Australian Competition & Consumer Commission

Determination

Final determination

Application for Authorisation

Inter-Hospital Agreement involving the Alwyn Rehabilitation Hospital, Wolper Jewish Hospital, Hornsby Day Surgery Centre, Longueville Private Hospital, Poplars Private Hospital, Mayo Private Hospital, Calvary Hospital Wagga Wagga and Hunter Valley Private Hospital

Date: 15 August 2001

Authorisation No:
A30203

File No:
C2000/24

Commissioners:
Fels
Cousins
Bhojani
Jones
Martin

Summary

On 24 December 1999, 12 independent private hospitals in NSW lodged an application for authorisation (A30203) with the Australian Competition and Consumer Commission in relation to conduct as provided in a proposed Inter Hospital Agreement (IHA). The IHA will provide, amongst other things, for joint negotiations of Hospital Purchaser Provider Agreements (HPPAs) with health funds and the Department of Veterans' Affairs (DVA). It will also enable fee and non-fee related information sharing by the applicants through a common agent.

On 17 July 2000 the Commission was advised that two hospitals had withdrawn from further involvement in the application. Similarly, on 8 September 2000, the Commission was advised that a further two hospitals had withdrawn from the application. Therefore the application and this determination relate to eight hospitals.

The applicants are small-to-medium sized private hospitals located throughout Sydney and regional NSW. They are the Alwyn Rehabilitation Hospital, Wolper Jewish Hospital, Hornsby Day Surgery Centre, Longueville Private Hospital, Poplars Private Hospital, Mayo Private Hospital, Calvary Hospital Wagga Wagga and Hunter Valley Private Hospital.

The applicants claim that the conduct as provided by the IHA will result in a benefit to the public that would outweigh the detriment to the public constituted by any lessening of competition that may result if the IHA were made or given effect to. The applicants claim that the proposed conduct would have a negligible effect on competition. They claim that they have relatively low market shares on both an individual and collective basis. In regional markets where the applicants have higher market shares, the applicants claim they are only sharing information with hospitals in a separate geographic market. Further, the applicants claim there is an unequal bargaining position between health funds and stand alone private hospitals when it comes to HPPA negotiations. The applicants submit that there is no risk that the proposed conduct would simply reverse the balance of negotiating power and transfer the alleged adverse effects of an imbalance from one group to the other.

The applicants identify five main areas where public benefits are likely to flow from the conduct, namely: countervailing power; information sharing/benchmarking; cost reductions/savings; better able to meet selective/competitive tendering requirements; and maintaining their viability.

The Commission sought submissions from a wide range of interested parties in relation to the application for authorisation and the public benefit and public detriment claims by the applicants. In general terms, the health funds, who oppose the application for authorisation, claim that the applicants do not need countervailing power in contract negotiations. The health funds submit that due to the need for funds to have adequate coverage many private hospitals, even small ones depending on their location, can have significant market power. The funds also claim that changing the balance of bargaining power in the manner proposed by the IHA will lessen the competitive pressure on the applicants.

The Commission issued a draft determination proposing to grant authorisation, subject to conditions, to elements of the conduct on 6 December 2000. The Commission did not receive any requests to hold a pre-determination conference in respect of its draft determination, however, two further submissions were received from interested parties.

The Commission considers that while the IHA, particularly as a result of joint negotiations through a common agent and sharing cost and fee related information, may have the effect of lessening competition for reimbursement levels paid to the applicant hospitals by health funds and the DVA, there are a number of factors specific to this application that limit the anti-competitive effect and any flow-on to membership premiums. These factors include the fact that few of the hospitals compete with each other, their relatively small size, the possibility that the reimbursement levels paid to each of the hospitals would not be the same even though they are represented in negotiations by a common agent, and that the IHA will not provide for collective action by way of a group boycott.

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. In particular, the Commission accepts that there is public benefit in efficiency improvements resulting from:

- a better informed group; and
- transaction cost savings.

The Commission did not consider that it had been provided with sufficient information to support the other public benefit claims made by the applicants.

Subject to a condition, the Commission has concluded that the public benefits, that are likely to result from the proposed conduct provided for in the IHA, would outweigh the detriment to the public constituted by any lessening of competition. Accordingly the Commission grants authorisation to the eight applicant hospitals in respect of the IHA the subject of application A30203. Authorisation is granted for a period of three years.

The interim authorisation granted by the Commission on 6 December 2000 is revoked and replaced with interim authorisation in the same terms as this determination.

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1. The application

Introduction

1.1 Organisations who engage, or propose to engage, in certain anti-competitive business arrangements or conduct that could breach the Trade Practices Act 1974 (the Act), may apply to the Australian Competition and Consumer Commission (the Commission) for authorisation of such arrangements or conduct. When an application for authorisation is made, the Commission is required under the Act to make a determination in writing either granting or dismissing the application. It is also required to take into account any submission made to it in relation to the application. The Commission is first required to issue a draft determination in writing. The applicant or any interested party dissatisfied with the draft may request that the Commission hold a conference with the applicant and interested parties. At the conference parties can discuss the operation and effect of the draft determination. After any such conference the Commission reconsiders the application taking into account the comments made, and further submissions received, and publishes its final determination.

1.2 The Commission may grant authorisation where the public benefit of the subject arrangements or conduct outweighs the public detriment, including the anti-competitive detriment. If granted, an authorisation provides immunity from legal proceedings under the Act in respect of the arrangements or conduct. This protection extends only from the time the authorisation is granted. Consequently, an organisation would not be protected from legal action under the Act in respect of any business arrangements or conduct engaged in prior to the granting of authorisation of such arrangements or conduct.

1.3 On 24 December 1999 an application for authorisation (A30203) was lodged with the Commission by 12 independent private hospitals operating throughout NSW. On 17 July 2000 the Commission was advised that two hospitals had withdrawn from further involvement in the application. Similarly, on 8 September 2000, the Commission was advised that a further two hospitals had withdrawn from the application. Therefore the application and this determination relates to eight hospitals.

1.4 The application was made under section 88(1) of the Act in relation to a proposed contract, arrangement or understanding which is likely to have the purpose or effect of substantially lessening competition within the meaning of section 45 of the Act.

1.5 The eight hospitals who have lodged the application and who are parties to the proposed conduct are the Alwyn Rehabilitation Hospital, Wolper Jewish Hospital, Hornsby Day Surgery Centre, Longueville Private Hospital, Poplars Private Hospital, Mayo Private Hospital, Calvary Hospital Wagga Wagga and Hunter Valley Private Hospital.

1.6 The applicants propose to enter into an Inter Hospital Agreement (IHA) that will provide, amongst other things, for the mutual co-operation of applicant hospitals in

relation to negotiations of Hospital Purchaser Provider Agreements (HPPAs) with health funds and the Department of Veterans' Affairs.

Draft Determination

1.7 The applicants initially sought authorisation for cascading levels of co-operation. The applicants advised that in the event the Commission grants authorisation the IHA will be amended to reflect the level of co-operation so authorised.

1.8 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;

- 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.

1.9 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, are 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.

1.10 In the draft determination the Commission stated that, in the interests of certainty, it would expect that the applicants amend the IHA to reflect precisely the conduct for which it seeks final authorisation.

1.11 On 6 December 2001, the Commission also granted interim authorisation in relation to the arrangements proposed to be authorised.

1.12 Interested parties were invited to request the Commission to hold a pre-determination conference in relation to the draft determination. No such request was received by the Commission, however, two further submissions were made (outlined at paragraphs 4.32 – 4.43).

1.13 The applicants have subsequently provided a revised IHA that incorporates the conduct the Commission proposed to authorise in the draft determination (although there is one area of difference see paragraph 1.46). A copy of the revised IHA is at Attachment A.

Chronology of Commission's assessment of application

1.14 The table below outlines the major stages of the Commission's assessment of the application for authorisation.

Date	Description
24 December 1999	Application lodged.
10 February 2000	Submissions sought from interested parties.
17 March 2000	Final deadline for submissions by interested parties.
5 April 2000	Commission considered and denied request for interim authorisation.
6 April 2000	Letter sent to applicants advising of Commission's decision to deny interim authorisation. Letter also requested any further information the applicants wanted to provide and a copy of the proposed IHA for which final authorisation is sought.
1 June 2000	Communication from applicants advising that they would send an amended IHA and a further submission responding to comments by interested parties.
29 June 2000	Amended IHA received from applicants.
17 July 2000	Letter from applicants advising that two hospitals had withdrawn from further involvement in the application.
11 September 2000	Letter received from applicants attaching a supplementary submission by applicants in response to submissions by interested parties. Letter also advising that a further two hospitals had withdrawn from further involvement in the application.

6 December 2000	Issue of draft determination and granting of interim authorisation.
29 January 2001 – 12 February 2001	Period for requesting pre-determination conference. No requests were received.
12 February 2001	Further submission received from Medibank Private.
6 March 2001	Further submission received from Mayne Nickless Limited.
4 June 2001	Copy of the revised Inter Hospital Agreement provided by the applicants.
15 August 2001	Final determination issued by Commission

The applicants

1.15 The applicants are eight small-to-medium sized private hospitals located throughout Sydney and regional NSW. They each provide a range of hospital and ancillary health care services. More detailed information about each of the applicants is set out below.

Sydney hospitals

Alwyn Rehabilitation Hospital

1.16 The Alwyn Rehabilitation Hospital is located at Strathfield in the inner western suburbs of Sydney. It is a specialist rehabilitation hospital and has 26 beds with the majority of admissions being for post-operative orthopaedic cases as well as neurological admissions.

1.17 The primary catchment area for the hospital is the inner western suburbs of Sydney, although patients are also drawn from the St George region and the Eastern Suburbs of Sydney.

1.18 During the 1998/99 financial year, total admissions were 380 of which 99 per cent were rehabilitation admissions and 1 per cent was medical admissions.

Wolper Jewish Hospital

1.19 Wolper Jewish Hospital is a non-profit organisation having exemption under the Charitable Collections Act. Wolper Hospital's aim is to cater to the health care needs of the community by providing quality hospital services, community health programs, community assistance and other services to meet the needs of the community within a framework of Jewish Religious requirements and traditions. Wolper Hospital is open to people from all religious and cultural backgrounds.

1.20 Wolper Hospital is a 66-bed facility located at Woollahra. It provides the following surgical and medical services: day surgery; ear nose and throat; general medicine; general surgery; gynaecology; opthamology; oral and maxillofacial surgery; orthopaedic surgery; palliative care; plastic surgery; rehabilitation and urology.

1.21 Forty five per cent of patients come from the eastern suburbs of Sydney. However, as it is the only hospital in Australia that caters for orthodox Jewish requirements patients also come from more diverse areas. For example, 7 per cent of patients come from the Sydney CBD, 5 per cent from the Sutherland Shire, 6 per cent from other Sydney areas, 9 per cent from outside the Sydney metropolitan area and 2 per cent from outside NSW.

1.22 During the 1998/99 financial year, total admissions to the hospital were 2 874 of which 63.8 per cent were surgical admissions and 36.3 per cent were medical admissions including rehabilitation.

Hornsby Day Surgery Centre

1.23 Hornsby Day Surgery Centre is located in Hornsby and conducts day surgery requiring one night post operation recovery care. It has four overnight beds and 17 day beds and provides the following range of services: day surgery; ear nose and throat; endoscopy; gastro-enterology; general surgery; gynaecology; opthamology; oral and maxillofacial surgery; orthopaedic surgery; paediatrics; plastic surgery; urology and vascular surgery.

1.24 The primary catchment area is the upper North Shore of Sydney to the Central Coast to the north, south to Chatswood and west to Parramatta. During the financial year 1998/99 total admissions to the hospital were 2 019.

Longueville Private Hospital

1.25 Longueville Private Hospital is a 32-bed medical/surgical hospital located at Longueville. The following services are provided: day surgery; oral and maxillofacial surgery; orthopaedic surgery; palliative care; plastic surgery and microsurgery.

1.26 The primary catchment area for the hospital is the lower North Shore and upper North Shore of Sydney.

1.27 During the 1998/99 financial year, total admissions to the hospital were 1 180 of which 61 per cent were surgical admissions, 34 per cent were medical admissions and 5 per cent were palliative care and nursing home admissions.

Poplars Private Hospital

1.28 The Poplars Private Hospital is located at Epping. The primary catchment area for the hospital is the lower Hornsby and Ryde city areas. However, its patients also come from Newcastle in the north and Liverpool in the south west and Katoomba in the west.

1.29 The hospital has 43 beds licensed to provide or support the following range of services: day surgery; endoscopy; general medicine; general surgery; gynaecology; opthamology; oral and maxillofacial surgery; orthopaedic surgery; paediatrics;

palliative care; plastic surgery; radiology; urology; vascular surgery and rapid opioid detoxification.

1.30 During the 1998/99 financial year, total admissions to the hospital were 2 931, of which 92.7 per cent were surgical admissions and 7.3 per cent were medical admissions.

Regional NSW hospitals

Mayo Private Hospital

1.31 The hospital is located in Taree in the Manning Darling District in NSW. The primary catchment area for the hospital is from the Manning Darling District including Old Bar, Taree, Wingham, Harrington, Upper Lansdowne and Moorland.

1.32 The Mayo Private Hospital has 39 beds providing medical and surgical services as follows: day surgery; ear, nose and throat; endoscopy; general medicine; general surgery; gynaecology; obstetrics (post natal); opthamology; orthopaedic surgery; paediatrics; palliative care and urology.

1.33 During the financial year 1998/99 the total admissions to the hospital were 3 339 of which 46 per cent were surgical admissions and 54 per cent were medical admissions.

Calvary Hospital Wagga Wagga Inc

1.34 Calvary Hospital Wagga Wagga Inc is a private not-for-profit hospital owned by the Sisters of the Little Company of Mary and is located at Wagga Wagga.

1.35 Calvary Hospital has 90 surgical and general medicine beds providing: day surgery; ear nose and throat; endoscopy; gastro-enterology; general medicine; general surgery; gynaecology; intensive care; neurology; obstetrics; opthamology; oral and maxillofacial surgery; orthopaedic surgery; paediatrics; palliative care; plastic surgery; respiratory medicine; sleep studies; urology, and vascular surgery.

1.36 The primary catchment area for the hospital is south western NSW bounded by Tumbarumba, Coleambally, Hay, Ivanhoe, Lake Cargelligo, West Wyalong, Young, Cootamundra, Tumut and Henty.

1.37 During the 1998/99 financial year total admissions to the hospital were 5 742 of which 71.8 per cent were surgical admissions and 28.2 per cent were medical admissions.

Hunter Valley Private Hospital

1.38 The hospital is a 40-bed unit located in Newcastle. It provides the following services: day surgery; ear nose and throat; endoscopy; gastro-enterology; general medicine; general surgery; gynaecology; opthamology; oral and maxillofacial surgery; orthopaedic surgery; plastic surgery; rehabilitation and muscular-skeletal medicine.

1.39 The hospital's primary catchment area is Newcastle, Maitland and the Port Stephens area. During the 1998/99 financial year, total admissions to the hospital were

3 565 of which 55 per cent were surgical admissions, 15 per cent were medical admissions and 30 per cent were rehabilitation.

The Inter Hospital Agreement

1.40 The applicants have lodged an application for authorisation to make and give effect to an Inter Hospital Agreement (IHA) that will provide for a network of mutual co-operation. A copy of the IHA is at attachment A.

1.41 The recitals to the IHA indicate that the 'hospitals recognise that certain factors, including rising costs and their bargaining position relative to certain funds, has and will make it increasingly difficult to maintain and improve the quality and scope of hospital and ancillary health care services provided by them.' To address these difficulties the hospitals advise that they propose to form a network and appoint an agent to manage the collection, exchange and presentation of information between them and to negotiate HPPAs with health funds and other supply contracts on their behalves.

1.42 Under the terms of the IHA, each hospital will nominate a representative to form a network committee for the purpose of administering the network. The functions of the network committee include, deciding membership of the network, selecting the agent, determining scope of the agent's functions, reviewing effectiveness of the agent, facilitating provision of information to the agent, providing a point of contact between the agent and hospitals, and budgeting and collecting hospitals' contributions in relation to costs of operating the network.

1.43 The IHA specifies that it is <u>not</u> a function of the network committee to enter into HPPAs on behalf of any member of the network or to advise or make recommendations to any member regarding the appropriateness of any HPPA offer communicated by the agent.

1.44 Under the IHA the functions of the agent are to:

a) manage the collection and exchange of non-fee and fee/cost/price information between network members on the terms set out at paragraph 1.45;

b) - manage the collection, exchange and presentation of non-fee and fee/cost/price information on behalf of network members to funds;

   - negotiate HPPAs on behalf of Network members with funds and the Department of Veterans' Affairs,

   on the terms set out in paragraphs 1.46 – 1.49; and

c) conduct negotiations on behalf of network members for the acquisition of goods and services on the terms set out at paragraph 1.50.

1.45 Information will be, or will be based on, current data and will be collected and presented on a disaggregated basis. Disaggregated information must comply with the following criteria:

- 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.

1.46 In the version of the IHA provided to the Commission in June 2001, 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 supply of private hospital services to health funds, and the DVA (based on current PHIAC statistical figures), with the view to procuring a HPPA between each of the participating hospitals and a fund and the DVA. The Commission notes that this differs from a condition in the draft determination that joint negotiations will only occur with health funds or groups of health funds having more than 10 per cent of the market for the provision of health insurance services to the general public. Upon seeking clarification from the applicants on this point , the applicants advised that they will amend the IHA to reflect the Commission's position.

1.47 The Commission understands that joint negotiations may involve all the applicants and the common agent discussing terms and conditions with each individual health fund and the DVA in a single sitting, particularly in respect of common terms. Joint negotiation does not mean a health fund, or the DVA, is required to negotiate or contract on an all or none basis.

1.48 The agent must communicate price offers directly to participating hospitals who must make independent and unilateral decisions on whether or not to accept the terms of any HPPA. Such hospitals may, however, seek the assistance and advice of the agent in deciding whether to accept the terms of any particular HPPA.

1.49 In addition, the IHA provides that each hospital is at liberty to choose not to avail itself of all or any of the services of the agent. Each hospital is free to adopt any other process for negotiating or concluding a HPPA. No hospital will be bound to, or to decline to, contract with a particular fund.

1.50 In relation to any arrangement negotiated by the agent on behalf of network members for the joint acquisition of goods and services:

- each hospital is at liberty to adopt any other process for negotiating or purchasing goods and services that it may choose;

- no hospital will be bound to, or to decline to, contract with respect to particular goods or services;

- a hospital may, at its election, notify the agent of its requirement to purchase specified amounts of particular goods or services; and

- for any arrangement negotiated by the agent to purchase goods or services, the purchase must account for less than 35 per cent of total sales of the purchased goods or services in the market for the purchased product in NSW and the cost of the goods or services must account for less than 20 per cent of the total revenue for

all goods and services sold by the participant in the negotiations with the agent and the join purchasing arrangement with the hospitals.

1.51 The IHA also includes dispute resolution procedures in relation to disputes arising between the parties in connection with the agreement.

1.52 The IHA sets out the membership requirements for the addition of new network members. In particular, any organisation is eligible to join the network provided that:

- it is a religious, charitable, community based or independently owned organisation;
- it operates a hospital or undertakes activities with a predominant focus on providing accommodation and health care services for the sick or infirmed;
- it holds ACHS accreditation or other equivalent accreditation acceptable to the network committee;
- it agrees to abide by the terms and conditions of this agreement and any conditions of the authorisation;
- it has in place a trade practices compliance program of a standard acceptable to the network committee; and
- the addition of such an organisation would not increase the combined market share of the network in any one market above 40 per cent of the market for the provision of hospital services to patients.

1.53 The IHA specifies that where an in principle decision to admit an organisation is reached by the network committee the applicant must apply to the Commission for a variation to the authorisation A30203. Membership will be granted where an in principle decision to admit an organisation has been made by the network committee and where a variation to A30203 has been made by the Commission.

1.54 A hospital may resign from the network at any time upon giving written notice to the network committee to that effect. A hospital will remain liable to pay the amount of its contribution to the costs of the network up to and including the date of resignation.

2. Background

The private health industry

2.1 Patients have the option of attending public or private hospitals when seeking the provision of hospital services. Where a patient chooses to enter a public hospital as a public patient, that patient has free access to the services provided by the hospital under Medicare. Where the patient chooses to enter either a public or private hospital as a private patient (either privately insured in a health fund or using their own resources) that patient is charged for the medical treatment and accommodation. Private patients are increasingly choosing to be treated in private hospitals rather than as private patients in public hospitals.

2.2 The recent introduction of a number of incentives by the Federal Government has turned around the steady decline in health fund membership that had been occurring since the mid-1980s. As at 31 March 2001 45.1 per cent of the population were covered by private hospital insurance compared to 32.2 per cent at the end of March 2000 and 30.5 per cent at the end of June 1999. These levels of hospital insurance coverage compare with 43.7 per cent in 1991 and 50 per cent in 1984.

2.3 One of the contributing factors to the decline in levels of health fund membership prior to the introduction of the recent reforms was patient dissatisfaction with having to make additional payments (usually referred to as gap or co-payments) even though the patient had private health insurance. This problem was partly due to the fact that prior to 1995, health funds were prohibited from paying benefits to doctors above that specified in the Commonwealth Medical Benefit Schedule (CMBS). Where the doctor charged more than the CMBS the patient was left with additional payments. In addition, although health funds have always been able to agree with hospitals on the level of payment for accommodation and associated hospital services, patients often still incurred out of pocket expenses for ancillary services (for example pharmaceuticals) or because they had an inadequate level of cover.

2.4 The young and healthy were the largest proportion opting out of private health insurance leaving the funds with higher risk members. This in turn increased health insurance premiums resulting in even more people opting out of private insurance.

2.5 To address these and other concerns, in 1995 the Federal Government introduced a number of incentives designed to encourage participation in private health insurance. Amongst other things, the reforms established a legislative framework in which the contracting process between health funds and private hospitals could take place. The legislation established that if a health fund does not have a Hospital Purchaser Provider Agreement (HPPA) with a hospital, it is required to pay the hospital a minimum amount, which is specified in the default table of the National Health Act 1953 (1st tier). If the hospital is able to meet certain criteria, such as quality accreditation and simplified billing, it may qualify for higher benefits even though it doesn't have a HPPA (2nd tier benefit). The 2nd tier benefit is set at 85 per cent of the average paid by that fund to similar hospitals for similar services. Where a HPPA exists the fund and hospital have been able to agree on a mutually acceptable rate.

2.6 Health funds are now able to offer 100 per cent coverage for hospital accommodation and theatre services to members who agree to use hospitals under contract to the fund. It should be noted that health fund members may still go to the hospital of their choice but if they choose a hospital that does not have a HPPA with their fund they will receive a lower benefit.

2.7 An aim of the legislation reforms has been to engender greater competition between private hospitals and between health funds. The legislation does not make it mandatory for health funds to have a HPPA with every hospital. As a result the health funds are able to compare prices between private hospitals and contract with hospitals on a quality and value for money basis.

2.8 The Federal Government has also introduced a number of incentives designed to encourage participation in private health insurance, including, from 1 January 1999, a 30 per cent rebate on the premium for an appropriate private health insurance policy. There is also a Medicare levy surcharge on people with incomes above a certain threshold without private hospital insurance. For taxpayers liable for the surcharge there is a strong incentive to take out private health insurance. In addition, a Lifetime Health Cover scheme commenced on 1 July 2000. An aim of the scheme is to encourage a lifetime commitment to private insurance through rewards of lower premiums for people who join before age 30.

2.9 Since the release of the Commission's draft determination in relation to this application, the Australian Private Hospitals Association and the Australian Health Insurance Association implemented a voluntary Code of Practice governing HPPA negotiations. The Code was developed over five years and aims to deal with procedural issues affecting the negotiations of contracts between private hospitals and health funds. The Code is outlined in more detail at paragraphs 2.21 – 2.25.

Health insurance funds

2.10 As at 30 June 2000, there were 44 registered health insurance funds in Australia of which 29 were available to the public generally and 15 were operated as restricted membership organisations. The open funds accounted for 94 per cent of memberships and the restricted funds the balance.

2.11 The majority of registered funds operate as not-for-profit organisations where any surpluses generated from carrying on business remain in the fund to be used for the benefit of contributors in the form of reserves to fund future increases in benefits or operating costs. Four organisations operate health funds on a 'for-profit' basis with moneys in excess of the statutory minimum reserves level able to be used for payment of dividends.

2.12 Table 2.1 shows the market shares of health funds nationally and by State/Territory. Collectively the six major national funds account for approximately 80 per cent of membership Australia wide. Market shares at the State/Territory level are

also highly concentrated. NSW, the State affected by this application, has four[1] main health fund providers all which are relatively competitive with each other and with no one fund dominating the market. This differs to most of the other States where one or two funds tend to dominate. For example, in Western Australia HBF has 74.6 per cent and in Queensland MBF controls 41.9 per cent and Medibank Private 31.3 per cent.

Table 2.1 Market share of health funds as at June 2000

FUND	NSW	VIC	QLD	SA	WA	TAS	NT	AUST
Medibank Private	21.7%	41%	31.3%	17.9%	15.0%	25.8%	46.7%	26.45%
MBF	22.4%	4%	41.9%	0.0%	0.7%	44.4%	28.3%	17.03%
HBF	0.1%	0%	0.2%	0.0%	74.6%	0.0%	0.0%	10.66%
AXA	0.9%	24%	3.2%	46.1%	1.0%	0.5%	17.5%	10.37%
HCF	22.5%	1%	1.7%	0.3%	0.1%	0.0%	0.0%	8.71%
NIB	11.5%	1%	1.5%	0.5%	0.2%	0.0%	0.0%	4.71%
Other	20.9%	29%[1]	20.3%	35.1%[2]	8.3%	29.3%[3]	7.6%	22.07%

Source: PHIAC Annual Report 1999-2000

Notes:

1. Australian Unity has a significant market share in Victoria with 10.1% of the market.
2. SGIO has a significant market share in South Australia with 12.9% of the market.
3. St Lukes has a significant market share in Tasmania with 18.2% of the market.

2.13 It is clear from the above Table that the major health funds control substantial amounts of business. Accordingly, the failure of a private hospital to negotiate a HPPA with a leading health fund may affect a significant proportion of its business. However, the actions of health funds in trying to negotiate the lowest possible price for their members is consistent with the competition and efficiency objectives of the recent legislative reforms.

Private hospitals

2.14 As at 30 June 2000 there were 509 private hospitals in Australia, comprising 278 acute hospitals, 24 psychiatric hospitals and 207 free-standing day facilities. During 1999/00 private hospitals treated 2.1 million patients. One out of every three patients admitted to hospital in Australia are private hospital patients or approximately one quarter of all days of hospitalisation are provided in private hospitals.

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[1] In addition, there is the Australian Health Service Alliance that is a collection of 28 small to medium sized private health insurance funds. The Australian Private Hospitals Association claims that in NSW 16 funds collectively negotiate through AHSA representing 21 per cent of the market.

2.15 While the total number of beds available in private hospitals has increased over time, the number of private hospitals has declined, indicating an increase in the size of hospitals. Australian Bureau of Statistics (ABS) data indicates that the average number of beds per hospital has increased from 68 in 1994-95 to 78 in 1999-00.

2.16 Private hospitals are either for-profit or not-for-profit institutions. For-profit facilities can be further divided into group or chain hospitals and independents. During the 1990s the size and number of group hospitals has increased while the size and number of independent hospitals has declined. Religious and charitable hospitals (non-profit) are on average considerably larger than for-profit hospitals.

2.17 ABS figures indicate that revenue generated at private acute and psychiatric hospitals during 1999-00 amounted to $4,012 million, an increase of 6 per cent over the previous year. A substantial proportion of this increase is reflected in the strong growth in the number of free standing day hospitals over the period. Almost 91 per cent of the 1999-00 revenue was patient fees and charges, most of which were paid by health funds on behalf of insured patients.

2.18 Private hospital expenditure is also increasing. During 1999-00 recurrent expenditure for acute and psychiatric hospitals amounted to $3,794 million, a 5 per cent increase over the previous year (or 1 per cent when costs are adjusted to remove the effects of price changes).

2.19 The average expenditure per patient day in private hospitals was $609 in 1999-00 compared with $598 in 1998-99. Typically, the average cost per patient day increases as hospital size increases. This is a reflection of the greater complexity of procedures undertaken at the larger hospitals. The more complex procedures necessitate greater use of highly trained staff, expensive equipment, drugs and medical supplies.

2.20 The net operating margin (derived by subtracting recurrent expenditure from revenue and expressed as a proportion of revenue) for private acute and psychiatric hospitals during 1999-00 was 5 per cent. This is lower than the average margin over the five years to 1999-00 which was 7 per cent.

HPPA Code of practice[2]

2.21 A voluntary Code of Practice for hospital purchaser/provider agreement negotiations between private hospitals and private health insurers came into force on 1 January 2001. An objective of the Code is to introduce a framework for HPPA negotiations based on principles of fairness and reasonableness in order to minimise disputes between the parties. However, the Code includes an independent dispute resolution process with final reference to the Private Health Insurance Ombudsman, where parties have irreconcilable differences in relation to the application of the Code to the negotiation process.

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[2] A copy of the Code of Practice can be found at the website of the Australian Private Hospitals Association, www.apha.org.au

2.22 The background statement to the Code outlines that parties who choose to become signatories to the Code agree to abide by the provisions of the Code including adherence to the agreed dispute resolution process. It is expected that the Code will result in an improved understanding by all signatories of their rights and responsibilities in relation to the contract negotiation process. In addition, adherence to the Code should lead to improved relations between private hospitals and health funds, including a better recognition of the interdependency between the two sectors.

2.23 Clause 5 of the Code sets out the core principles that signatories agree to abide by including the acknowledgment that:

- private hospitals compete on their own merits for contracts;
- there is no obligation on health insurers to offer contracts to all private hospitals and there is no obligation on a hospital to accept a contract;
- there are many ways to negotiate contracts, including but not limited to selective tendering arrangements; and
- hospitals and health insurers must ensure that the selection processes used to enter into contracts are fair and reasonable.

2.24 Clause 7 of the Code enables health insurers and hospitals to nominate contract negotiation agents. Negotiation agents acting on behalf of several hospitals or health funds must retain the confidentiality of separate negotiations, consistent with the requirements of the Trade Practices Act. An agent should, at the outset of any negotiation, advise the other party as to which organisations or individuals they may also represent.

2.25 A number of the applicant hospitals are signatories to the voluntary code.

Previous Commission decisions

Queensland hospitals

2.26 On 1 September 1999 the Commission granted authorisation (A50019) in relation to an IHA between five private not-for-profit hospitals located in Queensland (three are in regional areas and two are located in Brisbane). Authorisation was granted for a period of three years.

2.27 Amongst other things, that IHA provides for the appointment of a common agent to facilitate the exchange of aggregated data (fee and non-fee information) and to assist in the negotiation of HPPAs on behalf of the individual applicant hospitals.

2.28 The authorisation granted by the Commission was subject to a number of conditions, including safeguards on the exchange of information. These safeguards provide that:

- no information relating to current negotiations between a health fund and applicant hospitals may be exchanged;

- the information is to be sufficiently aggregated by the agent so it does not identify the prices charged by any individual hospital and the information will only relate to past negotiations with MBF and Medibank Private; and

- fee information shared among the applicant hospitals will be based on information that is at least three months old and must represent averaged data rather than 'best practice'.

2.29 There were a number of specific market conditions that the Commission recognised in its assessment of this application, including the fact that three of the applicants were regional hospitals, none of whom competed with each other, and the two metropolitan hospitals were estimated to have about 24 per cent of private hospital beds in Brisbane, and 9 per cent when public hospitals are included. In addition, in Queensland two health funds dominate the market – at the time of considering the application MBF had approximately a 54 per cent share and Medibank Private had approximately 37 per cent.

2.30 Since the final determination of application A50019, the Commission has considered and not opposed a merger involving two of the hospitals that are part of the authorised conduct.

Sydney hospitals

2.31 On 28 June 2000, the Commission denied authorisation (A90679) in relation to an application by three of Sydney's largest private hospitals for joint negotiations with health funds. The joint negotiations were part of an IHA between the applicants.

2.32 The Commission found that the proposed arrangement would not result in benefits to the public that would outweigh detriments arising from its anti-competitive nature. The arrangement included initial joint meetings between the hospitals and individual funds and the joint monitoring of progress in negotiations. The hospitals' proposal to negotiate with health funds individually through a common agent did not overcome the Commission's competition concerns.

2.33 The Commission found that there were a number of factors that differentiated this proposal with that involving the Queensland hospitals. In particular, there are four substantial health funds operating in NSW, each with approximately 20 per cent of the market. The Sydney applicants were three of the four largest private hospitals in the Sydney metropolitan area. These hospitals were found to have the highest reimbursement rates in NSW and had a disproportionate share of fund business (around 40 per cent). The applicants were estimated to have a 23 per cent share of private hospital beds in the Sydney metropolitan area and six per cent of the total Sydney hospital market. However, the Commission considered that there was merit in looking at a narrower geographic region than the Sydney metropolitan area. For example, in the North Sydney area the applicants have 39.2 per cent of private beds and in South Eastern Sydney the applicants have 23 per cent of private beds.

2.34 Further, the Commission did not accept the applicants' public benefit claims, particularly their need for countervailing power. The Commission noted that each of

the three hospitals is substantial in their own right and they already receive higher reimbursement levels from health funds than other private hospitals.

2.35 The Commission considered and did not oppose a merger involving two of these hospitals under the merger provisions of the Act. The fact that the merger excluded one of the hospitals, and that hospital would therefore remain as a competitor to the merged entity, was an important consideration for the Commission in allowing the merger to proceed. Following the merger, applications for authorisation (A90770, A90771, A90772) were lodged to facilitate the operation of the two hospitals through an individual economic entity.

3. Submission by the applicants

3.1 The applicants submit that in all the circumstances the provisions of the IHA, and the conduct required to give effect to that IHA, would 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 if the IHA was made or given effect to.

3.2 Among other things, the IHA will enable the applicant hospitals to share fee/price information and non-fee/price information and to jointly negotiate HPPA contracts with health funds by way of a common agent.

3.3 In support of their application the parties seek to rely, in part, on work by the US Department of Justice (DOJ) and the Federal Trade Commission (FTC) – United States competition agencies that have undertaken research into the competitive effects of horizontal arrangements in the American health industry.

3.4 A copy of the submission made by the applicants is on the public register maintained by the Commission. An overview of the main points raised in the submission is set out below.

Markets

Market definition

3.5 The applicants submit that the relevant markets 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.

3.6 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.

Market shares

3.7 The applicants provide the following estimates for the relevant hospital services/patient markets.

Metropolitan Sydney	**No. of hospitals**	**Beds**
Applicants combined total of private acute	5	177
Other private acute	36	3,114
Total for private acute		*3,291*
Total for public acute		9,465
Combined total for public and private acute		**12,756**
Applicants' share of private acute in metropolitan Sydney		5.4%
Applicants' share of combined acute in metropolitan Sydney		1.4%

Newcastle, Maitland & Port Stephens	**No. of hospitals**	**Beds**
Hunter Valley Private Hospital	1	40
Other private acute	6	447
Total for private acute	*7*	*487*
Total for public acute	10	1,491
Combined total for public and private acute	**17**	**1,978**
Applicants' share of private acute in Newcastle, Maitland & Port Stephens		8.2%
Applicants' share of combined acute in Newcastle, Maitland & Port Stephens		2.0%

Manning Valley District	**No. of hospitals**	**Beds**
Taree Mayo Private Hospital	1	39
Other private acute	-	-
Total for private acute	*1*	*39*
Total for public acute	4	322
Combined total for public and private acute	**5**	**361**
Applicants' share of private acute in Manning Valley District		100%
Applicants' share of combined acute in Manning Valley District		10.8%

Wagga Wagga & SW NSW	No. of hospitals	Beds
Calvary Hospital Wagga Wagga	1	90
Other private acute	5	n/a
Total for private acute	*6*	*n/a*
Total for public acute	2	n/a
Combined total for public and private acute	**8**	**n/a**
Applicants share of private acute in Wagga Wagga & SW NSW	61.5% of private hospital/day surgery acute admissions*	
Applicants share of combined acute in Wagga Wagga & SW NSW	44.9% of private admissions to private and public hospitals*	

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

3.8 The market shares and coverage of health funds in NSW and nationally are set out in Table 2.1 above.

Effect on competition

3.9 The applicants claim that in relation to the private hospital/health fund market the relevant geographic boundary is the State of NSW. On this basis, the combined market share of all the applicants is very small as compared with the total number and size of private hospitals in NSW. Further, the bargaining power of the applicants as compared with the major health funds and alliances of smaller health funds is heavily in favour of the health funds.

3.10 In relation to the private hospital/patient markets, the applicants submit that it is clear from the market share tables that where the applicants are participating in the same geographic market they have low shares. Where the applicants have higher market shares in a market, they are only sharing information with applicant hospitals participating in separate geographic markets. The applicants submit that this is without taking account that private hospitals compete with public hospitals for private patients.

3.11 Accordingly, the applicants claim that the effect of the proposed conduct on competition is likely to be negligible. The applicants claim that they are clearly not in a position to exercise market power due to their size (even in the event of joint negotiations) and due to the level of competition from public and private hospitals in the regions in which they operate. Further, there is no risk that permitting the authorisation would simply reverse the balance of negotiating power and transfer the alleged adverse effects of an imbalance from one group to another.

Public benefits

Inequality of bargaining power

3.12 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 reasons for this imbalance 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 knowledge about health costs across the range of hospitals they negotiate with and thus gain expertise in the process.

- 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.

3.13 The applicants submit that a major public benefit arising from the IHA and the proposed conduct is the potential for redressing the inequality of bargaining power with the health funds.

Cost reductions/savings

3.14 The HPPAs may require each hospital to establish a multiplicity of systems for contract administration and review. This process is particularly costly and time consuming for stand alone private hospitals in comparison with hospitals that operate within economically integrated structures that are able to co-ordinate negotiation strategies and processes. The applicants submit that the larger health funds and groups of alliances have had full time contract negotiators for HPPAs and MPPAs since the 1995 legislative amendments.

3.15 The applicants advise that presently they each individually negotiate contracts, generally on an annual basis, with health funds operating in NSW. While there are a large number of funds, the applicants note that the Australian Health Service Alliance negotiates on behalf of approximately 20 smaller health funds. There is presently little similarity in the form, content and manner in which health funds calculate reimbursement in the HPPAs. The applicants provided confidential information that identifies the likely cost savings flowing from joint negotiations with health funds and other suppliers and/or individual negotiations through a collective agent. In general terms, the applicants submit there is scope for significant savings in:

- senior management time and utilisation in both negotiating the HPPAs and seeking to implement the HPPAs;

- the legal costs associated with negotiating HPPAs, as well as contracts with suppliers of other goods and services to the applicants; and

- senior management time and utilisation in negotiating supply contracts with providers of goods and services to hospitals.

3.16 The applicants also submit that the cost of providing hospital and ancillary health care services in the private sector is rising and private hospitals are being forced to implement cost reduction strategies, develop greater efficiencies in the delivery of services and improve contracting processes to produce more efficient outcomes.

3.17 The applicants submit that, over time, there is likely to be a streamlining of negotiating processes, partly due to collective negotiation or agent driven negotiation by the parties, as well as general rationalisation within the private hospital industry that is seeing hospital ownership become more concentrated.

3.18 In relation to the collective acquisition of hospital related goods and services, the applicants claim:

- there will be savings in terms of the time and utilisation of senior management; and

- the increased volumes of purchases are likely to generate savings for each applicant. This will apply to surgical equipment and medical equipment such as prostheses and also in medical supplies which are areas where significant expenditure is incurred.

3.19 The applicants claim they are seeking authorisation for the IHA for the purpose of realising these efficiencies, as well as to equalise their bargaining power with health funds.

Information sharing/benchmarking

3.20 It is proposed that the agent be able to collect non-fee related data from the applicants about a particular procedure or procedures sought to be covered in a HPPA and other information pertaining primarily to quality/benchmarking issues such as clinical indicators, numbers of staff per hospital beds/admissions and operational data.

3.21 The applicants submit that such data:

- acts as a benchmark against which each hospital may measure itself in relation to standards of patient and hospital management;
- provides them 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;
- allows for the transfer of innovation among the applicants;
- 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 manual etc; and

- can result in improvements in quality which are likely to result in an increased ability to attract highly qualified personnel.

3.22 The applicants advise that there is presently little data regarding non-cost issues generally available. The sharing of such information will greatly assist in providing comparisons and benchmarks across a number of similarly sized hospitals.

3.23 In relation to the sharing of fee/cost/price related information the applicants submit that:

- sharing information about the costs provides benchmarks against which hospitals may measure themselves and aim to reduce costs. This is relevant to such items as "meals per day", cost of and utilisation of staff, linen, diagnostics, medical and non-medical consumables etc. This provides hospitals with information and scope for cost reductions. Sharing such information serves to improve the quality of information available to hospitals in negotiating with suppliers of such goods or services. The suppliers of many of these goods or services are to some extent similar 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;
- 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 sharing of this information will enable the hospitals to more accurately model the efficient costs of their operations and allow better informed negotiation;
- the sharing of such information will enable small hospitals to negotiate more efficiently with health funds on "case payments" (part of the HPPA whereby the health fund pays the hospital an agreed amount for the hospital's costs of a procedure). Health funds are at an advantage in that they have price information from a large number of hospitals about the same procedure;
- the sharing of such information will better inform the applicants of the general nature of offers that are being made by health funds to comparable sized hospitals – leading to more equality in the bargaining process;
- the sharing of this information may also reduce the extent of variations in payment structures by health funds (such as criteria for reimbursement, reimbursement levels, pricing structures) to similar sized hospitals which will significantly reduce the contract management costs of the hospitals;
- hospitals can use price related information to price their services more competitively and to offer compensation that attracts highly qualified personnel; and
- 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 heath fund or at the initiative of the hospitals.

3.24 The applicants submit that they have included safeguards for the sharing of fee related and price information as part of the IHA (see paragraph 1.45). The applicants referred to the finding of the DOJ and FTC that once such safeguards were in place they would not challenge competing hospitals from sharing such information absent extraordinary circumstances. These safeguards have also been included in the Commission's determination in relation to application A50019.

3.25 The applicants claim that the majority within the group are low cost efficient hospitals. They advise, however, that as cost benchmarking is only available through data that is dated and not available for comparable hospitals it is difficult to categorically determine this issue. The applicants reject HCF's claims that they are relatively inefficient in the delivery of their services and note that HCF did not specify the manner in which it calculated or determined efficiency.

3.26 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 and suppliers of goods and services. This equalises the bargaining power between the applicant hospitals and health funds and other suppliers.

Other public benefits

Better able to meet selective tendering requirements

3.27 The applicants submit that the manner in which health funds are conducting their negotiations with hospitals is changing dramatically as evidenced by the selective tendering process adopted by MBF in Queensland and which will be implemented shortly in NSW. The applicants advise that MBF is seeking tenders from private hospitals for the provision of hospital and associated services with the aim of creating an MBF network of hospitals for the benefit of MBF's members. Tenders will be evaluated based on a range of criteria including, competitive pricing, quality of care, aggregated billing, extent to which services are bundled into an inclusive price for each DRG, convenience of access for members and MBF's previous experience, if any, with the hospital.

3.28 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.

Viability of applicants

3.29 Despite the efficiencies of the applicants from an operational perspective, currently the information asymmetries when negotiating with health funds, their size as compared with the health funds and the negotiating stance taken by funds, threaten the viability of the applicants. Due to the efficiencies that are likely to result the proposed conduct will significantly improve the viability of each applicant.

3.30 The benefits of the continued existence of the applicants to the communities in which they operate are significant:

- the applicants allow choice of doctor, easy access to services and community based delivery of care in the regions in which the patients reside;

- generally, patients admitted to the applicants are not competing for attention with emergency department admitted patients. By admitting patients to the applicants, doctors effectively free public hospitals to focus on high level trauma patients, as well as the uninsured who choose not to self fund their health care; and

- as all surgery undertaken in the member hospitals is elective and therefore pre-planned, there are generally no cancellation of operations. In the same way there is always an appropriate level of nursing care.

3.31 The applicants claim that 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 to ensure the applicants remain viable providers of surgical and medical services and attain the benchmarks required by the health funds in the selective tendering processes.

Employment of, and availability of, medical personnel

3.32 The applicants provide employment opportunities for medical, nursing and support staff that may otherwise not be available or may only be available to a limited extent in a number of regions.

3.33 They also provide facilities that make it more viable for specialist doctors in various disciplines to operate practices in these areas.

3.34 In this regard, regional applicants have made significant investment to provide services that attract doctors who otherwise would not attend the hospital. For example, one hospital has built a pathology unit and psychiatric unit.

Availability of medical services to communities

3.35 The viability of the applicants in the regions in which they operate provides valuable medical infrastructure services in a number of regional areas. In some regions they provide the only alternative, or one of a small number of alternatives, to public hospitals. In some cases, their existence together with public hospitals makes the practices of various specialists commercially viable. Accordingly the applicants claim that they provide:

- the infrastructure necessary to attract specialists;
- freedom of choice for the community in terms of venues for medical and surgical procedures;
- the scope for elective surgery to be performed locally without the waiting lists of the public sector hospitals (and without the need for the patient to travel significant distances for surgery); and
- ease of access for relatives of the patient during the traumatic period surrounding surgery.

Employment and services within the community generally

3.36 The existence of the applicants within a region ensures the need for a variety of support services both within the hospital and to provide services to the hospital. The regional private hospitals are major employers within their local community, and support their local communities through the purchase of non-specialised goods and services from local businesses including food and repairs and maintenance services.

Similarly the Sydney applicants generally support local business by employing gardeners, repairers and other contractors from their local communities.

4. Submissions by interested parties

4.1 The Commission sought submissions from a wide range of interested parties in relation to the application for authorisation and the public benefit and public detriment claims by the applicants. Copies of the non-confidential submissions received by the Commission are on the public register. Set out below are the main points raised in submissions by interested parties.[3]

Submissions in support of the application

4.2 **Private Hospitals Association of NSW (PHA-NSW)** represents approximately 65 per cent of private hospitals in NSW as well as a number of accredited day procedure centres. PHA-NSW supports the application for authorisation by the independent hospitals who are all members of the association. The support is based on the perceived current imbalance of power between individual hospitals and health funds in one-on-one contracting. PHA-NSW also supports the application having regard to the relatively small and independent nature of each of the parties involved and the public benefits arising from the IHA, including the opportunity to benchmark non-fee and cost related information with the aim of reducing costs.

4.3 **Australian Private Hospitals Association Limited (APHAL)** advised that its policy position is one of explicit in-principle support for the establishment of authorised private hospital alliances that are intended to assist in the negotiation of contracts with health insurance funds. APHAL's policy position recognises that private hospital negotiation alliances have the potential to legitimately counter balance the excessive market power currently wielded by the funds.

4.4 APHAL referred to the Productivity Commission's finding[4] that small hospitals have significantly less capacity to dedicate resources to the HPPA negotiation process. By contrast, hospitals in the one ownership group are able to negotiate as a single bloc and may readily and legally share price related information. In addition, independent hospitals are doubly disadvantaged by their inability to offer a comprehensive range of private hospital services, as offered by large facilities and hospital groups.

4.5 In relation to the specific application, APHAL submitted that the hospitals are small to medium sized independent facilities which both individually and collectively represent a small market share. Similarly, they do not provide for a significant component of the market for any particular hospital service, although each is an important facility for patients and doctors within its local community. APHAL submitted that the applicant hospitals generally offer an alternative care setting to that available in larger, more sophisticated hospitals.

4.6 APHAL noted that the application seeks approval for the joint appointment of an HPPA negotiation agent, to act on behalf of the applicants in negotiations with

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[3] Interested parties were asked to provide comments in relation to the initial application for authorisation that involved 12 applicant hospitals.
[4] Productivity Commission Research Paper 'Private Hospitals in Australia', December 1999.

health funds, or health fund alliances, with more than 10 per cent of the market. APHAL advised that health funds, or alliances, with more than 10 per cent market share in NSW represent 20 out of the 28 funds operating in NSW in 1998/99. In particular, four health funds (MBF, Medibank Private, HCF and NIB) have market shares greater than 10 per cent and a further 16 health funds collectively negotiate through the Australian Health Services Alliance, the members of which represent an aggregate market share of 21 per cent.

Submissions opposing the authorisation

4.7 **Private Health Insurance Administration Council (PHIAC)** submitted that the outcome should not result in higher costs for hospitalisation than would otherwise occur if the hospitals concerned negotiated individually. PHIAC is unsure that the sharing of fee and non-fee related information would be used for any purpose other than to establish minimum levels of fees in negotiations with health funds. This could lead to increased prices that are ultimately passed on to consumers through the direct relationship between benefit costs and contribution rates in this largely not-for-profit industry.

4.8 PHIAC submitted that any authorisation that is granted should not require a health fund to contract with all hospitals as part of any agreement. In the event that a health fund seeks to selectively contract based on access requirements for its members, and provided that the fund has an appropriate mechanism for evaluating tenders which is non-discriminatory, then market forces should be allowed to determine the number of beds contracted and which hospitals receive contracts.

4.9 **CBHS Friendly Society Limited (CBHS)** provided a list of shareholders of each of the applicant hospitals which it claims indicates that 10 of the 12 are private for-profit companies owned by investors, trusts and superannuation funds for the purpose of obtaining a return on investment. CBHS claimed that this is in conflict with statements made by the applicants that any financial benefit derived from their proposed actions would be passed on to the hospital's clients rather than shareholders. CBHS also submitted that while the applicant hospitals are geographically dispersed, there are other small private hospitals in the same markets that will be disadvantaged by the conduct. In addition, a consequence of the conduct will be to prevent or deter other independent hospitals from entering the markets where the applicants operate, thus further restricting competition. CBHS claimed that this may occur because of a new entrant's inability to access the information available under the applicants proposed conduct.

4.10 **NRMA Health** submitted that many private hospitals, including small private hospitals, have substantial bargaining power in their relations with health funds. The bargaining power comes from the need health funds have for 'coverage'. In order to provide an adequate service to members, health funds must contract with at least one private hospital in each region. This need for coverage means that the private hospital/health fund market is regional rather than State-based as claimed by the applicants.

4.11 NRMA Health claimed that the conduct will affect the competitive dynamics in the private hospital/health fund market as the pressure exerted by the common agent (acting for all member hospitals) will tend to rigidify and even fix the benefits paid to applicant hospitals. This will occur because where the information exchanged between applicant hospitals is not aggregated each hospital will become aware of each other's cost structure and bargaining strategy and demand the same benefits. Further, the use of the common agent will necessarily put pressure on health funds to offer all applicant hospitals the same benefits received by the private hospitals that have the most bargaining power (ie. those with 100 per cent of the market). While the applicants deny that the conduct will involve collective boycott action or price fixing, NRMA Health claims that the conduct will be tantamount to both – member hospitals will in effect negotiate as a bloc.

4.12 NRMA Health submitted that the public benefit claimed by the applicants, namely to provide countervailing power against the health funds is not a public benefit. Changing the balance of bargaining power will not improve the allocative efficiency of the market or the economy more generally. It will however, lessen the competitive pressure and worsen the allocative efficiency of the private hospital market.

4.13 NRMA Health submitted that if authorisation is granted the competitive pressures introduced by the 1995 legislative reforms would be materially lessened and that the conduct will lead to increased hospital/medical costs and ultimately higher health insurance premiums.

4.14 **HCF** submitted that the relevant market is the private hospital market and does not include public hospitals. Calvary, Cape Hawke Community and Mayo Private substantially dominate their respective markets. HCF claimed that it would be impossible for any fund not to have these hospitals in its network if it is to provide access to private hospitals to members living in these areas. The nine other applicant hospitals operate in a more competitive environment and compete with other hospitals for the custom of private patients and doctors.

4.15 HCF submitted that the applicants have not provided evidence to support their claims that health funds negotiate on a 'take-it-or-leave-it' approach with individual private hospitals. Nor have the applicants demonstrated how their current contracting costs would be reduced by the proposed conduct or how savings will be realised as a result of joint purchasing of other goods and services.

4.16 HCF claimed that the Department of Health and Aged Care Services provides timely and accurate charging and benefit information which hospitals can access and manipulate without the need for the proposed conduct.

4.17 **Medibank Private** submitted that the relevant market for the provision of hospital services to health funds is regional rather than State-based. Health funds that wish to attract members in particular regions must have contracts with the private hospital in that region. Four of the applicant hospitals dominate their regional area and this market dominance will be enhanced through the collective negotiation process.

4.18 Medibank Private submitted that the health funds acting individually attempt to impose some measure of competitive constraint on hospital pricing and force them to