Private Healthcare Australia
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Catholic Health Australia Limited and Ors application for revocation of authorisation A91400 and substitution of AA1000677

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 21 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. Private health insurers provide benefits for almost 15 million Australians.

Submission

Thank you for the opportunity to provide a submission on the above application for revocation of authorisation A91400 and substitution of authorisation AA100067 **(Application)**.

Private Healthcare Australia (**PHA**) is the industry association representing Australia's private health insurance funds. Our role is to represent almost 15 million privately-insured Australians.

We make this submission on the Application on behalf of PHA. We acknowledge that individual funds may also make submissions in response to the Application that address areas specific to the operations of those funds.

1. General comments

1.1 We note the proposed conduct in the Application reflects the authorised conduct in Authorisation A91400 (**2014 Authorisation**). We also note Catholic Health Australia Limited's (the **applicant**) proposal to add UnitingCare Queensland (**UnitingCare**) to the authorisation.

1.2 Our concern that we set out in detail below pertains to the applicant's proposal to allow the applicant's members to collectively boycott the five largest private health insurers (**PHIs**) in Australia (based on national market shares) (**major PHIs**).

1.3 While we support the ability of members of the Revenue Negotiation Network (**RNN**) to collectively negotiate hospital and healthcare related funding arrangements with PHIs as we agree this can lead to transactional cost savings and efficiencies for the parties involved in the negotiations, we consider the proposed expanded collective boycott arrangements may result in significant public detriments that will materially outweigh any public benefits.

1.4 Given the state of flux in the industry, highlighted in the Applicant's submission, the ACCC may wish to consider a five year authorisation.

2. Public benefits claimed by the applicant

Bargaining power – consolidation of PHIs

2.1 The Applicant claims that the proposed collective boycott right would assist RNN members with their limited bargaining power as compared to that of the PHIs. Throughout its Application, the applicant heavily emphasises the "*significant bargaining power of private health insurers (as compared to the RNN members)*"[1].

2.2 The applicant attributes the disparity in bargaining power in large part to the increased consolidation of the private health insurance sector in the past decade, which has enabled

[1] Application, page 35.

the PHIs to engage in "*sharp and aggressive tactics in contract negotiation*".[2] Examples of the trend of consolidation provided include nib's acquisition of GU Health in 2017, HCF's acquiring of RT Health in 2021 and the ACCC authorisation in late 2021 authorising Honeysuckle Health and nib to form a collective buying group to collectively negotiate contracts with healthcare providers on private health insurers' behalf.[3]

2.3 Much of the information about the disparity in bargaining power between the health funds and private hospitals in this Application is inaccurate and not supported by the evidence. We set out our reasons for these views below.

2.4 The examples of the consolidation of health funds provided by the applicant do not demonstrate a material change in the structure of the private health insurance market or to the relevant PHIs' market shares, and have not contributed to a significant increase in bargaining power for those PHIs.

2.5 GU Health's national market share (based on total policies) was 0.7% at the time it was acquired by nib[4] and RT Health's national market share was 0.3% at the time it was acquired by HCF.[5] These small funds' consolidation with nib and HCF respectively have not had any meaningful impact on the market share of nib and HCF. Further, RT Health's small membership base is largely located in regional NSW, which is unlikely to change HCF's bargaining power vis a vis a national hospital group.

2.6 The bargaining power of the PHIs has also not increased as a result of the Honeysuckle Health buying group that was authorised by the ACCC in 2021. This is because:

(a) it was a condition of the ACCC authorisation that the major PHIs (other than nib) could not join the buying group so as to prevent any potential imbalance in bargaining power between the buying group participants and the healthcare providers;

(b) Honeysuckle Health and nib did not seek or obtain authorisation to engage in collective boycotts of any healthcare providers including hospitals in relation to any contract negotiations; and

(c) the buying group is not currently collectively negotiating hospital contracts on multiple PHIs' behalf, as nib is currently the only PHI participant in the buying group.

2.7 Therefore, the statement made by the applicant that the Honeysuckle Health authorisation "*significantly increased the bargaining power of a large number of private health funds"*[6] is false as there is only one PHI in the Honeysuckle Health buying group. Further, the health funds that can join nib in the Honeysuckle health buying group are not the same funds that the applicant wishes to collectively boycott. The existence of the Honeysuckle Health buying group is not a relevant consideration.

[2] Application, page 35.
[3] Application, page 22.
[4] Private Health Insurance Ombudsman 2019
[5] Private Health Insurance Ombudsman 2021
[6] Application, page 22.

Bargaining power – disparity in market power

2.8 The applicant also submits that the imbalance of market power is due to the substantial market shares of the major PHIs (i.e. 7.3% - 27.5%)[7], making it critical for private hospitals to secure funding agreements with them.[8]

2.9 While the national market share for some of these major PHIs is substantial, the applicant also makes reference to the combined market share of two of the major PHIs: "*The two major funds, Medibank (including ahm) and Bupa, together comprise over 52% of the membership market*."[9] The reference to any combined market share is unnecessary and misleading as the major PHIs would not in any circumstances join together to negotiate any agreement on a collective basis. They are not permitted to join the Honeysuckle Health buying group and therefore, would need to seek authorisation from the ACCC.

2.10 Further, although all references to the applicant's market share of private hospital beds in Australia are marked as confidential in the Application, it appears the applicant's market share of private hospital inpatient beds is approximately 30%[10], This is also a very significant figure, which would be increased further if UnitingCare is added as an additional member. No Australian health fund covers 30% of the market.

2.11 The references to the major PHIs' significant national market share is not a persuasive reason to allow the applicant to collectively boycott these funds. As described above, the major PHIs will never join to collectively negotiate funding agreements with the applicant's members. The difference in bargaining power based on market share, in some circumstances, will accordingly be substantially skewed in favour of the applicant, for example when negotiating with HBF which has a national market share of 7.3% compared to approximately over 30% for the applicant's members.

2.12 Measuring market share on a national basis also does not take into account the disparity in market share in certain regions, States and Territories between the applicant's members and each major PHI. It is possible that the market share of the applicant's members could be even higher compared to one of major PHIs in a particular region, including for the largest of the PHIs.

Financial dependence

2.13 The applicant submits that there are different implications for hospitals and health funds when a contract negotiation fails, and hospitals depend more on these contracts for their revenue.[11]

2.14 PHA disputes the assertions that a failure to negotiate a funding contract is less detrimental for a health fund. One of the main incentives for consumers to take out private health insurance is the understanding they will not face out of pocket costs for hospital treatment provided in hospitals within the relevant fund's network. Members of health funds, particularly the major PHIs, would expect that most large private hospitals in their area

[7] Application, page 9.
[8] Application, page 23.
[9] Application, page 23.
[10] Catholic Health Australia 2024
[11] Application, page 40.

would be included in the fund's network. If the member faced significant, unexpected out of pocket costs for receiving hospital treatment at a hospital of their choice, they would likely find an alternative fund to avoid these gap payments or seek treatment in the public hospital system.

2.15 Importantly, the applicant's members include a number of large and iconic hospitals that are strategically important to the major PHIs, including but not limited to St Vincent's Health Australia, Cabrini Health Limited and St John of God Health Care Inc. Having funding agreements in place with these major hospitals is vital for the viability of the PHIs, and the status and size of these hospitals provide significant bargaining leverage for the applicant.

2.16 Our position above reflects the ACCC's view in the ACCC Determination of St Vincent's Health Australia Limited application for authorisation A91400, dated 14 August 2014 (**2014 Determination**):

"…the ACCC has no evidence to suggest there is a significant disparity in bargaining power between RNN members and Funding Organisations. RNN members earn the majority of their revenue from private hospital patients and Funding Organisations require access to those hospitals for their fund members.

Moreover, both parties risk detriment if they fail to reach an agreement, either by losing patients to an alternative hospital with lower or no out of pocket expenses, or to another fund that has an arrangement with the relevant hospital or hospital group with lower or no gap fees. Accordingly, the ACCC would expect that generally, reaching a funding agreement is in the interests of both RNN members and Funding Organisations."[12]

Financial pressures

2.17 The applicant also emphasises the financial pressures that are currently being experienced in the private hospital sector. These arise, according to the applicant, in part due to the significant bargaining power exerted by the PHIs during funding agreement negotiations, and in part from external factors such as current low admissions growth and high operating costs.[13] Further, the applicant states that the Catholic hospitals are also at a financial disadvantage as compared to their competitors because of their non-for-profit status and their different motivators for providing hospital services.[14]

2.18 PHA acknowledges that the private hospitals, including the applicant's members, are presently facing financial difficulties as a result, in part, of COVID lockdowns and staffing costs. (There are signs of recovery, with the APRA data showing revenue from PHIs to hospitals increasing 9.7% in the year to March 2024.[15]) However, a collective boycott of the major PHIs is not the appropriate means by which the applicant should be able to strengthen its current financial position.

2.19 We strongly refute the applicant's assertion that the significant bargaining power exerted by the PHIs during funding agreement negotiations has contributed to the applicant's financial

[12] 2014 Determination, paragraphs 76 – 77.
[13] Application, page 20.
[14] Application, page 26.
[15] APRA 2024

situation. As set out above, the PHI market has not seen structural change of any significance and as widely reported, the private hospitals' financial troubles have been caused by COVID lockdowns between 2020 and 2022, reduced length of stays and health inflation, particularly for wages, food and power.

Additional benefits

2.20 The applicant also claims that the proposed conduct will yield the following benefits:

(a) cost savings and efficiencies, including streamlining of the negotiation process and reducing legal, administrative and financial resources required;

(b) improvements in clinical learning resulting from information sharing; and

(c) the ability to redirect surpluses to provide community services and charitable works, which reflect the Catholic health sector not-for-profit ethos.

2.21 We consider that all the public benefits described in paragraph 2.20 above can be achieved from the applicant's right to collectively negotiate hospital and healthcare related funding arrangements. The right to collectively boycott the major PHIs does not increase the likelihood of any of these public benefits occurring, and is outweighed by the significant associated public detriments described below.

3. Public detriments of expanded collective boycott arrangements

3.1 PHA posits that the applicant's proposal to expand its collective boycott right in respect of large product and services suppliers, to include the major PHIs, is anti-competitive and will result in a number of public detriments.

Imbalance of bargaining power

3.2 Consistent with the ACCC's position in 2014 (cited in paragraph 2.16), there is currently no significant disparity between the applicant and PHIs. If the applicant's proposal to be able to collectively boycott a major PHI where the parties have failed to successfully negotiate a contract is authorised, this will lead to significantly higher bargaining power in favour of the applicant, and have detrimental effects.

3.3 Indeed, the applicant states that they have not had to exercise their current limited collective boycott right they received in relation to the Joint Purchasing Network (**JPN**) (through which the applicant's members *purchase* goods and services) since receiving authorisation in 2014 but the very existence of this right can "*strengthen the JPN's negotiation capability in certain scenarios*".[16]

Forced agreement to higher indexation and other terms

3.4 We consider that one of the main implications of the proposed collective boycott right for the applicant is that the major PHIs will be forced to pay higher rates under their funding agreements with the applicant's member hospitals. If the RNN fails to collectively negotiate a funding agreement with a major PHI and threatens to collectively boycott that PHI, the PHI

[16] Application, page 33.

will feel forced to agree to higher rates under the agreement than other comparable hospitals, in order to retain the applicant's members in their hospital provider network and not to go out of contract.

3.5 The applicant can also collectively boycott a major PHI where the parties fail to agree on any non-price terms of a funding agreement. We consider a collective boycott in this context is effectively akin to coercive powers as in the vast majority of cases, the major PHIs will not accept a terminated contract negotiation in lieu of a funding agreement on compromised terms.

Premium increases

3.6 The expanded collective boycott arrangements would have detrimental implications for consumers. If the major PHIs are forced to agree to pay higher indexation under the funding agreements, this would lead to a material increase in their hospital benefit expenditure considering the combined size of the applicant's members. The major PHIs would not be able to simply absorb higher indexation for around 30% of its benefit outlay. This would ultimately require PHIs to pass these increased costs onto their members by way of premium increases. This would exacerbate the cost of living pressures currently felt by these members.

3.7 Increased premiums would also push members out of private health insurance, placing more pressure on the public hospital system that is already stretched with ballooning hospital waiting lists.

Forced contracts with certain hospitals

3.8 In its Determination of St Vincent's Health Australia Limited application for authorisation A91099, dated 29 January 2009 (**2009 Determination**), the ACCC expressed the view that the proposed boycott of private health funds were likely to result in significant public detriment.

4. We consider that a number of the potential detriments raised in the 2009 Determination equally apply in this context. In addition to being forced to accept terms and conditions during a contract negotiation offered by the applicant's member hospitals, the major PHIs may also feel forced to enter into agreements with hospitals they would not otherwise deal with.[17] This would result in inefficient pricing as the major PHIs would not be able to negotiate lower rates for the smaller hospitals that are generally paid lower rates to reflect lower operating costs.

Disruption to hospital services and hospitals

4.1 Where the applicant's member hospitals and the major PHIs fail to reach agreement in relation to a contract and the major PHIs are accordingly boycotted, this will cause disruption to the availability of hospital services and a disruption to the hospitals themselves by extension.[18] Where the major PHIs' members are unable to receive the services they require, either because their out of pocket costs would be prohibitive or because the services are no

[17] 2009 Determination, paragraph 7.26.
[18] 2009 Determination, paragraph 7.103.

longer available at the hospitals, they may opt to seek treatment at a public hospital, which would place additional strain on the public health sector.

4.2 We echo the ACCC's view expressed in the 2009 Determination that *"the threat of a boycott – even without it ultimately being engaged in – is likely to come at a high cost to society.* "[19]

4.3 It is PHA's view that the only reason a collective boycott should be permitted is to correct an imbalance in the market, in order to produce public benefits. If this expanded collective boycott right were authorised, it would create a significant imbalance in bargaining power in favour of the applicant's member hospitals, leading to significant public detriment.

If any further information is required in relation to this submission, please contact me on email ben.harris@pha.org.au or telephone 0418 110 863.

[19] 2009 Determination, paragraph 7.89.