PRIVATE HOSPITAL
COLLECTIVE BARGAINING GROUP

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Dr Richard Chadwick
General Manager
Adjudication Branch

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Dear Dr Chadwick,

Response to Draft Determination for authorisation A919293

Thank you for the opportunity to respond to the ACCC's recent draft determination regarding the Private Hospital Collective Bargaining Group's application for authorisation.

Overall, the PHCBG is satisfied with the ACCC's draft findings and does not wish to call a conference to discuss matters further.

Despite this, the PHCBG would like to highlight two areas of concern regarding the proposed limits placed on the operation of the PHCBG. These areas are:

1. the method of measuring PHCBG membership; and
2. the proposed five year authorisation period.

1. *The Method of Measuring PHCBG Membership*

   The PHCBG understands that limits must be placed on membership as an assurance against potential monopolies in the marketplace. *Section 4.7* of the draft determination proposes to grant authorisation on condition that:

   The overall number of PHCBG member hospitals is restricted to 50 hospitals of no more than 200 beds each with no more than 10 small private hospitals in any one Australian state or territory.

The method described above is of particular concern to the PHCBG as history demonstrates that the majority of suppliers determine costing based on quantities purchased.

As a general rule, hospitals with greater bed counts will purchase more supplies and perform more operations then hospitals with less beds. By limiting membership to 50 hospitals nationally, the PHCBG will be forced to choose hospitals with larger bed counts over their smaller counterparts.

This approach would be adopted purely from an economic standpoint, as the success of the PHCBG's negotiations hinge on the group's size.

1.1 Preferred Solution – Capping Beds

To circumvent the abovementioned problem, the PHCBG proposes a cap on beds, rather than hospitals. *Section 3.78* of the draft determination states:

While bed numbers would generally provide a more precise measure of market share and may therefore be thought of as a more precise way of limiting the size of the group an advantage of setting the upper limit by capping the number of private hospitals in the PHCBG is that it is easily verified, it does not depend upon the precise definition of the market or interpretation of market share data, and does not fluctuate when a given private hospital increases or decreases its bed numbers.

The PHCBG argues that bed counts within a hospital fluctuate rarely, if ever. To increase the bed count of a hospital, the owner must undergo a rigorous process involving in-depth planning and approvals with the Health Department. This process can take years and costs hundreds of thousands of dollars. In reality, a hospital's bed count stays largely the same because small independent private hospitals do not have the incentive to increase beds.

1.2 Measuring Bed Count

During accreditation, a private hospital must declare the number of beds it has. These figures are then submitted to the Health Department.

The PHCBG understands that tracking bed count data must be simple for administration purposes. As such, the PHCBG proposes to provide an annual statement of member hospitals and bed counts to the ACCC.

Further, this approach ensures independent private hospitals – with one bed or 200 beds – have the same opportunity to take advantage of group pricing. Inclusiveness is an important aim of the PHCBG and something we strongly desire to uphold. Using bed count information, rather than hospital numbers would allow us to achieve this aim.

1.3 Suggested Bed Cap

The PHCBG respectfully requests its membership be capped at 1500 beds per state or territory with a maximum of 7500 beds nationally. These figures are based on the ACCC's proposal to allow ten hospitals per state, as 1500 beds per state or territory averages to 150 beds per hospital if the ACCC's original proposal were enforced. As such, we aim to stay within the ambit of the ACCC's proposal.

2. *The proposed five-year authorisation period.*
   Section 4.8 of the draft determination proposes a five-year authorisation period. After further consultation with negotiators who have worked with private hospital groups from around Australia, the PHCBG has discovered that establishing the processes and agreements required to effectively operate a collective bargaining group can take between two and three years to set up. In light of this, the PHCBG requests an authorisation period of six years.

Once again, thank you for providing the PHCBG with the opportunity to comment on the ACCC's draft determination. If you have questions or require more information please contact me.

Kind Regards,

Sarah Robinson