



The Council of Procedural Specialists

Submission to the Australian Competition and Consumer Commission

**In respect of the application for authorisation under
section 88(1) of the *Competition and Consumer Act
2010* (Cth)**

Applicants: Honeysuckle Health Pty Ltd and nib health funds limited

15 February 2021

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1. Introduction

- 1.1 The Council of Procedural Specialists (**the Council**) provides the following submission in response to the application by Honeysuckle Health Pty Ltd (**HH**) on behalf of itself and nib health funds ltd (**nib**) (together, the **Applicants**) seeking authorisation under s 88(1) of the *Competition and Consumer Act 2010* (Cth).
- 1.2 The Applicants seek authorisation to form the HH Buying Group for the purposes of collectively bargaining with health care providers to purchase health services and to provide certain contracting services to health care payers (the **Proposed Conduct**). Authorisation is sought for a period of ten years.
- 1.3 The Commission may authorise a collective bargaining arrangement where the public benefits of such an arrangement are *likely* to occur, and outweigh any public detriments, i.e., there is a net public benefit.
- 1.4 Public benefits include '*anything of value to the community generally*' and address a source of market failure or imperfection.¹ Similarly, public detriment has a broad meaning of '*any impairment to the community generally*' and '*any harm or damage to the aims of ... economic efficiency*.'²
- 1.5 The Council will primarily address those aspects of the Application that concern the proposal for collective bargaining with medical specialists.

Executive Summary

- 1.6 The Council notes that the main focus of the Application appears to be directed to collective bargaining with hospitals rather than medical specialists.
- 1.7 In relation to the likely impacts on medical specialists, the Council has a number of concerns with the Application and submits that authorisation should not be granted.
- 1.8 Alternatively, if some form of authorisation were to be granted, it should be narrowly confined in duration and scope to avoid or minimise a number of significant public detriments.

Inclusion of other major health funds as participants in the HH Buying Group

- 1.9 From the Council's perspective, the Application provides scant detail or substantiation as to the claimed public benefits likely to result from the proposed collective bargaining conduct in relation to medical specialists.
- 1.10 The Application does not identify which funds will be members of the bargaining group. Even large funds like Medibank Private, Bupa and HCF are contemplated as joining the collective group for some '*bespoke contracting services*'.³ This could mean that most Australian private health funds might join the HH Buying Group and negotiate collectively. This would be of significant concern to the Council.
- 1.11 The Council submits that no authorisation should extend to permit collective bargaining by a major fund like nib with medical specialists and that the large private health funds - in particular, Bupa, Medibank Private and HCF - should be specifically excluded from any

¹ ACCC *Guidelines for Authorisation of Conduct (Non-merger)* (March 2019), para. 8.1.

² *Ibid.* para. 8.2.

³ Application, para. 1.5.

bargaining group. Any authorisation should also be subject to strict conditions governing the future composition of the HH Buying Group.

- 1.12 The lack of clarity as to the membership of the HH Buying Group makes it difficult to assess any claimed public benefits or detriments, because it is unclear as to which private health funds may join the HH Buying Group and what may be the outcomes from any collective bargaining by that Group. It is also difficult to properly assess net public benefits, given the lack of data provided as to the negotiations process currently conducted and that proposed under collective bargaining.
- 1.13 The Council's experience is that medical specialists are presented with printed standard form contracts by health funds on a take it or leave it basis and confidentiality imposed by the funds to prevent that information being shared or discussed. It is not suggested in the Application that anything will change in that respect, if collective bargaining was to be permitted.
- 1.14 The Applicants' confidentiality claims exclude Annexures B, C and D from the public register.⁴ Given the lack of information in the public version of the Application, it is not apparent why Annexures B, C and D to the Application could not be disclosed if they support the benefits claimed.
- 1.15 To the extent the Application proposes permitting other major private health funds to join the HH Buying Group, there is a clear risk of the HH Buying Group speaking or acting for private health funds holding a large share of the Australian private health fund market (over 70% if Bupa, Medibank Private and HCF participate). Such an outcome would raise substantial concerns as to anti-competitive conduct and risks of monopsony behaviour by the HH Buying Group.
- 1.16 In the Council's submission, fundamental questions arise in relation to the claimed public benefits of the proposed collective bargaining:
- (a) What are the Applicants' streamlined processes and how will they improve efficiency compared to the status quo?
 - (b) What is the magnitude of reduced transaction costs and will consumers benefit or only shareholders?
 - (c) How will an increase in information sharing and data analytics result in better health outcomes compared to the status quo?
 - (d) What measures will the private health funds have in place to ensure that no concerted practices conduct arises and that patient information is secure?
 - (e) How will the proposed authorisation result in reduced premiums for consumers, by how much, and over what timeframe?

The Application is not based on the accepted public benefits of collective bargaining

- 1.17 The Application is also quite unusual as it does not identify any of the typical types of benefits one would expect to arise when competitors propose to engage in collective bargaining. Usually, collective bargaining is permitted as a public benefit to address a disparity in bargaining power by small traders or asymmetries in information flows, or in circumstances where collaboration would result in substantial savings in transactional costs, or where the

⁴ Application, Confidential Annexures B, C and D.

targets of the collective bargaining would derive efficiencies as well as the members of the bargaining group.⁵

- 1.18 Here, however, the collective bargaining is proposed for a group of private health funds who are unlikely to be considered 'small business' or in need of the Commission's assistance in negotiations with individual medical specialists (who themselves may either be self-employed sole practitioners or members of a small group practice or associateships, sharing overhead costs).
- 1.19 Medical specialists are independent professionals lacking any degree of bargaining or market power when it comes to negotiations with a group of health insurers. They will be vulnerable to an undue imbalance of bargaining power if this Application were to be approved.

The Application assumes that the HH Buying Group's contracts will be accepted

- 1.20 The decision of medical specialists whether to contract with private health funds is voluntary. As far as the Council is aware, most procedural specialists have not signed contracts (other than to participate in MPPAs on an opt-in/opt-out basis) with private health funds. On the evidence provided by nib, to date there has not been a substantial uptake by medical specialists of the nib Clinical Partners Program.
- 1.21 The Council's experience is that most medical specialists are not contracted with private health insurers - their contract is with the patient (or consumer), who is reimbursed from Medicare, the health fund, the compensable payer, or from their own resources.
- 1.22 The Application does not provide any clarity as to the type or content of the proposed contracts to be negotiated on a collective basis with medical specialists if the Application were to be approved. As far as the Council is aware, there are standard opt-in/opt-out MPPAs (also known as no-gap and known-gap schemes). There are also other contracts like the Bupa Medical Gap Scheme, which imposes stricter obligations on the doctor concerned and requires 60 days' notice of termination.
- 1.23 The Applicants refer to the nib Clinical Partners MPPA but have not explained how that contract will operate or which aspects of the contract will be open for negotiation under collective bargaining if approved.
- 1.24 The Council understands the typical nib Clinical Partners MPPA is a 12 month rolling contract which includes certain obligations on doctors to target numbers of orthopaedic patients admitted to overnight surgery, as a cost minimisation tactic.
- 1.25 The Applicants have not clarified the nature of what is proposed to be offered to doctors as value-based contracts, which would be the subject of the proposed collective bargaining.
- 1.26 In these circumstances the Applicants have not explained why their collective bargaining contract proposals are likely to be attractive and of value to medical specialists if offered. Rather (without revealing the substance of these proposed contracts), the Applicants appear to assume that increased contracting in the form they propose would be a likely outcome of that bargaining and would deliver a net public benefit.

The claimed public benefits assume that contracts will be agreed with specialists

- 1.27 Most of the benefits cited by the Applicants from collective bargaining predict that various savings or other outcomes will be achieved, on the assumption that collective bargaining with medical specialists will be successful. However, the Council submits that, as the Application is

⁵ [ACCC Small Business Collective Bargaining Guidelines \(December 2018\)](#).

framed, such prediction is uncertain and there is nothing by which the ACCC could reliably assess that that will be the outcome.

- 1.28 Unless the Applicants can show that the collective bargaining is likely to be successful with medical specialists in the terms proposed by the Applicants, most of the claimed public benefits will never eventuate. Collective bargaining by health funds will more likely serve as a threat to the professional, contractual and pricing independence of medical specialists.
- 1.29 The Applicants have not otherwise identified any specific public benefits of significance that will result merely from negotiation by the private health funds occurring on a collective basis. The Council has identified a number of detriments, explained below, which suggest that the proposed authorisation gives rise to a net public detriment and should not be given.

Unsubstantiated claims of reduced health costs and lower insurance premiums

- 1.30 The Applicants also claim that collective bargaining will lead to lower health care costs and lower premiums for consumers;⁶ however, it is not clear from the Application whether the Applicants' claims on this point refer to the total resource cost of an episode of treatment, including insurance co-payments, etc., or merely the costs which are met by the health fund.
- 1.31 The Applicants rely⁷ upon certain reductions in costs reported by Cigna⁸ in the United States, which appear to be cost reductions in amounts paid out by the insurer, rather than reductions in the total resource cost of the treatment. The claims of 'better quality' referred to are unexplained in the Application and therefore unverified. Accordingly these claims of cost savings from 'value based contracting' must be viewed with some scepticism, as they may involve cost shifting, rather than genuine improvements in patient care and reductions in total resource costs.
- 1.32 The Application also fails to address concerns that attempts by a combination of private health funds to coordinate their activities to jointly drive down the volume or cost of health expenditures may adversely impact on consumers/patients and not result in any lowering of premiums to consumers. This is discussed below.

Detriments of coordination and concerted practices between health funds

- 1.33 In considering possible detriments from the collective bargaining conduct the Application does not address the risks of excessive buying power being used by the HH Buying Group nor the risks of information sharing and cooperation that could occur between competitor funds within the HH Buying Group. The Application raises clear risks of concerted practices in the private health provider market as well as in the downstream consumer insurance market.
- 1.34 These are real concerns that need to be addressed even if major health funds are not included. It is a matter of public record that the private health insurance market is reasonably concentrated with the four big private health funds (Bupa, Medibank Private, HCF and nib) accounting for over 70% of expenditures.

⁶ Application, 4.12

⁷ Application, paras. 4.13 to 4.14. Note: these claims are made without citing any sources or verification.

⁸ HH is a joint venture between nib and Cigna Corporation. Cigna is a global health services company based in the United States. In 2020 Cigna was ranked thirteenth on the Fortune 500 list of US corporations. It has a current market capitalisation of \$76.29 billion and its 2020 revenue was \$160.4 billion.

Authorisation should not be granted or the scope of any authorisation significantly narrowed with conditions

- 1.35 For the reasons set out above, the Council submits that on the basis put forward in the Application, no authorisation should be granted to permit private health funds to collectively bargain with medical specialists.
- 1.36 If, despite the foregoing, the Commission is minded to grant some form of authorisation to permit collective bargaining with medical specialists, the authorisation should not be granted without:
- (a) conditions governing the size and membership of the group (e.g., to exclude all large health funds), or impose a cap on the size and membership of the HH Buying Group; and
 - (b) conditions limiting the risks of concerted conduct by those private health funds involved in collective bargaining; and
 - (c) conditions ensuring that:
 - (i) participation in any collective bargaining by medical specialists is their decision, and is voluntary (and does not preclude them from access to and participation in standard opt-in/opt-out MPPA arrangements with any private health fund);
 - (ii) the private health funds within the HH Buying Group are required to offer bilateral negotiation on an independent basis to any medical specialist who elects not to engage in collective bargaining with the HH Buying Group.

Collective Bargaining by medical specialists and by other health providers

- 1.37 Furthermore, any authorisation of collective bargaining by health funds with medical specialists is likely to require consideration of whether it would be appropriate for medical specialists to form their own collective bargaining group or groups as a response to the bargaining power of the private health funds if authorised.

2. **Parties**

The Council of Procedural Specialists

- 2.1 Council is a committee of national procedural specialist organisations who formed to provide a voice for Australian medical practitioners involved in procedural medicine. Members of its constituent organisations practice in both Australia and New Zealand.
- 2.2 The organisations comprising its membership are:
- (a) the Australian Society of Ophthalmologists;
 - (b) the Australian Society of Orthopaedic Surgeons;
 - (c) the Interventional Radiology Society of Australasia;
 - (d) the Australian and New Zealand Association of Oral and Maxillofacial Surgeons;
 - (e) the Australian and New Zealand Society for Vascular Surgery;

- (f) the Medical Surgical Assistants Society of Australia; and
 - (g) the Australian Society of Anaesthetists.
- 2.3 The Council liaises with federal and state governments, federal and state medical associations, medical colleges, medical defence organisations, consumer groups, and senior decision-makers in the public and private healthcare sector.
- 2.4 Consumers typically engage their services only after referral from a general practitioner. The services they provide include medical procedures for which admission to a hospital (public or private) will be necessary.
- 2.5 The Council's members participate in Medicare rebate arrangements. Some procedural specialists participate in Medical Purchaser Provider Agreement (**MPPA**) arrangements with health funds on an opt-in, opt-out basis.

Intended participants in the HH Buying Group

- 2.6 The Applicants "anticipate that private health insurers that currently outsource their contracting services to AHSA or AHRG are the healthcare payers that are most likely to join the HH Buying Group".⁹
- 2.7 Set out below is a description of the activities of the AHSA and AHRG, and the private health funds that they represent:
- (a) **AHSA:** a service company that represents a number of small to medium-size private health insurance funds. The company was formed in 1994 and now covers 2.17 million Australians, which in total represent a 19.06% share of the national market for private health insurance.¹⁰ AHSA represents 27 of the 37 private health insurance funds in Australia and paid more than \$2 billion in benefits to healthcare providers in 2019.
 - (b) **AHRG:** a group of health insurance funds operating predominantly in regional areas. Its primary role is to negotiate Hospital Purchaser Provider Agreements on behalf of its four member funds.
- 2.8 The Applicants state that the major private health funds 'may be interested in purchasing bespoke parts of the contracting services to supplement their internal functions'¹¹. The major health funds are:
- (a) **Medibank Private:** Australia's largest health insurance provider with 3.76 million members and 26.94% of the market across their two brands Medibank and ahm.¹² In 2020, Medibank Private had \$5.5 billion dollars in benefits payable to their customers, supported 1.3 million hospital admissions and 22.7 million extra services. The provider was previously an Australian Government enterprise that operated for almost 40 years, before being privatised in 2014 and is now a publicly listed company on the ASX.

⁹ Application, para. 1.5.

¹⁰ AHSA 2019 Corporate Profile. See: https://www.ahsa.com.au/web/ahsa/corporate_profile.

¹¹ Application, para. 1.5.

¹² Medibank Private 2020 Annual Report.

- (b) **Bupa:** a foreign-owned private company that began operations in Australia in 2002 and currently serves over 4 million customers in Australia and New Zealand. In 2019 Bupa ANZ generated \$8.33 billion in revenue.¹³
- (c) **HCF:** Australia's largest not-for-profit health fund covering over 1.5 million Australians in 52 locations across the country.
- (d) **nib:** is an Australian health care fund a publicly listed company on the ASX, serving over 1.5 million customers in Australia and New Zealand.¹⁴ The company was established in 1952 and generated \$2.5 billion in total revenue in 2020.¹⁵

3. Analysis of the claimed public benefits

Overview

- 3.1 As a preliminary point, the Council notes that most of the public benefits asserted by the Applicants presume that the Applicants will be successful in their negotiations with medical specialists, i.e., that the outcome of the negotiation is a successfully negotiated contract with the medical specialist.
- 3.2 For the Commission to take into consideration these claimed public benefits, it would have to be satisfied that the proposed collective bargaining arrangements are likely to result in those outcomes. On the available evidence, the Commission cannot reliably assess that that will be the outcome.
- 3.3 It is the experience of the Council's members that only a relatively small number of medical specialists have signed contracts with health funds. It is unclear why this should change following any authorisation. Further, the Application does not explain why it would anticipate significant take up of these agreements by medical specialists following authorisation, or why they would be considered attractive.
- 3.4 The Commission should therefore not place any weight on the claimed benefits, which assume a specific outcome from the bargaining process.

Transaction cost savings and increased efficiencies for health funds in the HH Buying Group

- 3.5 The Application contains no evidence or information by which the Commission can evaluate the existence or magnitude of any cost savings which might result from collective bargaining with medical specialists.
- 3.6 There is currently no form of collective bargaining process available to medical specialists when presented with health fund contracts and no formal negotiation process between private health funds and medical specialist groups or organisations.
- 3.7 Doctors who have received contracts may seek advice from lawyers but the contracts presented are typically marked 'Commercial in Confidence'. As far as the Council is aware, the typical health fund approach to date has not involved any negotiation process, simply offers of contracts on a take it or leave it basis. The Applicants have not established that there

¹³ Bupa 2019 Annual Report.

¹⁴ Private Health Insurance Ombudsman, *State of the Health Funds Report 2019*.

¹⁵ nib 2020 Annual Report.

will be a genuine opportunity to negotiate the terms of these arrangements or which terms will be up for negotiation.

- 3.8 The Application does not shed any light on the current process of negotiations with specialists. For example, no information has been provided in the Application concerning:
- (a) how many MPPAs or Clinical Partners Contracts nib has agreed with medical specialists or the process and resources engaged to finalise those contracts;
 - (b) how many MPPAs or Clinical Partners Contracts the Applicants expect would be agreed and the savings of resources and time in those processes if authorisation were granted;
 - (c) which health funds would be participants of the HH Buying Group, which would seek to negotiate MPPAs or contracts with medical specialists;
 - (d) how many specialists the health funds currently contract with, and expect to contract with, upon joining the HH Buying Group; or
 - (e) the magnitude of the reduction in transaction costs for those health funds which join the HH Buying Group, which are said to justify granting authorisation.
- 3.9 Absent any evidence or modelling substantiating the claimed transactional cost savings, the Council questions whether the Application has met the standard necessary to permit authorisation.
- 3.10 Moreover, the Council queries whether savings of substance would result from contracting with medical specialists in the manner proposed. From the perspective of medical specialists, there do not seem to be any significant cost savings from dealing with a group of, say, four funds, as opposed to dealing with each fund separately.
- 3.11 The experience of specialists in negotiations with health funds as reported to the Council is largely that standard form contracts are presented on a basis that is 'take it or leave it'. The Council therefore questions whether public benefits are likely to arise from the Applicants' claimed streamlining of contract negotiation, procurement and management procedures¹⁶ and, if so, the magnitude of any benefits.
- Claims of greater choice of buying group for health funds*
- 3.12 The Applicants claim that the authorisation would allow private health funds the option to join an alternative buying group, thus affording those funds greater choice.¹⁷
- 3.13 The benefit of greater choice appears only to benefit the private health funds. However, the Application does not provide evidence or modelling upon which it can readily be said that this choice would be attractive to insurers, or that those insurers might achieve cost savings or other benefits as a result.
- 3.14 The Applicants also note that private health funds would benefit from access to a '*differentiated model of funding*', that being '*value-based contracting*'. The Council rejects that model outright on the basis that medical specialists not the health funds should determine their fees, as they

¹⁶ Application, para 2.38.

¹⁷ Application, para. 4.10.

do now, in a contract with the patient (or consumer), not have those fees determined by the private health funds.

- 3.15 Accordingly, the claimed benefit appears to be either insignificant or non-existent.

Claims of better health outcomes at a lower cost

- 3.16 The Council submits that the Commission has not been supplied the material necessary to find that the HH Buying Group would achieve greater efficiency through a '*value-based contracting relationship*'.

- 3.17 *First*, as noted earlier, it has not been shown why the Commission should assume that the HH Buying Group would be successful in its negotiations with medical specialists, such that the claimed outcomes might be realised.

- 3.18 *Second*, even if it is assumed that some proportion of medical specialists would contract with the HH Buying Group, the Application provides no evidence as to how value-based contracting would result in '*higher than standard quality outcomes*'. No evidence or information is provided as to:

- (a) how this would occur;
- (b) its implications for patient care;
- (c) the contract mechanisms that would deliver these superior outcomes; or
- (d) why better patient outcomes might be expected to occur as a result of value-based contracts and not otherwise.

- 3.19 *Third*, the Applicants rely¹⁸ upon certain reductions in costs reported by Cigna in the United States, which appear to be cost reductions in amounts paid out by the insurer, rather than reductions in the total resource cost of the treatment. The claims of '*better quality*' referred to by the Applicants are unexplained in the Application and therefore unverified. Accordingly these claims of cost savings from '*value based contracting*' must be viewed with some scepticism, as they may involve cost shifting, rather than genuine improvements in patient care and reductions in total resource costs. There is a real question about whether value-based contracting such as that used in the US delivers better health outcomes at a lower cost.¹⁹

- 3.20 *Fourth*, the Council notes that certain MPPAs impose obligations on specialists to target their patient care, the effects of which are unclear. **[Confidential]**:

[Confidential].

- 3.21 The Application does not consider the public benefits or detriments to medical specialists or patients of this targeting obligation or obligations of a similar kind. The Council submits that before finding that '*value based contracting*' will improve outcomes and result in a net public benefit, the terms of those contracts, and their effects, require close examination.

¹⁸ Application, paras. 4.13 to 4.14. Note: these claims are made without citing any sources or verification.

¹⁹ Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, available at < <https://interactives.commonwealthfund.org/2017/july/mirror-mirror/> >

Claims of increased data analytics and information

- 3.22 The Council submits that, assuming collective negotiations were successful, the Application does not evidence or explain the public benefits which are to be derived from private health funds having greater access to shared data analytics.
- 3.23 For example, the Application does not say whether data analytics would be shared with medical specialists or other third parties, or whether it is to be kept confidential within the HH Buying Group. If the information were to remain confidential, it is difficult to see how the claimed information-sharing arrangements would amount to a 'public benefit'.
- 3.24 The Council also notes that these benefits could be achieved otherwise than by entering a collective bargaining arrangement.

Claims of a better 'no gap' experience for health fund customers

- 3.25 The Council's view in relation to health fund members encountering a gap or out-of-pocket expenses is that that reflects a shortfall in the appropriate level of insurance cover offered by the private health funds.
- 3.26 The Commission is not in a position to predict the outcome of any collective bargaining, or that those negotiations would result in an increased number of 'no gap' commitments.
- 3.27 The Council understands that nib's Clinical Partners Program has not been widely taken up either by medical specialists or by the broader Australian health industry, because the terms offered are not attractive to medical specialists.
- 3.28 Therefore, it is doubtful that collective bargaining by a group of private health funds, to offer the Clinical Partner Program on a wider basis, would deliver any significant public benefits (or any benefit at all). The Council also expects that collective bargaining will not address the concerns of many of its members that the Clinical Partners Program does not provide commercially reasonable terms and conditions to medical specialists.

Lower healthcare costs and premiums for members

- 3.29 The Applicants claim that the proposed bargaining arrangements with medical specialists will:
- increas[e] the value of benefits paid by healthcare payers for health services and reduc[e] overall spend particularly in relation to hospital benefits.
- 3.30 As a consequence, they say that this will '*reduce pressure on premium increases for health insurance policies.*' However, this claim is unsubstantiated and the Council submits that this claimed benefit is unlikely to materialise and should not be given any weight, in circumstances where the private health funds would collectively exercise significant bargaining power vis-à-vis individual medical specialists.
- 3.31 The Applicants submit that the collective bargaining group are able to negotiate lower contract prices on the understanding that the insurance funds will in return direct a greater volume of business towards "effective providers".
- 3.32 The Application states:
- The development and expansion of the Clinical Partners Program will focus on efficient and effective providers who provide quality standards of care based on the available hospital quality and outcomes data. The establishment of MPPAs with these Providers will drive more volume to them (as health insurers will be able to actively promote the financial certainty for Customers and referrers) and will also service to place pressure on non-participants specialists to moderate their out-of-pocket practices due to the risk of loss of patient volume.

- 3.33 The Council is concerned that the more likely outcome of the collective bargaining which is proposed is that the private health funds would exploit their superior bargaining power to the detriment of both medical specialists and patients (consumers) and may push fees for services below the competitive level required for these services to be properly rendered to patients.

Other claimed benefits

- 3.34 It is noteworthy that the Application does not suggest that private health funds are under any disadvantage in access to information or resources in negotiations with medical specialists. This is because the private health funds seeking the benefit of collective bargaining are already in a stronger bargaining position compared to medical specialists who have fewer resources and poorer access to information in any negotiation of a contract with a private health fund.
- 3.35 The Applicants do claim that smaller health funds would benefit from access to additional information that could be obtained from nib, were the proposed collective bargaining permitted. The Applicants suggest that the contracts used by nib would, in effect, be rolled out to smaller health funds and form the basis of the negotiations by the HH Buying Group.²⁰ However, were that to occur, there is a concern that nib's existing contracts would be adopted by the HH Buying Group, and presented to medical specialists, on a *'take it or leave it basis'* which has no inherent public benefit.

4. **Analysis of public detriments**

Overview

- 4.1 The Council submits that no public benefit is likely to arise from the proposed authorisation. However, if the Commission determines that the proposed collective bargaining would result in some public benefit, the authorisation should nevertheless be refused because the public detriments would be likely to outweigh any public benefits.

Implied collective boycotts

- 4.2 The Applicants assert that the Proposed Conduct *'does not involve a collective boycott'*.²¹ However, the Council is concerned that, were a medical specialist to refuse to agree to a contract offered by the HH Buying Group, and then seek to renegotiate a separate contract with a private health fund that was a member of the Group, the specialist could face the same *'take it or leave it'* offer from the fund (i.e., no variation in the terms on offer on an individual versus collective basis).
- 4.3 Especially for smaller private health funds, there is a strong risk of this outcome because, absent alternatives, their offer may be anchored or tailored to the HH Buying Group offer. Therefore, the Council sees a strong risk of concerted practices arising from the proposed collective bargaining and sharing of contract terms within the HH Buying Group and *de facto* boycott terms which might be offered to specialists by a fund within that Group. The risk of this conduct occurring appears clear. It is noteworthy that it is not addressed at all in the Application.
- 4.4 The Council is also concerned that the HH Buying Group also proposes to act as an agent for funds outside of the buying group terms. This would suggest that HH Buying Group could be

²⁰ Application, para. 2.8.

²¹ Application, para. 1.4.

in a position to facilitate inappropriate information sharing between competing health funds when it is acting as agent on behalf of two or more of them.

- 4.5 Although the Applicants claim that *'providers would also not be prevented from contracting with participants individually'*,²² there is nothing in the Application to suggest that medical specialists will practically be able to enter individual agreements with HH Buying Group members, in the event the specialist chooses not to contract with the Group.

Health funds achieving monopsony power is not a solution to controlling healthcare costs

- 4.6 The Council does not accept that adequate evidence has been put forward by the Applicants which could reasonably satisfy the ACCC that the proposed value based contracts, negotiated collectively by insurance funds, would be likely to result in improved outcomes for patients and a public benefit for the overall healthcare system.
- 4.7 The Applicants submit that, through collective negotiation, private health funds are likely to secure lower prices in exchange for directing greater volumes towards participating medical specialists, and that this is a public benefit. The premise for this pro-competitive effect is an assumption that price reductions will be shared, and flow downstream to medical specialists and consumers.
- 4.8 Where a bargaining group is formed to counteract a disparity in bargaining power (not this case), this may be true. However, a study in the United States on the effects of mergers of health funds on health costs has questioned whether improved buyer power by a merger of health funds is likely to be in the public interest.²³
- 4.9 In that study, Professor Kirkwood questions whether mergers are a generally attractive method of utilising buyer power to control healthcare costs. His conclusion is that they are not, as any resulting reductions in prices and fees paid to providers are only be passed on to consumers if the downstream market is competitive.
- 4.10 In respect of the proposed authorisation, the Commission must be satisfied that the HH Buying Group would not be able to exercise monopsony power to push down provider prices below the competitive level: even if the private health funds are able to extract 'savings' from efficient collective bargaining, what incentives are there for these 'savings' to be passed through to consumers through lower premiums?
- 4.11 In the textbook monopsony model, consumers do not benefit from lower input prices obtained by a monopsonist. Instead, the monopsonist reduces the volumes of purchases of medical services below the competitive level which, in turn, lowers the quantity of medical services output which the monopsonist offers to consumers. The outcome of this is that consumers pay higher not lower prices: *'in the monopsony model, in short, there is no pass through of lower input prices to consumers'*.²⁴
- 4.12 The Council is concerned that the monopsony power of the private health funds could allow specialists to be exploited. Moreover, the Council submits that the effect of lower fees for a higher volume of services may harm consumers. Medical specialists' incentives to supply more medical services (work longer hours, see more patients etc) may be increased and in the longer term there may be other impacts such as fewer, or less patient-focussed doctors

²² Application, para. 2.19.

²³ John Kirkwood, *Buyer Power and Healthcare Prices*, (2015) 91 *Wash L. Review* 253, 286. See: [link](#)

²⁴ *Ibid.*

entering the profession. Furthermore, this could also result in longer waiting times for patients with complications that require more time and resources.

- 4.13 The Council further submits that a key issue for the Commission to consider is the ability for the collective bargaining to lower competition in the downstream insurance market. In the context of a merger, that will clearly occur where large private health funds are involved. In the context of the proposed collective bargaining, while it may be difficult to detect, the Council submits that there is a risk that increased information exchange in order to perform data analytics will lead to a softening of competition or a concerted practice between the private health funds which could substantially hinder or reduce competition for consumers (e.g., by higher premiums or less inclusions for the same price).
- 4.14 The Council notes the Applicants simply assert that any reductions in costs paid to specialists will be passed on.²⁵ The Applicants have not provided any evidence or analysis of competition in the downstream health fund market in Australia which could clearly demonstrate that the proposed collective bargaining would be likely to reduce pressure on premium increases for health insurance policies.
- Any bargaining group including nib would exercise significant market power*
- 4.15 The Council submits that the proposed collective bargaining could reduce competition between private health funds in the HH Buying Group.
- 4.16 The Applicants claim that the potential competitive detriments are minimal, because the private health insurers most likely to join the HH Buying Group already engage in group buying activities; they would therefore simply be switching those collective activities from one buying group to another.
- 4.17 That submission does not address the critical differences in this proposal: nib would be a party to the HH Buying Group and other larger funds may join for 'bespoke services'. The Council submits the presence of nib raises the prospect of competitive detriments.
- 4.18 There is also a concern that the proposed collective bargaining conduct would allow members of the HH Buying Group to exchange information. As noted in the ACCC Guidelines, '*this can create an environment where businesses are more willing to cooperate than they were previously. This can lead to cooperation that goes beyond what was originally proposed and approved and may create detriment by reducing the level of competition*'.²⁶
- 4.19 The Applicants have not addressed these potential risks in their Application. Subject to understanding which other health insurers join the HH Buying Group, the lessening of competition in the Australian market for health insurance could be significant if the authorisation is granted.
- Impact on medical specialists contracting*
- 4.20 The Applicants submit that the impact of the HH Buying Group will be minimal in the market for medical specialist services because these involve localised geographic areas of competition and a separate market for each speciality of practice.²⁷

²⁵ See: paras. 3.27, 4.28.

²⁶ [ACCC Small Business Collective Bargaining Guidelines \(December 2018\)](#).

²⁷ Application, para. 5.11.

- 4.21 The Council agrees that medical specialists are likely to operate in localised geographic areas of competition and that there is a separate market for each speciality of practice.
- 4.22 However, medical specialists in these localised areas lack bargaining power and there is likely to be a significant further erosion of their bargaining power if the authorisation is granted. With the authorisation, there is a clear risk that the HH Buying Group will be able to apply pressure to force medical specialists to agree to clinical partner contracts on the basis that they will otherwise lose a larger proportion of patient referrals in their geographic area than if they agree. This is a public detriment.

Claimed transaction cost savings arising from negotiations with specialists

- 4.23 The Applicants have not substantiated their claim that collective bargaining would result in cost savings, nor do they provide any evidence as to the quantum of any savings.
- 4.24 The Applicants refer to nib's network of providers consisting of 21,764 medical specialists. However, the Council understands that nib only has contracts with a very small number of medical specialists in its Clinical Partners Program and that that Program has not been attractive to many specialists.
- 4.25 According to recent nib investor presentations, the Clinical Partner Program orthopaedic pilot project (undertaken by nib since February 2019) has impacted 550 nib members in the 12-month period. Relative to the number of orthopaedic procedures conducted in Australia over the same period, that number is inconsequential and suggests that nib has negotiated very few clinical partner contracts for orthopaedic services.
- 4.26 Furthermore, the Applicants have not explained or justified any transaction cost-savings in negotiations with medical specialists in the Application.

Value based contracting

- 4.27 Contrary to the Applicants' claims that value based contracting will provide for more efficient contracts which deliver superior outcomes, the Council is concerned that outcomes for specialists and consumers will suffer.
- 4.28 It should first be observed that the Application does not explain how the proposed model is supposed to operate. All that is apparent from the Application is that HH intends to compare the fees paid to a particular specialist in a local region and adjust those fees (downward) so that it equates to *'the value being delivered by the provider'*.
- 4.29 While they contend that providers who offer higher quality services will be paid more, how 'quality' is to be measured and assessed is not explained. Similarly, nothing is said of how collective bargaining would lead to *'higher quality outcomes'*.
- 4.30 The Council considers the more likely outcome to be that collective bargaining by the HH Buying Group will exert pressure on specialists to reduce fees and services provided, in an effort to reduce outlays made by the private health funds.
- 4.31 Moreover, given that the Applicants give no indication of the quality assessment metrics, there is a significant risk that specialists will be pressured to agree to performance criteria as determined and assessed by health funds, which lack an independent or clinically valid basis.

Analytics and data science

- 4.32 The Applicants claim that collective bargaining will allow larger health funds greater access to the complex analytics and data science required to support the development of value based funding models.²⁸
- 4.33 These claims are unsubstantiated. No information as to the manner or quantity of information-sharing is offered to demonstrate how the purported gains would be achieved. If it is correct that small private health funds are most likely to join the bargaining group, it is unclear that a threshold scale necessary to realise these benefits would be reached (unless other large funds were to join the HH Buying Group).
- 4.34 To the extent that a high degree of consolidation is required, any potential benefit is likely outweighed by the consequent anti-competitive effects. Particularly if the authorisations permit collective bargaining by the big four health funds, the detrimental effects on efficient market outcomes are more likely to outweigh the claimed benefits.

5. **Conclusion**

- 5.1 The Council submits that the discussed detriments significantly outweigh the benefits claimed by the Applicants.
- 5.2 The benefits relied upon by the Applicants are largely speculative. Each assumes that the collective bargaining process will result in agreements of the kind asserted by the Applicants. There is no evidence available to the Commission to conclude that these outcomes are likely to emerge.
- 5.3 Even accepting the Applicants' submissions in that regard, there is no explanation of how collective bargaining is productive of, or necessary to achieve, the Applicants' desired aims.
- 5.4 Importantly, at no stage do the Applicants grapple with the fact that the proposed collective bargaining involves bolstering the bargaining positions of private health insurers whose market positions are already significant.
- 5.5 For those reasons, the public benefits, if they exist, are insignificant. The Council submits that the authorisation should be refused, as the anti-competitive effects of establishing the HH Buying Group, and their consequences for healthcare practitioners and consumers, are overwhelming.
- 5.6 The Council of Procedural Specialists is committed to supporting its members' ability to maintain the highest possible standards of procedural medicine for all Australians and requests the Commission to carefully consider the matters we have raised in this submission.

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Chairman Council of Procedural Specialists

²⁸ Application, para. 4.16.