Medical Technology Association of Australia

Private Hospital Collective Bargaining Group authorisation application

Submission by Medical Technology Association of Australia

4 April 2012

1 Executive summary

- The Medical Technology Association of Australia (**MTAA**) recognises that efficiencies can arise from collective negotiations in certain circumstances.
- The general nature of the collective bargaining authorisation application made by the Private Hospital Collective Bargaining Group (**PHCBG**) (**Application**) overlooks some important features of the medical devices industry that are relevant to the public benefits and detriments claims by the PHCBG.
- There is insufficient information provided in the Application to allow the conduct proposed by the PHCBG to be properly understood and assessed or to conclude that the applicant has satisfied its burden of demonstrating that there is a net public benefit likely to arise from the conduct.
- In contrast to the existing authorisation granted to the Catholic Negotiating Alliance (A91099) (**CNA**), the Application does not propose an appropriate framework to govern the PHCBG's activities.
- Based on experience with other negotiating alliances, the MTAA does not consider that significant transaction cost savings would result from the PHCBG. Small private hospitals are also a relatively diverse group and it will be difficult or impossible to negotiate a "one size fits all" outcome.
- The medical device sector is highly competitive and small private hospitals already have significant negotiating leverage and receive competitive pricing.
- The PHCBG is potentially a relatively large negotiating block and its competitive bargaining may give rise to significant market distortions and anticompetitive detriment.
- It appears that the data sharing regime proposed by the PHCBG is considerably broader than that proposed by the CNA, goes further than is required for benchmarking purposes, and lacks appropriate restrictions on data sharing and confidentiality.

2 Background

2.1 MTAA

This submission is made by the MTAA on behalf of its member companies.

The MTAA is the national industry body representing the medical technology industry. MTAA members are manufacturers and suppliers of medical technology used in the diagnosis, prevention, treatment and management of disease and disability. The range of medical technology is diverse with products ranging from familiar items such as syringes and wound dressings, through to high-technology implanted devices such as pacemakers, defibrillators, hip and other orthopaedic implants. Products also include hospital and diagnostic imaging equipment such as ultrasounds and magnetic resonance imaging machines.

The MTAA has consulted with a cross-section of its members in formulating this submission, which has been endorsed by the MTAA Board.

2.2 The supply of medical devices to private hospitals

The supply of medical devices to private hospitals is governed by specific reimbursement processes, which do not apply to the supply of other products to private hospitals.

Private health insurers are required, under the *Private Health Insurance Act 2007*, to pay mandatory benefits for products on the "Prostheses List" that are provided as part of an episode of hospital treatment where a Medicare benefit is payable for the associated surgery. There are more than 9,000 products on the Prostheses List.

Because the reimbursement rate is fixed for products on the Prostheses List, suppliers of these devices do not negotiate pricing for the products with private hospitals. Suppliers may, in some circumstances, agree rebates on prostheses with private hospitals, which are typically attached to loose hospital commitments around purchasing.

Medical consumables, such as surgical dressings, IV solutions and surgical instrument, are not on the Prostheses List. Suppliers of consumables will reach a specific agreement with private hospitals regarding pricing and discount levels for these products.

The MTAA also notes that the PHCBG appears to misunderstand the process through which private hospitals procure medical devices. In particular, section 5 of the Application appears to suggest that negotiations in respect of medical and surgical supplies occur with medical wholesalers. Pharmaceutical wholesalers have no role in the distribution of medical devices.

3 Scope of proposed conduct

The Application contains few details regarding the collective bargaining and data sharing processes that are proposed by the PHCBG. It is difficult for the MTAA's members to properly assess the likely impact of the proposed

collective bargaining without more detail and greater clarity regarding the conduct that is contemplated.

The MTAA is also concerned that there are insufficient parameters or limitations proposed to govern the PHCBG's participation in what are complex and already highly competitive procurement processes, which could potentially result in significant competitive detriment.

3.1 Members of bargaining group

The Application does not identify the particular hospitals that it is proposed would participate in the PHCBG. While the MTAA recognises that the *Competition & Consumer Act* permits authorisations to be expressed to apply to persons who may become a party to the relevant contract or arrangement in future, it is clearly desirable that at least the initial members of the proposed arrangement should be identified.

Because the participating hospitals are not identified, it is particularly important that the eligible hospital group is defined precisely. The MTAA considers that the definition of the eligible hospitals in section 2(b) of the Application requires clarification. For instance, the term "small private hospital group" is not defined, with the result that it is not clear whether:

- a hospital group comprising hospitals with fewer than 200 beds but with greater than 200 beds in aggregate could participate in the PHCBG, notwithstanding that it already aggregates its purchasing across its group – it appears that this is what was intended; or
- a larger hospital group could participate in the PHCBG only in respect of its hospitals with fewer than 200 beds.

3.2 Collective negotiations, contracting and data sharing

The Application provides few details regarding how the proposed PHCBG process would function. Given the complexity of medical device procurement negotiations, the MTAA submits that a transparent framework for collective negotiations is important – primarily to ensure that authorisation is not provided for an uncertain and inefficient process.

The MTAA submits that the Application requires greater clarification regarding issues including:

(a) whether the PHCBG will identify to suppliers before commencing negotiations which hospitals are participating in its bargaining group;

(b) whether collective boycott conduct is proposed – the Application states that targets may refuse to enter negotiations with the PHCBG, but does not specifically address collective boycott conduct;

(c) whether any form of framework agreement would govern the operation of the PHCBG and its members' participation;

(d) what terms would be collectively negotiated;

(e) whether any dispute resolution mechanism is proposed;

(f) whether the proposed data sharing will involve the use of supplier data only for the PHCBG's own internal benchmarking purposes or the data would be distributed to member hospitals;

(g) whether the supplier data will be aggregated before distribution and whether any specific confidentiality obligations will be imposed on the data; and

(h) how the PHCBG proposes to overcome the confidentiality obligations that will be included in the vast majority of suppliers' contracts with private hospitals.

The MTAA notes that equivalent detail regarding the proposed negotiation framework was provided in the CNA's authorisation application.

4 Public benefits

4.1 Reduction in transaction costs

The MTAA does not consider that significant transaction cost savings would result from the proposed collective bargaining.

The Application states that, under collective bargaining, *"each hospital will no longer be involved in multiple negotiations with Targets"*. While this may be true for some non-medical commodity products, the MTAA submits that individual negotiations will still be required with hospitals and hospital groups. Although a "headline" pricing structure may be agreed, the MTAA expects hospitals will seek to negotiate further discounts and to negotiate a range of non-price issues.

This is consistent with MTAA members' general experiences negotiating with the CNA, which has not been found to significantly reduce negotiation times or transaction costs. MTAA members report that the CNA has difficulty bringing its members together as a cohesive negotiating block and that there are typically at least two rounds of negotiation – with the CNA and then with the individual hospitals or groups. MTAA members have also found that, after a commercial proposal is made to the CNA on the basis of the volumes represented by its negotiating group, various hospitals and groups will often splinter from the negotiating group and seek to negotiate a preferred arrangement.

It is also likely that the PHCBG would face greater difficulties than the CNA, which represents a relatively homogenous group of hospitals, in negotiating a "one size fits all" outcome. The PHCBG members are likely to be a disparate group of hospitals with substantial variation in sub-specialties, size and operational practices. For example, if a hospital has a particular specialty in cardiology, the volume of its purchases from that category may be substantial and warrant a more significant discount, even if the hospital's bed count is relatively small.

In addition, small hospitals often rely on bundled proposals from suppliers to acquire capital equipment without a substantial upfront expense. Whereas

large corporate groups typically focus on achieving the lowest unit cost, small hospitals often invite bundled proposals under which the hospital receives free, loan or subsidised capital equipment (such as radiology equipment) in return for agreeing to some commitment to purchase the associated consumables. These details can only be negotiated bilaterally with each hospital.

Finally, in some circumstances, the supplier's principal contractual relationship may be with a clinical care group that leases or rents facilities from the hospital. In such cases, the hospital agreement may reflect benefits from the arrangement negotiated between the supplier and the clinical care group.

4.2 Increase in bargaining power

The MTAA considers that the Application significantly understates small hospitals' relative bargaining power with suppliers and provides little evidence for its claims. Small hospitals may already have significant negotiating leverage and input into contracts and receive competitive pricing – it is difficult to see how their commercial position could be meaningfully enhanced through the PHCBG process.

In particular, the MTAA submits that:

(a) A 200 bed hospital is a large hospital and may purchase a substantial quantity of medical devices. The Application also appears to envisage that some substantial private hospitals groups may participate in its process.

(b) It is also important to recognise that, particularly with smaller hospitals, bed numbers are a poor proxy for a hospital's purchasing power in medical devices. Volume-based discounts and rebates are typically referable to a hospital's purchases within a particular product category. As discussed above, small hospitals are more likely to focus on a particular specialty and, within that speciality, may be substantial accounts – even compared with large corporate groups. For example, a small hospital that performs a substantial number of catheter procedures may purchase a similar quantity of those products to a large corporate group. The MTAA recognises, however, that consumables volumes are generally roughly correlated with hospitals' bed numbers.

(c) Medical device markets are intensely competitive and suppliers compete vigorously to supply hospitals of all sizes. Smaller hospitals can be as profitable for device manufacturers as large hospitals and, for that reason, net pricing is often similar and all hospitals have substantial input into contractual terms.

(d) The Application states that the PHCBG seeks to negotiate with "large scale" suppliers from "powerful industries". Some of the MTAA's members are relatively small manufacturers and distributors.

(e) Small hospitals often realise significant commercial benefits from negotiating bilaterally with device suppliers. For instance:

(i) medical device suppliers often offer highly attractive site-specific deals, irrespective of total volumes, to hospitals that commit to particular behaviours – such as growth targets, trialling of new products and access by the suppliers' product specialists to provide training;

(ii) small hospitals also often receive new and innovative products that they would not otherwise have access to in return for behavioural commitments; and

(iii) as discussed in section 4.1 above, suppliers may also subsidise the cost of expensive capital equipment as part of a bundled proposal with the associated consumables.

It is more difficult to offer these deals to large corporate groups and negotiating alliances because there is usually little communication with individual hospitals or visibility of the hospital's compliance with commitments.

4.3 Information asymmetry

As discussed in section 3.2 above, it is very difficult to assess the likely impact of the data sharing proposed by the PHCBG without more information. The MTAA notes, however, that the PHCBG appears to be seeking authorisation for a substantially broader data sharing regime than was sought by the CNA.

However, the MTAA does not consider that appreciable public benefits are likely to arise from the PHCBG's data sharing proposal proposal. Certainly, any benefits that are likely to arise could be achieved by the PHCBG using aggregated data for benchmarking purposes (assuming they were able to access that data), without disclosing that data to its member hospitals.

In the context of prostheses, it is also relevant that the Prostheses List is already a publicly declared price list and is a readily available and widely used benchmarking tool.

4.4 Pass through

The Application makes various claims regarding the likelihood of cost savings being passed through by hospitals and the associated benefits to patient care, job creation and the financial viability of hospitals. No basis is provided for these claims and they appear doubtful.

In the context of prostheses, it is important to recognise that the private hospital reimbursement system assumes that hospitals will pass device costs (and cost savings) through to insurers. Third party funders are the norm in delivering private healthcare – the patient is rarely the direct funder of medical devices – and any savings should be passed through to health funds. The PHCBH application does not propose any mechanism through which any costs savings may result in lower charges to health funds.

5 Public detriments

5.1 Impact upon competition

The MTAA submits that the PHCBG potentially represents a substantial negotiating block that may have a significant distortionary effect on medical device markets.

The Application includes public hospitals in calculating its potential market coverage. Because public hospitals procure medical devices under completely separate State-based regimes, the MTAA does not consider that this approach reflects the potential competitive significance of the PHCBG. On the PHCBG's own figures, it could potentially negotiate on behalf of 29% of private hospitals in Australia, which would make it the second largest hospital procurement entity by hospital numbers (although not by total beds). It is also relevant that the CNA, which is the largest hospital procurement "entity", does not negotiate as a unified group.

In the context of considering the CNA authorisation, the ACCC noted that, because some members of the CNA were related corporations, the relevant counterfactual could lawfully involve significant collective negotiation irrespective of the authorisation. In this case, the relevant counterfactual for assessing the proposed conduct is separate bilateral negotiation by a substantial number of independent competitors.

The MTAA also disagrees with the statements in the Application that PHCBG hospitals are unlikely to compete with each other. Competition between small hospitals within particular regions is likely to be strong, unless the hospital has a unique sub-specialty.

The MTAA also submits that the seven year term of the authorisation sought by the PHCBG is also too long relative to the usual contracting cycles for medical devices. Contracts for medical devices are often 12 months in duration and rarely longer than 2-3 years (occasionally with a short extension option). Authorisation of the PHCBG for seven years would allow it to be involved in several contractual cycles. In the circumstances, the MTAA considers that it is appropriate that there be an opportunity for a thorough review of the proposed arrangement after no more than five years.

5.2 Existing negotiations

The ACCC has previously identified that anti-competitive detriments from collective bargaining are more likely to be limited where the current level of negotiations between group members and targets is low.

As discussed in section 4.2 above, medical device suppliers compete vigorously to supply private hospitals of all sizes. The current level of negotiations is high; small private hospitals are able to have substantial input into all aspects of their contracts with major suppliers. This has ensured that contractual terms are efficiently tailored to each hospital or group's particular size, location and specialty. Separate negotiation has allowed private hospitals to secure highly competitive pricing, and often very innovative and advantageous product offerings.

5.3 Boycott

The Application states that suppliers may refuse to enter negotiations with the PHCBG, but does not specifically address collective boycott conduct. In any event, given the potential size and scope of the PHCBG and the competitiveness of the industry, it is likely to be commercially imperative for suppliers to engage with the PHCBG.

5.4 Data sharing

The MTAA submits that substantial competitive detriment may flow from the proposed data sharing regime. Supplier pricing data is highly confidential and the sharing of this data between hospitals presents significant risks of facilitating coordinated behaviour beyond the scope of what may be authorised. As outlined in section 3.2 above, there are no parameters currently proposed to govern the use of supplier pricing data.

The MTAA thanks the ACCC for the opportunity to comment on the Application and would be pleased to provide any additional information that would assist the ACCC.

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