PRIVATE HOSPITAL
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Mr David Jones
A/g General Manager
Adjudication Branch
Australian Competition and Consumer Commission
GPO Box 3131
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18 July 2012

Dear Mr Jones,

Response to Submissions Re. Draft Determination for authorisation A919293

Thank you for providing me the opportunity to respond to submissions lodged in response to the ACCC's recent Draft Determination.

The PHCBG seeks to comment on queries raised by the Medical Technology Association of Australia ("MTAA") in its submission dated 29 June 2012.

MTAA refers to confirmation in the Draft Determination that the PHCBG will disclose the names of hospitals to targets before negotiations take place. The PHCBG seeks to clarify that only hospital numbers, bed count figures and quantities will be provided, not the specific names of PHCBG members.

MTAA assumes that because a centralised ordering system is not mentioned in the Draft Determination it is not authorised conduct. The PHCBG seeks to clarify that it does intend to use a centralised ordering system in order to streamline ordering and provide a more

efficient system for its members. The PHCBG has not sought authorisation for this conduct, as it recognises the system to be a means by which ordering can occur.

Finally, in relation to measuring membership by hospital numbers, the PHCBG strongly contends that this method will cause difficulty for the group's operation due to the following factors:

1. *Small Private Hospitals More Likely to have 0-50 beds*[1]

   Most hospitals eligible to join the PHCBG are between 0-50 beds. This means that the actual size of the group – in terms of bed count – will be small. A hospital with a larger bed count will inevitably order more, providing more leverage in negotiations.

   In practice, if the PHCBG has ten member hospitals with 25 beds on average per hospital, this equates to only 250 beds per state. This is half the size of one hospital in a large hospital network such as the Catholic Negotiating Alliance. As such, the per-hospital method has significant limitations.

2. *The Very Small Private Hospitals Miss Out*

   The primary goal of the PHCBG is to provide small independent private hospitals with the bargaining power they need. If a per-hospital criterion is authorised, it is outside the PHCBG's interest to recruit very small private hospitals with as little as 5 beds. Economic logic dictates that the PHCBG will need to recruit private hospitals with a bed count closer to 200, as higher bed counts result in better pricing.

   Various health funds, including Medibank Private, argue that bed counts are not relevant to health fund increases as they deliver increases on a service by service basis. They argue that because the entire hospital is assessed before providing an increase, this model cannot work.

   The PHCBG strongly contends that this approach may be adopted for larger private hospitals; however, it is certainly not the status quo for small, independent private hospitals. In their situation, health funds are more likely to provide a blanket increase which applies to every service they offer. By way of example, if a hospital

[1] Data extracted from myhospitals.gov.au.

offers cataract surgery, colonoscopies and other procedures, their increase will apply to every service, despite their differences. Using a bed count cap will not impact negotiations with health funds or other targets.

The PHCBG does seek to comment on the submission further and looks forward to providing another submission by the end of next week.

Thank you for your time. If you have questions or require more information please contact me.

Kind Regards,

Sarah Robinson