Level 36, Grosvenor Place
225 George Street
Sydney NSW 2000
Australia

Blake Dawson

T 61 2 9258 6000
F 61 2 9258 6999
DX 355 Sydney

Locked Bag No 6
Grosvenor Place
Sydney NSW 2000
Australia

www.blakedawson.com

Joanne Palisi
Director
Adjudication Branch
Australian Competition & Consumer Commission
GPO Box 3131
CANBERRA ACT 2601

30 October 2008

Your reference
C2008/1288

Our reference
PJA 02 1416 5493

Partner
Peter Armitage
T 61 2 9258 6119
peter.armitage
@blakedawson.com

Contact
Tihana Berak
T 61 2 9258 6343
tihana.berak
@blakedawson.com

Attention: Sharon Clancy

Dear Ms Palisi

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

In this letter, the Applicants respond to some of the issues raised by interested parties in their submissions to the ACCC some of the Third Party (**"Third Party Submissions"**).

1. Overview

1.1 The Applicants consider that some of the Third Party Submissions contain many errors and mis-descriptions. The Applicants have not sought to respond or comment on all of these errors and mis-directions.

1.2 The Applicants have sought, as far as possible, to avoid repeating information supplied to the ACCC in the Blake Dawson letter of 17 October 2008.

1.3 The Applicants' responses to matters raised by interested parties are set out below. The material is organised by reference to extracts from the Third Party Submissions.

1.4 There are two issues on which most of the interested parties have made submissions. It is convenient to summarise the position of the Applicants in relation to those common issues in one place.

1.5 The first common issue is the contentious matter of the short and medium term impacts for hospitals and funding organisations going out of contract. The arguments in favour of granting authorisation do not depend on the ACCC reaching a concluded view on this issue but the Applicants consider that the Third Party Submissions on this issue contain a number of materially incorrect assertions and propositions.

1.6 There can be no real dispute that the short term impacts of going out of contract are more severe for a hospital than a funding organisation. The hospital suffers an immediate and significant loss of income. Without volume, and with fixed costs on average being approximately 40%

(Round 11 NHCDC, excluding prostheses), hospitals lose money. Many of the funding organisations refuse to back date contracts and, as a consequence, if a negotiation is prolonged and an increment is late, then the hospital loses that income, effectively forcing hospitals to deliver care at yesterday's prices.

1.7 By contrast, the proportion of a funding organisation's members, who require hospitalisation when a particular hospital goes out of contract and for whom that hospital is the only real choice, is very small. According to their 07/08 Annual report, Medibank's private health insurance covers over 3.2 million people. Assume that a regional hospital admits 10,000 patients a year and that Medibank patients constitute over 25% of its activity. Such a hospital is more susceptible to the negative impacts of an out of contract situation than Medibank. This 25% of hospital activity represents less than 0.08% of Medibank's total cohort. In other words, the impacts on the hospital and the funding organisation are very different and this materially affects the balance of bargaining power. It should be noted that consumers in this situation are protected by portability allowing them to change funds without re-serving waiting periods. This also promotes competition between funds encouraging them to pay appropriate market rates.

1.8 It has been asserted that the second tier benefit arrangements effectively reduce this bargaining imbalance. This is not the case. The hospital does not know what the second tier benefit payable to it will be. The second tier benefit is typically 85% of the average rates payable by that fund to comparable hospitals in the relevant state. The funding organisation is not obliged to disclose those rates to a hospital until after a decision has been made between the parties to formally terminate their contractual agreement. Therefore a hospital can not make a fully informed decision as to the likely financial impact on it of going out of contract. Relevantly this asymmetry of information disclosure was lobbied for strongly by the private health insurance industry in Australia.

1.9 The second common issue is the widespread objection of funding organisations to the sharing of data between the Applicants. As discussed in the letter of 17 October 2008, authorisation is sought to enable data from a funding organisation to be collected, collated, aggregated and analysed without risk of contravening the Trade Practices Act. This will enable the Applicants to inform themselves as to the treatment of their hospitals by that health fund in comparison with peer hospitals.

1.10 The funding organisations, virtually without exception, object to this. There seems to be no rational basis for those objections. Indeed, it is hard to understand what objection there can be to the injection of some transparency into an important part of the economy. The vehemence of the objections is such that, it is difficult to escape the inference that at least some of the funding organisations either do not, of their accord, fully and frankly disclose relevant comparable data to hospitals or they prefer to take advantage of isolated hospitals and pay benefits below the market rate. The only basis for the objections appears to be the suggestion that this will result in higher prices being paid to inferior hospitals. This suggestion is not, for the reasons discussed on page 6 of the letter of 17 October, credible.

2. ARHG

2.1 As mentioned previously however, ARHG has a total national membership representation fewer than 3% of the privately insured market, well under the cited 20% representation in any state that is of concern to the SCHSL. Given this, the authorization the SCHSL is seeking will create a direct disadvantage to the ARHG Funds and any other of the smaller funding organisations who do not form part of the major health fund negotiating bodies.

As their market share is well under the proposed 20% threshold for a collective boycott for price terms, ARHG will not be impacted by the large fund boycott for price negotiations.

2.2 Funding organisations are strictly forbidden to share information about exchange

fees, cost, price and specific contract terms and conditions with each other. There is currently no exception to this rule and in our experience, funding organisations respect this requirement and adhere to it. That the SCHSL should ask that they be required to "only contract with Funding Organisations that agree to this data sharing" - i.e. the data sharing that funding organisations are prohibited from doing - is unfair.

This submission by ARHG is surprising. As a group of independent funding organisations, they offer a single contract to a hospital with the same rules and prices for each of their organisations. Also, as a group, they reject funding proposals from hospitals. They appear to do this without the benefit of any authorisation under the *Trade Practices Act*. The same circumstances apply to the AHSA.

2.3 **The submission requests that the acquisition of goods and services "occur only through the Joint Purchasing Network and upon terms agreed by members of the Joint Purchasing Network". This one-sided request has neither credibility nor integrity.**

It is not clear why the ARHG objects to the efficiency enhancing JPN – the conduct in question concerns dealings with suppliers to hospitals, not funding organisations.

2.4 **There is already a mechanism in place for hospitals and funding organisations to call upon a mediator if negotiations are not proceeding appropriately. Further to recent legislative change, the Private Health Insurance Ombudsman (PHIO) was granted powers to mediate contract negotiations between hospitals and funding organisations in the event that parties are unable to reach agreement. The PHIO has authority to preside over negotiations and direct an outcome that will ensure the members of the public are appropriately served. As the hospitals have this avenue available to them, the option to boycott is not necessary. In fact, to do so would undermine the authority of the PHIO, particularly if the PHIO hands down a decision that can subsequently be circumvented by the authorization granted by the ACCC.**

The PHIO does not have legal nor legislative capacity to arbitrate, rule on or dictate terms of an agreement for a final and binding negotiation outcome.

2.5 **Funding organisations ... are not able to access information about hospital "rack rates" so once again, funding organisations are disadvantaged by being required to disclose 2nd tier rate information while the hospitals have no such imposition forced upon them.**

This is incorrect. Hospitals are required to send HCP data (standard legislated industry data extract containing morbidity data and revenue information) to funding organisations. Funding organisations can tell what is being charged to their members. Therefore, should a hospital and a funding organisation not be in contract, the HCP data provided by the hospital to the fund would contain the "rack rates" charged to the fund's members who had been treated at the hospital.

2.6 **The submission states that hospitals should be allowed to share data so that they can "identify areas in respect of which they were being paid substantially below fair competitive prices." In other words, the submission clearly says that some hospitals are being paid more than others by certain funders. In the interest of a fair trading environment therefore, should funding organisations not be offered the same opportunity to share data with each other so that they can identify areas where they are paying above fair competitive prices?**

Health funds do have access to such information: the PHIAC data shows health fund data by state so that a fund can tell if they are paying prices that are higher on average than their competitors.

2.7 **Section 7.5 of Part C of the submission talks about the Catholic population and their need to "obtain health care in an environment that understands and supports their religious beliefs". This is a philosophical argument that is irrelevant to the core issues of the submission and it should be pointed out that most other hospitals - public and private - are able to provide religious services relevant to the needs of individual patients. The SCHSL also makes mention of their not-for-profit status, and the fact that they return all profits back to their consumer base. In the interests once again of keeping things in perspective, it should be noted that ARHG Funds - and indeed the majority of funding organisations also operate on a not-for-profit basis, returning profits back into the business for the benefits of policy holders.**

Catholic hospitals are mission based and therefore patient/consumer advocacy is one of their core values. This is different from the for profit sector who are required to make profits for shareholders. It should be noted that two of Australia's largest funding organisations by membership are for-profit. Medibank (Australia's largest fund) is likely to go down the for-profit route in the near future. ARHG's argument may be true for them, but they do not represent the majority of the market.

2.8 **Section 8.1 (c) of the submission talks about the "unique provisions and anomalies" that have evolved in contracts over time, making reference to the fact that in some negotiations rates in one area of a contract will be held down to facilitate an increase in another area of the contract. The submission says "Other hospitals will have negotiated different trade-offs, resulting in rates, terms and methods of calculation that cannot be directly compared from hospital to hospital." By its own admission, the submission notes the current disparities in contracts so if the CNA is allowed to share data amongst its member hospitals, the resultant aggregation of data is likely to be skewed, creating an unreal platform from which to basis future negotiations.**

As stated in the letter of 17 October, the disclosure of rate schedules would be of limited utility. What is proposed is that revenue of RNN members will be aggregated and benchmarked.

2.9 **If funding organisations are not in a position to share data to verify the analysis of the CNA, how can they reasonably determine an acceptable position to respond to the position of the CNA?**

Funding organisations can compare their rates through the PHIAC data.

2.10 **Under the proposed arrangement, there is no recourse for funds to verify the position of the hospitals. We also seek to remind you that under the terms of the previous authorization, hospitals only shared data with each other in aggregated format.**

This is not correct. Under the terms of the current authorisation, the relevant hospitals could compare prices at price schedule level. However, in practice this was not done because of the risk that, at that level, information may be skewed.

2.11 **Our concerns about the hospitals being able to share raw data as reiterated through this document lead us to request that if this authorization is granted, the hospitals still be permitted to only share aggregated, not raw data.**

In order to carry out data aggregation efficiently the raw data must be sent by the hospitals to the CNA agent (SCHS). Patient confidentiality issues prevent the CNA agent and the hospitals from exchanging raw patient data directly between hospitals.

2.12 **Section 8.3 talks about the challenge of finding skilled negotiators and states that "none of the CNA members has a large enough network of hospitals to enable it to**

support employing a specialized negotiation and support team at corporate level." We challenge the credibility of this statement as in our experience, the negotiators from all of the current and proposed CNA hospitals are professional, purposeful, knowledgeable and skilled. In general, the procurement of quality staff is a challenge all employers in the Australian marketplace face - certainly not a unique situation for the members of the CNA.

Unlike the funding organisations, CNA hospitals do not employ people to negotiate contracts as their sole and/or primary professional core function. Health fund contract negotiation usually forms a small part of their role thereby making it difficult to become specialised at it.

2.13 **Section 9.I(c) states that funding organisations have the opportunity to generate short-term revenue by deliberately delaying negotiations. It should be pointed out that most hospitals request back-dating of contracts as a fundamental part of the negotiations and ARHG is very accommodating of such requests if ARHG has in any way contributed to the delay of the negotiations.**

ARHG may have been accommodating of such requests but certain other funding organisations have not been accommodating at all.

3. **AHSA**

3.1 **On a literal reading of the terms of the 'large health fund boycott', the CNA members must only negotiate contracts with large funding organisations through the Revenue Negotiation Network (RNN) and all members must agree on all of the terms of each member's contract with every health fund. These requirements would compel the CNA members to undertake all their negotiations with large funding organisations collectively, and would prevent any CNA member from having separate negotiations on any contract term with a large health fund. However, AHSA does not believe that this is what is intended or what is likely to occur in practice.**

This is incorrect. A hospital can choose whether or not to be part of a joint negotiation or boycott.

3.2 **AHSA would be very concerned if the authorisation allowed the RNN to pick and choose which hospitals form part of any negotiation, including unrelated hospitals from different States, and then collectively boycott in relation to that selected sub-group of hospitals. The RNN could use such a strategy to include a hospital that they know funds cannot afford to not have an agreement with such as St Vincent's Sydney in order to force an agreement with other unrelated hospitals.**

This submission by the AHSA is surprising as it describes its own method of operation. The AHSA negotiate a deal with a hospital and once this has been concluded then an AHSA member funding organisation can decide whether or not to take it up.

3.3 **Many of the hospitals in the CNA can demand and get very high increases as they have substantial market power in their region. The bargaining power of the hospitals in these situations is greater than the funds. Should the CNA extend their power to collectively boycott, this can be used with great effect as the CNA would be able to exploit their market power in one region to force through high increases in another region where they do not have market power. As funds cannot walk away when the hospital is the only or principal hospital in the region, the CNA will be able to force through their demands for higher prices in both regions.**

This argument carries little or no weight because it is too general and theoretical. The argument first assumes that there are certain hospitals which are regarded by funding organisations as "must have" hospitals which have market power as a consequence. The

argument then asserts that there are other hospitals, unrelated to the "must have" hospitals, which can use the authorisation of collective bargaining to achieve higher prices than otherwise would be the case in a competitive market. The first problem with this is that there is no real consensus as to whether any particular hospital is a "must have" hospital. For example, Medibank decided, in 2005, that certain leading private hospitals, such as St Vincents Private Hospital, Sydney and the Epworth Hospital, Richmond Campus in Melbourne would not be "Members Choice Hospitals". The reality is that there are few, if any, "must have" private hospitals. Secondly, the fundamental premise of the argument, namely, that each of the other unrelated hospitals faces competition, means that funding organisations can readily go out of contract, or threaten to do so, with each of those hospitals because their members have alternative hospitals available. In other words, the threat by a "must have" hospital, in the context of collective negotiations, to go out of contract with a funding organisation, is balanced by the threat of the funding organisation to go out of contract with all the hospitals for which there are competitive alternatives. Accordingly, collective negotiations involving such groupings of hospitals can not result in pricing above the competitive level.

4. HCF

4.1 **All hospitals have the ability to benchmark a range of information with other hospitals and do. Information relating to price can be de-identified and aggregated for all funds and then applied to the agreed benchmarking model. Individual fund prices are not critical to this type of exercise.**

Benchmarking the prices of a particular funding organisation is necessary if a hospital wants to ascertain whether that funding organisation is telling the hospital the truth about their pricing level in relation to comparable hospitals.

4.2 **Simple price comparisons between different hospitals can be misleading as they may not take into account:**

- **PHI fund member demographics;**
- **Payment model differences;**
- **Health Fund product differences;**
- **Contract negotiation history;**
- **Differences in clinical practice between states and hospitals;**
- **Timing of contract renewal;**
- **Length of stay; and**
- **Case mix variations per fund.**

The CNA team consists of specialised casemix experts who are capable of taking these sorts of variables into account and the lack of utility/usefulness of simple price comparisons was acknowledged in the letter of 17 October.

Non-price contract terms

4.3 **There would be a significant financial risk to private health insurers should authorisation be granted for the CNA Revenue Negotiation Network to dictate non-price terms. This risk would be realised should the CNA's request for an extension to their current boycott powers also be approved. Non-price terms cover funding models, business rules, audit processes, payment terms and privacy and dispute clauses to name but a few. Costs to funding organisations associated with changes**

to non-price terms can be extraordinary and may include system changes, staff education and legal advice. Furthermore there would be no guarantee that the CNA would not make further changes as part of future negotiations.

The object of collective negotiation of non-price terms with a funding organisation is to achieve, as far as possible, a standard template contract for that funding organisation with all RNN members. That would appear to be efficiency enhancing and beneficial to the funding organisation (simpler to administer etc) and to the RNN members.

Collective boycott of large funding organisations

4.4 **Should the collective boycott authorisation be approved and enacted by the NSW CNA hospitals, 20,000 HCF member hospital admissions would be affected with many in regional areas having limited access to the private hospital sector should they choose to remain HCF members.**

The threat of a collective boycott would be a last resort in the face of inability to reach agreement with HCF in New South Wales. The HCF members' interests would be protected by portability, ie the members could transfer to another fund. What HCF appears to object to is the possibility (even if it is very remote) of competition, between itself and other funding organisations, for those members. The Applicants acknowledge that a consequence of the Authorisation will be to intensify competition between funding organisations but the Applicants submit that this is beneficial for consumers.

5. MBF/BUPA

5.1 **As funding organisations we appreciate that negotiations through an agent, with the benefit of shared information and terms, may reduce the operating costs of hospitals, unfortunately, it has been our overwhelming experience over the term of the current authorisations, that the mechanisms authorised for bringing about these cost savings and efficiencies were not utilised. Instead the information sharing authorisation allowed hospitals and their administering entities to selectively construct agreements, based on the terms that appealed, from contracts to which each entity in the group had been granted access. It has been our experience to date that there has only been a token use of the RNN agent authorised to negotiate on behalf of the group.**

Throughout the MBF/BUPA submission, there are assertions that:

- collective negotiations of price terms have not taken place; and
- CNA has played little, if any, role in negotiations.

The Applicants acknowledge that collective negotiation of price terms has, to date, been limited. The criticism made by MBF/BUPA seems to be that, because the current Authorisation was not exploited to the fullest extent possible, none of the claimed benefits were derived. That is not correct. Submissions have been made by the Applicants to the ACCC as to the benefits derived from the current Authorisation. The criticism also overlooks the fact that authorisation involves a balancing of benefits and detriments. In the circumstances that MBF/BUPA describe, namely an absence of collective negotiation of prices, there was relevantly no anti-competitive detriment.

The criticism of CNA is also misplaced. CNA has generally played a variety of roles for the hospitals. To date, many of those roles have generally not been visible to the funding organisations, as they have involved benchmarking and behind the scenes contract negotiation advice.

5.2 **Without the hospitals cost savings achieved through the collective negotiation process it is difficult to argue that a public benefit can be derived from the current**

and presently sought authorisations. Indeed the information sharing in the absence of collective negotiation is more likely to have resulted in a public detriment through the increased premium costs that result from the higher benefits paid to RNN hospitals.

MBF/BUPA baldly asserts that information sharing under the current Authorisation has resulted in higher benefits paid by MBF/BUPA to RNN hospitals. It is difficult to understand how this could be the case. MBF/BUPA is one of the funding organisations which has been most aggressive in its attitude to confidentiality obligations. MBF/BUPA has consistently sought to thwart information sharing. The suggestions that benefits paid to RNN hospitals are higher than their peer hospitals and that this is because of information sharing should be rigorously proved by MBF/BUPA if the ACCC is to rely on these assertions.

5.3 **BUPA Australia submits that the RNN facilities, in particular, are such that the authorisation is not required to achieve equality in negotiating with insurers. The following market data from BUPA Australia and MBF records sets out factors contributing to the respective bargaining and the regions in which CNA members have a dominant or significant market share, evidencing that the authorisation is not required for those facilities. In light of the CNA's reluctance to utilise collective negotiating power during the term of the current authorisations, the following market data reinforces the extent to which a lack of market power is unlikely to be an accurate depiction of the RNN's motivation in submitting the Application.**

The information supplied by MBF/BUPA confirms that, in each State, the critical issue is whether and, to what extent, the bargaining position of RNN Members is altered by the Authorised arrangements and conduct. The Applicants submit that the bargaining positions of the relevant parties are not radically altered by the Authorisation. For example, in Victoria MBF/BUPA has a market share of members of approximately 28%. The combined private bed share of the RNN members and prospective members is approximately 27% - not a basis for asserting dominance. Without the Authorisation, the RNN Members and potential members would have separate market shares of 6% (Sisters of Charity); 9% (Cabrini) and 12% (St John of God). It is clear that, without the Authorisation, none of the RNN Members or potential Members is "dominant".

5.4 **Furthermore, whilst Canon and civil Law inhibit Catholic hospitals from merging neither regime prohibits mergers completely. If a merger would effectively level the playing field in terms of competition with commercial private hospitals, this is something that should be considered before resorting to Commission authorisations.**

The position is that, in the short to medium term, mergers of some or all of the groups of RNN Members are very unlikely. This is the counterfactual against which the ACCC must assess the Application.

5.5 **Revenue modelling - All current private hospital billing systems are computer based with hospitals required to export episode data to both funding organisations and the Commonwealth. The most sophisticated modelling necessary for a hospital may be performed using this data on a simple Microsoft Excel spreadsheet. Complexity grows with the diversity of the facility and these skills will continue to exist in facilities that require them regardless of collective negotiations.**

Each funding organisation uses a different payment/funding model. The extract that BUPA/MBF are referring is not enough to source data for all funding models (in fact, MBF's own funding model can not be built from an HCP extract as HCP itself does not include elements such as private room and same day banding). Modelling can be done in Excel, but it is not simple and requires very high level formulae writing and analysis skills.

5.6 **Benchmarking -The benchmarking activities listed in the Application can be carried out regardless of the existence or otherwise of the RNN, Hospitals also have access to second tier benefits rates from each fund, which provide them with information regarding benefits, paid by that fund relative to peer hospitals in the relevant state.**

This statement is incorrect. The second tier rates are not disclosed to a hospital unless the hospital has formally terminated that funding organisation's contracts.

6. **MBP**

6.1 **The value of Medibank health insurance is the ability of our members to access private hospital services with little or no out-of-pocket expenses. If the Boycott Authorisations are allowed and invoked by all Member Hospitals, the value of Medibank health insurance would be severely undermined and would likely result in Medibank members moving to another health fund (which had not been boycotted by the Member Hospitals) or dropping their health insurance altogether and instead relying on the public system. The detriment to the public of large numbers of members reverting to the public system could be significant.**

The Applicants consider that the concerns expressed by Medibank Private about the boycott aspects of the Authorisation are exaggerated. MBP has approximately 30% of the national market for private health insurance. The impact for the RNN hospitals of going out of contract with Medibank Private would be so significant as to make a boycott by any of those hospitals a very last resort. The significance of such a boycott should be assessed in the light of the very remote possibility of it occurring. The consequences of such a boycott are also not likely to be as suggested by Medibank Private. In 2005, Medibank Private publicly stated that they wished to contract only 90% of beds in the market and, at that time, they excluded St Vincent's Private Hospital, Sydney and Epworth Hospital, Richmond Campus, Melbourne from their Members Choice Hospitals. Notwithstanding this, Medibank Private's profits and membership grew.

7. **HBF**

7.1 **Firstly, we would like to highlight the inaccuracies in the application, which do not provide an accurate picture of the Western Australian market. The figures quoted in the application for Mercy Private Hospital (174 beds) reflect current occupancy levels, however the hospital has a potential occupancy of 244 beds. All other hospital beds quoted in the submission are for potential occupancy not actual occupancy levels.**

It is incorrect to report that 174 beds reflect Mercy Hospital's current bed occupancy. While Mercy is licensed for up to 244 private beds, it only has 174 private beds on site.

7.2 **HBF may have no option but to accept the negotiating position of the RNN to prevent the following outcome from collective boycotts...a large number of privately insured Western Australians may not be able to receive care at half of the acute hospital facilities in Western Australian because of large out of pocket costs (eg gaps will occur where an agreement between RNN and health fund can not be reached because in the absence of an agreement the health fund may revert to funding a minimum mandated benefit levels)...due to the unique situation in Western Australia (HBF's market share is 60% and the proposed RNN market size is 51%), the effect on hospital negotiations and the public detriment from a collective boycott is far higher in Western Australia than other states in Australia.**

The Applicants submit that these propositions are seriously exaggerated. The St John of God Hospitals can currently lawfully negotiate collectively in Western Australia because they are related bodies corporate. The only change relevant to the assessment of the benefits and detriments of the Authorisation is the possibility that both the St John of God

Hospitals and the Mercy Care Hospital at Mt Lawley may become members of the RNN. The Applicants submit that the consequences described by HBF will not flow from, in effect, authorising the Mercy Care Hospital at Mt Lawley to negotiate collectively with the St John of God Hospitals.

Please contact us if you require any clarification or further information concerning these issues.

Yours sincerely

Peter Armitage
Partner