health funds in that they are often larger than the individual private hospitals and have the advantage of being the suppliers to a large number of hospitals;

(ii) small hospitals do not have the resources individually to undertake the cost and revenue modelling required to negotiate with health funds on an equal footing (the health funds use such models as the basis for their negotiations on the extent of payments to hospitals). The sharing of this information will enable the hospitals to more accurately model the efficient costs of their operations and allow better informed negotiation;

(iii) the sharing of information will enable small hospitals to negotiate more efficiently with health funds on "case payments". Case payments are agreements entered into (as part of the HPPA) whereby the health fund pays to the hospital an agreed amount for the hospital's costs of a procedure. Health funds are at an advantage, particularly where the procedures are not very common, in that they have price information from a large number of hospitals about the same procedure. The sharing of information will provide the Applicants with a larger "sample size" from which they can calculate the costs of procedures and provides for a more equal negotiation process;

(iv) the sharing of information will better inform the Applicants of the general nature of offers that are being made by health funds to comparably sized hospitals - again leading to more equality in the bargaining process;

(v) the sharing of information may also reduce the extent of variations in payment structures by health funds to similar sized hospitals. In the longer term this will reduce significantly the cost of administration by the hospitals in contract management as at present each fund has a different pricing structures, criteria for reimbursement and reimbursement levels that require additional administrative staff in order to manage the complexities of the variations in the contracts;

(vi) hospitals can use price related information to price their services more competitively and to offer compensation that attracts highly qualified personnel; and

(vii) fee-related information can help health funds to efficiently develop reimbursement terms to be offered to the hospitals and may be useful to a health fund when provided in response to a request by the health fund or at the initiative of the hospitals.

In their statements of Antitrust Enforcement Policy on healthcare, the DOJ and FTC stated that:

> "factual information concerning the fees charged currently or in the past for the providers' services, and other factual information concerning the amounts, levels or methods of fees or reimbursement, does not necessarily raise antitrust concerns. With reasonable safeguards, providers' collective provision of this type of factual information to a purchaser of health care services may provide pro-competitive benefits and raise little risk of anti-competitive effects" (page 18 of 63 - internet version of these statements).

Similarly, the DOJ and FTC stated that:

> "participation by competing providers in surveys of prices for health care services, or surveys of salaries, wages or benefits of personnel, does not necessarily raise antitrust concerns. In fact, such surveys can have significant benefits for health care consumers. Providers can use information derived from price and compensation surveys to price their services more competitively and to offer compensation that attracts highly qualified personnel. Purchasers can use price survey information to make more informed decisions when buying health care services........" (page 20 of 63 - internet version of these statements).

The DOJ and FTC recommended safeguards for both fee related and price information and stated that once such safeguards are in place, these agencies will not challenge the providers "absent extraordinary circumstances" (see page 18 & 20 of 63 - internet version of these statements).

The safeguards proposed by these agencies and also set out in the ACCC's Determination of Authorisation No. A50019 were as follows:

1. the collection of fee related information (or the surveys of price information) is managed by a third party (in this case the agent);

2. although current fee related/price information may be provided to purchasers, any information that is shared among or is available to the Applicants furnishing the data must be more than three months old;

3. for any information that is available to the providers furnishing the data, there are at least five providers' reporting data upon which each disseminated statistic is based and no individual provider's data may represent more than 25% on a weighted basis of that statistic (the ACCC settled on a figure of 30%);

4. any information disseminated must be sufficiently aggregated such that it would not allow recipients to identify the prices charged by any individual provider.

The DOJ and FTC stated that such safeguards are "intended to ensure that an exchange of price or cost data is not used by competing providers for discussion or coordination of provider prices or costs" (page 19 of 63 - internet version of the statements).

The Applicants have included all of the above safeguards in the terms and condition of the proposed Inter Hospital Agreement.

The Productivity Commission stated that "one aspect of the current policy framework that warrants further attention is the prohibition on private hospitals (other than those within the one ownership group) voluntarily sharing information on the outcomes of recent rate negotiations. While this prohibition may help to prevent collusion between hospitals it may also impose costs. For example ..., some of the major health funds are no longer offering contracts to all hospitals. In these circumstances the sharing of information on prices may help individual hospitals determine what performance improvements are necessary to secure contracts ... In effect the current arrangements disadvantage stand-alone hospitals given that hospitals in the one ownership group can readily and legally share price information." (Page 108 Productivity Commission Report, Private Hospitals in Australia).

(c) **The agent to negotiate purchaser/ provider contracts on behalf of each Applicant hospital with health funds or groups of health funds having in excess of 10% market share for the provision of private hospital services for health insurers.**

The proposed Inter Hospital Agreement includes the appointment of the agent referred to above to conduct negotiations with health funds having a market share in excess of 10% of the market for the supply of private hospital services to health insurers, on behalf of each individual applicant, in order to attempt to redress the inequality of bargaining power and information referred to above and to promote more efficient outcomes.

The proposed Inter Hospital Agreement provides that the Applicants may seek the assistance and advice of the agent in deciding whether to accept a term of offers made to them by the health funds.

It is further envisaged that over time, following experience of continuous negotiations with health funds, the applicants will move toward the development of a model form of contract dealing with all issues other than price.

At present private hospitals in New South Wales must enter into negotiations and subsequently contract with at least 7 health insurer entities (there are alliances of a large number of the smaller health funds). Each of these entities have different pricing structures, criteria for reimbursement and reimbursement levels – and these structures and criteria of each health insurer have, in the past, changed annually.

The almost completely different criteria require several account managers to manage the administrative burdens. There would be substantial cost savings of the Applicants (and indeed the whole industry in the medium term) by working toward a model form of contract that at least has consistency of criteria such as standardised patient classification and model for payment methodology.

There would also be benefits to the users of health insurers as they may be able to compare insurers on a more "like for like basis".

The Applicants have taken account of the concerns raised by the ACCC in its Determination of Authorisation No. A50019 and have included the following safeguards in the proposed Inter Hospital Agreement:

(i) that the negotiation process does not extend to joint price by the Applicants;

(ii) that the agent will communicate price offers directly to each Applicant hospital. The hospital will then make an independent and unilateral decision on whether or not to accept the terms of any particular contract. The Applicants as a collective or a committee of applicants will not enter into HPPAs on behalf of any individual Applicant hospital;

(iii) the Applicants as a collective will not advise or make recommendations to any individual Applicant member regarding the appropriateness of any particular price offer communicated by the agent; pricing decisions are to remain entirely within the domain of the individual Applicant hospital;

(iv) the proposed Inter Hospital Agreement is non-exclusive in relation to the terms and conditions concerning negotiations with health funds. Accordingly:

- each Applicant hospital will be at liberty to choose not to avail itself of the services of the common agent;
- each Applicant hospital may adopt any other process it sees as appropriate for negotiating and concluding an HPPA;
- no Applicant hospital is bound to contract or to decline to contract with any particular health fund;

(v) the Applicants agree that any confidential information that comes into their possession regarding a competitor will not be used for any other purpose other than for sharing of information between the Applicants and negotiations with health funds; and

(vi) that any of the Applicant hospitals may choose to resign from the group of Applicants and not be bound by the proposed Inter Hospital Agreement upon giving notice in writing to that effect.

Together with the collection and sharing of the price/fee and non-fee information referred to above, the Applicants' proposals relating to negotiations with health funds will:

(a) allow the Applicant hospitals to access information and expertise in bargaining HPPAs to enable them to compete more efficiently against the integrated hospital when contracting with health funds and to seek to contract with health funds with more equality of bargaining power;

(b) be likely to result in increased bargaining expertise and will, in time, result in the reduction of the costs of obtaining such information and negotiating HPPAs and reduce the "cost of doing business" by private hospitals;

(c) result in increased efficiencies and a reduction in the cost of providing hospital services and ancillary health care;

(d) result in an increase of the quality of the services provided by the Applicant;

The Applicants took account of the ACCC's concern in both Authorisations that it is only in negotiations with the larger health funds that the Applicants are likely to be disadvantaged and where the proposed use of an agent may properly be utilised to enhance their negotiating position. Accordingly, the Applicants are only seeking, in the Application for Interim Authorisation to have the agent negotiate on behalf of each individual Applicant with health funds or groups os health funds having excess of 10% market share in the market for the provision of hospital services to health funds in NSW. At present the largest four health funds in New South Wales and possibly the alliance of smaller health funds have market shares in excess of 10%.

**The Issue of Inequality in Negotiating Power/Countervailing Power**

The Applicants generally concur with the statements made by the ACCC on pages 42-45 of the Determination of Authorisation No A50019 about the inequality of bargaining power between private hospitals and the larger health funds.

The balance of negotiating power does rest with the large health funds, particularly when compared with small hospitals. A Senate Committee (SCALC 1996) went further than the ACCC in that it found that "health funds are generally in a much stronger negotiating position than the hospitals (page 82 Productivity Commission Report in Private Hospitals in Australia). The resources allocated by the health funds and groups of health funds provides further evidence of their expertise and power in terms of negotiations with Private Hospitals. The Applicants understand that at least the larger health funds and health fund alliances have full-time contract negotiators for HPPAs and MPPAs.

The Applicants making this Application, who are all small private hospitals, further submit that one relevant issue that the ACCC may not have taken into account in its Determination of Authorisation No. 50019 is the fact that the manner in which health funds are conducting their negotiations with hospitals is changing dramatically. An example on the changing negotiation landscape is the selective tendering process which has been commenced by Medical Benefits Fund of Australia Limited ("**MBF**") in Queensland and will shortly be implemented in New South Wales.

However, MBF is not the only fund to have commenced such a process. AXA Health Insurance (formerly National Mutual) ("**AXA**") commenced a similar process in Victoria and South Australia in 1997. The Productivity Commission stated that "AXA uses a competitive tendering process to select private hospitals with which it will contract for 100% cover. In 1997-98 this process provided for 100% cover for some 70% to 80% of

private hospital beds in Victoria and South Australia. ... eight criteria are used to assess tenders: location/demand; range of specialties; capacity; vision; performance, facilities; quality and price ..." (page 79 Productivity Commission Report in Private Hospitals in Australia).

The Productivity Commission also noted that "the Private Hospitals which did not receive contracts in the AXA Health Insurance's 1998 Victorian tender were predominantly small facilities." (page 83 Productivity Commission Report in Private Hospitals in Australia).

MBF is seeking tenders from private hospitals for the provision of hospital and associated services. The aim is to create an MBF network of hospitals for the benefit of MBF's members.

The tenders will be evaluated based on the following criteria:

- Competitive pricing for services offered;
- Level of quality care both in terms of method of care and patient outcomes;
- Extent to which services are bundled into an inclusive price for each DRG;
- Willingness and ability to offer aggregated billing (that is, aggregation of hospital's and individual service providers' bills into a single bill);
- Plans for doctors' participation in the MBF schedule of medical fees or other arrangements with doctors;
- Level of use of clinical pathways, to demonstrate quality and efficiency of care;
- Convenience of access for MBF members, especially in the areas with limited choice or difficulties of access;
- Use of technology such as electronic data interchange;
- Financial viability of the tenderer;
- The extent to which a tenderer is non-complying, including the extent of any changes sought to the HPPA;
- MBF's previous experience (if any) with the hospital.

(MBF Request for Tender, Part B Tendering, Part B-7).

The Applicants submit that the conduct that is the subject of this Application will assist them in attaining the MBF criteria.

MBF has stated in the Request for Tender that:

"MBF currently contracts with approximately 90% of private hospitals in Queensland. MBF will, in future, meet the health care needs of our members by establishing a limited network of hospitals..... MBF anticipates it will need to purchase approximately 70% of

the beds currently accessible to MBF members." (MBF Request for Tender, Part B Tendering, part B-2).

Accordingly, MBF expressly states that 30% of the hospitals (or more correctly hospital beds) that are currently the subject of contracts with MBF will not be so contracted following the conclusion of this tender process.

MBF states that:

"MBF benefits paid at those hospitals who are not successful or do not submit a tender bid will be substantially less than agreement rates. MBF envisages that there will be no benefit for pharmacy, single use items or, in some cases, theatre. Benefits could be as low as default benefits, as determined by the Minister of the Commonwealth Department of Health and Aged Care............ Hospitals should note that MBF Network Hospitals will be required to comply with substantially higher quality standards than under MBF's previous contracting policy. MBF understands that this will increase the threshold criteria, set by the Minister, to qualify for Second Tier Default Benefits. Therefore, MBF expects fewer hospitals to comply for these benefits than is currently the case." (MBF request for tender – part B tendering – part B – 11).

It is clear that MBF is adopting a "take it, or leave it" approach. It is also clear that the hospital that are not chosen by MBF to be in the MBF group of hospitals are likely to experience financial difficulty. We refer to the ACCC's Determination of Authorisation No. 50019 which states that "acceptance of Second Tier Benefit (which is effectively what is available to the hospitals not entering into HPPAs with MBF) implies accepting a price of approximately 15% below the market average. Evidence available to the ACCC suggests that very few hospitals achieve a 15% margin on operations and so acceptance of a Second Tier would be equivalent to accepting a loss. Thus it is unlikely that hospitals could use the existence of a Second Tier as a viable fall back position" (ACCC Determination of Authorisation number 50019, page 50 of 78).

Anecdotal evidence available to the Applicants suggests that all of the major health funds are proposing to pursue a form selective tendering process. The AHSA is seeking to introduce a form of selective tendering in Victoria (even the Department of Veterans Affairs is seeking to introduce selective tendering in New South Wales and Victoria). The Productivity Commission states that Medibank Private also uses a tendering approach (page 79 Productivity Commission Report, Private Hospitals in Australia).

It is also clear that the small unintegrated hospitals who have less information and are less likely to provide bundled services required by the abovementioned tender are at a greater disadvantage taking into account the criteria of the MBF Request for Tender.

The Applicants also submit that even in their negotiations with some of the smaller health funds there is inequality as a number of these funds have formed into alliances such as AHSA which provides management services to its member funds and negotiates entry into HPPAs with private hospitals.

The Applicants submit that a major public benefit arising from the proposed Inter Hospital Agreement and the proposed conduct of the Applicants is the potential for redressing of the inequality of bargaining power with the health funds.

Unlike the circumstances of Authorisation No. A90679, the current proposal may "coexist with effective competition" in that the sharing of information and use of the agent to

negotiate HPPAs will merely increase the capacity of each Applicant to negotiate with health funds and to compete more effectively with other private hospitals.

The Applicants, at least in terms of the interim Authorisation are not seeking an "all or none" collective negotiation process with health funds (the terminology used by the ACCC on p28 of the Draft Determination of Authorisation No. A90679). Even if they sought to do so health funds are unlikely to be "severely disadvantaged" if they did not contract with the Applicants (as was the concern of the ACCC on p38 of the Draft Determination). In this regard the Applicants note that, in terms of beds, the Sydney Adventist Hospital, by itself, has more capacity than all of the Applicants to this Authorisation that participate in the Sydney market.

In relation to each of the Applicants, it is improbable in the current negotiating environment that a submission may be made "that it is unlikely that the Applicants negotiating individually would fail to reach contracts with the health funds (as the ACCC stated on p36 of the Draft Determination of Authorisation No. A90679) as notwithstanding the inequality that is likely to lead to the Applicants accepting whatever offer is made by health funds, the selective tendering process may nevertheless result in no HPPAs for the Applicants.

Further, the negotiating power of the Applicants, simply armed with better information, is unlikely to be in excess of the smaller funds.

Finally, if improved information and the use of an agent for negotiations were to lead to an increase in reimbursement levels to the Applicants, the reimbursement would be utilised in ensuring the Applicants remain viable providers of surgical and medical services and attain the benchmarks required by the health funds in the selective tendering processes.

**Other Issues for Consideration**

6. **Nexus between the public benefits and the authorisation**

In the ACCC's Determination of Authorisation No. A50019, reference was made to submissions by those opposing the Application that information was readily available to the Applicant hospitals in the form of Hospital Case Mix Protocol Data, the APHA's Performance Indicator Comparison Service, ABS statistics etc.

The Applicants submit as follows:

(a) the information that is publicly available is generally not timely and contains inaccuracies;

(b) the information did not have consistent definitions and was not comparative, particularly in a historical sense;

(c) the information is generally highly aggregated and is not in a form that may be "manipulated" by the Applicants in order to obtain the information in a particular manner; and

(d) information relevant to the Applicants, such as costs/price information is generally not available or is included in such an aggregated manner so as to be of little assistance, particularly to small private hospitals.

Accordingly, all of the information sought to be shared by the Applicants is necessary for their negotiation strategies as well as the future strategic and investment planning.

7. ***Scope for Negotiation by the Agent***

The Applicants note the concern of the ACCC in its Determination of Authorisation No 50019 about the possibility that the scope of the common agent section be altered (page 55 of 78 of the Determination).

The proposed Inter Hospital Agreement provide that the scope of the agent's negotiation power will be as per the requirement of the ACCC in that Determination.

8. ***The addition of new network members to the contract arrangement or understanding.***

In its Determination of Authorisation No A50019 the ACCC stated that if the network wished to add new members it must apply for a variation of the Authorisation. At present, the market share of the participants in each of the markets that participate is low save for a number of regional hospital/patient markets. However, in these markets the particular Applicant is not sharing information with any other hospital in the same geographic market.

The proposed Inter Hospital Agreement will expressly state that parties may be added to the group only to the extent that the addition of a party does not extend the combined market share of the group in any one market beyond 40% of the market. Where there is only one Applicant hospital in a hospital/patient market the sharing of information with hospitals outside the market is unlikely to result in a substantial lessening of competition.

9. ***The Urgency that Necessitates an Interim Authorisation***

The Applicants are a number of small hospitals operating in a number of regions in New South Wales. The Applicants are operating in a market in which the conditions are being altered dramatically due to the selective tendering processes referred to above and other HPPA requirements. Accordingly, in order for the Applicants to continue to operate viably and provide services to their patients the Applicants must be in a position to have the information and the ability to utilise that information in the bargaining process that will commence shortly with MBF and is likely to be repeated in some form in the short term with the other major health funds.

Further, all of the issues that are the subject of this Application for Interim Authorisation have been canvassed in detail in the ACCC Determination of Authorisation No. A50019, 1 September 99 and the Applicants have taken account of all of the conditions set out by the ACCC in its Determination.

10. ***Issues Subject to the Application for Authorisation (Other Than Interim Authorisation)***

(a) **The proposed collection and sharing of current fee/cost/price information and non-fee related information by Applicants through the agent on a disaggregated or alternatively on an aggregated basis**

To date, the duration of HPPAs in New South Wales is 12 months. Accordingly, the sharing of aggregate three month old information is beneficial to the Applicants, generally only from a historical perspective. Such information sets

out the costs associated with Agreements with health funds that occurred in the previous year.

The current proposal by MBF is for contracts with hospitals for a two year period. Accordingly, the information, in so far as its practicability for the negotiation of upcoming contracts with health funds, may, in effect, be two years out of date. While it provides useful historical information it is likely to be only of marginal utility for proposed negotiations.

As the reason that the Applicants are seeking to enter into the proposed Inter Hospital Agreement to share information is to equalise bargaining power in current negotiations, the fact that the information will in effect be two years old is of little assistance.

In relation to disaggregated information, the safeguards that the Applicants propose to have in place are that:

(i) the information will refer only to the size of the hospital in terms of beds and admissions; and

(ii) the information will not refer to the name of the hospital or region in which the hospital participates.

In the event that the ACCC does not accept the Applicants' submission about the safeguards in place regarding disaggregated information the parties submit that current information that is aggregated should be shared by the Applicants.

The Applicants submit that in such circumstances, all of the safeguards referred to above about aggregated information will apply (save for the age of the information).

Current information will also assist all the hospitals to price their services more competitively and offer compensation that attracts highly qualified personnel. As stated above, the Applicants are in competition with a large number of other hospitals for the attraction of quality personnel. Up to date information allowing the hospitals to benchmark themselves will provide them with better opportunities to attract better staff as well as attracting visiting medical personnel that carry out procedures in private hospitals. The information that is shared by the Applicant will not, in any way, place a restraint on the manner in which the visiting medical officers propose to charge patients for any procedures undertaken at that hospital.

The sharing of current cost information relating to, for example, consumables serves to identify a hospital's position as against benchmarks set by a larger sample of hospitals.

The Applicants reiterate that this information merely serves to improve the quality of information available to hospitals in negotiating with suppliers of such goods or services. These negotiations take place between the individual hospital and the supplier of goods or services. The supply of many of these goods or services are to some extent in a similar position to the health funds in that they are often larger than the individual private hospitals and have the advantage of being the suppliers to a large number of hospitals.

(b) **The proposed collection of one month old fee/cost/price information and non-fee related information by the Applicants on a disaggregated or alternatively aggregated basis.**

In the event that the ACCC does not accept the submissions of the Applicants in subparagraph (a) above, the Applicants seek that the proposed Inter Hospital Agreement provide for the collection and sharing of one month old fee/cost/price and non-fee related information. The primary reason for the submission is that while the information will not be current, it is sufficiently recent as to be of assistance to the Applicants in current negotiations with health funds and other suppliers of goods and services.

The Applicants also repeat the submission set out in subparagraph (a) above about the safeguards in place in circumstances where the ACCC Authorises the sharing of disaggregated information.

In the alternative the Applicants submit that aggregated information should be shared between the Applicants.

(c) **Joint negotiations by the Applicants, by way of the agent, with all health funds, and the DVA on a non-exclusive basis.**

The Applicants submit that while the information sharing referred to above will allow each applicant to negotiate with health funds with the benefit of an increased level of knowledge, the negotiations remain unequal due to the small size of each individual applicant hospital.

Accordingly, as stated in paragraph 5(c) above, the health funds in the negotiation process, are likely to continue with the "take it or leave" approach to the small hospitals seeking to negotiate HPPAs. While the DVA is not a Registered Health Benefit Organisation it is engaged in the same contracting processes as health funds and is seeking, in Victoria and New South Wales, to engage in selective tendering.

Accordingly the only practical method of seeking to equalise bargaining power with the health funds is by joint negotiation by the Applicants with the health funds for HPPAs.

The combined market share of the members of the IHA in the hospital/health insurance market in New South Wales is quite small. The Applicants are unlikely to be in a position to wield market power against any of the health funds.

The Applicants also note that entities such as Mayne Nickless Ltd trading as Health Care of Australia has 8 hospitals just in the Sydney Metropolitan area and negotiates in respect of all its hospitals with all health funds participating in New South Wales with a much greater degree of success than stand alone private hospitals.

Even in circumstances where the individual hospitals may have a significant share of the hospital/patient market in its region, the actual size of the hospital in terms of beds and admissions against the size, particularly of the larger health funds is small.

In relation to the smaller health funds the Applicants reiterate that the combined market share in the hospitals/health insurance market is small.

The Applicants also submit that even the smaller health funds have available to them much greater level of information due to their negotiations with a large number of hospitals than the smaller private hospitals. Further, as stated above, some of these health funds have also formed alliances for negotiation purposes. In any event many of the smaller health funds do not participate in regional areas of New South Wales.

The Applicants also repeat all of the submissions referred to the ACCC's Draft Determination in Authorisation No. A90679 that were set out in paragraph 5(c) above under the heading "Inequality of Negotiating Power".

In addition, the Applicants submit that their combined market share is in most cases quite low and as a collective will not substantially change the bargaining dynamics with health funds.

(d) **Joint negotiations by the Applicants, by way of the agent, with health funds having a greater than 10% share of the market for the supply of private hospital services to health funds in New South Wales and the DVA, on a non-exclusive basis.**

In the event that the ACCC has similar concerns as those expressed on page 44 of its Determination of Authorisation number A50019, namely that in negotiations with smaller health funds larger private hospitals may in fact have bargaining power, the Applicants submit that as an alternative to the submission in paragraph (c) above the Applicants be permitted to jointly negotiate with health funds having greater than 10% share of the hospital/health insurance market in New South Wales. In this regard the Applicants reiterate all the submissions made in paragraphs 20(c), 21 and 26(c) above.

The Applicants refer to table 2 on page 34 of this Application setting out the market shares of health funds in New South Wales.

The proposed joint negotiations with health funds having in excess of 10% market share will ensure that only the largest four will be the subject of joint negotiations with the Applicants.

(e) **Joint negotiations and purchasing of goods and services, by way of the collective agent, on a non-exclusive basis.**

The Applicants submit that:

(i) Joint negotiation and purchasing by the Applicants with suppliers of goods and services is likely to lead to volume discounts for all of the Applicants and a reduction of transaction costs;

(ii) The Applicants, as individual hospitals and collectively represent only a small market share of the total number of beds and admissions in each region and accordingly in relation to the purchase and usage of these goods and services are not in a position to exercise market power; and

(iii) Many of the suppliers of these goods and services are larger than the Applicants and have the benefit of negotiating with a larger number of hospitals for a provision of these services.

In their Statements of Anti-trust Enforcement Policy on Health Care, the DOJ and FTC stated that:

> "Most joint purchasing arrangements among hospitals or other health care providers do not raise antitrust concerns............... Joint purchasing arrangements usually involve the purchase of a product or service used in providing the ultimate package of health care services or products sold by the participants. Examples include the purchase of laundry or food services by hospitals, the purchase of computer or data processing services by hospitals, the purchase of computer or data processing services by hospitals or other groups of providers, and the purchase of prescription drugs and other pharmaceutical products. Through such joint purchasing arrangements, the participants frequently can obtain volume discounts, reduce transaction costs, and have access to consulting advice that may not be available to each participant on its own...........
>
> Joint purchasing arrangements are unlikely to raise antitrust concerns unless (1) the arrangement accounts for so large a portion of the purchase of a product or service that it can effectively exercise market power in the purchase of the product or service, or (2) the products or services being purchased jointly account for so large a proportion of the total cost of the services being sold by the participants that the joint purchasing arrangement may facilitate price fixing or otherwise reduce competition. If neither factor is present, the joint purchasing arrangement will not present competitive concerns...........
>
> The Agencies will not challenge, absent extraordinary circumstances, any joint purchasing arrangement among health care providers where two conditions are present: (1) the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and (2) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement."
>
> (Page 22 of 63 - Internet version of these statements).
>
> The DOJ and the FTC also stated that:
>
> > "Joint purchasing arrangements among hospitals or other health care providers that fall outside the antitrust safety zone do not necessarily raise antitrust concerns. There are several safeguards that joint purchasing arrangements can adopt to mitigate concerns that might otherwise arise. First, antitrust concern is lessened if members are not required to use the arrangement for all their purchases of a particular product or service. Members can, however, be asked to commit to purchase a voluntarily specified amount through the arrangement so that a volume discount or other favourable contract can be negotiated. Second, where

negotiations are conducted on behalf of the joint purchasing arrangement by an independent employee or agent who is not also an employee of a participant, antitrust risk is lowered. Third, the likelihood of anticompetitive communications is lessened where communications between the purchasing group and each individual participant are kept confidential, and not discussed with, or disseminated to, other participants.

These safeguards will reduce substantially, if not completely eliminate, use of the purchasing arrangement as a vehicle for discussing and coordinating the prices of health care services offered by the participants. The adoption of these safeguards also will help demonstrate that the joint purchasing arrangement is intended to achieve economic efficiencies rather than to serve an anticompetitive purpose. Where there appear to be significant efficiencies from a joint purchasing arrangement, the Agencies will not challenge the arrangement absent substantial risk of anticompetitive effects."

The Applicants propose to include all these safeguards in an amended Inter Hospital Agreement and agreement of joint negotiations and purchasing. Accordingly, the Applicants submit that these safeguards should allay any concerns of the ACCC about the anti-competitive effects of joint negotiations and purchasing of goods and services by suppliers servicing public and private hospitals.

**Independent Private Hospitals Association**
**Application to Australian Competition and Consumer Commission for Authorisation– Possible List of Interested Parties**

- NSW Health
  Locked Bag 961
  NORTH SYDNEY NSW 2050
- Private Hospitals Association - NSW
  Private Bag 938
  NORTH SYDNEY NSW 2059
- Australian Private Hospitals Association

- MBF
  97-99 Bathurst St
  SYDNEY NSW 2000
  - Lake Macquarie Private Hospital
- HCF
  G.P.O. Box 4242
  SYDNEY NSW 2001
- Medibank Private
  G.P.O. Box 9999
  SYDNEY NSW 2001
- Australian Health Service Alliance
  26B, 446 Pacific H'Way
  ARTARMON NSW 2064
  N.B. negiotiates Hospital Purchaser Provider Agreements on behalf of funds including
  - ACA Health Benefits Fund
  - Army Health Benefits Fund
  - Australian Health Management Group (includes Illawarra Health Fund, Government Employees Health Fund, Mercantile Mutual Health)
  - AMA Health Fund
  - Australian Unity Friendly Society
  - Commonwealth Bank Health Society
  - Druids
  - FAI Health
  - Grand United Friendly Society
  - IOR Health Benefits NSW
  - IOOF NSW
  - Lysaghts Hospital & Medical Club
  - Manchester Unity Friendly Society
  - NSW Teachers Federation Health Society
  - Phoenix Welfare Association
  - Railways & Transport Friendly Society
  - Reserve Bank Health Fund
  - Transport Friendly Society
  - BHP Transition Society

- NIB
  Locked Bag 2010
  NEWCASTLE NSW 2300
  - NIB Private Hospital
- St Vincents Private Hospital
  406 Victoria St
  DARLINGHURST NSW 2010
- Mater Misericordiae Private Hospital
  Rocklands Rd
  NORTH SYDNEY NSW 2059
- Sydney Adventist Hospital
  185 Fox Valley Rd
  WAHROONGA NSW
- St Lukes Private Hospital
  18 Roslyn St
  POTTS POINT NSW 2011
- Roma Private Hospital
  9 William St
  RANDWICK NSW 2031
- Eastern Suburbs Private Hospital
  8 Chapel St
  RANDWICK NSW 2031
- Health Care of Australia
  Level 34 Northpoint 100 Miller St
  NORTH SYDNEY NSW 2059
  - Prince of Wales Private Hospital
  - Strathfield Private Hospital
  - Castlecrag Private Hospital
  - Mosman Private Hospital
  - Christo Road Private Hospital
  - Lingard Private Hospital
  - Warners Bay Private Hospital
- Ramsay Health Care Australia Pty Ltd
  9/154 Pacific H'Way
  ST LEONARDS NSW
  - North Shore Private Hospital
  - Albury Wodonga Private Hospital
- Macquarie Hospital Services
  35 Moore St
  LEICHHARDT NSW
  - Manly Waters Private Hospital
- Alpha Health Care
  Level 6 Lippo House 210 George St
  SYDNEY NSW 2000
  - Hunters Hill Private Hospital
- Petersham Private Hospital
  5 Croydon St
  PETERSHAM NSW
- Dalcross Private Hospital

28 Stanhope St
KILLARA NSW

- Delmar Private Hospital
  58 Quirk St
  DEE WHY NSW
- Hirondelle Private Hospital
  10 Wyvern Ave
  CHATSWOOD NSW 2067
- Mandalay Private Hospital
  2 Addison Rd
  MANLY NSW 2095
- NSW Private Hospital
  Locked Bag 12
  ASHFIELD NSW 2131
- Toronto Private Hospital
  P.O. Box 333
  TORONTO NSW
- Albury Day Surgery Centre
  4 Baker Court
  Albury NSW 2640
- Wagga Wagga Endoscopy Centre
  50 Best Street
  Wagga Wagga NSW 2650
- Albury Wodonga Private Hospital
  1125 Pemberton Street
  West Albury NSW 2640
- Mercy Private
- Murray Valley Private Hospital
  Nordsman Drive
  Wodonga Vic 3690
- Department of Veterans Affairs