seek efficiency improvements. However, the proposed conduct will create inappropriate incentives and will lead to an inefficient allocation of resources.

4.19 The overall effect of the conduct will be to increase the benefits paid to hospitals at a point beyond what they would be as a result of the normal contracting process with the funds. This will contribute to increases in the premiums to fund members.

4.20 In relation to the joint acquisition of goods and services, Medibank Private is of the view that some benefits will result, in particular, efficiencies and economies of operation which should flow on as savings. These savings should be reflected in the negotiation process with heath funds.

4.21 Medibank Private submitted that the exchange of price related information (fund benefits) is likely to give rise to anti-competitive collusion and price fixing as it will tend to set minimum or floor prices. Hospitals below the average for any form of service will want to move to the average.

4.22 **MBF** claimed that it purchases acute care and ancillary services on behalf of its members based on quality, cost effectiveness, access to necessary services, the ability to comply with legislative guidelines and the commitment to make the overall hospital experience better for its members. These services must be purchased at an appropriate price for the continued viability of the industry. MBF does not believe that in the current health care environment, health funds should continue to 'fund' hospitals without regard to their demonstrable ability to provide quality services at an affordable price.

4.23 MBF argued that not-for-profit organisations enjoy tax exempt status due to their charitable contributions to the community. This status allows them substantial leeway in the operation of their facilities. Ensuring the viability of the private health sector requires all private hospitals to compete based on their ability to provide quality and value at an affordable price, not to be subsidised because of their reputation, charitable activities, or tax exempt status.

4.24 MBF submitted that the current method for HPPA negotiations is a straightforward procedure. In the past when external lead negotiators have been used by hospitals to conduct the negotiations, the procedure has not necessarily been expedited nor has the consultant necessarily added value to the negotiation process.

4.25 MBF advised that in February 2000, it invited hospitals to submit an expression of interest to receive the "request for tender" documentation. Whilst the tender process may vary from previous negotiations, the same issues of quality, access and coordination of the delivery of care remain critical to MBF's determination of who it contracts with.

4.26 MBF claimed that benefits available to the hospital are only one component of the discussions. However, the negotiation procedure proposed by the applicants focuses largely on the mediation of higher benefits for the hospitals and fails to address the issues of quality of care, access to services and the coordination of care delivery.

4.27 MBF submitted that it is difficult to see how negotiating as a group will be of a benefit to the public unless the hospitals agree to implement uniform quality, access, coordinated care and documentation of clinical outcome provisions. However, it is likely that negotiation as a group will lead to increased complexity of negotiations with no demonstrable public benefit.

4.28 MBF considered the sharing of non-fee related data can provide the opportunity for external benchmarking and lead to efficiencies. However, these benefits can be achieved without the need to exchange fee related information which can result in price fixing and reduce competition.

4.29 MBF advised that it has never been without an agreement with any of the applicant hospitals.

4.30 MBF claimed its actual market share in NSW is less than 25 per cent of those with private health insurance. Hospitals report to MBF that it has only about 20 per cent of their overall volume.

4.31 MBF submitted that authorisation should not be granted because the combined negotiation status for the hospitals would:

- have the likely effect of reducing competition;
- increase costs in an already strained health care industry;
- provide negligible public benefit;
- inhibit improvements in efficiency, value and quality;
- mitigate against necessary reform and operations improvements necessary for the viability of the industry;
- lessen the growth in private health fund membership due to increased health insurance premiums; and
- unnecessarily complicate and delay major hospital negotiations.

Submissions following the draft determination

4.32 A further submission was made by **Medibank Private**, following the release of the Commission's draft determination. Medibank Private submitted that after considering the draft determination in detail it accepted that there is no significant public detriment if the majority of the hospitals included in the authorisation are prepared to act as a single unit for the purposes of negotiating with funds and for purchasing goods and services.

4.33 Medibank Private also indicated that, in this particular case, there may be public benefits through negotiations with a common agent resulting from increased efficiencies for hospitals in the group and partnered health funds.

4.34 However, Medibank Private submitted that it is not in the public interest for hospitals such as Mayo Private Hospital and Calvary Private Hospital to be allowed to be covered by the authorisation. These two regional hospitals are much more community focussed in that they have stronger community ties than the hospitals located in the Sydney metropolitan area. The Mayo and Calvary hospitals have between 100 per cent and 61.5 per cent of private acute beds in their respective catchment areas and are therefore able to exercise substantial market power. Medibank Private claimed that health funds that wish to attract and service members in those areas must have contracts with these hospitals. Medibank Private submitted that the market dominance of these two hospitals will be further enhanced through the collective negotiation sought in the application.

4.35 Medibank Private claimed that market definition is a critical factor. The applicants overlook the fact that private health funds are reliant upon private hospitals to support the product that insurers are selling – private hospital care. The value of this product in the eyes of the community is significantly reduced where ready access to private hospital services is not available. Hence funds are under pressure to maintain contracts with providers, particularly in regional areas.

4.36 Medibank Private submitted that it should be a requirement that the terms of reference for the network committee and agent job description are attached to the agreement. Medibank Private also recommended that the Commission include a provision within the authorisation that the hospitals become and remain signatories to the recently launched Code of Conduct for Hospital Purchaser Provider Agreements that deals with negotiations between private hospitals and private health insurers.

4.37 Medibank Private advised that the Code was strongly supported by the Federal Minister for Health and Aged Care, the Australian Private Hospitals Association and the Australian Heath Insurance Association. Medibank Private claimed that the dispute resolution procedures contained in the Code will further assist in making sure the interests of the public are maintained.

4.38 Medibank Private submitted that the authorisation should be unambiguous and subject to periodic review and any behaviour by the hospitals that is contrary to the authorisation will be brought to the attention of the Commission for investigation.

4.39 **Mayne Nickless Limited**, a company that operates chain of private hospitals and medical, pathology and diagnostic imaging centres, also provided the Commission with a submission following the release of the draft determination. Mayne Nickless advised that it did not wish to request a pre-decision conference, or seek to alter the conclusions reached by the Commission, however, Mayne Nickless was seriously concerned about the views expressed by the Commission in relation to market definition. Mayne Nickless submitted that the issue of competition between public and private hospitals is important not only in relation to this application but to virtually any decision which the Commission is required to consider involving hospitals and for that reason Mayne Nickless is concerned to ensure the issue of market definition is fully considered.

4.40 Mayne Nickless submitted that the demand and supply side substitution between public and private hospitals is such that they are in the same market. Mayne

Nickless submitted that patients can acquire hospital services from a public or private hospital. The patient's choice is influenced by perceptions of the quality of service including the extent of waiting lists balanced against the cost or price to the patient, including direct costs via Medicare and health insurance premiums. In addition, the patient's choice is influenced by the distance the patient is required to travel to the hospital. The fact that some people might be able to, in effect, consume services free of charge at public hospitals may distort the market for hospital services but it does not change its boundaries.

4.41 Mayne Nickless submitted that a patient will calculate the costs and benefits of private and public hospital services and decide whether or not to join a health insurance fund. It is at this point that there is substitutability between public and private hospitals. While some patients will require a particular quality of services regardless of the cost, this would not represent the view of the majority of patients. Mayne Nickless claimed that for the most part, a patient is likely to consider the quality of the service being offered as well as the price or cost of the service and decide whether to take out private health insurance and attend private hospitals or to stay within the public system.

4.42 Mayne Nickless submitted that if the price or cost is high, patients may sacrifice quality of care for affordable care. On the other hand, if the quality of the care offered is very low, patients may make other sacrifices so that they obtain the better quality service. Mayne Nickless claimed that the choice which customers make between private and public hospitals is demonstrated by the shifts which have been seen in the number of people taking out private health insurance. These shifts reflect the fact that there are limits on the extent to which customer will pay for the provision of health care and that they are in the same market.

4.43 Mayne Nickless claimed that the current structure of private health insurance arrangements and the incentives offered to members has encouraged the public to take out private health insurance for the simple reason that the changes have reduced the cost of private health insurance and the out-of-pocket expenses incurred by patients attending private hospitals. This has made private hospitals a more attractive option for a greater number of patients and has meant that, for these people, there is a real choice between public and private hospitals.

5. Statutory test

5.1 Application A30203 was made under section 88(1) of the Act to make and give effect to a contract, arrangement or understanding containing a provision which may have the purpose or effect of substantially lessening competition within the meaning of section 45 of the Act.

5.2 The Act provides that the Commission shall only grant authorisation if the applicant satisfies the relevant test in section 90(6) of the Act. Section 90(6) provides that the Commission shall grant authorisation only if it is satisfied in all the circumstances that:

- the provision of the proposed contract, arrangement or understanding would result, or be likely to result, in a benefit to the public; and

- that benefit would outweigh the detriment to the public constituted by any lessening of competition that would be likely to result from the proposed contract, arrangement or understanding.

5.3 In deciding whether it should grant authorisation, the Commission must examine the anti-competitive aspects of the arrangements, the public benefits arising from the arrangements, and then weigh the two to determine which is the greater. Should the public benefits or expected public benefits outweigh the anti-competitive aspects, the Commission may grant authorisation or grant authorisation subject to conditions.

6. Commission consideration

6.1 The Commission's consideration of the application for authorisation is in accordance with the statutory test set out in section 5 of this determination. As required by the test it is necessary for the Commission to assess the public benefit and public detriment, constituted by any lessening of competition, that are likely to flow from the proposed conduct for which authorisation is sought.

6.2 On 6 December 2000 the Commission issued a draft determination proposing to grant authorisation to the following conduct:

- joint negotiations by way of a common agent with health funds or groups of health funds who have more than 10 per cent of the market for the provision of health insurance services to the general public and the Department of Veterans Affairs on a non-exclusive basis, subject to the proposed safeguards;

- the exchange of current or one month old data on either a disaggregated or aggregated basis, subject to the proposed safeguards; and

- joint purchasing of goods and services on a non-exclusive basis.

6.3 The authorisation the Commission proposed to grant in relation to joint negotiations and the exchange of information was subject to the following conditions:

- that the safeguards proposed by the applicants are included in the final IHA. The safeguards relate to:

  - the collection and presentation of information;

  - the conduct of joint negotiations; and

  - the role of the agent.

- clause 1.1 (b) of Schedule B of the proposed IHA be amended to provide that the agent will conduct joint negotiations on behalf of Network members with a fund or group of funds having greater than a 10 per cent share of the market for the provision of health insurance services to the general public, and the DVA.

- clauses 4.2 to 4.4 of the proposed IHA, permitting the addition of other hospitals to the Network, were not proposed to be authorised. If new members wish to join the Network and gain the protection provided by authorisation, the applicants may apply for a variation to the authorisation pursuant to section 91A of the Act.

6.4 The Commission proposed to grant authorisation for a period of three years. The Commission also granted interim authorisation in relation to the proposed conduct, subject to the proposed conditions.

6.5 The Commission did not receive any requests to hold a pre-determination conference in relation to the draft determination, however, two further submissions were made (see paragraphs 4.32-4.43).

Market definition

6.6 Public benefits and detriments arising from the conduct sought to be authorised are assessed in the context of a market. Market definition is not an end in itself but rather a tool for analysis. In assessing an application for authorisation, and applying the relevant public benefit test, the Commission is not required to form a view as to whether the conduct is likely to breach the Act. Therefore, in the authorisation context, it is only necessary to delineate the relevant market to the extent needed to assess the public benefits and detriments of the proposed conduct.

The applicants' submissions on market

6.7 The applicants submit that the markets relevant to this application are:

a) **The provision of private hospital services to health insurers (HPPAs).** In this market private hospitals enter into contracts with health funds under which private hospitals provide guaranteed prices for services offered to members of the health funds.

   The applicants advise that they concur with the Commission's finding in relation to the Queensland hospitals' application (see paragraphs 2.26 – 2.30) that public hospitals are not a part of this market as they are usually limited to default benefit table payments (rather than the HPPAs). Further, access to public hospitals by private patients cannot be guaranteed. Accordingly, on the supply side, public hospitals have only limited substitution. Similarly, on the demand side, access by patients to private and public hospitals as private patients covered by health insurance is not substitutable as access to public hospitals is on the basis of clinical need rather than insurance status.

   The applicants claim that there is a wide geographic boundary to this market as the major health insurers operate at least on a state, if not national basis. The manner in which MBF is proceeding with its current tender process suggests that there may be particular circumstances in each state that require changes to the tender process on a state by state basis to take account of differences. It is also indicative that health funds may have to contract with hospitals on a city by city/town by town basis to ensure coverage for their members. The applicants submit that for the purposes of this application the relevant geographic market is the whole of NSW.

b) **The provision of hospital services to patients.** Hospitals offer a variety of services to patients, namely, surgical and medical services, accommodation, nursing and ancillary services.

   The applicants advise that they concur with the Commission's finding in the Queensland hospitals' application that on both the supply and demand side, public and private hospitals are substitutable in this market. On the supply side, basic facilities and services offered by public and private hospitals are similar and are directed at achieving the same outcomes. The applicants claim that on the demand side, patients indicate that private and public hospitals are substitutable by the fact that:

(i) in recent years an increasing number of patients have chosen to attend public hospitals as public patients rather than maintain their membership with private health insurance and go to a private hospital;

(ii) some privately insured patients choose to use public hospital services as private patients; and

(iii) NSW Health promotes the use of its hospitals by private patients and sets revenue targets for each Area Health Service which is then devolved to the individual hospitals.

In relation to the geographic market for the provision of hospital services to patients, the applicants submit that, on the supply side, hospitals are prepared to admit patients from as large a catchment area as is possible. However, in general it is the demand side that determines the geographic boundaries of this market. From the demand side it is only where specialised services are required that patients are likely to travel longer distances to hospitals. Therefore the market is likely to be localised.

6.8 Accordingly the applicants submit that the product and geographic markets relevant to this application are:

- The market for the provision of private hospital services to health funds in the state of NSW;
- The market for the supply of hospital services to patients in Sydney;
- The market for the supply of hospital services to patients in Newcastle, Maitland and Port Stephens region;
- The market for the supply of hospital services to patients in the Manning Valley District; and
- The market for the supply of hospital services to patients in the Wagga Wagga and South Western NSW region.

6.9 In addition, as the conduct also involves joint purchasing by the applicants from suppliers of a variety of goods and services such as medical consumables, linen services, catering, gardening and possibly diagnostic services, there may be a number of other markets that are relevant.

Interested party submissions on market

6.10 Submissions by the health funds generally opposed the applicants' broad definition of the relevant markets. In particular, health funds submit that there is a market for the supply of private hospital services to patients (ie. one that did not include public hospitals as claimed by the applicants) based on localised geographic areas. In addition, the health funds submit that there is a localised market for the supply of private hospital services to health funds rather than State-wide as claimed by the applicants. The health funds claim that they must maintain 'coverage' across all areas so as not to exclude any potential fund members in a certain region. As such health funds must negotiate HPPAs with at least one private hospital in each region.

6.11 Following the draft determination, Mayne Nickless lodged a submission expressing concern about the Commission's views on market definition and the market framework used for the competition analysis of the application. In effect, Mayne Nickless agreed with the applicants that demand and supply side substitution between public and private hospitals means that the two are in the same market (see paragraphs 4.39 – 4.43).

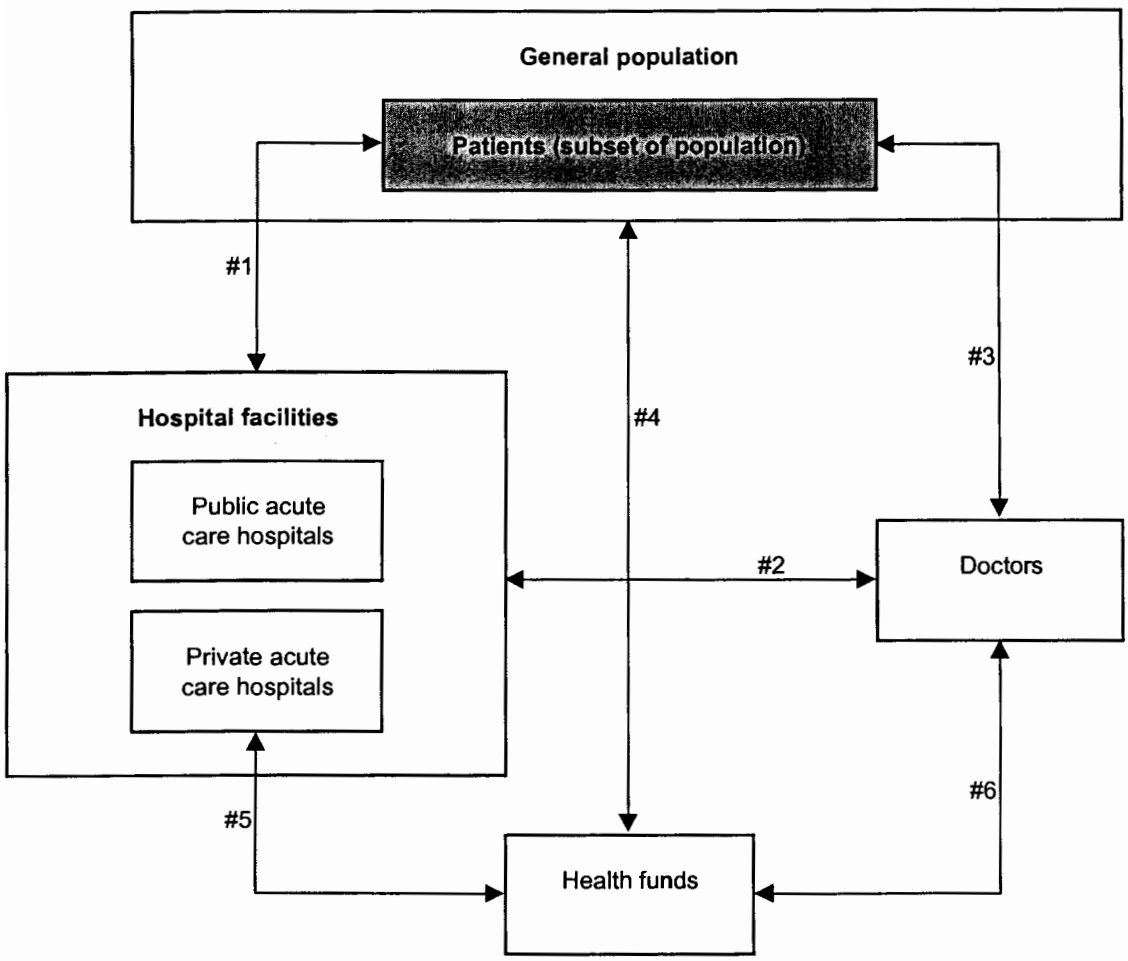
6.12 This is in contrast to the other submission received by the Commission following the draft determination, namely from Medibank Private (see paragraphs 4.32 – 4.38). In general terms, Medibank Private submitted that private hospitals offer a different service to public hospitals.

The Commission's assessment

6.13 As discussed at paragraphs 2.26 – 2.35 the Commission has previously considered similar conduct in relation to applications by hospital groups in Queensland and Sydney. In assessing these applications the Commission considered that there are a number of health sector product markets and that the geographic area of each is likely to vary. In particular, the Commission found that the health sector involves five principal groups: public hospitals, private hospitals, doctors, patients and health funds. All are inter-related in one way or another and each depends on the other to varying degrees. In relation to the geographic dimension, where hospitals are involved, the market 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 local practitioners, but where highly specialised services are involved such services may only be available in metropolitan centres and patients must travel.

6.14 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. It is important to remember that an individual or firm may participate in more than one market. For example, private hospitals compete in numerous markets which encompass doctors, patients and health funds. In the Queensland Hospitals determination the Commission reached the view that there are six main markets involved (see Diagram 6.1 for graphical representation). Each of these is briefly discussed below.

DIAGRAM 6.1: HEALTH SERVICES MARKETS



Market #1 - The market for the provision of hospital services to patients

6.15 The Commission considers that hospital services include accommodation, medical infrastructure, nursing and ancillary services (eg pharmaceuticals, catering, cleaning). A patient may "consume" hospital services in three main ways. First, as a public patient under Medicare. Second, as a self insured person opting to use either public or private hospitals depending on clinical need and availability at the time. And third, as a patient insured through a health fund.

Market #2 - The provision of hospital facilities and services to doctors

6.16 The Commission considers there is a market between hospitals and doctors. Doctors have the choice of utilising either public or private hospitals or even a combination of the two. Many doctors provide services to public patients in public

hospitals and to private patients in private hospitals, some treat both public and private patients in public hospitals while some provide services in private hospitals only.

Market #3 - The provision of medical services to patients by doctors

6.17 The Commission considers that the market for medical services provided by doctors to patients represents a separate market. In most instances it originates outside the hospital (eg patient sees a surgeon in the surgeon's consulting rooms) although there are flow on effects which are initiated inside the hospital (eg a patient may see an anaesthetist for the first time only after admission to hospital). Generally, the medical service could be provided at a number of different hospitals and so is not hospital specific.

Market #4 - The provision of health insurance services to the general public

6.18 The Commission considers that there is a separate market for health insurance. It operates at a higher level than the provision of hospital services in that it is focussed at the population as a whole, whereas hospital and medical services are focussed at the patient level. Patients represent a subset of the general population. Health insurance also covers other services, such as dental, optical, physiotherapy, ambulance and alternative medicine.

Market #5 - The provision of private hospital services to health insurers (HPPAs)

6.19 The Commission considers that there is a separate market operating between private hospitals and health insurers. Private hospitals provide health insurers with guaranteed prices for services offered to members of funds. Private hospitals become more attractive to potential patients who are members of a given fund because there will be no gap payment or a known gap payment for hospital services. The funds benefit because they can advertise a more attractive product to the general public and potentially attract more members. The Commission does not consider that this market includes public hospitals. It has reached this view because public hospitals are usually limited to the default benefit table payment (making HPPAs redundant) and access to public hospitals by private patients cannot be guaranteed (it is supposed to be on the basis of clinical need, not insurance status). There is no doubt that the outcomes achieved in this market affect the market between health insurers and the general population. However, while there is a flow on effect they are separate markets as there are no substitution possibilities between them.

Market #6 - The provision of private medical services to health insurers (MPPAs)

6.20 There is also a market between doctors and health insurers for the provision of private medical services to privately insured patients. The development of this market is quite limited at the moment and has not developed as rapidly as envisaged under the 1995 health reforms.

6.21 In relation to this application (as with the other two hospital related authorisation applications) the most relevant product markets that are directly impacted by the proposed arrangements are broadly considered to be the hospital/patient market (market #1) and the private hospital/health fund market (market #5).

Hospital/patient market

6.22 The Commission has previously found that there is a degree of demand and supply side substitutability between public and private hospitals, particularly as the basic facilities and services offered by public and private hospitals are similar and are directed at achieving the same outcomes.

6.23 However, the Commission can also see value in assessing the competitive impact of the proposed conduct on a narrower view of the market that focuses on privately insured patients and private hospitals. In its consideration of the Sydney hospitals application the Commission looked at the competitive impact of the proposed conduct on both the broadly defined market that includes all patients and public and private hospitals as well as the narrower market. The Commission considered that although private hospitals face competition from the public hospital system the degree and nature of this competition is changing. For example, figures from the Productivity Commission[5] showed there has been a steady decline in the number of insured private patients opting to receive their treatment in public hospitals (19 per cent of insured separations in 1997-98 as compared with 36 per cent in 1993-94). The decline in the number of private patients opting for treatment in public hospitals could be expected to accelerate following the growth in health fund membership that has been triggered by the recent legislative reforms (as outlined in section 2). The Productivity Commission also suggested that a significant proportion of private patients treated in public hospitals initially enter as 'emergency' patients or to receive treatment not available in nearby private facilities.

6.24 In addition, while public hospitals draw their patients from both the uninsured and the insured, the latter as both private and public patients, private hospitals tend to draw their patients from a narrower group. According to the Productivity Commission, 76 per cent of private hospital patients are privately insured, nine per cent are Department of Veterans' Affairs patients, nine per cent are self-paying, five per cent are compensable patients and two per cent are eligible public patients. A substantial proportion of insured patients will always look to private hospitals for treatment for such reasons as to avoid waiting lists, to obtain the doctor of their choice, or for perceived quality of service.

6.25 In any event, in the current circumstances the Commission considers that the net public benefit is likely to be the same regardless of whether the product market includes only private hospitals or whether it is expanded to include public and private hospitals. While the Commission agrees with the claim by Mayne Nickless that the market framework and competition analysis involving public and private hospitals is relevant to many Commission decisions involving hospitals, as already mentioned, in the context of assessing an application for authorisation it is only necessary for the Commission to define the market to the extent necessary to assess the public benefits and detriments likely to result from the conduct sought to be authorised.

6.26 In terms of the geographic boundaries for the hospital/patient market, the Commission has previously stated that it is of the view that this market is likely to be

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[5] Productivity Commission Research Paper 'Private Hospitals in Australia', December 1999, page 92

relatively local for the reasons outlined in paragraph 6.7b. Only if the required medical service is not available locally are patients likely to travel to a hospital outside their local area. Indeed, in relation to the Sydney hospitals application the Commission considered there was merit in looking at a narrower geographic region than the Sydney metropolitan area. The Commission notes that submissions by both the applicants and interested parties in response to the current application tend to support the view that the hospital/patient market is local or regional.

Private hospital/health fund market

6.27 As outlined at paragraph 6.7a there is likely to be limited demand and supply side substitutability between public and private hospitals for the provision of services to health funds and as such the Commission does not consider this market to include public hospitals.

6.28 The geographic extent of the private hospital/health fund market is less clear. The applicants submit that the relevant geographic boundary is the whole of NSW. However, the health funds argue that the market is regional due to their need to have contracts with private hospitals within each local area so as to provide adequate coverage to their members.

6.29 The Commission acknowledges there is merit in the claim by health funds in relation to the importance of maintaining coverage and therefore the need to negotiate HPPAs with private hospitals in regional areas for the benefit of fund members and potential fund members in those areas. Indeed, there is a strong commercial incentive for health funds to contract with private hospitals within their areas of operation, ie. where they draw their members from.

6.30 Consistent with its consideration of the Brisbane hospitals' application, the Commission does not consider it necessary to define the geographic extent of the private hospital/health fund market in relation to the current proposal. The Commission is of the view that the ultimate outcome is likely to be the same whether the geographic market boundaries are regional or wider. In these circumstances, the Commission has considered the impact of the proposed arrangements in terms of both a regional and state-based view of the market.

Effect on competition

Hospital/patient market

6.31 In its consideration of the Sydney Hospitals application, the Commission found that the three applicant hospitals competed with each other for patients and the proposed conduct for negotiating with health funds was 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 provision of services by other private hospitals in competition with the applicants.

6.32 The Commission does not consider it likely that these outcomes would flow from the proposed conduct the subject of this application. Given that the Commission

considers the geographic boundaries of the hospital/patient market are likely to be relatively local, the Commission is of the view that there is only limited competition between the applicants for patients.

6.33 In particular, the Commission does not consider that the three applicant hospitals located in regional areas compete with each other for patients. Of these regional hospitals, the Hunter Valley Private Hospital and Calvary Hospital Wagga Wagga both face competition from other private hospitals located in their respective geographic markets. For example, in the Newcastle, Maitland and Port Stephens region there are seven private hospitals, and the Hunter Valley Private Hospital has an 8.2 per cent share of private acute beds in the area. The Calvary Hospital Wagga Wagga faces competition from five other private facilities within the Wagga Wagga and South Western NSW region. The applicants estimate that Calvary Hospital's market share is 61.5 per cent of private hospital/day surgery acute admissions.

6.34 In the remaining region, whilst the Mayo Private Hospital located in Taree is the only private hospital operating in the Manning Vale district, the conduct the subject of the authorisation will not increase the market power of this hospital in the region.

6.35 The Commission considers that any competition between the other five applicant hospitals located in Sydney is likely to be minimal. The Commission notes that none of these hospitals are regarded as super-speciality hospitals that would enable them to draw patients from a wide geographic area. The five applicant hospitals provide limited general hospital services and as such tend to draw their patients from their immediate surrounding area. There is limited overlap in the catchment areas of these hospitals.

6.36 Even if it was considered that the five applicant hospitals located in Sydney are in direct competition with each other for patients, their combined market share is relatively low and is not likely to have a significant effect on competition for the custom of private patients (and doctors). For example, in metropolitan Sydney the applicants' combined share of private acute beds is 5.4 per cent.

Private hospital/health fund market

6.37 The environment in which private hospitals and health funds deal with each other has changed dramatically in recent times. The past relationship tended to be characterised by private hospitals simply passing on cost increases to health funds, who would simply accept the increases and, in turn, pass them on to consumers in the form of higher premiums. In this environment there was little incentive for hospitals to contain costs and maintain efficiency levels.

6.38 However, in the face of rising premiums and falling membership, health funds were forced to become more pro-active in rate negotiations. This change in the hospital/health fund relationship was given legislative backing with the 1995 reforms that also encouraged health funds to become active purchasers of services and pursue aims of cost containment while delivering quality of care for their members. This has put pressure on hospitals to look at the way they are managed with a focus on increasing cost efficiencies and improving service delivery. The development of the voluntary Code of Practice for HPPA negotiations is also in recognition of these

changes. The Commission notes the recommendation by Medibank Private that, as part of the authorisation process, the Commission require the applicant hospitals to become and remain signatories to the Code. The Commission considers that implementation of the Code and its dispute resolution mechanisms can contribute to improve the relationship between health funds and private hospitals and, in conjunction will the goodwill of parties to the Code, will have a positive effect on the level of disputes in contract negotiation. While the Commission strongly encourages parties in both sectors to become signatories to the Code it does not propose to make this a condition of authorisation. The Commission considers that as the Code is voluntary and its success hinges on the willingness and good faith of the parties involved, it is not appropriate for the Commission to force parties to become signatories.

6.39 Australian Bureau of Statistics data indicates that almost 91 per cent of the revenue generated at private acute and psychiatric hospitals in 1999-00 was constituted by patient fees and charges, most of which were paid by health funds on behalf of insured patients. The enormity of this figure reflects the importance of the contracting process between hospitals and health funds, particularly in terms of the financial performance and viability of the private hospital.

6.40 HPPA contract negotiations generally occur annually, although some funds are now entering into longer contracts of two or three years. Negotiation of rates to be paid by a health fund to a private hospital in respect of services provided to the fund's members is a major part of HPPA negotiations. Submissions by the health funds indicate that some of the factors that are important in these negotiations and that would presumably impact on the negotiated rate (and indeed whether or not to enter into a HPPA with a particular hospital at all) are quality of service, profile, efficiency and location of the hospital. The Commission considers that underlying these factors is the relative bargaining strength of the two parties.

6.41 NRMA Health submits that due to the need for health funds to have adequate coverage many private hospitals, even small ones depending on their location, have substantial bargaining power in their relations with health funds.

6.42 Table 6.1 illustrates the presence of the applicant hospitals in the relevant geographic regions.

Table 6.1: Number of private acute hospitals

	Metropolitan Sydney	Newcastle, Maitland, Port Stephens Region	Manning Vale District	Wagga and South Western NSW
Number of private acute hospitals	41	7	1	6
Number of applicant hospitals	5	1	1	1
% share	12.2	14.2	100	16.6

Source: Table compiled using data from NSW Health; Hospital and Health Services Yearbook, 1998 and applicants' submission

6.43 The applicants claim that there is an inequality of bargaining power, in favour of the funds, particularly in negotiations between large health funds and small private hospitals. The applicants point to the resources allocated by the health funds as further evidence of their expertise and power in negotiations with private hospitals. To overcome these difficulties the applicants propose to exchange non-fee/fee/cost/price information and jointly negotiate with health funds through an 'expert' bargaining agent.

6.44 The Commission considers that some anti-competitive effect is likely to result from the proposed conduct. In particular, joint negotiations and sharing cost and fee related information may have the effect of setting or standardising the reimbursement levels paid to the applicant hospitals by health funds. In their submission the applicants acknowledge that the sharing of information may reduce the extent of variations in payment structures by health funds to similar sized hospitals.

6.45 In addition, the level at which the reimbursement fees are set may be at a rate higher than would be obtainable under individual negotiations. NRMA Health submitted that health funds often pay higher benefits to a private hospital where it is the only, or one of a few, hospital/s in a region due to the bargaining power possessed by such hospitals. NRMA Health believes that the proposed conduct will tend to put pressure on health funds to offer all member hospitals the same benefits received by those with the greatest bargaining power such as the Mayo Private Hospital at Taree in the Manning Vale District (see Table 6.1).

6.46 Any anti-competitive detriment would be compounded if joint negotiations and information sharing removed the incentives for the applicants to seek efficiencies and improvements in service delivery and quality of care while containing costs.

6.47 In addition, the Commission considers that there are significant commercial and regulatory barriers facing new private hospital entrants. Some of these barriers include the need for Government approvals, a large initial capital investment, the need to attract doctors, the current financial performance of the hospital industry and the long lead times in bringing a new private hospital to full operation. For a more detailed

discussion on barriers to entry see the Commission's determination in relation to the Queensland hospitals' application.

6.48 The Commission found that significant anti-competitive effects were likely to flow from the collective negotiation conduct proposed in the application by the three Sydney hospitals. The Commission considered that the primary objective of the collective negotiation involving three of the four largest private hospitals in Sydney was to achieve higher reimbursement levels from the health funds than would otherwise be the case. The Commission noted that the applicant hospitals were already receiving higher reimbursement levels from health funds than other private hospitals. The Commission considered that this would have a negative impact on competition. This detriment was particularly in the form of increased costs to health funds, potentially impacting on health insurance premiums and membership levels and an easing of competitive pressure on the applicants to improve quality and efficiency of operations due to the opportunity to pass on cost increases.

6.49 In relation to the current application, if the geographic market is taken to be regional, the Commission does not consider that the applicant hospitals in regional NSW compete with each other for contracts with health funds. For similar reasons as discussed at paragraph 6.35 – 6.36, competition between the Sydney hospitals is likely to be minimal. Even if the geographic market is defined as State-based, and therefore the applicants would be regarded as in competition with each other for HPPAs with funds, the Commission considers that there are a number of factors specific to this application that would appear to minimise the effect on competition and limit any flow-on effect on membership premiums.

6.50 First, the eight applicant hospitals are small to medium sized facilities that are located throughout Sydney and regional NSW. The applicants range in size from the Hornsby Day Surgery Centre with 21 beds (four overnight and 17 day) and approximately 2 000 annual admissions, to the Calvary Hospital Wagga Wagga with 90 beds and over 5 700 annual admissions. Nevertheless, even the largest of the applicants is still relatively small.[6]

6.51 The Commission notes the claim by health funds, including Medibank Private following the draft determination, that the Mayo Private Hospital located in Taree and the Calvary Hospital Wagga Wagga have substantial bargaining power due to their significance in the region. The Commission recognises the interdependence of private hospitals and health funds and the need for both sectors to negotiate and deal with each other in good faith. However, in terms of the likely competitive effects of including these hospitals in the IHA, the Commission considers that there would be a minimal effect on the overall business activities of a health fund not contracting with these hospitals and therefore a minimal effect on competition in general. However, it is likely that the reverse would be true in terms of the viability of the Mayo Private Hospital and the Calvary Hospital Wagga Wagga where they are unable to contract with the major health funds. This is likely to act to counter any attempt by these

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[6] This contrasts with the Mater Misericordiae Private Hospital (195 beds), St Vincent's Private Hospital (245 beds) and Sydney Adventist Hospital (324 beds). The Commission denied authorisation in relation to an application by these hospitals to engage in collective negotiations (see paragraphs 2.31 – 2.35).

hospitals to exercise any market power arising from their positions under the IHA. This is particularly the case in light of the fact that the IHA does not provide for boycott activity by the applicants (this is discussed further in paragraph 6.54). Further, the application for authorisation is not expressed to apply to boycott activity by the applicants.

6.52 Secondly, the reimbursement levels paid by health funds in respect of each of the applicant hospitals may not be the same even though they are represented in negotiations by a common agent. The IHA does not provide for joint pricing by the applicants. The Commission understands that the reimbursement rates negotiated between health funds and hospitals are based on a number of factors including the hospital's costs, procedures available, quality and location of the hospital. Where these factors are similar across applicant hospitals it could be expected that the rates would be similar. However, the Commission notes that the size of the applicant hospitals varies from 21 beds to 90 beds, and that services provided range from rehabilitation to day surgery to more general medical and surgical procedures through to plastic surgery and neurology. In addition, the locations of the applicant hospitals range from regional areas such as Taree and Wagga Wagga to Sydney suburbs.

6.53 The Commission has been provided with some limited information from Hospital Casemix Protocol (HCP) data from the Commonwealth Department of Health and Aged Care (DHAC) based on the actual total charges of the applicant hospitals for a number of Diagnosis Related Groups (DRGs) and the total charges of all hospitals in NSW. The information did not identify individual hospitals. Based on 1997-98 data, the figures indicate that some of the applicants charge higher than the State average while some charge lower than the average. It was not possible to produce statistics for NSW based on regional and metropolitan areas. However, the Commission understands that those hospitals with the higher charges exist in the Sydney metropolitan area where operating costs such as rent are also presumably higher. The Commission notes that submissions by health funds did not indicate that the applicant hospitals were already receiving high or unreasonable reimbursement levels relative to other private hospitals.

6.54 Finally, the IHA will not provide for collective action in the way of a group boycott of a particular health fund. The applicants as a collective will not advise or make recommendations to any individual applicant regarding the appropriateness of any price offer communicated by the agent. Pricing decisions are to remain entirely within the domain of the individual applicant hospital. Further, the IHA is non-exclusive and each hospital can leave the group (upon giving written notice) or adopt any other process it chooses in order to negotiate with health funds. Thus it is open to any fund to negotiate a HPPA with only some of the applicant hospitals based on its own commercial requirements. This is likely to act as a further restraint on the applicants trying to collectively exercise any market power arising from their position under the IHA.

6.55 In the draft determination the Commission recognised that the anti-competitive detriment could increase where the applicants are able to exercise combined market power in negotiations with smaller health funds. As such the Commission proposed as a condition of authorisation that the applicants could only negotiate jointly through the agent with health funds or a group of health funds who have more than 10 per cent of

the market for the provision of health insurance services to the general public. Following the draft determination the applicants amended the IHA to provide for joint negotiations through the agent with health funds of a group of health funds having greater than a 10 per cent share of the market for the supply of private hospital services to health funds (based on current PHIAC statistical figures). The applicants did not provide any reasons for maintaining the difference between the two markets identified. Upon seeking clarification from the applicants' solicitor the Commission was advised that the applicants would amend the IHA to reflect the Commission's position.

6.56 Overall, the Commission considers that these factors will limit the extent to which the joint negotiations and the use of a common agent will impact on health insurance premiums and fund membership levels. It is also not considered likely that the conduct would result in an easing of the competitive pressures faced by the applicants thereby enabling them to act inefficiently and simply pass on cost increases to funds.

Joint purchasing of goods and services

6.57 The IHA also provides for the agent to negotiate supply contracts for the acquisition of certain goods and services on behalf of the network members in order to achieve volume discounts and reduce transaction costs. The applicants advise that such goods and services may include medical consumables, linen services, catering, gardening and possibly diagnostic services.

6.58 The Commission notes that the IHA provides that any arrangement negotiated by the agent to purchase goods and services must comply with the following criteria:

- hospitals are not bound to, or to decline to, contract with respect to particular goods or services and each hospital is at liberty to adopt any other process for negotiating or purchasing goods and services that it may choose;

- a hospital is able to notify the agent of its requirements to purchase specified amounts of particular goods or services;

- the purchase must account for less than 35 per cent of total sales of the purchased product or service in the market for the purchased product in NSW; and

- the cost of the product or service purchased must account for less than 20 per cent of the total revenue for all products or services sold by the participant in the negotiations with the agent and the joint purchasing arrangement with the applicant hospitals.

6.59 The Commission considers that given the relatively small market shares held by the applicants any anti-competitive effect on the markets for the particular goods and services that may result from joint purchasing arrangements in the current circumstances are likely to be minimal.

Public benefits

6.60 The applicants claim that a number of public benefits will result from the IHA and the conduct the subject of the application for authorisation. Details of the public benefits claimed by the applicants are set out in section 3 of this determination. The applicants identify five main areas where public benefits are likely to flow from the conduct:

- Countervailing power;
- Information sharing/benchmarking;
- Cost reductions/savings;
- Better able to meet selective/competitive tendering requirements; and
- Maintaining the viability of the applicants.

Countervailing power

6.61 The applicants submit that a major public benefit arising from the IHA is the countervailing power it will provide them in negotiations with the health funds. The applicants submit that there is an unequal bargaining position between health funds and stand alone private hospitals when it comes to negotiating HPPAs. The applicants claim that health funds adopt a 'take-it-or-leave-it' approach to small hospitals seeking to negotiate HPPAs. The applicants claim that the reasons for the imbalance between health funds and hospitals are that:

- each private hospital that is not economically integrated into a network of hospitals is required to negotiate the HPPAs on a one-to-one basis with each health fund. This process is repeated depending on the number of contracts the private hospital proposes to enter into;
- health funds, by virtue of the fact that they negotiate with large numbers of stand-alone and integrated hospitals, are able to centralise and consolidate the negotiation process. Health funds are in a position of considerable knowledge about health costs across the range of hospitals they negotiate with, and thus gain expertise in the process; and
- hospitals must have HPPAs with larger health funds to ensure their viability. The importance of the individual private hospital to the health fund is likely to be far less than the importance of the major health fund to the hospital.

6.62 The applicants claim that the proposed arrangements, including joint negotiations through a common agent and information sharing, will assist in redressing the imbalance and will bring about fairer and more efficient outcomes.

6.63 Conversely, the health funds do not accept that the applicants need countervailing power in contract negotiations and question whether increasing the bargaining position of the applicants would constitute a public benefit. In particular,

Medibank Private claims that the applicants misrepresent the power of the funds and misconceive the competitive role the funds perform. For example, each private hospital has the discretion to increase prices, the funds provide a measure of countervailing power, to an extent limiting that discretion. NRMA Health claims that increasing the countervailing power could only be a benefit if the market is grossly inefficient, particularly in terms of allocative efficiency resulting from the exercise of monopsony power. Changing the balance of bargaining power will lessen competitive pressure, leading to a worsening of the allocative efficiency of the private hospital market.

6.64 In addition, MBF claims that the current method for negotiating HPPAs is a straightforward procedure. Prior to expiry or review date the parties contact each other with the aim of renewing the HPPA. MBF forwards a draft HPPA to the hospital and a meeting is scheduled. MBF advises that its negotiators are the Contract manager and a specialist from its Provider Relations Division. The hospital representatives are usually from Finance or Information Technology. Throughout the negotiations quality, contract compliance and funding methodology are discussed, data is exchanged and experts in operations or claims are brought in to resolve specific issues as necessary.

6.65 Arguments based on increasing countervailing power essentially relate to a change in the power relativities of the parties to a proposed agreement. An increase in countervailing power, raised in the authorisation context, typically involves one party attempting to improve its bargaining position relative to another, for example through a collective arrangement. The Commission does not accept that a mere change in the amount of countervailing power is, in itself, a public benefit. Rather, the Commission will focus on the likely outcomes resulting from the change in the bargaining position flowing from the proposed arrangement for which authorisation is sought. It is these likely outcomes which are essential to the net public benefit test. Generally the Commission would accept an argument about increasing countervailing power as a public benefit where it is satisfied that enhancing the bargaining power of the applicants would benefit the broader community, for example if a likely result of increasing a party's bargaining power was the lowering of prices for consumers. The Commission examines arguments about increasing countervailing power in the context of the structural features of the market, the level of competition in linked markets, the nature of the proposed arrangements (for example inclusion of safeguards or conditions), and any other relevant issues, to ensure that the public benefits are passed on, and that the anti-competitive effects are limited.

6.66 The Commission has previously stated that the balance of negotiating power – and possible public benefits from addressing any imbalance – will depend on the circumstances involved. In the Queensland hospitals determination the Commission accepted that the applicant hospitals were at a disadvantage in their negotiations with large health funds. The Commission found that the proposed collective arrangements which would lead to an enhanced negotiating position for the applicants, resulted in a net public benefit flowing from transaction cost savings and efficiencies flowing from the sharing of information. However, the Commission did not consider that there was an imbalance in the relative bargaining positions in negotiations between the applicant hospitals and smaller health funds and therefore did not accept there was public benefit in relation to collective negotiations with these funds. In the Sydney hospitals determination the Commission did not consider that there was an imbalance of power

between the applicants and health funds or that any changes to the balance of power would result in a benefit to the public.

6.67 The Commission has previously recognised that private hospitals and health funds are in a relationship of mutual dependence to the extent that the viability of one depends upon the viability of the other. In such a situation it is not in the interests of either party to act in a manner that is detrimental to the long-term viability of the other, for example, by imposing take-it-or-leave-it offers. However, while the Commission recognises the importance of some smaller regional hospitals to health funds in terms of maintaining adequate coverage for their members, the Commission believes that health funds are unlikely to be severely disadvantaged if they did not contract with one of the applicant hospitals. For example, the absence of one regional hospital in a fund's list of contracted hospitals is not likely to have a major impact on the fund's membership levels and financial viability. On the other hand, the failure of an applicant hospital to secure a contract with a health fund, particularly one of the major funds, could significantly reduce the hospital's potential source of patients and therefore revenue. As such the Commission is of the view that there is an imbalance of power between the funds and the individual applicants in relation to HPPA negotiations.

6.68 The Commission considers that this imbalance is exacerbated by the fact that the applicants, being small to medium hospitals, tend not to employ specialist contract managers or negotiators whereas the health funds tend to have full time staff dedicated to contract negotiations who gain knowledge and expertise in the process. There may also be an information imbalance as health funds are more actively involved in acquiring market and cost information across the range of hospitals they deal with. The applicants, on the other hand, being stand alone hospitals do not have access to information on the fees and charges and related data of other similar hospitals in order to measure their performance to assist in contract negotiations. The public benefits associated with having a better informed group are outlined in more detail below.

6.69 For similar reasons, the Commission considers there is also an imbalance in bargaining power between the individual applicant hospitals and the DVA.

6.70 The IHA seeks to redress the imbalance by providing for joint negotiations through a common 'expert' agent. Under the IHA the applicants may seek the assistance and advice of the agent in deciding whether to accept a term of offers made to them by health funds (subject to the condition that such funds or a group of funds have more than 10 per cent of the market for the provision of health insurance services to the general public) and the DVA. Although the agent will be aware of offers made to the other applicant hospitals the Commission notes that the conduct does not provide for boycott activity and health funds and the DVA are able to contract with all or some of the applicants. The Commission considers that the IHA will help to redress the imbalance in negotiation positions by providing the applicants with improved information and the services of a common agent with expertise in bargaining. Given the size of the applicants and their market share on either an individual or aggregate basis, it is not considered that the proposed conduct will simply reverse the respective positions of the parties.

6.71 The Commission notes the arguments by the applicants that they desire greater bargaining power in negotiations with health funds. In the circumstances of the

proposed arrangements, the Commission is not satisfied that simply redressing an imbalance of bargaining power results in a public benefit. However, the Commission considers that a number of public benefits are likely to result from the proposed conduct particularly in terms of the efficiency gains resulting from access to an improved contracting and negotiation process. While it may be a subtle distinction, it is important to note that these benefits result from the collective nature of the proposed activities by the applicants as provided by the IHA, rather than from the fact that the applicants will have greater bargaining or countervailing power as a result of entering into the IHA.

6.72 The efficiency benefits that are relevant to the current proposal are as a result of:

- a better informed group;
- transaction cost savings; and
- greater incentives to increasing productivity and investment in infrastructure.

A better informed group – information sharing/benchmarking

6.73 Consistent with the Commission's draft determination the applicants amended the IHA to allow for the collection and exchange of non-fee and fee/cost/price information that is, or is based on, current data. Included in the IHA are safeguards suggested by the applicants dealing with the collection and presentation of information by the agent on a disaggregated basis whereby:

- the information will refer only to the size of the hospital in terms of beds and admissions; and
- the information will not refer to the name of the hospital or the region in which the hospital operates.

6.74 Under the IHA the agent will manage the collection and exchange of information between the applicant hospitals. The information will include non-fee related data about a particular procedure or procedures sought to be covered in a HPPA and other quality/benchmarking information such as clinical indicators, numbers of staff per hospital beds/admissions and operational data. In addition, the applicants propose to share fee/cost/price related data. Such data is likely to include information on hospital costs such as meals per patient day, cost of staff, linen, salaries, diagnostics, medical and non-medical consumables, as well as costs of procedures and offers made by health funds.

6.75 The applicants submit that the sharing of both fee and non-fee related information allows them to benchmark their performance against other similar sized hospitals and improves the quality of information available to them in negotiations with health funds, the DVA and suppliers of goods and services. This assists in equalising the bargaining power between the applicant hospitals and health funds, the DVA and other suppliers.

6.76 HCF submits that hospitals already have access to information collated by the DHAC that enables the applicant hospitals to benchmark their operations without the need for information sharing under the IHA. The DHAC provided information to the Commission in relation to the HCP data it collects and disseminates. The HCP statistical and benchmarking package is distributed free of charge to all private hospitals and health funds and enables the preparation of customised reports down to DRG or Commonwealth Medical Benefits Scheme (CMBS) item level, on a state or national basis, 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.

6.77 Each hospital and health fund can identify its own data for benchmarking purposes while data for all other organisations remains anonymous. The DHAC advises that data for the 1998/99 financial year was available in April 2000, however, if all parties adhered to the timing of reporting requirements financial year data would be available within six months of the end of that year. The DHAC advises that for statistical reasons there are some limitations on reporting, for example, there is a need for at least 10 episodes of a particular type before a report is generated. This may mean that for small private hospitals the package would not generate reports for some episodes that occur less frequently. However, the DHAC advises that its own analysis has not shown significant variations in charges based on hospital size, although, it recognises that facilities may wish to compare themselves with peer hospitals. The DHAC states that the package could be modified to allow this, subject to compliance with the Trade Practices Act.

6.78 In response to the information provided by the DHAC, the applicants advise that while each hospital has access to its own HCP data, it is not helpful when attempting to benchmark their performance against similar organisations. In addition, a large proportion of the cases performed by the hospitals are of a small volume over a wide number of cases and therefore do not represent a sufficient sample size to make a credible analysis.

6.79 The applicants also advise that the other information that is generally available is either too old to be of value for benchmarking, uses outdated classification systems or provides data that is not useful to the applicants given their size and procedures performed. For these reasons the applicants claim that such data is also not of any assistance or relevance to HPPA negotiations involving them.

6.80 The Commission notes the joint statement by the US Department of Justice and the Federal Trade Commission on enforcement policy in health care where the antitrust agencies stated that in relation to non-fee related information the 'collective provision of such information poses little risk of restraining competition and may help in the

development of protocols that increase quality and efficiency.'[7] In relation to fee related information they state that health care '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.'[8] The DoJ and FTC considered that surveys among competing providers of prices for health care services or surveys of salaries, wages or benefits or personnel can have significant benefits for health care consumers. However, without appropriate safeguards, information exchanges among competitive providers may facilitate collusion or otherwise reduce competition on prices or compensation resulting in increased prices or reduced quality and availability of services. The safeguards imposed by the DOJ and FTC are that:

- The collection is managed by a third party;

- Although current fee-related information may be provided to purchasers, any information that is shared among competing providers furnishing the data must be more than three months old; and

- For any information that is available to the competing providers furnishing the data there are at least five providers reporting data upon which each disseminated statistic is based; no individual provider's data may represent more than 25 per cent of a weighted basis of that statistic; and any information disseminated must be sufficiently aggregated such that it would not allow recipients to identify the prices charged by any individual provider.

6.81 While the Commission notes that there are alternative data sources, the Commission understands that the HCP data and other currently available information is limited in the manner in which the applicants can customise and interrogate it for the purposes of comparing their performance against that of comparable hospitals. For example, HCP data is based on averages that are calculated on the full range of hospitals and it is not possible to make a distinction between hospital location. There may also be some limitations on the reporting for particular episodes that do not have a sufficient sample size. The Commission considers that sharing information in the manner set out in the IHA will provide the applicants with higher quality information that can be tailored to the needs of the applicants.

6.82 The Commission notes that the exchange of non-fee information may not raise competition concerns, however, the Commission is satisfied that this forms part of the conduct for which authorisation is sought and that such information is unlikely to be exchanged by the applicants absent the IHA. The Commission considers that the sharing of non-fee related information will enable the applicants to benchmark their standards and performance against other similar hospitals which may result in benefits such as quality and efficiency gains. The Commission is satisfied that there is a nexus between the sharing of non-fee related information, that is part of the conduct for which

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[7] See http://www.usdoj.gov/atr/public/guidelines/1791.htm
[8] Ibid.

authorisation is sought, and a benefit to the public from the sharing of such information.

6.83 In relation to the sharing and exchange of fee/price related information, the Commission notes its finding in relation to the Queensland hospitals application, namely that the sharing of information relating to the prices of a wide range of services would help the applicants to identify areas for cost savings – such as employee remuneration, competitive pricing of their services and prices for medical supplies. In that instance, the Commission accepted that the exchange of such price related information may enable the applicants to improve their overall cost efficiency and without the exchange of such information the claimed efficiency gains would be unlikely to eventuate.

6.84 The Commission has not been provided with information that would cause it to change such a finding in relation to the current application. The Commission is satisfied that access to fee and cost information can result in more informed decision-making and increased efficiency for the applicants. Access to such information and the ability for the applicants to benchmark their performance and identify cost savings has the potential to improve their efficiency levels. To the extent that information sharing between the applicants enables them to improve their efficiency and cost competitiveness it is likely that the applicant hospitals could provide stronger competition against other players in the industry.

6.85 In relation to the safeguards proposed by the applicants (paragraph 6.73), the Commission considers that given the small number of hospitals that will exchange information, the criteria in the IHA will not prevent recipients from identifying the source of the information. However, given that the Commission considers the anti-competitive effects of the collective conduct including information sharing, are likely to be minimal the Commission does not object to the safeguards as proposed.

6.86 In summary, the Commission accepts that information sharing, as provided in the IHA, provides the applicant hospitals with an opportunity to benchmark their performance, quality and costs against other similar sized hospitals. This represents a public benefit through the provision of higher quality services for the same inputs or the provision of existing services with fewer resources. It may even enhance competition overall as efficiency improvements will make the applicants more competitive.

Transaction cost savings

6.87 Saving on transaction costs is another public benefit outcome resulting from collective arrangements. The applicants claim there may be cost savings and efficiencies in the negotiation process arising from joint negotiations and the use of a common agent. The Commission has previously considered that the duration of negotiations may be reduced because of the skill and knowledge of the common agent and/or the ability of funds and the hospitals, via the agent, to reach common ground on procedural matters. This may deliver cost reductions to both the applicants and the health funds with whom they collectively negotiate.

6.88 The Commission also notes that despite providing for collective negotiations, the IHA still requires each applicant hospital to enter into a separate HPPA with each

health fund and, as discussed above, the terms and reimbursement levels may differ between hospitals. As such the Commission considers that the transaction cost savings flowing from the use of a common agent and joint negotiations are limited.

6.89 The Commission considers there are also likely to be some transaction cost savings as a result of the joint negotiations for purchases of goods and services. The Commission also recognises that there can be benefits resulting from collective buying groups particularly where they operate in competitive markets. For example, in an industry which is highly competitive, joint activity in matters such as collective bargaining with suppliers and the acquisition of new and unique products on terms which are better than those which would be available to the individual retailer outside the group, can have a positive effect on competition. In this regard, Medibank Private in submissions both prior to, and following, the draft determination, suggested that there could be efficiencies and economies of operation for the hospitals in the group. These savings should flow into the cost structures of the individual hospitals and Medibank Private would expect that they would be reflected in the negotiation process with partnered health funds. Therefore there may be some benefit to health funds as well as the hospitals in the group. The Commission is satisfied that the public benefits will outweigh any public detriments likely to result from joint negotiations and purchasing of goods and services on a non-exclusive basis.

Greater incentives to increase productivity and investment in infrastructure – maintaining the viability of the applicants

6.90 Collective arrangements can also result in public benefit efficiency gains through the encouragement of parties to invest more in infrastructure to remain in an industry. The applicants claim that their viability is threatened due to their position relative to health funds and the stance taken by health funds in HPPA negotiations. The applicants claim that the benefits to the communities in which they operate are significant and include:

- the choice and convenience provided to local patients;
- employment opportunities for medical, nursing and support staff;
- the provision of infrastructure necessary to attract specialists; and
- other wider regional benefits such as purchasing local services contributing to employment in the community.

6.91 The Commission considers that efficient private hospitals can provide direct and indirect benefits, including those identified by the applicants, to the communities in which they operate.

6.92 In general terms, the Commission considers that if suppliers are forced to sell below competitive prices they may go out of business. Suppliers acting collectively may be encouraged to invest more in infrastructure to remain in an industry if returns are higher. However, the Commission has not been provided with information to suggest that the applicants are being forced to accept unreasonable, or below competitive, prices from health funds and that absent the proposed conduct the applicants would be forced out of business.

Better able to meet selective/competitive tendering requirements

6.93 The applicants claim that the conduct the subject of the authorisation will assist them in attaining the health fund tender criteria, particularly that of MBF. The applicants claim that hospitals not chosen by MBF to be part of its group are likely to experience financial difficulty and that small unintegrated hospitals who have less information and are less likely to provide bundled services as required by the tender, are at a greater disadvantage than larger fully integrated hospitals.

6.94 The Commission does not consider that the applicants have provided sufficient information to support this claim. As discussed above, the Commission considers that the sharing of information and use of a common agent may assist the hospitals to identify efficiency improvements and become more competitive, and thereby assist them in the tender process. However, the Commission notes that the IHA does not provide for boycott activity, and health funds and the DVA are able to enter into HPPAs with all or some of the applicants. Health funds and the DVA are able to conduct competitive tender processes to determine which hospitals they will contract with. The Commission has not been provided with sufficient information to cause it to conclude that this particular claim by the applicants constitutes a benefit to the public beyond those already identified.

Conclusion

6.95 The Commission is satisfied that there is a benefit to the public that outweighs the detriment likely to result from the proposed joint negotiations by the eight applicant hospitals by way of a common agent.

6.96 However, consistent with its view in the draft determination, the Commission considers that the anti-competitive detriment could increase where the applicants are able to exercise their combined market power in negotiations with smaller funds. Therefore the authorisation that the Commission grants is on condition that the IHA is amended to provide that the agent will conduct joint negotiations on behalf of network members with a health fund, or group of health funds, having greater than a 10 per cent share of the market for the provision of health insurance services to the general public, and the DVA, on a non-exclusive basis.

6.97 In addition, for the reasons outlined in this section and in the context of the current application, the Commission considers that information sharing through the common agent provides the applicants with an opportunity to benchmark their performance, quality and costs against other similar hospitals. To the extent that information sharing between the applicants enables them to improve their efficiency and cost competitiveness it is likely that the applicant hospitals could provide stronger competition against other players in the industry. The Commission is of the view that the usefulness and relevance of the information to the applicants is enhanced if the information is current. Further, the Commission considers that prices are not likely to fluctuate on a monthly basis and as such there is not likely to be much difference between current or one month old information. Similarly, disaggregated information may also be more useful to the applicants as it will enable them (and health funds) to identify similarities and differences between the hospitals which may translate into similar or different reimbursement levels.

6.98 The IHA includes safeguards proposed by the applicants whereby for the dissemination of disaggregated data, the information will refer only to the size of the hospital in terms of beds and admissions and will not refer to the name of the hospital or the region in which the hospital operates. The Commission considers that these safeguards will not necessarily prevent the identity of the hospitals providing the information from being known, given the small numbers of hospitals involved. However, given that the Commission considers the anti-competitive effects of the collective conduct and information sharing are likely to be minimal the Commission does not object to the safeguards as currently proposed.

6.99 The Commission is of the view that the fact that few of the hospitals compete with each other, their small market share on either an individual or collective basis, and that there is no provision for boycott activity will ensure that the public benefits from exchanging current information on a disaggregated basis will outweigh any anti-competitive detriment that may result.

6.100 The Commission is satisfied that the public benefits likely to result from the proposed joint purchasing arrangements on a non-exclusive basis will outweigh any public detriments likely to result from these arrangements. The Commission notes that the applicants have included safeguards in relation to joint purchasing in the IHA (paragraph 6.58). In the draft determination the Commission indicated that it would not require these safeguards to be included as a condition of authorisation. The Commission considers that these safeguards are likely to be difficult to monitor and given that the market shares specified are high relative to the size of the hospitals they may have no practical impact. However, the Commission considers that given the relatively small market shares held by the applicants and the limited number of hospitals involved the anti-competitive effects of the joint purchasing arrangements are likely to be minimal and therefore the Commission does not object to the safeguards as currently proposed.

6.101 In the draft determination the Commission indicated that it did not propose to authorise clauses 4.2 to 4.4 of the IHA that allow for new members to join the Network. Following the draft determination the applicants amended the IHA to provide that new members could only join the network subject to certain qualifying criteria and if the Commission agrees to vary the current authorisation. There are statutory procedures the Commission must follow in order to vary an application for authorisation, including a public consultation process. The Commission considers that the amended provisions in the IHA dealing with new members satisfy the Commission's concerns expressed in the draft determination and therefore does not consider it necessary to impose a condition in respect of this issue in the final determination.

6.102 The applicants advise that over time, following experience of continuous negotiations with health funds, the applicants will move toward the development of a model form of contract that will deal with all issues other than price. The Commission also considers that the environment in which private hospitals and health funds (and the DVA) are negotiating HPPAs is changing, particularly in light of the impact of the Government initiatives on fund membership levels and recent merger proposals. Therefore, consistent with its views in the draft determination the Commission has decided to grant authorisation subject to a three-year time limit. If at the end of this time period, the applicants wish to retain the benefits of authorisation (ie immunity

from prosecution under the Act) in respect of joint negotiations and information sharing they would need to lodge a fresh application for authorisation to be considered by the Commission.

7. Determination

7.1 For the reasons outlined in section 6 of this determination, and subject to the condition set out in paragraph 7.3, the Commission is satisfied that in all the circumstances the proposed arrangements for which authorisation is sought:

- are likely to result in benefit to the public; and
- that benefit would outweigh the detriment to the public constituted by any lessening of competition that would be likely to result from the proposed arrangements.

7.2 The Commission therefore grants authorisation to the eight applicant hospitals in respect of the proposed arrangements contained in the IHA (Attachment A) the subject of application A30203.

7.3 The authorisation the Commission grants is subject to the following condition:

- Clause 1.1 (b) of Schedule B of the IHA be amended to provide that the agent will conduct joint negotiations on behalf of Network members with a fund or group of funds having greater than a 10 per cent share of the market for the provision of health insurance services to the general public, and the DVA.

7.4 The Commission has decided to revoke the interim authorisation granted on 6 December 2000. In its place the Commission grants interim authorisation subject to the conditions contained in this determination, until this determination comes into force or until the Commission or the Australian Competition Tribunal decides to revoke interim authorisation.

7.5 This determination is made on 15 August 2001. If no application for review of the determination is made to the Australian Competition Tribunal, it will come into force on 6 September 2001. If an application is made to the Tribunal, the determination will come into force:

- where the application is not withdrawn – on the day on which the Tribunal makes a determination on the review; or
- where the application is withdrawn – on the day on which the application is withdrawn.

7.6 This authorisation that the Commission grants in relation to application A30203 will remain in force until 6 September 2004.