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17 October 2008

Your reference
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Attention: Sharon Clancy

Dear Ms Palisi

Sisters of Charity Health Service Limited (SCHS) Application for Revocation and Substitution A91099 – ACCC request for further information

We refer to your letter of 2 October 2008.

In this letter the following terms are used:

- **Application** – this refers to application A91099 for revocation of a non-merger authorisation and substitution of a new authorisation dated 8 August 2008.
- **Applicants** – this refers to the Sisters of Charity Health Services Limited and each of the entities identified in Item 4 (a) of the Application.
- **Price Terms** – this refers to those terms in contracts with funding organisations in which "prices" in dollar amounts are specified and includes price schedules which are typically appended or annexed to the contracts.
- **Non-price Terms** – this refers to all terms of contracts with funding organisations in which no "price" is specified in dollars and, for the avoidance of doubt, includes provisions which prescribe the allocation of costs eg whether payment is made for splints and other consumables and whether or not high cost drugs are included in payments made to hospitals.

Before addressing the ACCC's specific questions the applicants for authorisation wish to make the some general observations.

The private health sector in Australia is going through a period of significant consolidation. Ramsay Health Care and Healthscope have emerged as significant operators of private hospitals. There has also been significant consolidation among the health funds either formally such as the merger of MBF and BUPA or informally through negotiating alliances. The Applicants are seeking to achieve, through the authorised conduct/arrangements, some of the efficiencies resulting from consolidation because merger is not available to them.

The Applicants submit that the detriments of the proposed conduct should be analysed as though the participants were, for the period of the authorisation, merged. Viewed in this way it would be clear that, in each of the relevant State and national markets, the "synthetic merger" would not substantially lessen competition ie there is, on a worst case view, no material anti-competitive detriment.

The responses to the ACCC's requests for further information are set out below.

1. **How will the proposed collective bargaining arrangements for the Revenue Negotiation Network (RNN) operate in practice? For example, how will the Catholic Negotiating Alliance (CNA) seek input from RNN members as to desired outcomes from negotiations? Will contracts between RNN members and funding organisation be negotiated on a state basis?**

   Non-price terms

   The object of collective negotiation in relation to non-price terms is to achieve, as far as possible with each funding organisation, a standard template contract for all members of the RNN. At present there are significant differences in the non-price terms in the contracts between a particular funding organisation and various hospitals which are part of the RNN.

   The authorisation is sought to enable members of the RNN to authorise CNA to negotiate, on their behalf, with each funding organisation a standard template contract for that funding organisation.

   Members of the RNN are not obliged to authorise CNA to negotiate on their behalf and cannot be compelled to do so. It is, however, anticipated that the self-evident efficiency benefits of standardising, to the greatest extent possible, the non-price terms and thereby avoiding the need for each member of the RNN to negotiate in relation to those terms separately, will mean that most, if not all, of the RNN members will authorise CNA to negotiate non-price terms on their behalf.

   The negotiation process between CNA and the funding organisation is expected to involve the following steps:

   - A proposed template contract is put forward.
   - CNA will prepare an issues log against the proposed contract and send the log to the RNN members.
   - RNN members then provide feedback to CNA.
   - CNA will negotiate with the funding organisation on the non-price terms of a standard template contract (there may be multiple iterations seeking feedback from RNN members, depending on the changes a funding organisation agrees to in a template).
   - This contract template would then be used as the root/foundation document upon which negotiations would be based.
   - In addition to the standard template, there may be issues which are specific to particular RNN members and which need to be addressed through non-standard, non-price terms that may apply on an individual contract by contract basis. For example, there may be business rules applicable to a particular hospital concerning specific programs such as Hospital in the Home or Neonatal Intensive Care.

The geographic dimension of collective negotiations concerning non-price terms will vary and is likely to reflect the negotiating practices of the funding organisations. Typically, to date, the funding organisations have negotiated on a state by state basis and, if that continues to be the case, the Applicants would envisage that the collective negotiations in relation to non-price terms would also be conducted on a state by state basis. If, however, the funding organisations move to negotiations on a national basis, the Applicants anticipate that they would respond and negotiate on the same basis.

Price terms

By contrast, the collective negotiation of price terms is not intended to achieve "standard" prices for all hospitals. The benefits of collective negotiation of price terms include the availability to hospitals of experienced negotiators, who are familiar with the increasingly complex models and arrangements adopted by funding organisations and who can advise those hospitals, or negotiate on their behalf.

The Applicants anticipate that collective negotiation of price terms may be limited in the first year or so of the authorisation, while the management of the various RNN members develop confidence in the outcomes of the collective negotiations concerning non-price terms.

The Applicants do not anticipate in the short to medium term that there will be collective negotiation of price terms on behalf of all RNN members. It is more likely that collective negotiations of price terms will involve sub-sets of the RNN members.

The geographic dimension of any collective negotiations of price terms will reflect the practice of the funding organisations.

2. **Under SCHS's proposed arrangements, non-price terms have been distinguished from price terms of revenue contracts. Please specify what non-price terms are. Why are non-price terms of revenue contracts subject to proposed collective boycott if agreement cannot be reached between RNN members and funding organisations whereas it is proposed that price terms be subject to collective boycott if agreement cannot be reached with large health funds only?**

The distinction between price terms and non-price terms is set out above.

Non-price terms

The object of the collective negotiations of non-price terms of contracts with funding organisations is to achieve standard template contracts for all RNN members with each funding organisation. In other words, it is to avoid the inefficiencies resulting from different members of the RNN having different non-price terms. Given that standard template contracts are the desired outcome, the ability to negotiate "as one" in relation to those non-price terms is essential. The ability to engage in, or more importantly to threaten to engage in, collective boycotts is essentially a defensive measure to prevent funding organisations from seeking to divide and conquer the hospitals and maintain different non-price terms.

Attempts by individual hospitals to modify unreasonable or onerous non-price terms can result in protracted negotiations which, among other things, delay the introduction of new rates. This delaying tactic, if repeated over a number of years, has a significant negative impact on the revenue base of the hospital. This consequence discourages individual hospitals from pursuing these issues.

The persistence of onerous and unreasonable non-price terms reflects the historical imbalance in bargaining power between RNN members and a number of the funding organisations and the success of the divide and conquer strategies of some of those funding organisations. Examples of such terms include:

intended to put them in the position, for the purposes of the Act, that they would be in if they were related bodies corporate.

4. **Please clarify the proposed data sharing arrangement including more information about the type of data to be sharing and whether it is proposed that RNN members will be able to participate in the proposed data sharing arrangement without also participating in the proposed collective bargaining arrangement with funding organisations? If a funding organisation does not agree to the proposed data sharing, how will RNN members deal with that funding organisation?**

The types of data and the way in which it is envisaged they would be shared with RNN members are set out below.

Revenue Data

The disclosure of the rate schedule of one hospital to another hospital would be of limited utility and this is not what is proposed. Rather, the data exchange that is envisaged is that revenue data of RNN members is aggregated and benchmarked (eg revenue per bed day by fund, price weight of one by fund). This provides hospitals with a relative performance benchmarking overview of their business. Such benchmarking will show where, on a "league table" of peers, a hospital is placed. This will mean that a hospital may be satisfied that its remuneration by a particular funding organisation is in line with its peers and little additional time will be spent on negotiating those prices. Alternatively, if a hospital is underpaid by comparison with its peers it will be able to use the benchmark data to negotiate, on a properly informed basis, with the funding organisation. The benchmarking also enables CNA to advise RNN members on negotiation strategies.

Activity, Costs and Efficiency Data

There are enormous benefits for hospitals, consumers and funding organisations if hospitals can obtain benchmarking in relation to a wide range of performance parameters. Examples of benchmarking include:

- **Day of surgery on admission** – benchmarking the incidence of "day of surgery on admission" can assist hospitals to decrease the number of patients that come into hospital on the day before surgery.
- **Length of stay** – benchmarking data concerning length of stay can assist hospitals to target ways in which to decrease length of stay. Length of stay decreases are supported through increased efficiency in pre-admission processes, discharge planning and general multidisciplinary co-ordination of care. Current evidence suggests that decreasing a patient's length of stay in a hospital also decreases the risk of nosocomial infection, both in rate and severity. Decreasing length of stay is of benefit for our patients (consumers) from a clinical perspective, and for funding organisations and hospitals from a financial perspective.
- **Safety improvement** - benchmarking data can assist hospitals to target the areas of safety improvement by comparing rates of incidence of adverse events. This means that hospitals can target resources into areas of need to improve patient care. This benefits patients from a clinical perspective and funding organisations and hospitals from a financial perspective through decreased lengths of stay and re-admission rates.
- **National Hospital Cost Data Collection studies** - the collection and collation of data for benchmarking also assists in submitting and collating data for the National Hospital Cost Data Collection studies performed by the Commonwealth.

The RNN members and CNA wish to be able to exchange such data for benchmarking purposes, without fear of any challenge as to the lawfulness of their conduct under the Act.

Objects of data sharing

The data sharing described above is essential to achieving efficient outcomes across the RNN members ie correlating performance with revenue outcomes. It is the authorisation of sharing of data by the RNN members with the CNA that will enable it to perform its function as negotiating agent and adviser to the hospitals effectively and without threat of legal action from the funding organisations.

It has been suggested, in at least some of the submissions to the ACCC, that the object of the exchange of data is to enable inferior hospitals to increase their rates by reference to the rates achieved by superior hospitals. This suggestion is misplaced and misconceived. That is not the object of the data exchanges and it will not happen in practice.

The ACCC is aware that the major private hospital groups own and operate a large number of private hospitals throughout Australia. Each of them, as a matter of law, is able to negotiate in respect of their hospitals in ways which, if the hospitals were separately owned, would involve price fixing and collective boycotts. Nonetheless, the Applicants understand that the outcomes are that different prices are paid to different hospitals within those groups, ie, even when conduct substantively identical to price fixing and collective boycotts is lawful, inferior hospitals do not receive the same prices as superior hospitals. There is simply no basis for thinking that the outcomes for the RNN members, as a result of the authorised conduct, would be any different.

Another object is to ensure that funding organisations are dealing frankly with all RNN members. The experience of the Applicants is that funding organisations do not always and necessarily make full and frank disclosure of these matters. This enables them to take advantage of the fact that, without data exchange and benchmarking, individual hospitals and even small groups of hospitals have little way of knowing how their performance and remuneration from a funding organisation compares with their peers. It would be difficult to understand why some funding organisations object to disclosure of the data outlined above unless they are not currently fully and frankly responding to requests from hospitals for comparative information concerning peer hospitals and disclosure of data will expose this conduct.

Refusal by funding organisations to permit data sharing

Some of the funding organisations, including some of those with the most significant bargaining power, go to the considerable lengths to seek to prevent the exchange of data. This is typically done by imposing stringent confidentiality obligations. Some of the funding organisations sought to thwart the previous Authorisation by imposing and seeking to enforce confidentiality obligations.

These confidentiality obligations are one of the non-price terms in respect of which the Applicants seek the ability to engage in collective boycotts. In other words, the Applicants wish to be able lawfully to engage in a collective boycott, or threaten to do so, if a funding organisation seeks to impose confidentiality obligations which would impede or prevent the data exchanges which are a key feature of the authorised conduct.

The benefits of data sharing are not limited to collective negotiation of prices

The benefits of data sharing can be derived by a particular RNN member even if that RNN member is not engaged in collective negotiation of price terms because the RNN member has the benefit of the benchmarking exercises performed by CNA and the benefit, if they desire it, of negotiating advice from CNA.

As a general principle, transparency on pricing through data exchanges, benchmarking and the role of CNA is likely to result in outcomes that better correlate remuneration with performance than the current practice of some funding organisations of preferring to divide and conquer by keeping individual hospitals and small groups of hospitals ignorant of market developments. Full and frank disclosure of data by funding organisations is, of itself, a benefit to consumers, hospitals and health funds.

5. **Please clarify the proposed collective boycott processes including whether participation in the proposed non-price terms boycott and the proposed large health fund boycott is voluntary for RNN members and in what circumstances is it proposed that a collective boycott take place?**

Proposed Collective Boycott process:

- The hospital, in conjunction with the CNA will undertake the standard contract negotiation process with a funding organisation as contemplated by the current provisions of the "HPPA Code of Practice".
- In instances where the contracting parties are unable to reach a mutually acceptable, negotiated agreement over the terms of the proposed HPPA, and all options available to escalate the issues under dispute up through the management structures of each party have been exhausted, then the matter will be referred by the affected hospital/hospital group directly, or via its RNN Agent, to the CNA Network Committee for review.
- Following a review, the CNA Network Committee may make recommendations to the relevant RNN members about collective boycott of a funding organisation by those RNN members engaged in a collective negotiation with that organisation.
- The CEO/Executive Authority of each relevant RNN member will determine whether that member participates in a collective boycott (ie, individual members will decide whether or not to join boycott).
- Notification of intention to enter into a collective boycott, including effective dates of boycott implementation, will be communicated in writing to the designated contracting officer of the funding organisation. If a boycott eventually results in the relevant RNN members going out of contract, there will be notification to stakeholders in line with the PHIO's current recommendations in this regard, as well as fulfilling all obligations for the treatment of all pre-booked hospital admissions for patients, who are members of the relevant funding organisation.

6. **How will the proposed collective bargaining arrangements for the Joint Purchasing Network (JPN) operate in practice? For example, how will the Catholic Negotiating Alliance (CNA) seek input from JPN members as to desired outcomes from negotiations? Is participation in the JPN voluntary for eligible hospitals?**

JPN Collective Bargaining Arrangements:

- The proposed collective bargaining arrangements for the JPN will operate in practice along the lines of the current version of the Purchasing Network Operational Guidelines (See **attachment** 1). These Guidelines are confidential and the ACCC is requested to treat them as commercial in confidence.
- The Guidelines provide a framework for the day-to-day operational activities of the JPN, the purpose of which is to achieve, through the collective bargaining process, price savings for JPN Members and, through the coordination of these negotiations on a centralised basis, transaction cost savings for all JPN members.

- The Purchasing Network Operational Guidelines include details on each of the following operational matters:
  - communication process;
  - negotiating process;
  - opportunity identification process;
  - a information gathering and opportunity analysis process;
  - a JPN recommendation process;
  - a negotiating process detail (including issue of formal request for quotations to suppliers, evaluation);
  - acceptance and implementation of supplier proposals.

7. Please advise whether it is envisaged that new members will be admitted to the RNN or the JPN. What eligibility requirements will apply to new members?

The only new members that may be admitted to the RNN and/or the JPN and in respect of whose participation authorisation is sought through the Application are those identified in Annexure D to the Supporting Submission.

The Applicants consider that some of the submissions to the ACCC in relation to the Application from interested parties contain factual errors. A letter concerning those issues, to the extent they are not dealt with in this letter, will be sent to you next week.

Yours sincerely

Peter Armitage
Partner