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AUSTRALIAN COMPETITION TRIBUNAL

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Lodgment and Details

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Important information

This Notice has been inserted as the first page of the document which has been accepted for electronic filing. It is now taken to be part of that document for the purposes of the proceeding in the Tribunal and contains important information for all parties to that proceeding. It must be included in the document served on each of those parties.

HOUSTONKEMP
Economists

nib and HH collective buying group

Expert report of Greg Houston

A report for Minter Ellison

Confidential version

14 June 2022

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Executive summary

1. I have been asked by Minter Ellison to prepare this report on behalf of nib Health Fund Ltd (nib) and Honeysuckle Health Pty Ltd (HH). The context for my report is the applications by the National Association of Practising Psychiatrists (NAPP) and the Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) to the Australian Competition Tribunal (the Tribunal) for review of the 21 September 2021 determination of the Australian Competition and Consumer Commission (ACCC) in relation to an application for authorisation by nib and HH.

2. In December 2020, nib and HH made an application to the ACCC under the *Competition and Consumer Act 2010* (Cth),[1] seeking authorisation for HH to form a collective buying group (HH buying group) and provide a number of contracting services to private health insurers (PHIs) and other healthcare payers.[2] On 21 September 2021, the ACCC made a final regulatory determination (final determination) to authorise the proposed collective bargaining conduct (the proposed conduct) for a five year term,[3] subject to the condition that the HH buying group could not provide services to any major PHIs (ie, Medibank, Bupa, HCF and HBF in Western Australia).

3. Minter Ellison has asked me to prepare an expert report that provides my opinion on whether and to what extent net public benefits would arise from the proposed conduct.

With and without analysis

4. Two states of the world must be compared in order to assess whether the proposed conduct is likely to lead to a net public benefit, ie:

    a. one in which the proposed conduct is authorised, ie, the factual; and

    b. one in which the proposed conduct is not authorised, ie, the counterfactual.

5. The key differences between them are that:

    a. minor PHIs have an additional option for purchasing health provider contracting services (including the negotiation, administration and management of contracts with health providers) in the factual, ie, the HH buying group; and

    b. major PHIs have the option of joining the HH buying group's BCPP in the factual, as opposed to procuring separate and independent BCPP services from HH under the counterfactual.

6. For medical specialists, the proposed conduct will give them an additional option for supplying services to customers of minor PHIs that use the HH buying group, ie, the BCPP, which is not available in the counterfactual.

[1] *Competition and Consumer Act* 2010 (Cth).

[2] Honeysuckle Health, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 23 December 2020.

[3] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, p 4.

Market definition

7. In my opinion, there are no close substitutes for health provider contracting services on the demand or supply side, and so there exists a relevant market for the provision of these services. These services are provided across Australia, so the geographic dimension of the market is Australia-wide.

8. The addition of a new provider of health provider contracting services has the potential to affect:

    a. the supply of services that are being contracted for by the new provider, ie, specialist medical and hospital services; and

    b. the supply of services by buyers of health provider contracting services, ie, private health insurance and other insurance services.

9. For the reasons I explain in my report, in my opinion there are local markets for medical services for each speciality, local markets for hospital services, a national market for private health insurance and separate national markets for each additional type of insurance.

Assessing net public benefits

10. Total economic surplus is the sum of consumer and producer surplus. The net effect of the increases and decreases in surplus accruing to the various parties determines the change in total surplus. This amounts to an unweighted total welfare standard, where the same level of importance is applied to surplus accruing to consumers and that accruing to producers, or any other parties.

11. Since economic surplus is difficult to measure, it is often helpful to focus on the alternative and equally valid question as to whether output – in either its quantitative or qualitative dimensions – in one or more markets is likely to increase or decrease.

12. I conclude that the proposed conduct will lead to net public benefits in some markets and no public detriments in any relevant markets. I thereby conclude that the proposed conduct results in an overall net public benefit.

Assessment of public benefits

13. In my opinion, competition to supply minor PHIs with health provider contracting services is presently (and so in the counterfactual) weak, because:

    a. there are only two suppliers, one of which is very small;

    b. there appears to be no switching between suppliers; and

    c. barriers to entry appear to be high.

14. Competition to supply minor PHIs with health provider contracting services will be stronger under the proposed conduct because there will be the additional option of the HH buying group. In my opinion, the addition of a new provider in a market with weak competition represents a significant improvement in the competitive conditions relative to the counterfactual. Higher levels of competition for health provider contracting services will increase total surplus in the factual, and so the quantity and/or quality of output.

15. The HH buying group will offer a differentiated service to the incumbent buying groups, including:

    a. an alternative contracting model that increases flexibility for participants;

    b. value-based contracting;

c. data analytics services not presently available under the incumbent buying groups; and

d. a greater range of medical specialist contracting than existing buying groups.

16. This too will lead to an increase in total surplus, which represents a net public benefit.

17. I conclude from the above analysis that the proposed conduct will lead to a net public benefit in the market for health provider contracting services. In addition, I find that a net public benefit arises in other, dependent markets by means of increases in the take-up and/or quality of private health insurance products.

Assessment of public detriments

18. I find that no public detriments arise in either the primary or any other, dependent markets, and thereby conclude that the proposed conduct results in a net public benefit in both the primary and dependent markets.

19. No public detriment arises from an increase in monopsony power in setting medical gap scheme contracts due to the proposed conduct because:

a. PHIs in the HH buying group will not have substantial monopsony power because they each only purchase a small fraction of the total medical specialist services supplied to PHIs;

b. all of the PHIs that could use the HH buying group medical gap scheme combined will have a share of less than 31 per cent of premium revenue (and so a similar share of purchases of medical specialist services by PHIs), and face competition to purchase medical specialist services from several major PHIs and the public system – so the HH buying group would not have monopsony power even if it was purchasing services collectively (which it is not);

c. even if it is assumed that the HH buying group is the buyer of medical specialist services (which it is not), the difference in the share of medical specialist services purchased by the buying groups as between the factual and counterfactual is very small, and so the difference in the degree of monopsony power would not be significant; and

d. competition between PHIs to provide no gap services to their customers means it is against PHIs' individual best interests to have fewer medical specialists provide services under medical gap schemes, so minor PHIs are not likely to use a medical gap scheme that causes a detriment by fewer medical specialists using it.

20. Further, no public detriment arises from any increase in bargaining power on the part of PHIs in relation to agreeing MPPAs with medical specialists as a result of the proposed conduct because:

a. in the counterfactual, it is likely that there will be few MPPAs between minor PHIs and medical specialists, so any increase in bargaining power with respect to MPPAs would have a very limited effect. In general, the BCPP MPPAs represent an additional contracting mechanism available to minor PHIs and medical specialists; and

b. the proposed conduct would not result in a material change in bargaining power between minor PHIs and medical specialists, even if they could enter into MPPAs in the factual and counterfactual.

21. In my opinion, the proposed conduct will not lead to public detriment by restricting specialists' freedom, inducing medical specialists to behave in a manner that is contrary to the best clinical outcome patients, or by disclosing confidential information because:

a. the freedom of medical specialists to act in the best interest of patients is protected by law;

b. the code of conduct for doctors in Australia requires doctors not to allow any financial or commercial interest in a hospital or other healthcare organisation or company providing or manufacturing healthcare services or products to adversely affect the way patients are treated; and

c. the *Privacy Act 1988* (Cth) and equivalent state and territory legislation impose obligations on PHIs to safeguard patient information.

Response to questions

22. Minter Ellison has asked me to prepare an expert report that:[4]

(a) identifies and explains the key economic principles that should be applied in assessing the Proposed Conduct in this context for the purpose of identifying and assessing whether and to what extent net public benefits would arise from the Proposed Conduct;

(b) applying the principles identified in 2.1(a), provides my opinion on whether and to what extent net public benefits would arise from the Proposed Conduct, having regard to, inter alia:

(i) which markets are relevant to the assessment of net public benefits in this context;

(ii) whether and to what extent public detriments would arise from the Proposed Conduct in a future in which the Proposed Conduct is authorised compared to a future in which the Proposed Conduct is not authorised; and

(iii) whether and to what extent public benefits would arise from the Proposed Conduct in a future in which the Proposed Conduct is authorised compared to a future in which the Proposed Conduct is not authorised.

23. As regards the key economic principles that should be applied for the purpose of identifying and assessing the net public benefits from the proposed conduct, I explain:

a. that two states of the world must be compared in order to assess whether the proposed conduct is likely to lead to a net public benefit in section 3; and

b. the appropriate framework for assessing net public benefits in section 5.1.

24. In providing my opinion on the extent to which net public benefits would arise from the proposed conduct:

a. in section 4, I define the relevant markets for my assessment of the net public benefits that may be expected to arise as a result of the produced conduct;

b. in section 5.3, I discuss whether and to what extent public detriments would arise as a result of the proposed conduct; and

c. in section 5.2, I discuss whether and to what extent public benefits would arise as a result of the proposed conduct.

[4] Letter to Mr Greg Houston entitled 'Instructions for expert report – ACT 4 of 2021: National Association of Practicing Psychiatrists Application for review of Authorisation AA1000542 Determination made on 21 September 2021 – ACT 5 OF 2021: Rehabilitation Medicine Society of Australia and New Zealand Application for review of Authorisation AA1000542 Determination made on 21 September 2021', 13 May 2022, para 2.1.

1. Introduction

1. I have been asked by Minter Ellison to prepare this report on behalf of nib Health Fund Ltd (nib) and Honeysuckle Health Pty Ltd (HH). The context for my report is the applications by the National Association of Practising Psychiatrists (NAPP) and the Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) to the Australian Competition Tribunal (the Tribunal) for review of the 21 September 2021 determination of the Australian Competition and Consumer Commission (ACCC) in relation to an application for authorisation by nib and HH.

2. In December 2020, nib and HH made an application to the ACCC under the *Competition and Consumer Act 2010* (Cth),[5] seeking authorisation for HH to form a collective buying group (HH buying group) and provide a number of contracting services to private health insurers (PHIs) and other healthcare payers.[6] On 21 September 2021, the ACCC made a final regulatory determination (final determination) to authorise the proposed collective bargaining conduct (the proposed conduct) for a five year term,[7] subject to the condition that the HH buying group could not provide services to any major PHIs.[8]

3. NAPP and RMSANZ subsequently made separate applications for review of the final determination to the Tribunal.[9]

4. In its statement of facts, issues and contentions (SOFIC) filed on 4 April 2022, NAPP sought orders from the Tribunal regarding the terms of the medical specialist contracts negotiated under the proposed conduct. NAPP requested that, in the event orders are not made in relation to all contractual arrangements, they are made with respect to contractual arrangements with practising psychiatrists.[10]

5. In its SOFIC, RMSANZ also sought orders from the Tribunal as regards the terms of the medical specialist contracts negotiated under the proposed conduct, and specifically in relation to terms pertaining to rehabilitation medicine.[11]

6. nib and HH filed their SOFIC on 19 April 2022, seeking orders from the Tribunal that it should affirm the ACCC decision to authorise the proposed conduct, and otherwise vary the decision such that:[12]

    a. the term of authorisation is extended from five years to 10 years; and

    b. the condition preventing major PHIs from joining the HH buying group with respect to medical services contracting is removed.

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[5] *Competition and Consumer Act* 2010 (Cth).

[6] Honeysuckle Health, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 23 December 2020.

[7] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, p 4.

[8] The major PHIs include Medibank, Bupa, HCF, and HBF in Western Australia; ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, p 1.

[9] NAPP, *Application for review of the ACCC's final determination re Honeysuckle Health and nib health funds ltd application for authorisation AA1000542*, 8 October 2021; RMSANZ, *RMSANZ Application for review of authorisation AA1000542 determination made on 21 September 2021*, 8 October 2021.

[10] NAPP, *Applicant's statement of facts, issues and contentions*, 4 April 2022, paras 137-138.

[11] RMSANZ, *Applicant's statement of facts, issues and contentions*, 4 April 2022, para 163.

[12] nib and HH, *Authorisation applicants' statement of facts, issues and contentions*, 19 April 2022, para 96.

1.1 Instructions

7. Minter Ellison has asked me to prepare an expert report that:[13]

> (a) identifies and explains the key economic principles that should be applied in assessing the Proposed Conduct in this context for the purpose of identifying and assessing whether and to what extent net public benefits would arise from the Proposed Conduct;
>
> (b) applying the principles identified in 2.1(a), provides my opinion on whether and to what extent net public benefits would arise from the Proposed Conduct, having regard to, inter alia:
>
> (i) which markets are relevant to the assessment of net public benefits in this context;
>
> (ii) whether and to what extent public detriments would arise from the Proposed Conduct in a future in which the Proposed Conduct is authorised compared to a future in which the Proposed Conduct is not authorised; and
>
> (iii) whether and to what extent public benefits would arise from the Proposed Conduct in a future in which the Proposed Conduct is authorised compared to a future in which the Proposed Conduct is not authorised.

8. I attach a copy of Minter Ellison's letter of instructions and related correspondence as Annexure A.

9. Subsequent to Minter Ellison's letter of instructions, I have also been provided with an affidavit from David Du Plessis, dated 13 June 2022.[14]

1.2 Experience and qualifications

10. I am a founding Partner of the economic consulting firm HoustonKemp. Over a period of more than thirty years I have accumulated substantial experience in the economic analysis of markets and the provision of expert advice and testimony in litigation, business strategy and policy contexts. I have developed that expertise in the course of advising corporations, regulators, and governments on a wide range of competition, regulatory and financial economics matters.

11. My industry sector experience spans aviation, beverages, building products, car parking, digital platforms, e-commerce, electricity and gas, employee remuneration, gambling, grains, healthcare, insurance, litigation funding, maritime services, medical waste, mining, office products, payments networks, petroleum, ports, rail transport, retailing, scrap metal, securities markets, shipping, steel, stevedoring, telecommunications, thoroughbred racing, waste processing and water. I have filed expert reports and/or given expert evidence on matters concerning these industries on numerous occasions before arbitrators, appeal panels, regulators, the Federal Court of Australia, the Tribunal, the Fair Work Commission, state Supreme Courts, the High Court of New Zealand and other judicial and adjudicatory bodies.

12. Of particular relevance to matters the subject of my report:

> a. in 2021, I prepared expert reports and gave evidence before the Tribunal in the context of its review of the decision by the ACCC to authorise collective bargaining for port access services by Hunter Valley coal producers; and

[13] Letter to Mr Greg Houston entitled 'Instructions for expert report – ACT 4 of 2021: National Association of Practicing Psychiatrists Application for review of Authorisation AA1000542 Determination made on 21 September 2021 – ACT 5 OF 2021: Rehabilitation Medicine Society of Australia and New Zealand Application for review of Authorisation AA1000542 Determination made on 21 September 2021', 13 May 2022 (hereafter 'Letter of instructions'), para 2.1.

[14] Affidavit of David Malcolm Du Plessis, 13 June 2022.

b. during 2017 to 2019, I prepared expert reports and gave evidence in the context of Federal Court proceedings brought by the ACCC against Ramsay Healthcare in relation to conduct by Coffs Harbour-based surgeons.

13. I hold a BSc(Hons) in Economics, a University of Canterbury post-graduate degree, which I was awarded with first class honours in 1983. I attach a copy of my curriculum vitae as Annexure B.

14. In preparing this report I have been provided with a copy of the Expert Evidence Practice Note (GPN-EXPT), the Harmonised Expert Witness Code of Conduct (the Code), and the Concurrent Expert Evidence Guidelines. I acknowledge that:

a. I have read and understood the Practice Note, the Code and the Concurrent Expert Evidence Guidelines, and agree to be bound by them; and

b. my opinions set out here are based wholly or substantially upon my specialised knowledge.

15. I have been assisted in the preparation of this report by my colleagues Luke Wainscoat, Tony Chen and Mathew Ditchburn. Notwithstanding this assistance, the opinions in this report are my own and I take full responsibility for them.

1.3 Structure of the report

16. I have structured my report as follows:

a. in section 2, I set out some contextual information relevant for my assessment of the net public benefits that may be expected to arise in relation to the proposed conduct;

b. in section 3, I set out the factual and the counterfactual, ie, the states of the world with and without the proposed conduct respectively;

c. in section 4, I define the relevant markets for my assessment of the net public benefits that may be expected to arise as a result of the produced conduct;

d. in section 5, I assess whether and to what extent the proposed conduct would lead to net public benefits in the relevant markets;

e. section 6 contains my declaration in compliance with the Code;

f. appendix 1 explains what is meant by the term ‘economic surplus’;

g. appendix 2 describes why increased competition can be expected to lead to greater efficiency and so economic surplus;

h. appendix 3 explains the concept of monopsony power;

i. appendix 4 describes when it is appropriate to apply a bargaining framework to the assessment of competition and the considerations that determine outcomes in that framework; and

j. appendix 5 summarises the health insurance policies available from certain PHIs.

2. Background

17. In this section, I set out some contextual information regarding the provision of medical services to consumers in Australia, including the arrangements for funding their provision through private health insurance. I also describe the services that the HH buying group will offer to PHIs if the proposed conduct is authorised.

2.1 Industry structure

2.1.1 Arrangements by which medical services are provided

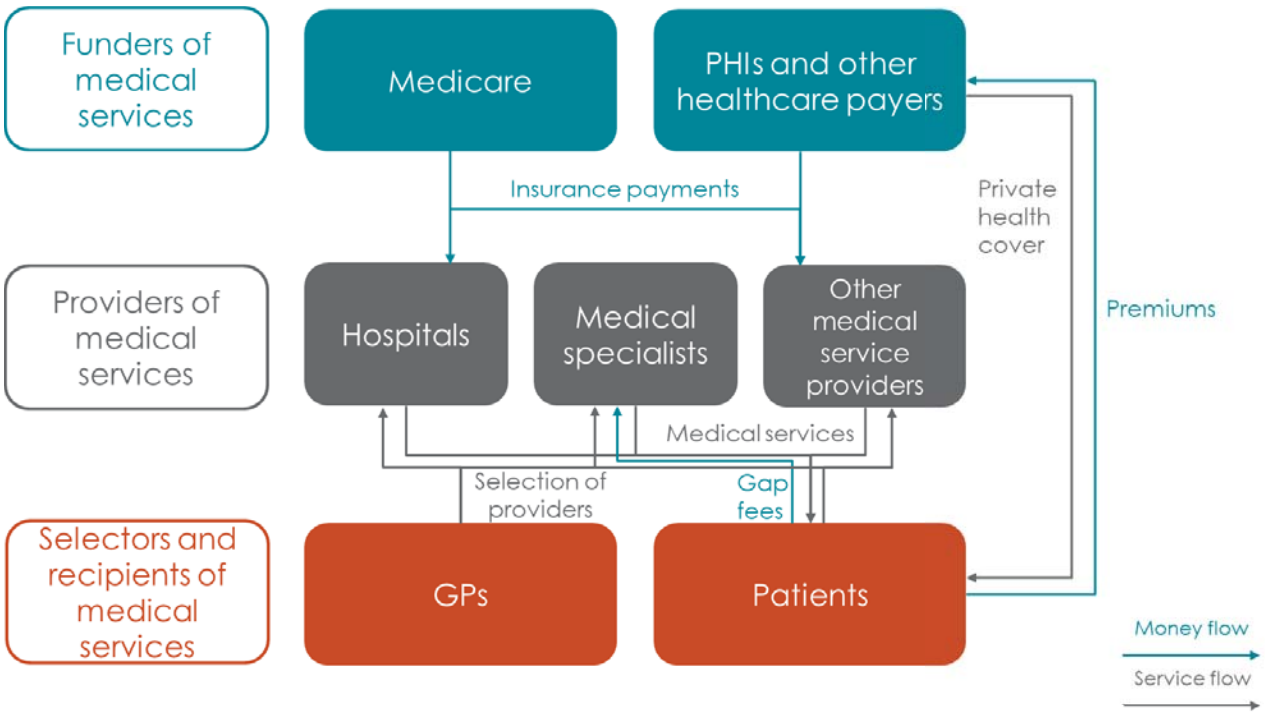
18. In Figure 2.1 below, I depict the various roles and economic relationships involved in the procurement of medical services, distinguishing between:

    a. PHIs and Medicare, both being purchasers of medical and hospital services;

    b. hospitals, medical specialists and other medical service providers, all of whom are providers of medical services; and

    c. patients and GPs, who are involved in the selection and/or receipt of medical services.

Figure 2.1: Economic relationships arising in the procurement of specialist medical services



Source: Section 2.1.

19. Care delivered at hospitals by medical specialists is provided under one of two broad arrangements, ie:[15]

    a. the public system, where the cost of hospital and medical services are funded by the federal, state and territory governments – a significant component of hospital and medical services are funded by Medicare, through the Medicare levy and Medicare levy surcharge;[16] and

    b. the private system, where the costs of hospital and medical services are funded by a combination of Medicare, private health insurance funds and patients.[17]

2.1.2 Payments in the private health system

20. Patients with a potential need for specialist medical services will typically first consult with their general practitioner (GP) who identifies the need for treatment.[18] If a need for treatment at a hospital is identified, the GP will refer the patient either to a medical specialist as a private patient or to an outpatient clinic for review and referral on to a public hospital waiting list. In making the referral, the GP will have regard to whether the patient:[19]

    a. has private health insurance or is willing to self-fund the procedure;

    b. is willing and able to cover any out-of-pocket expenses; and

    c. wishes to be treated through the private or public system, including the patient's preferences (if any) as to their treating specialist.

21. People who wish to be treated in the private system have two choices when it comes to funding their treatment, ie:

    a. self-funding, where a patient would fund the portion of costs associated with their private hospital and medical care that is not funded by Medicare;[20] or

    b. private health insurance funds, where a patient would purchase private health insurance with hospital cover that would meet many but not necessarily all costs of private hospital and medical care that are not funded by Medicare.[21]

22. Treatment in the private system, while funded in part by private health insurance funds (and out-of-pocket fees), also attracts subsidises from Medicare, making Medicare a significant purchaser of medical specialist services in the private system.[22] 75 per cent of Medicare Benefits Schedule (MBS) fees for in-hospital medical specialist services provided to patients admitted to hospital as private patients are paid by Medicare.[23]

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[15] Department of Health, https://www.health.gov.au/about-us/the-australian-health-system#medicare-the-foundation-of-our-health-system, accessed 2 June 2022.

[16] Australian Taxation Office, https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/, accessed 10 June 2022.

[17] HH and nib, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 6 May 2021, para 5.13.

[18] Referrals are required for some non-emergency treatments. General practitioners are the primary source of referrals. See: Department of Health, *Medicare Benefits Schedule Book*, Operating from 1 March 2022, pp 25-26; Affidavit of David Malcolm Du Plessis, 13 June 2022, para 22.

[19] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 22.

[20] NSW Health, https://www.health.nsw.gov.au/Hospitals/Going_To_hospital/Pages/your-choices.aspx#option2, accessed 2 June 2022.

[21] Department of Health, https://www.health.gov.au/health-topics/private-health-insurance/about-private-health-insurance, accessed 8 June 2022.

[22] Medicare funded approximately 47 per cent of total private health insurance treatments in the December 2021 quarter. See: APRA, *Quarterly Private health insurance medical gap*, December 2021 (released 2 March 2022), tab T1.

[23] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 59(c).

23. The remaining 25 per cent must be paid by PHIs,[24] while any additional medical specialist fees above the MBS schedule fees are paid by either PHIs or out-of-pocket by patients themselves, depending on the private health insurance coverage the patient has purchased and arrangements between PHIs and the medical specialist.[25]

24. Medicare's subsidy of private health care extends only to medical specialist fees and not services provided by the hospital, eg, theatre fees, medication and hospital accommodation.[26]

25. People who wish to fund their treatment through a private health insurer need to have made their decision prior to seeking treatment and pay PHIs premiums to be covered by a private health insurance policy. There are two distinct types of health insurance policy, ie:[27, 28]

    a. hospital cover, which provides cover for the cost of fees charged by a hospital for medical services and accommodation – Medicare will contribute towards the medical specialist fees associated with the hospital stay, but patients may incur out-of-pocket costs in the form of gap fees; and

    b. extras cover, which provides for cover of certain treatments delivered outside of hospitals, which are not generally covered by Medicare – examples include physiotherapy, optical and dental services.

26. People select the level of cover[29] based on their perceived needs, and policy characteristics such as cost and perceived quality of the cover provided.[30] This may include considerations of financial limits and gaps, treatments and procedures covered, and the network of hospitals and healthcare providers available under a policy.[31]

27. These policy characteristics are informed, at least in part, by the terms of contracts between PHIs and hospitals/medical specialists.

2.1.3 Contracts with health providers

Types of contracts with health providers

28. PHIs and other healthcare payers maintain four types of contracts with health providers as the basis for obtaining health services, ie:

    a. hospital contracts, ie, hospital purchaser provider agreements (HPPAs), where PHIs agree with private hospitals on fees for hospital services provided to customers;[32]

    b. medical specialist contracts, ie, medical purchaser provider agreements (MPPAs), where PHIs contract with individual medical specialists regarding price and non-price terms for select services provided to customers in hospital;[33]

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[24] *Private Health Insurance Act* 2007 (Cth), section 72-1; *Private Health Insurance (Benefit Requirements Rules) 2011;* Affidavit of David Malcolm Du Plessis, 13 June 2022, para 61.

[25] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 62.

[26] https://www.servicesaustralia.gov.au/health-care-and-medicare?context=60092#accessing, accessed 7 June 2022.

[27] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 19.

[28] I focus on health insurance products relating to hospital cover in consideration of the proposed conduct as extras cover is not relevant.

[29] I explain levels of cover further in paragraph 50.

[30] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 45.

[31] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 45.

[32] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 92.

[33] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 81.

c. medical gap schemes open to all medical specialists, where PHIs offer to pay medical specialists a set fee for services provided to customers in hospital, which medical specialists can opt into on a patient-by-patient basis;[34] and

d. general treatment networks, which are arrangements for extras services not provided in hospital, eg, services by physiotherapists, dentists or optometrists, in which these health providers agree to a standard set of rates and terms proffered by PHIs for each type of service.[35]

29. At Table 2.1 I summarise the different types of contracting arrangements that PHIs or patients have with medical specialists.

Table 2.1: Types of contracting arrangements with medical specialists

Contracting arrangements	Features	Charge to customers	Minimum amount paid to specialist
MBS rate	• Based on Medicare Benefits Schedule (MBS) rates • Medicare pays 75% of MBS rate, PHI pays 25% of MBS rate • Customer pays any charge over and above the MBS rate	Specialist's discretion	Legislative minimum, fees over and above are at specialist's discretion
Medical gap scheme	• Schedules of rates for all medical specialists • Specialists register with a PHI • Specialists can opt out on a case-by-case basis	No gap or known gap	More than regulated premium, fixed rate
MPPAs (excluding the BCPP)	• Contracts with specific medical specialists • Specialists do not typically opt out on a case by case basis	No gap	More than medical gap scheme, fixed maximum rate
BCPP MPPA (a variant of MPPAs from HH and nib)	• Contracts with specific medical specialists • Data sharing and quality requirements • Specialists cannot opt out on a case-by-case basis	No gap	Most, fixed maximum rate

Source: Affidavit of David Malcolm Du Plessis, 13 June 2022.

30. The MBS rate is the legislative minimum amount to which that medical specialists are entitled for treating an insured customer, based on the MBS schedule fees.[36] I explain in section 2.1.2 that treatment in the private health system attracts subsidies from Medicare, such that 75 per cent of MBS schedule fees for medical specialist services provided to private patients are paid by Medicare, with the remaining 25 per cent of the MBS rate covered by the customer's PHI.

[34] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 66-67.

[35] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 96-97.

[36] *Private Health Insurance Act 2007* (Cth), section 72-1; *Private Health Insurance (Benefit Requirements Rules) 2011*; HH and nib, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 6 May 2021, para 5.13.

31. Medical specialists may charge above the MBS rate, the payment of which would accrue to the patient in the absence of a medical gap scheme or MPPA.[37] Medical specialists face no restrictions in setting fees,[38] so may choose to charge customers gap fees at their discretion.

32. Medical gap schemes are offered by PHIs to pay medical specialists a set fee for each type of professional service the specialists provide to their customers, in accordance with a standard set of terms and conditions.[39] Set fees are higher than required by the *Private Health Insurance Act 2007* and the *Private Health Insurance (Benefit Requirements Rules) 2011*.[40] Medical specialists must register for a PHI's gap scheme.[41] Each medical gap scheme will have its own set of terms and conditions to which a medical specialist must adhere.[42]

33. In return for higher fees, medical specialists agree either to forgo charging PHI customers out-of-pocket amounts (ie 'no gap') or to charge PHI customers known amounts ('known gap').[43] Medical specialists can elect to charge patients under medical gap schemes where they are a party to a medical gap scheme contract with the patient's PHI, but can opt out on a case-by-case basis.[44]

34. Medical purchaser provider agreements (MPPAs) are agreements between PHIs and individual medical specialists with price and non-price terms in relation to the provision of specialist medical services.[45] MPPAs are designed to eliminate gap payments for patients and provide funding certainty for providers.[46]

35. MPPAs require medical specialists to forgo charging patients who are customers of the PHI any out-of-pocket amounts.[47] Patients that are treated under MPPAs may still be required to pay gap fees or other out-of-pocket costs because MPPAs may not cover all medical specialists needed to provide a particular treatment.[48] Unlike under medical gap schemes, medical specialists generally do not opt out of MPPAs on a patient-by-patient basis.[49]

Contracting with health providers

36. Engaging, organising and administering the contracts in order to provide private health insurance offerings is a far from trivial task. The scope of agreements across geography and specialties necessarily involves substantial effort that lends itself to economies of scale and scope.[50]

37. PHIs must maintain contracts with a sufficient network of hospitals and medical specialists to provide no gap treatment to customers.[51]

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[37] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 71.

[38] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 62.

[39] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 67, 70.

[40] *Private Health Insurance Act 2007* (Cth), section 72-1; *Private Health Insurance (Benefit Requirements Rules) 2011.*

[41] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 69.

[42] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 70.

[43] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 68.

[44] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 67, 78.

[45] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 81.

[46] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 81.

[47] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 64.

[48] HH and nib, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 6 May 2021, para 2.20.

[49] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 81.

[50] I understand that the size and costs of the contracting task do not vary significantly with the size of the private health insurer, which leaves substantial scope for economies of scale to be realised. See: Affidavit of David Malcolm Du Plessis, 13 June 2022, para 111.

[51] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 67, 74(b), 111.

38. PHIs cover a very broad scope of services. By way of illustration, Figure 2.2 lists 40 different included services that are covered by nib's Gold Top Hospital cover. It follows that PHIs need to engage and contract with a wide range of hospitals and medical specialists to achieve the coverage of services required in their insurance offerings.[52]

Figure 2.2: Services included in nib's Gold Top Hospital cover

Source: nib, Gold Top Hospital factsheet*, 1 October 2020.*

39. In order to realise economies of scale and simplify the contracting task,[53] minor PHIs contract with health providers using buying groups, of which there are two, ie:[54]

    a. the Australian Health Services Alliance (AHSA); and

    b. the Australian Regional Health Group (ARHG).

40. The AHSA and the ARHG buying groups represent 23 and 4 minor PHIs, respectively.[55] The ARHG services health funds operating predominantly in regional areas, whereas the AHSA offers services to a broader range of PHIs.[56]

[52] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 111, 233.

[53] For further discussion of costs of maintaining health services contracting functions, see: Affidavit of David Malcolm Du Plessis, 13 June 2022, para 111.

[54] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 104.

[55] The AHSA represents 23 minor PHIs, including HBF in all states other than Western Australia. See: Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 104-105.

[56] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 107.

41. I understand that the AHSA offers hospital contracting services and, to a limited extent, medical specialist contracting services to its members, whereas the ARHG only offers hospital contracting services.[57] In respect of medical specialist contracting, I understand that:[58]

    a. the AHSA's contracting is predominantly limited to known gap schemes, which member PHIs can elect to join as part of their buying group services;

    b. the ARHG provides some administrative support services for its members' gap schemes, but each member PHI runs its own bespoke no gap or known gap schemes;

    c. limited MPPAs are in place for radiology and pathology services, but neither buying group offers general treatment networks nor programs like the Broad Clinical Partners Program (BCPP).

42. In contrast to the minor PHIs, the four major PHIs undertake the contracting task internally.[59] nib outsources its contract procurement and management task to HH.[60, 61]

43. Traditionally, smaller PHIs, including those who contract through collective buying groups like the AHSA and the ARHG, have focused on costs of care.[62] In contrast, major PHIs have access to larger data sets that enable them to undertake complex analytics to provide insight into how best to structure prices and services.[63]

44. The contracts with medical specialists and hospitals in relation to which HH provides services to PHIs are struck between the medical specialists and PHIs on an individual basis, and HH is not a party to those contracts.[64] [redacted]

45. For ease of exposition throughout my report, where there are no benefits from delineating between the exact services provided to PHIs, I use the term 'health provider contracting services', which include:[66]

    a. contract negotiation and drafting;

    b. data analytics;

    c. contract administration and management;

    d. dispute resolution (in relation to contractual arrangements);

    e. management of complaints; and

[57] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 110.

[58] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 110.

[59] HBF undertakes contract procurement internally in WA, and indirectly through the AHSA in other states. Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 103, 105.

[60] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 104.

[61] I explain the full range of HH's services provided to nib in section 2.2.

[62] HH and nib, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 6 May 2021, para 4.16.

[63] HH and nib, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 6 May 2021, para 4.16; Affidavit of David Malcolm Du Plessis, 13 June 2022, para 146.

[64] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 183(e).

[65] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 201.

[66] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 102.

f. performance and compliance assessment (reporting and oversight of parties' adherence to terms and conditions of contractual arrangements).

46. To clarify, providers of health provider contracting services include:

a. the incumbent buying groups;

b. HH in the counterfactual;

c. the HH buying group in the factual; and

d. self-provision by the major PHIs.

2.1.4 Private health insurers

47. Table 2.2 below shows that the four major PHIs make up the bulk of hospital policies, and there is a relatively large number of very small PHIs. There are currently 34 PHIs in Australia, including:[67]

a. Medibank, Bupa, HCF and HBF in Western Australia, which I term the 'major PHIs';

b. nib; and

c. 29 small PHIs, which I term the 'minor PHIs'.[68]

Table 2.2: Industry overview

	Major PHIs	nib	Minor PHIs
PHI	Four PHIs excluding nib – Medibank, Bupa, HCF and WA branch of HBF	nib	30 PHIs including the non-WA business of HBF
Share of total hospital policies	69.2 per cent	9.7 per cent	21.0 per cent (19.4 per cent the ASHA, 1.6 per cent the ARHG)
Contract procurement methodology	Performed in-house	Outsourced to HH	Collective bargaining under either the ASHA (23 PHIs) or the ARHG (four PHIs), or owned by a major PHI (three PHIs)

Source: HoustonKemp analysis of APRA, Operations of Private Health Insurers Annual Report 2020-21, 27 October 2021; https://www.privatehealth.gov.au/dynamic/insurer, accessed 7 June 2022; Affidavit of David Malcolm Du Plessis, 13 June 2022.
Note: HBF has been double counted in the number of PHIs. Share of total hospital policies may not add to 100 per cent due to rounding.

48. Table 2.3 shows that the minor PHIs that use the AHSA have approximately 20 per cent of the total hospital policies and of premium revenue. The four minor PHIs in the ARHG make up less than two per cent of hospital policies and premium revenue.

[67] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 29.

[68] I define minor PHIs as all PHIs excluding Medibank, Bupa, HCF, HBF WA and nib.

Table 2.3: Market share of PHIs by contract procurement entity

Contract procurement entity	Share of hospital policies	Share of premium revenue
Medibank	26.06%	25.42%
Bupa	24.19%	25.84%
The AHSA	19.38%	20.24%
HCF	13.00%	12.73%
HH	9.74%	8.47%
HBF WA	6.00%	5.67%
The ARHG	1.63%	1.63%

Source: HoustonKemp analysis of APRA, Operations of Private Health Insurers Annual Report 2020-21, 27 October 2021.
Note: Share of total hospital policies or premium revenue may not add to 100 per cent due to rounding.

49. Private health insurers compete with one another in relation to the setting of premiums (ie, cost of insurance), the products they provide, and their sales strategy.[69] In addition to price, insurance products vary by the level and quality of cover.[70]

50. The supply of private health insurance is highly regulated. In particular:

    a. insurers must recognise waiting periods for hospital treatment that have been served with a previous insurer, ensuring customers can switch PHIs without incurring detriments;[71]

    b. insurers must classify their private hospital products under one of four tiers, ie, gold, silver, bronze or basic, and each product tier must cover a pre-determined minimum number of clinical categories;[72] and

    c. insurance premiums are price regulated, with increases in premiums requiring approval by the Minister of Health, following a process that requires validation and evidence to justify any increases.[73]

51. My analysis of private health insurer's websites indicates that over half of all minor PHIs offer at least one product from all four hospital tiers, and a further six offer a product from at least three tiers. I present the results of that analysis at Table 2.4.[74]

[69] HH and nib, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 6 May 2021, para 5.4.
[70] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 42-45.
[71] *Private Health Insurance Act 2007* (Cth), section 78-1; Affidavit of David Malcolm Du Plessis, 13 June 2022, para 36.
[72] *Private Health Insurance (Complying Product) Rules 2015*, part 2B; Affidavit of David Malcolm Du Plessis, 13 June 2022, para 42.
[73] *Private Health Insurance Act 2007* (Cth), section 66-10; Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 48-49.
[74] See Appendix A5.

Table 2.4: Summary of hospital cover by tiers from minor PHIs

Tiers offered	Number of minor PHIs	Percentage of minor PHIs
All four tiers	14	52 per cent
Gold, silver, bronze	1	4 per cent
Gold, silver, basic	1	4 per cent
Gold, bronze, basic	1	4 per cent
Gold, basic	2	7 per cent
Gold only	3	11 per cent
Silver, bronze, basic	3	11 per cent
Silver, bronze	2	7 per cent

Source: HoustonKemp analysis of PHIs' websites as of 10 June 2022; See Appendix A5.

2.2 nib and HH

52. nib is a major private health insurer that supplies private health insurance policies to Australian and New Zealand residents.[75]

53. HH is a health services and data science company founded in December 2019 as a joint venture between nib and Cigna Corporation (Cigna).[76] HH acts independently of nib and Cigna with its own board and separate management.[77]

54. In October 2020, nib appointed HH to provide contract negotiation and drafting, data analytics, contract administration and management, dispute resolution and performance and compliance assessment services for nib's contracts and arrangements with providers.[78] Those services are provided on an arms-length basis.[79]

55. HH currently negotiates MPPAs for the BCPP on behalf of nib.[80] The BCPP is intended to provide customers with a no gap experience for a single course of care involving multiple specialists.[81] This involves contracting with several specialties needed to provide a 'no gap' fee experience when a patient is admitted to hospital to receive a treatment.[82] The BCPP does not allow the medical specialist to opt out on a case-by-case basis when providing services to nib customers.[83]

56. The BCPP differs from traditional medical gap schemes because under the BCPP:[84]

[75] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 8.
[76] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 9.
[77] nib and HH, *Authorisation applicants' statement of facts, issues and contentions*, 19 April 2022, para 6.
[78] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 11.
[79] nib and HH, *Authorisation applicants' statement of facts, issues and contentions*, 19 April 2022, para 7.
[80] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 156, 183.
[81] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 84.
[82] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 84.
[83] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 86(b).
[84] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 67, 84, 86.

a. all medical specialists, including anaesthetists and assistant surgeons, will agree to provide a no gap experience to customers during an episode of care; and

b. participating medical specialists agree to treat all nib customers requiring joint replacements under the BCPP, as opposed to traditional medical gap schemes where specialists can opt in and out of the scheme on a case-by-case basis.

57. Currently, nib offers the BCPP for knee and hip replacements, and is expanding the program to include more orthopaedic procedures.[85]

[85] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 84-85.

3. With and without analysis

58. Two states of the world must be compared in order to assess whether the proposed conduct is likely to lead to a net public benefit, ie:

    a. one in which the proposed conduct is authorised, ie, the factual; and

    b. one in which the proposed conduct is not authorised, ie, the counterfactual.

59. In this section, I describe these two states of the world and explain that the key differences between them are that:

    a. minor PHIs have an additional option for purchasing health provider contracting services in the factual, ie, the HH buying group; and

    b. major PHIs have the option of joining the HH buying group's BCPP in the factual, as opposed to procuring separate and independent BCPP services from HH under the counterfactual.

60. For medical specialists, the proposed conduct will give them an additional option for supplying services to customers of minor PHIs that use the HH buying group, ie, the BCPP, which is not available in the counterfactual.

3.1 Factual, with the proposed conduct

61. Under the proposed conduct, nib and HH would form and operate the HH buying group to negotiate and manage collectively contracts with hospitals, medical specialists and other healthcare providers on behalf of PHIs and other healthcare payers.[86]

62. The HH buying group would offer contracting services to major PHIs only in respect of the BCPP,[87] and offer a suite of contracting services to other PHIs and other healthcare payers including contract negotiation and drafting, data analytics, contract administration and management, dispute resolution services, management of customer complaints, and performance and compliance assessment services for contracts and arrangements with providers.[88]

63. PHIs would be members of the HH buying group on a voluntary and non-exclusive basis.[89, 90] Whether a participating PHI accepts contracts negotiated by the HH buying group will be at its own discretion.[91] If a PHI is not satisfied with the terms proposed, the PHI may enter into an agreement independently of the HH buying group by negotiating directly with the medical specialist, or not entering into any agreement with the medical specialist.[92]

[86] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 165 and 168.

[87] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 174.

[88] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 178.

[89] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 174 and 176.

[90] I understand that although the HH buying group is non-exclusive, the commercial reality is that a PHI would not be able to split their health provider contracting services procurement efficiently between multiple buying groups; See: ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, para 4.10.

[91] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 184.

[92] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 184.

64. I understand that as a result of the proposed conduct being authorised:[93]

    a. some members of existing buying groups are likely to join the HH buying group; and

    b. one or more major PHIs may join the HH buying group and acquire the BCPP services.

65. For the purposes of my assessment, I assume that the proposed conduct includes the amendments sought from the Tribunal by nib and HH, ie:[94]

    a. the period of authorisation is ten years;[95] and

    b. there is no condition preventing major PHIs from joining the HH buying group in respect of medical specialist contracting (ie, the BCPP).

3.1.1 Provision of health provider contracting services

66. The options available to major PHIs in relation to health provider contracting services if the proposed conduct is authorised include:

    a. the self-provision of all health provider contracting services;[96] or

    b. procuring BCPP services from the HH buying group,[97] and the self-provision of the remaining health provider contracting services.

67. On the assumption that self-provision is impracticable,[98] the providers of health provider contracting services available to minor PHIs and other healthcare payers under the factual include:

    a. the HH buying group;[99] or

    b. one of the existing collective buying groups, ie, the AHSA and the ARHG.[100]

3.1.2 Options available to medical specialists

68. At Figure 3.1 below I present the options available to medical specialists for servicing customers with private health insurance under the proposed conduct, which depend on whether the customer's insurance company is part of the HH buying group, and whether the customer's insurance company is a major PHI.

[93] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 291.

[94] nib and HH, *Authorisation applicants' statement of facts, issues and contentions*, 19 April 2022, para 96.

[95] I note that the duration of the authorisation has no effect on the conclusions in my report.

[96] See section 2.1.3.

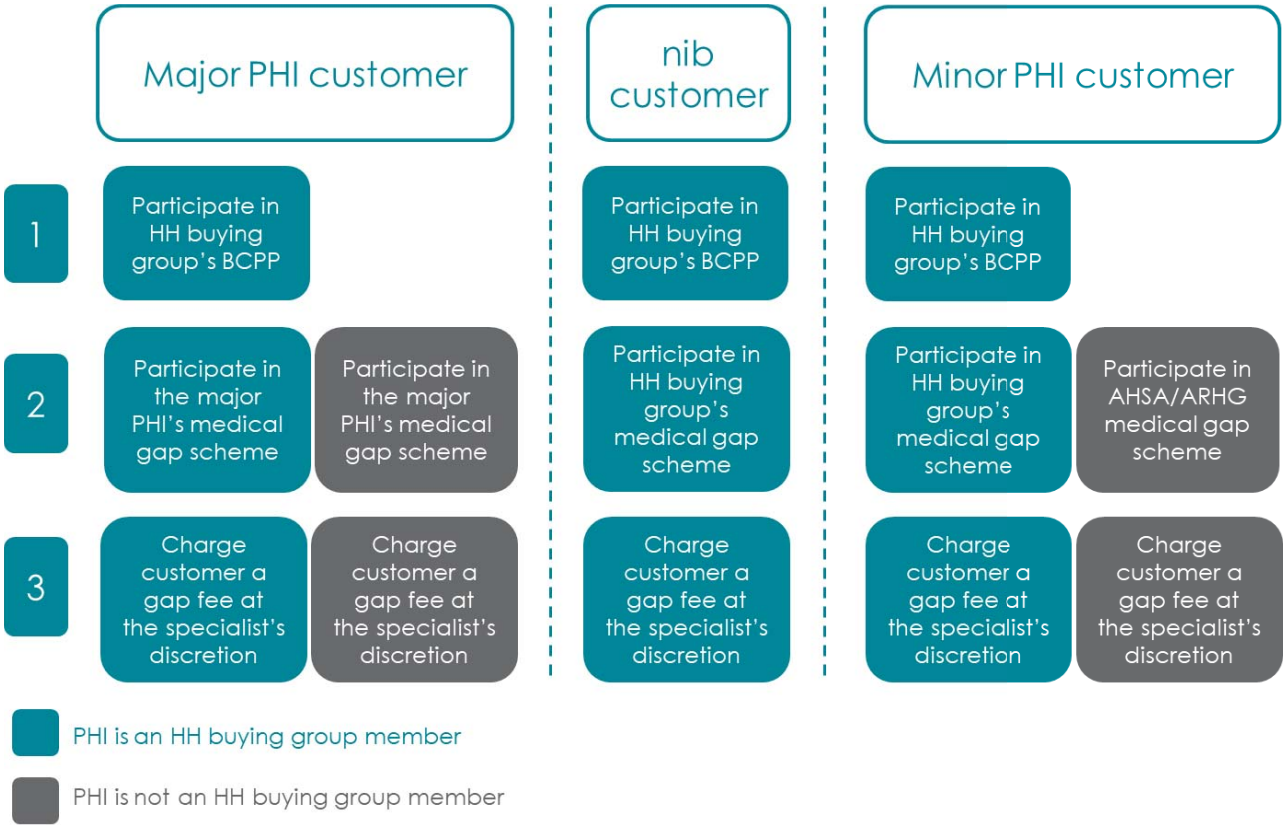
[97] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 290.

[98] I am aware that the scale of the contracting task is largely independent of the size of the insurer. See paragraph 36, Affidavit of David Malcolm Du Plessis, 13 June 2022, para 111.

[99] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 290.

[100] See section 2.1.3.

Figure 3.1: Options available to medical specialists for servicing customers in the factual



Source: Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 290, 292.

69. I note that in their applications for review, NAPP and RMSANZ submit that under the proposed conduct:[101]

    a. the participants in the HH buying group, including the major PHIs, would be likely to negotiate BCPP MPPAs with applicable medical specialists;

    b. the members of the HH buying group, excluding the major PHIs, would be likely to negotiate MPPAs with medical specialists; and

    c. specialists would have no option but to enter into the BCPP MPPAs and MPPAs proposed by members of the HH buying group.

70. I note that in their applications for review, NAPP and RMSANZ do not discuss the option for medical specialists to utilise:

    a. HH buying group's medical gap scheme for nib or minor PHI customers; or

    b. major PHIs' medical gap schemes for customers of major PHIs.

71. However, I understand that the ACCC has acknowledged that:

[101] RMSANZ, *Applicant's statement of facts, issues and contentions*, 4 April 2022, paras 16(b)-16(c), 90; NAPP, *Applicant's statement of facts, issues and contentions*, 4 April 2022, paras 6(b)-6(c), 72.

a. the proposed conduct does not allow major PHIs to participate in the HH buying group's medical gap scheme;[102] and

b. under the proposed conduct, the HH buying group would maintain coverage under a medical gap scheme,[103] which minor PHIs and other healthcare payers can use.[104]

72. It follows that under the proposed conduct medical specialists will still have the option of providing services to customers of participants in the HH buying group under medical gap schemes. Specifically:

a. for customers of major PHIs participating in the HH buying group, medical specialists can participate in the major PHI's medical gap scheme; and

b. for customers of minor PHIs and other healthcare providers, medical specialists can participate in the HH buying group's medical gap scheme.

3.2 Counterfactual, without the proposed conduct

73. Under the counterfactual:[105]

a. nib will continue to use the services offered by HH, and HH may individually contract with other PHIs and healthcare payers;

b. existing buying groups will continue to act on behalf of minor PHIs; and

c. all major PHIs will continue to undertake contracting services internally.

74. I understand that, under the counterfactual, HH's individual contracts with other PHIs would be limited to:

a. offering the BCPP to major PHIs, which already have their own network of hospital contracts;[106] and

b. potentially offering general treatment services contract procurement to minor PHIs, which the AHSA does not currently offer to its members – however, I understand that HH has not undertaken a full assessment of the financial viability of this offering.[107]

3.2.1 Provision of health provider contracting services

75. Under the counterfactual, I understand that, with the exception of general treatment services for out of hospital treatment, HH would not offer services to PHIs currently serviced by the AHSA or the ARHG, or other healthcare payers, because HH cannot feasibly offer hospital contracting services without leveraging nib's existing HPPAs.[108] These hospital contracts are required to deliver customers no gap treatment in hospitals.[109]

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[102] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, para 4.126.

[103] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 189-191.

[104] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, paras 1.32-1.33.

[105] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 293-294.

[106] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 293(d), 296.

[107] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 293(c), 297.

[108] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 293(d), 296.

[109] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 296.

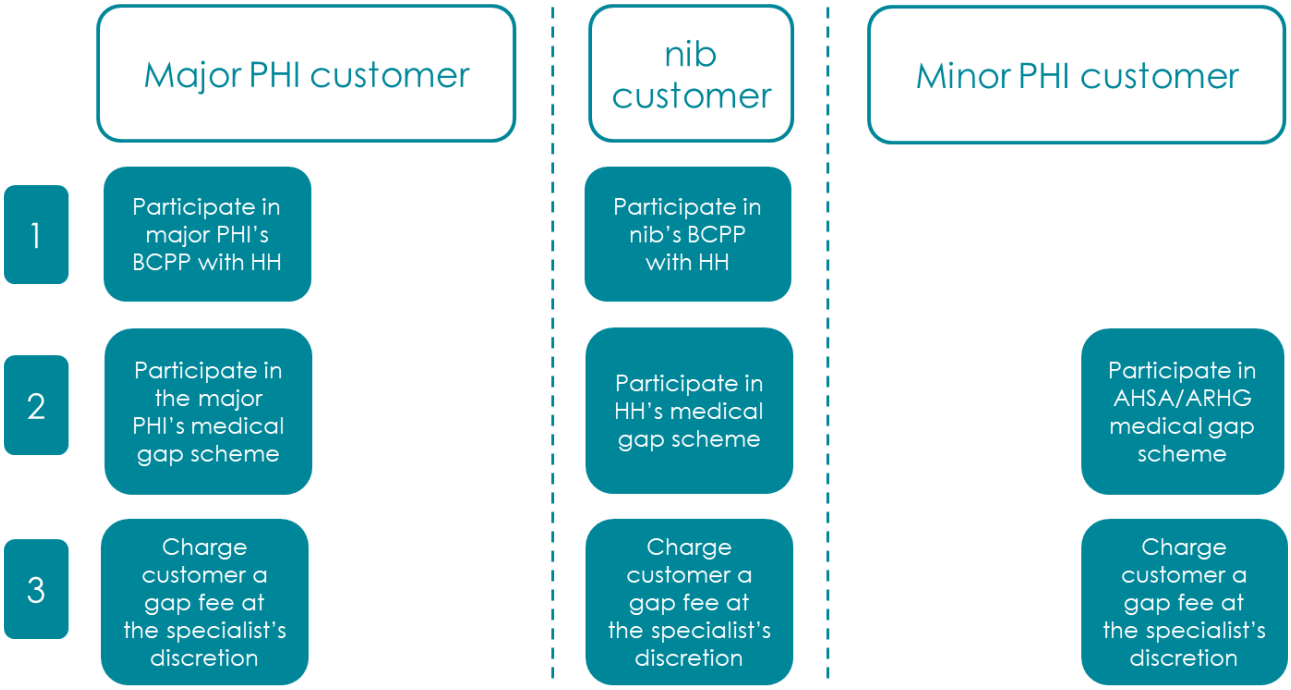
76. It follows that only the existing providers – the AHSA and the ARHG – will offer health provider contracting services[110] to PHIs under the counterfactual.

77. Under the counterfactual, HH would offer to negotiate BCPP contracts for individual major PHIs, but will not be able to bargain collectively for these services, or share data and analytics across nib and participating major PHIs.[111] By consequence, medical specialists could agree to separate contracts to service nib and each participating major PHI's customers, as compared to the factual, where medical specialists could agree to a single BCPP contract to service all HH buying group participants' customers.[112]

3.2.2 Options available to medical specialists

78. At Figure 3.2 I present a summary of options available to medical specialists for treating customers with private health insurance under the counterfactual. Under the counterfactual, medical specialists do not have the option of participating in the BCPP for any customers of minor PHIs.

Figure 3.2: Options available to medical specialists for treating customers in the counterfactual



Source: Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 293, 295.

3.3 Key differences

79. Under the factual, minor PHIs have an additional option for purchasing health provider contracting services, ie, the HH buying group. This is not available in the counterfactual.

80. The health provider contracting services options for major PHIs remain similar under the factual and counterfactual, ie:

[110] Excluding the self-provision of contracting services, which is currently undertaken by the major PHIs.

[111] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 293(d).

[112] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 183(d).

a. the self-provision of all health provider contracting services; and

b. the procurement of BCPP services from HH or the HH buying group, and the self-provision of the remaining health provider contracting services.

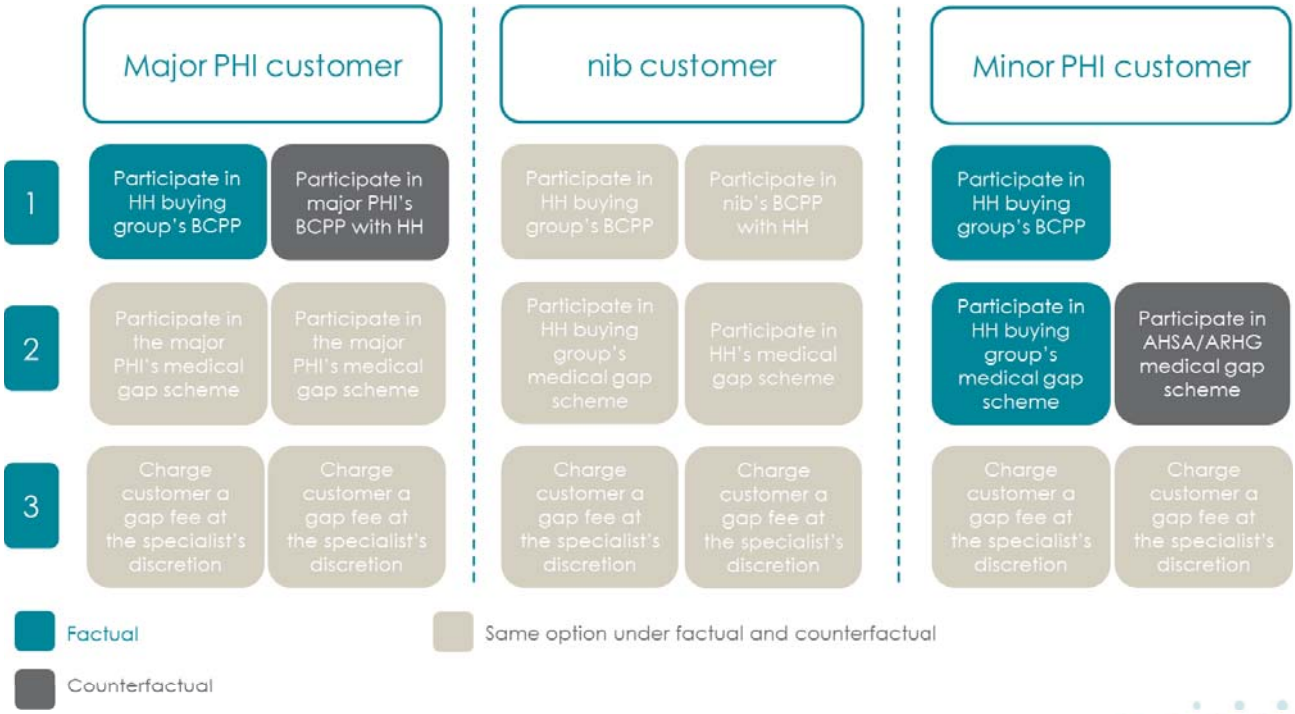
81. Under the factual, major PHIs have the option of joining the HH buying group's BCPP whereas, under the counterfactual, major PHIs have the option of procuring separate and independent BCPP services from the HH buying group.

82. I understand that some medical specialists may be deterred from participating in the BCPP if it does not cover a sufficient proportion of their patients.[113] Each BCPP would cover a smaller proportion of a medical specialist's customers under the counterfactual, because nib's BCPP MPPAs would be negotiated separately from each major PHI's BCPP MPPAs. By consequence, medical specialists' take-up of the BCPP is likely to be lower under the counterfactual, as compared to the factual.[114]

83. For customers of PHIs that **would not** have used the HH buying group's services, there is no difference in the options available to medical specialists under the proposed conduct, relative to the counterfactual.

84. For customers of PHIs that **would** join the HH buying group, the proposed conduct gives rise to an option available to medical specialists to participate in the HH buying group's BCPP, which is not available in the counterfactual – see figure 3.3.

Figure 3.3: Differences between options available to medical specialists for treating customers of PHIs that would have joined the HH buying group



Source: Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 290-295.

[113] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 244-245.

[114] The participation of one or more major PHIs would increase the volume of customers able to be serviced under the BCPP. See: Affidavit of David Malcolm Du Plessis, 13 June 2022, para 242.

4. Market definition

85. In this section I describe the markets that are relevant to my assessment of the net public benefits from the proposed conduct.

86. The proposed conduct gives rise to an additional supplier of health provider contracting services to minor PHIs. In my opinion, there are no close substitutes for these services on the demand or supply side, and so there exists a relevant market for the provision of health provider contracting services. This service is provided across Australia, and so the geographic dimension of the market is Australia-wide.

87. The addition of a new provider of health provider contracting services has the potential to affect:

    a. the supply of services that are being contracted for by the new provider, ie, specialist medical and hospital services; and

    b. the supply of services by buyers of health provider contracting services, ie, private health insurance and other insurance services.

88. For the reasons I explain below, in my opinion, there are local markets for medical services for each speciality, local markets for hospital services, a national market for private health insurance and separate national markets for each additional type of insurance.

4.1 Framework for defining markets

89. A market is the area of close competition between firms, ie, the field of actual and potential transactions between buyers and sellers amongst whom there can be strong substitution.[115]

90. The boundaries of a market are conventionally determined by reference to four dimensions, ie:[116]

    a. the product dimension, being the goods or services supplied;

    b. the geographic dimension, being the geographic area over which the relevant products are supplied (or could be supplied);

    c. the functional dimension, being that element of the supply chain in which competition takes place; and

    d. the temporal dimension, being the time period over which substitution can take place.

91. The generally accepted framework for defining markets[117] involves the application – at least, conceptually – of the hypothetical monopolist test, which:

[115] 'So a market is the field of actual and potential transactions between buyers and sellers amongst whom there can be strong substitution, at least in the long run, if given a sufficient price incentive.' *Re Queensland Co-operative Milling Association Ltd; Re Defiance Holdings Ltd* (1976) 25 FLR 169. The High Court has described a market as '…a metaphorical description of an area or space (which is not necessarily a place) for the occurrence of transactions. Competition in a market is rivalrous behaviour in respect of those transactions. A market for the supply of services is a market in which those services are supplied and in which other services that are substitutable for, or otherwise competitive with, those services also are actually or potentially supplied'. See: *Australian Competition and Consumer Commission v Flight Centre Travel Group Ltd*, [2016] HCA 49, (2016) 261 CLR 203, (2016) 91 ALJR 143, (2016) 339 ALR 242, [2016] ATPR 42-529, 2016 WL 7209127, para 66.

[116] ACCC, *Merger Guidelines*, November 2017, para 4.8.

[117] ACCC, *Merger guidelines*, November 2017, paras 4.10-4.26.

a. commences with the narrowest reasonable market definition, established by reference to the purpose at hand;

b. assesses whether a hypothetical monopolist in the candidate market would be closely constrained by products or services from outside the market, by contemplating the effect of imposing a small but significant non-transitory increase in price (SSNIP) from the competitive level – if the hypothetical monopolist would profitably be able to impose such a price rise, then the next step is applied or, otherwise, the candidate market is appropriate; and

c. expands one or more dimensions of the market to include the close constraints on the hypothetical monopolist in the candidate market, and then re-applies the previous step.

92. There is no simple and generally accepted method for determining the narrowest reasonable market, and so some degree of judgement is required. The overarching principle is to ensure that the narrowest reasonable market definition is consistent with the purpose at hand. The High Court has said that market definition is a focusing process undertaken with a view to assessing whether the substantive criteria for the particular contravention in issue are satisfied, in the commercial context the subject of analysis.[118]

93. The substitutability of the relevant products or services is key to market definition and applying the hypothetical monopolist test.[119] Substitution is the act of buyers or sellers substituting one product or service for another in response to changes in prices or quality.[120] A market encompasses the range of business activities and geographic areas within which, if given a sufficient economic incentive:

a. buyers will switch to a significant extent from one source of supply to another ('demand-side' substitution); and/or

b. sellers will switch to a significant extent from one production plan to another ('supply-side' substitution).

4.2 Health provider contracting services

94. In my opinion, the scope of the proposed conduct should guide the starting point for defining the relevant markets. The proposed conduct will lead to an additional supplier of health provider contracting services to minor PHIs.[121] It follows that the narrowest reasonable product dimension of the market is health provider contracting services.[122]

95. The options available for PHIs seeking health provider contracting services are:[123]

a. for major PHIs, HH (with respect to the BCPP) and self-provision of the remaining services; and

[118] *Air New Zealand Ltd v Australian Competition and Consumer Commission* [2017] HCA 21, para 58. The High Court has also said that 'And it recognises that market identification depends upon the issues for determination - the impugned conduct and the statutory provision proscribing anti-competitive behaviour that the conduct is said to contravene.' *Air New Zealand Ltd v Australian Competition and Consumer Commission* [2017] HCA 21, para 59.

[119] *Australian Competition and Consumer Commission v Pfizer Australia Pty Ltd*, [2018] FCAFC 78, (2018) 356 ALR 582, 2018 WL 2397940, para 265.

[120] *Australian Competition and Consumer Commission v Pfizer Australia Pty Ltd*, [2018] FCAFC 78, (2018) 356 ALR 582, 2018 WL 2397940, para 265.

[121] See section 3.3.

[122] These services are described at paragraph 45.

[123] See section 3.

b. for small PHIs, a buying group only.

96. I am not aware of any other services to which PHIs could switch that would provide the same or similar features as health provider contracting services.[124] On this consideration, I conclude that there are likely no close demand-side substitutes for health provider contracting services.

97. In my opinion, there are also no close supply-side substitutes because significant investments in sunk costs are required to provide these services, and it is not possible to provide them in a short period of time.[125] I explain in section 2.1.3 that the incumbent buying groups and major PHIs maintain contracts with a network of hospitals and medical specialists, which implies that these are necessary before PHIs will consider switching.[126] In addition, new or incumbent buying groups may require authorisation to provide certain services, given that nib and HH are requesting authorisation of their proposed conduct.

98. It follows from these observations that the product dimension of the market is the provision of health provider contracting services.[127]

99. I understand that the HH buying group would provide health provider contracting services across Australia.[128] The geographic dimension of the market is therefore likely to be Australia-wide.

100. On these considerations, I conclude that there is a national market for health provider contracting services. I refer to this as the 'primary market' because it is directly affected by the conduct, ie, in the factual, another provider of these services will become available to supply minor PHIs. This is consistent with the ACCC's observation that:[129]

> …the supply of buying group services to PHIs on a national basis is also a relevant area of competition.

Buyers and sellers

101. Buyers in the market for health provider contracting services include PHIs and other healthcare payers, such as travel insurers.

102. Table 4.1 and table 4.2 show that the suppliers in this market vary in the factual and counterfactual, and also by the identity of the buyer. There is an additional supplier to minor PHIs in the factual, ie, the HH buying group.

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[124] I assume that the minimum required health provider contracting services for PHIs include those currently provided by the ARHG, ie, hospital contracting and administrative support services with respect to medical gap networks. See: Affidavit of David Malcolm Du Plessis, 13 June 2022, para 110.

[125] Massimo Motta notes there are several conditions that should be fulfilled for supply substitution to widen the relevant market, including that switching production must be easy, rapid and feasible, the producer of another good must already have the skills and assets required to produce the product under construction, and any barriers to entry must be surmountable in a rapid and relatively cheap way. See Motta, M, *Competition policy: theory and practice*, Cambridge University Press, 2004, chapter 3, p 4.

[126] [redacted]

[127] In my opinion, there is only one potential functional dimension of the market, ie, services are provided to PHIs. The temporal dimension of the market is the period over which PHIs may switch providers of health provider contracting services. There is no need to draw a specific conclusion on this dimension because it does not affect my assessment.

[128] All PHIs are currently registered to operate on a national basis, and so I assume the HH buying group would provide nationwide contracting services. See: Affidavit of David Malcolm Du Plessis, 13 June 2022, para 33.

[129] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, p 15.

Table 4.1: Suppliers of health provider contracting services – factual

	HH buying group	Existing collective buying group	Self-provision of health provider contracting services
Major PHI	BCPP only	✗	✓
nib	✓	✗	✗
Minor PHI	✓	✓	✗

Source: Affidavit of David Malcolm Du Plessis, 13 June 2022.

103. I explain in section 3.2 that, under the counterfactual, HH may offer BCPP services to major PHIs on an individual basis and without data sharing arrangements. However, under the counterfactual HH will not offer services to minor PHIs, with the possible exception of offering general treatment services.[130]

Table 4.2: Suppliers of health provider contracting services – counterfactual

	HH	Existing collective buying group	Self-provision of health provider contracting services
Major PHI	BCPP only	✗	✓
nib	✓	✗	✗
Minor PHI	✗	✓	✗

Source: Affidavit of David Malcolm Du Plessis, 13 June 2022.

4.3 Dependent markets

104. Changes in the primary market (ie, the market for health provider contracting services in Australia) may give rise to effects in other, dependent markets, which may affect net public benefits. There may be changes to markets in which:

    a. the buyers of health provider contracting services operate, ie, the providers of private health insurance and other healthcare payers; and/or

    b. the parties negotiating with suppliers of health provider contracting services operate, ie, the providers of hospital and medical specialist services.

105. In relation to the first category of market transactions I identify above, in my opinion there is a national market for private health insurance. Private health insurance products vary across a number of different dimensions, including what is covered, the excess/gap fees and the price of premiums.[131] Insurance products must be categorised into one of four product tiers, ie, basic, bronze, silver and gold, with each category containing minimum coverage requirements.[132] I understand that most PHIs

[130] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 297.

[131] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 42-47.

[132] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 42-43.

offer each category of insurance and so there is likely to be supply-side substitution between the various categories.[133]

106. PHIs compete with each other in relation to price and additional services covered over and above the pre-determined minimum standard of the clinical categories for that product tier.[134] In addition, there are portability rules that allow customers to switch PHIs without being subject to any additional waiting times or exclusions.[135]

107. In my opinion, there are no close demand-side substitutes for private health insurance. The only other options would be not to have private health insurance and to rely on Medicare and/or to self-fund the private health treatment.[136] It follows that the product dimension of the market is likely to be private health insurance.

108. I understand that each of the 34 PHIs is registered to operate on a national basis[137] and offers similar private health insurance products across Australia.[138] On these considerations, the geographic dimension of the market is Australia-wide, which is consistent with the ACCC's opinion.[139]

109. In addition, consistent with the conclusion drawn by the ACCC I assume there are markets for international medical and travel insurance that operate on a national basis, although this does not affect my conclusions.[140]

110. In relation to the second category of market transactions that I identify above, medical specialist services include a wide range of different services provided by parties including radiologists, pathologists, anaesthetists and surgeons.[141] Medical specialists only provide services that relate to their particular speciality and are generally unable to provide other medical services.[142] I also understand that patients usually require a particular type of speciality. It follows that there is limited, if any, demand or supply-side substitution between the services provided by different types of medical specialist.

111. Patients require their medical specialist to be reasonably accessible relative to their place of residence,[143] and so I expect the geographic dimension of the market will comprise many local areas, although I do not need to define this precisely for the purpose of this report.

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[133] I have reviewed hospital cover tiers offered by minor PHIs by way of review of their websites on 10 June 2022 and noted that 52 per cent of minor PHIs offer all four tiers of cover (gold, silver, bronze and basic), while 37 per cent of minor PHIs offered two or three tiers of cover. Only three out of 27 minor PHIs (11 per cent of minor PHIs) offered a single tier of hospital cover. See Table 2.4, Appendix A5.

[134] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 47.

[135] *Private Health Insurance Act* 2007 (Cth), section 78-1; Affidavit of David Malcolm Du Plessis, 13 June 2022, para 36.

[136] See section 2.1.2 for my explanation of options available for customers receiving hospital or medical care.

[137] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 33.

[138] See paragraph 105.

[139] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, para 4.6.

[140] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, para 4.6.

[141] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 76.

[142] Sections 115, 118 and 119 of the *Health Practitioner Regulation National Law*, set out in the Schedule to the *Health Practitioner Regulation National Law 2009* (Qld), which applies as law in each state and territory.

[143] HH and nib, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 6 May 2021, paras 5.5 and 5.11.

112. I therefore conclude that there are a large number of markets for each medical speciality, delineated by various local areas.[144]

113. Finally, consistent with the ACCC's conclusion, I assume there are state-wide or local markets for hospital services.[145] I am not aware of any close demand or supply-side substitutes for these services.

[144] This is consistent with the ACCC's consideration that a relevant area of competition is likely to include the acquisition of medical specialist services for each specialty practice on a localised basis. See: ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, para 4.6.

[145] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, para 4.6.

5. Assessing net public benefits

114. I have been asked to assess the net public benefits that can be expected to arise from the proposed conduct. Specifically, I have been asked to provide my opinion on:[146]

> (ii) whether and to what extent public detriments would arise from the Proposed Conduct in a future in which the Proposed Conduct is authorised compared to a future in which the Proposed Conduct is not authorised; and
>
> (iii) whether and to what extent public benefits would arise from the Proposed Conduct in a future in which the Proposed Conduct is authorised compared to a future in which the Proposed Conduct is not authorised.

115. I have structured this section so as:

a. first, to set out the analytical framework relevant for my assessment of public benefits and detriments;

b. second, to provide my assessment of the net public benefits that would be expected to arise in the primary and other, dependent markets as a result of the proposed conduct; and

c. last, to discuss the net public detriments that may arise as a result of the proposed conduct being authorised.

116. I conclude that a net public benefit arises in the primary market (ie, the market for health provider contracting services in Australia) through increased competition arising from the introduction of an additional buying group available for minor PHIs to access health provider contracting services. In addition, I find that a net public benefit arises in other, dependent markets by means of increases in the take-up and/or quality of private health insurance products.

117. I also find that no public detriments arise in either the primary or any other, dependent markets, and thereby conclude that the proposed conduct results in a net public benefit in both the primary and dependent markets.

5.1 Framework for assessing public benefits

118. I describe in appendix A1 that total economic surplus is the sum of consumer and producer surplus where:

a. consumer surplus is the benefit consumers gain from the purchase of the product or service in question, being the difference between the value each consumer derives from consumption (reflected by the maximum willingness to pay) and the prevailing price; and

b. producer surplus is the economic profit suppliers receive by producing and selling the product or service, being the difference between the marginal cost of production (ie, the minimum price for which they are willing to sell) and the selling price.

119. The net effect of the increases and decreases in surplus accruing to the various parties determines the change in total surplus. This amounts to an unweighted total welfare standard, where the same level of importance is applied to surplus accruing to consumers and that accruing to producers, or any other parties.

[146] Letter of instructions, para 2.1(b).

120. The Tribunal has identified a total welfare standard but giving more weight to outcomes that are deemed to be beneficial to the community:[147]

> …the enquiry should be directed towards the extent to which the benefit has an impact on members of the community, that is society. Does it fall into the category of "anything of value to the community generally"? If it does, what weight should be given to that benefit, having regard to its nature, characterisation and the identity of the beneficiaries of it?
>
> ….
>
> However, the weight that should be accorded to such cost savings may vary depending upon who takes advantage of them and the time period over which the benefits are received.

121. A transfer of surplus from one party to another does not change the total surplus. However, the existence of such transfers may give rise to a public benefit if more weight is given to surplus accruing to one party than another.

122. Since economic surplus is difficult to measure, it is often helpful to focus on the alternative and equally valid question as to whether output – in either its quantitative or qualitative dimensions – in one or more markets is likely to increase or decrease. A change in economic surplus in the factual, relative to the counterfactual, requires that the conduct proposed for authorisation gives rise to both:

    a. a change in economic conduct; and

    b. a change in the quality or quantity of output in one or more markets.

123. A change in economic conduct that gives rise to an increase in the quality and/or quantity of output in a market will increase the total surplus in that market.[148] Similarly, an increase in total surplus in a market implies that there has been an increase in the quality and/or quantity of output in that market.

5.2 Assessment of public benefits

124. I have assessed whether authorisation will lead to a net public benefit by examining the difference in the quality or quantity of output in the markets I identify in section 4 under the proposed conduct, relative to the counterfactual.

5.2.1 Market for health provider contracting services

Greater competition

125. In my opinion, competition to supply minor PHIs with health provider contracting services is presently (and so in the counterfactual) weak, because:

    a. there are only two suppliers, one of which is very small;

    b. there appears to be no switching between suppliers; and

    c. barriers to entry appear to be high.

126. First, minor PHIs presently have the option of using two buying groups to purchase health provider contracting services, ie, the AHSA or the ARHG.[149] The ARHG appears to be a weak competitive constraint on the AHSA in the market for health provider contracting services because:

[147] *Re Qantas Airways Limited* [2004] ACompT 9 (12 October 2004), paras 187-189.

[148] This assumes that the negative externalities from consumption or production of the product or service do not outweigh the additional surplus from increased consumption.

[149] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 104, 106, 198.

a. only four PHIs use the ARHG and it makes up less than two per cent of hospital policies and premium revenue;[150]

b. on the other hand, 23 PHIs use the AHSA and it has approximately 20 per cent of hospital policies and premium revenue;[151] and

c. the ARHG primarily represents health funds operating in predominantly regional areas, whereas the AHSA offers services to a broader range of PHIs.[152]

127. [redacted][153]

128. Third, the barriers to entry into the market for health provider contracting services appear to be high, thereby weakening competition. I explain in section 4.2 that it appears to be difficult for a new provider of health provider contracting services to start providing services. Specifically, I explain that it:[154]

a. requires contracts with a network of hospitals;

b. likely requires medical gap scheme fees for medical specialist services provided to insureds; and

c. potentially, requires an application for authorisation.

129. Consistent with there being high barriers to entry, I understand there has been no new providers of health provider contracting services since 1995.[155]

130. Competition to supply minor PHIs with health provider contracting services will be stronger under the proposed conduct because there will be the additional option of the HH buying group.[156] In my opinion, the addition of a new provider in a market with weak competition represents a significant improvement in the competitive conditions relative to the counterfactual. Higher levels of competition for health provider contracting services will increase the total surplus under the proposed conduct, and so the quantity and/or quality of output.[157]

131. The increase in competition will put pressure on the incumbent buying groups to lower their prices for health provider contracting services and/or to innovate to attract and retain PHIs,[158] leading to greater efficiency and an increase in surplus. Put another way, greater competition will result in an increase in the quality of health provider contracting services (ie, quality of output), and put downward pressure on the price of health provider contracting services.

[150] See Table 2.3.

[151] See Table 2.3.

[152] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 107.

[153] [redacted]

[154] See paragraph 97.

[155] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 106.

[156] See section 3.3.

[157] I set out in appendix A2 how an increase in competition leads to greater total surplus.

[158] nib and HH, *Authorisation applicants' statement of facts, issues and contentions*, 19 April 2022, para 45.

Differentiated product

132. The HH buying group will offer a differentiated service to the incumbent buying groups, including:[159]

    a. an alternative contracting model that increases flexibility for participants;

    b. value-based contracting;

    c. offering data analytics services not presently available under the existing buying groups; and

    d. a greater range of medical specialist contracting than existing buying groups.

133. If PHIs choose the HH buying group's services over the incumbent buying groups' services, it must be that these services are better for PHIs (taking into account their price and quality). This applies to minor PHIs, but also to major PHIs because, if the proposed arrangements are authorised, the HH buying group will be able to offer the major PHIs a service that shares data and analytics across the participating members, which would not be possible in the counterfactual.[160]

134. This too will lead to an increase in total surplus, which represents a net public benefit.

135. I conclude from the above analysis that the proposed conduct will lead to a net public benefit in the market for health provider contracting services.

5.2.2 Dependent markets

Private health insurance

136. In my opinion, there is a net public benefit in the private health insurance market from the proposed conduct, because:

    a. PHIs will avail themselves of better health provider contracting services and pass some of that benefit on to consumers;

    b. minor PHIs will improve the services they purchase relative to major PHIs and so will place a stronger competitive constraint on major PHIs; and

    c. the BCPP will reduce cost uncertainty for consumers of private health insurance, increasing the demand for private health insurance.

137. First, the minor PHIs that procure better quality or lower priced health provider contracting services will be able to provide improved and/or cheaper private health insurance to their customers.

138. The extent to which such lower cost or higher quality health provider contracting services will be passed on to consumers in the private health insurance market depends on a number of factors, including how many firms are affected and the degree of competition in that market.[161] It is complex to determine the degree of pass-through, but it would be very unusual for there to be no pass-through to consumers at all.

139. In my opinion there are several features of the private health insurance market which mean it can be presumed that most of the reduction in costs in health provider contracting services will be passed through to consumers. In particular:

[159] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 198.

[160] See paragraphs 77 and 80-82.

[161] RBB Economics, *Cost pass-through: theory, measurement, and potential policy implications - A report prepared for the Office of Fair Trading*, February 2014, p 4.

a. the structure of the private health insurance market, which has five major PHIs and a large number of smaller PHIs,[162] implies that competition between PHIs is effective, a circumstance that generally implies the full pass-through of cost savings to consumers;[163]

b. the predominant form of any cost savings for PHIs are likely to be in marginal costs,[164] because the membership fees for the HH buying group will be based on the number of customers;[165] and

c. the market for private health insurance is highly regulated, including that:

   i. insurers must recognise waiting periods for hospital treatment that have been served with a previous insurer, ensuring customers can switch PHIs without detriment, which strengthens competition;[166, 167]

   ii. insurance premiums are price regulated[168] such that premiums are aligned to costs;[169] and

   iii. the private health insurance industry is highly scrutinised by the ACCC and Parliament.[170]

140. Further, even if my presumption as to the effectiveness of competition between PHIs were to be over-optimistic, the existence of market power per se does not significantly diminish the likelihood of a substantial proportion of any savings in variable costs being passed through to consumers. Even a monopolist can be expected to reduce its prices somewhat in response to a reduction in its marginal cost.[171]

141. Second, under the arrangements proposed for authorisation, minor PHIs that join the HH buying group will be able to procure the full suite of services offered by the HH buying group, including value-based

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[162] See section 2.1.4.

[163] For perfect competition, any savings in marginal cost are expected to be passed through to consumers. See: RBB Economics, *Cost pass-through: theory, measurement, and potential policy implications - A report prepared for the Office of Fair Trading*, February 2014, pp 56-57.

[164] Marginal cost savings are more likely to be passed on than fixed cost savings because optimal prices for a firm depend on its marginal cost. For example, in a perfectly competitive market, a firm will set a price equal to its marginal cost and a firm that is a monopoly will set its price such that its marginal revenue is equal to its marginal cost. See: Perloff, J M, *Microeconomics*, Addison-Wesley, Boston, 2012, pp 236, 354-364.

[165] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 175.

See: RBB Economics, *Cost pass-through: theory, measurement, and potential policy implications - A report prepared for the Office of Fair Trading*, February 2014, pp 36-37.

[166] *Private Health Insurance Act 2007* (Cth), section 78-1; Affidavit of David Malcolm Du Plessis, 13 June 2022, para 36.

[167] In general, pass-through is greater in more competitive markets. Pass-through is complete in perfectly competitive markets where price is equal to marginal cost. Perloff, J M, *Microeconomics*, Addison-Wesley, Boston, 2012, p 236.

[168] *Private Health Insurance Act* 2007 (Cth), section 66-10.

[169] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 48-50.

The Minister of Health regularly considers costs and profits when approving or declining increases in premiums. See: https://www.smh.com.au/politics/federal/health-funds-hit-back-after-minister-rejects-3-5-per-cent-premium-hike-20191123-p53ddj.html, accessed 13 June 2022; https://www.dailytelegraph.com.au/news/nsw/health-minister-greg-hunt-tells-health-funds-to-reduce-price-rises/news-story/39a477b8804f407c2008f194fb4b86d5?amp&nk=cb0c03ab8dc459d0609ef01dbe1affdd-1655083889, accessed 13 June 2022.

[170] For example, the ACCC must annually report to the Australian Senate on competition and consumer issues in the private health insurance industry.

See: Senate procedural order no 18 Health – Assessment reports by the Australian Competition and Consumer Commission agreed to 25 March 1999, by means of an amendment to the motion that the report of the committee on Health Legislation Amendment Bill (No 2) 1999 be adopted. J.626, amended 18 September 2002 J.761.

[171] The optimal price for the most extreme form of market power, ie, a monopolist, is a function of the firm's marginal cost. In particular, it sets a price such that its marginal revenue is equal to its marginal cost. See: Perloff, J M, *Microeconomics*, Addison-Wesley, Boston, 2012, pp 354-364.

contracting and data analytics, to which they presently do not have access through existing buying groups (and will remain without access in the counterfactual).[172] Major PHIs will only be able to procure the HH buying group's BCPP, and will not be able to purchase its full suite of services.[173] By consequence, the proposed conduct will increase the competitive constraint that minor PHIs pose on major PHIs.

142. Last, the BCPP improves the cost certainty for private health insurance customers when undergoing an episode of care, because medical specialists who have chosen to sign up to the BCPP cannot charge customers of the member PHIs a gap fee for eligible treatments.[174] Under the proposed arrangements, the HH buying group services, including the BCPP, will be available to minor PHIs. This will expand the availability of the BCPP to customers of more PHIs, resulting in more customers having access to a no gap fee private health insurance product. Such an improvement in the quality of private health insurance can be expected to increase demand for such insurance, thereby leading to greater output.

143. Drawing on the above analysis, I conclude that the proposed conduct will give rise to an improvement in the quality and/or quantity of private health insurance purchased. It follows that the proposed conduct will lead to a net public benefit in the market for private health insurance.

Medical specialist services

144. An increase in the quantity of private health insurance purchased will lead to an increase in demand for medical specialist services funded by private health insurance. I expect this will increase the price paid by PHIs to medical specialists,[175] and the quantity of medical specialist services provided. Longer term, this increase in demand can be expected to cause more people to become private medical specialists.

145. On these considerations I conclude that there will be a net public benefit in the markets for medical specialist services.

Markets for international medical and travel insurance

146. I understand that international medical and travel insurance providers do not typically have agreements with hospitals and medical specialists because of a lack of local knowledge and volume to develop networks.[176] nib currently provides network access to a small number of travel insurers,[177] and will continue to do so in the counterfactual.

147. By contrast, under the arrangements proposed for authorisation, international medical and travel insurance providers will be able to use the health provider contracting services provided by the HH buying group.[178] To the extent that more international medical and travel insurance providers take up this offer, it will improve their products and/or reduce the cost of providing them. This can be expected to lead to an increase in the quantity and/or quality of services they provide, and so lead to a net public benefit in this market.

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[172] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 178.

[173] See paragraph 62.

[174] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 86.

[175] An increase in demand for medical specialist services is a shift of the demand curve for medical specialists up along the supply curve, which corresponds to an increase in price. See appendix A1.

[176] HH and nib, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 6 May 2021, para 3.11.

[177] HH and nib, *Application for authorisation under section 88(1) of the Competition and Consumer Act 2010 (Cth)*, 6 May 2021, para 3.12.

[178] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 290.

5.3 Assessment of public detriments

148. In the section below I assess the potential public detriments that have been described by the NAPP, RMSANZ and the ACCC in the dependent markets. I am not aware of any other potential detriments from the proposed conduct.

5.3.1 No harm from increased bargaining power of PHIs

149. The ACCC states that:[179]

> …if the Proposed Conduct enabled small and Major PHIs to join the BCPP up to the point where they represented 80 per cent of hospital policies, this would be likely to result in public detriment by creating an imbalance in bargaining power between PHIs and medical specialists, leading to inefficient outcomes in the provision of health services by medical specialists.

150. I examine whether the proposed conduct could lead to public detriment by increasing the bargaining power of PHIs in:

a. setting medical gap schemes; and

b. negotiating MPPAs, including BCPP MPPAs.

151. For the reasons I explain below, different economic frameworks apply to these two situations, and so I examine them separately.

Medical gap schemes

152. Medical gap schemes are contracts with standard terms and conditions[180] published by PHIs,[181] for which medical specialists can sign up.[182] Put another way, medical gap schemes are not negotiated between PHIs and individual medical specialists. It follows that the appropriate framework to assess the power of PHIs in setting medical gap scheme rates is that of monopsony power, which I explain in appendix A3. I have not applied a bargaining framework (set out in appendix A4) because there is no bilateral bargaining between individual medical specialists and PHIs in setting medical gap schemes.[183]

153. In my opinion, no public detriment arises from an increase in monopsony power in setting medical gap scheme contracts due to the proposed conduct because:

a. PHIs in the HH buying group do not have any monopsony power because they each only purchase a small fraction of the total medical specialist services supplied to PHIs;

b. all of the PHIs that could use the HH buying group medical gap scheme combined would have a share of less than 31 per cent of premium revenue (and so a similar share of purchases of medical specialist services by PHIs), and face competition to purchase medical specialist services from several major PHIs and the public system – so the HH buying group would not have monopsony power even if it was purchasing services collectively (which it is not);

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[179] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, p 2.

[180] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 66-67, 70.

[181] I note that medical gap schemes are offered by buying groups on behalf of minor PHIs, and by HH on behalf of nib.

[182] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 69.

[183] See paragraph 224 and appendix A4.

c. even if it is assumed that the HH buying group is the buyer of medical specialist services (which it is not), the difference in the share of medical specialist services purchased by the buying groups as between the factual and counterfactual is very small, and so the difference in the degree of monopsony power would not be significant; and

d. competition between PHIs to provide no gap services to their customers means it is against PHIs' individual best interests to have fewer medical specialists provide services under medical gap schemes, so that minor PHIs are not likely to use a medical gap scheme that causes a detriment by fewer medical specialists using it.

154. First, the proposed conduct involves the HH buying group only assisting PHIs with contract procurement and management, and HH would not be a party to any agreement between PHIs and medical specialists.[184] It follows that, when assessing the contracts between PHIs and medical specialists, it is appropriate to consider the bargaining power of the PHIs, rather than that of the HH buying group.

155. Each individual minor PHI purchases only a small fraction of the total medical specialist services supplied to PHIs. In total, the 27 PHIs represented by the AHSA and the ARHG have approximately 22 per cent of the share of premium revenues (and so approximately this share of medical specialist services purchased through private health insurance), while nib has an 8.5 per cent share.[185] The public system also purchases medical specialist services.[186] The minor PHIs would not have any monopsony power because this only arises when a buyer is responsible for a large share of the total amount purchased.[187]

156. Further, there is no reason that the shares of PHIs will be different between the factual and counterfactual, so there is no difference in their monopsony power.

[redacted]

159. Second, the PHIs that could use the HH buying group medical gap scheme would have a combined share of less than 31 per cent of premium revenue (and so a similar share of purchases of medical specialist services by PHIs),[190] and would fac competition to purchase medical specialist services from several large PHIs and the public system. It follows that the HH buying group would have limited monopsony power even if the HH buying group was collectively buying medical specialist services using the medical gap scheme. I explain in paragraph 234 that, when there are many buyers, a single buyer is not able to materially influence the price by purchasing less.

[184] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 183(e).

[185] See Table 2.3.

[186] AIHW, https://www.aihw.gov.au/reports-data/myhospitals/themes/hospital-workforce, accessed 10 June 2022.

[187] ACCC, *Report of the ACCC inquiry into the competitiveness of retail prices for standard groceries*, July 2008, p 511.

[redacted]

[190] See paragraph 155.

160. Third, even if it is assumed that the HH buying group is the buyer of medical specialist services (which it is not), the difference in the share of medical specialist services[191] purchased by the buying groups as between the factual and counterfactual is very small, and so the difference in the degree of monopsony power would not be significant.

161. Under the arrangements proposed for authorisation:[192]

    a. the AHSA's share of premium revenue will be less than or equal to 20 per cent (its current level);

    b. the ARHG's share of premium revenue will be less than or equal to two per cent; and

    c. the HH buying group's share of premium revenue will be between 8.5 and 31 per cent.

162. I assume that, under the counterfactual, the shares of premium revenues will remain at the current levels, ie:[193]

    a. the AHSA will have a 20 per cent share;

    b. the ARHG will have a two per cent share; and

    c. HH will have an 8.5 per cent share.

163. Similarly, I assume that the share of premium revenues is approximately equal to the share of medical specialist services purchased by PHIs.

164. Depending on how successful is the HH buying group, the buying group with the largest share of premium revenue may appear under either the factual or the counterfactual. For example, under the proposed conduct, the HH buying group may only have around ten per cent of premium revenue, with the AHSA having 19 per cent and the ARHG two per cent. In that instance, the factual will have less concentration of medical specialist purchases than in the counterfactual.

165. The scenario with the greatest monopsony power under the proposed arrangements is one in which the HH buying group has a 31 per cent share, compared to the AHSA having a 20 per cent share in the counterfactual. This represents a small change in the market structure, taking into account that specialist medical services are purchased by four major PHIs and the public system.

166. It follows that, even in the 'worst case' scenario the increase in monopsony power is not likely to be significant, even if I assume that the HH buying group could compel its members to use its medical gap scheme (which it could not, because minor PHIs could alternatively use the medical gap scheme from the AHSA).

167. Last, I understand that PHIs compete to provide no gap services, with medical gap schemes assisting PHIs to attract customers by offering known or no gap fees across a broader treatment network.[194] The proposed conduct does not affect the way in which PHIs compete to provide services to their customers, so competition to provide no gap coverage will continue under the arrangements proposed.

168. Detriment arises in the circumstances of monopsony from a reduction in the quantity purchased,[195] which in this case would involve fewer medical specialist services being provided. However, in my

[191] I use the share of premium revenue as a proxy for the share of medical specialist services. See Table 2.3.

[192] See Table 2.3.

[193] See Table 2.3.

[194] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 74.

[195] See appendix A3.

opinion competition from other PHIs would prevent any reduction in the quantity of medical specialists performing treatment through medical gap schemes that offer no gap or known gap services.

169. Uncertainty about gap fees is one of the major concerns or causes of dissatisfaction for customers.[196] As such, customers consider financial limits and gaps when purchasing private health insurance.[197] I understand that over 89 per cent of all in-hospital medical specialist procedures performed on private patients in 2020-21 were no gap services, with a further 7.8 per cent covered by known gap agreements.[198]

170. It follows that a PHI that was not able to offer a high proportion of in-hospital medical specialist procedures on a no gap or known gap basis would be substantially out of step with its rival PHIs and at significant risk of losing customers. It would therefore not be in the interest of minor PHIs to use the HH buying group's medical gap scheme if it offered lower rates to medical specialists, such that fewer of the minor PHIs' customers had procedures that were no gap or known gap services.

171. In addition, I understand that under the proposed arrangements the HH buying group would neither discontinue its medical gap scheme nor reduce the payment rates.[199] The HH buying group could not reduce the payment rates of its medical gap scheme without member PHIs providing advance notice to their customers, which would detrimentally affect the insurer's reputation amongst customers and medical specialists.[200]

172. Consequently, in my opinion no public detriment would arise from the proposed conduct in relation to medical gap schemes.

MPPAs, including the BCPP

173. HH currently negotiates MPPAs for the BCPP.[201] MPPAs are negotiated individually between PHIs (or buying groups) and medical specialists,[202] ie, each MPPA may have different terms and conditions.[203]

174. I describe in appendix A4 that the bargaining framework is the appropriate tool to assess bargaining power between two parties when they enter bilateral contracts with each other. As such, it is appropriate to apply the bargaining framework to examine any change in bargaining power between PHIs and medical specialists caused by the proposed conduct in relation to MPPAs.

175. In my opinion, no public detriment arises from the proposed conduct in relation to any increase in bargaining power on the part of PHIs in agreeing MPPAs with medical specialists, because:

    a. in the counterfactual, it is likely that there will be few MPPAs between minor PHIs and medical specialists,[204] so any increase in bargaining power with respect to MPPAs would

[196] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 76.

[197] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 45.

[198] APRA, *Operations of Private Health Insurers Annual Report data 2020-21*, June 2021 (released 27 October 2021), tab Medical services.

[199] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 190-191.

[200] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 191.

[201] See paragraph 55.

[202] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 81.

[203] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 183(d), 184(a).

[204] I understand that existing buying groups negotiate contracts with medical specialists to a limited extent and that Mr Du Plessis is not aware of any MPPAs between individual buying group members and medical specialists. See: Affidavit of David Malcolm Du Plessis, 13 June 2022, para 110.

have a very limited effect. In general, the BCPP MPPAs represent an additional contracting mechanism available to minor PHIs and medical specialists;[205] and

b. the proposed conduct would not result in a material change in bargaining power between minor PHIs and medical specialists, even if they could enter into MPPAs in the factual and counterfactual.

176. First, there are currently very few MPPAs between minor PHIs and medical specialists.[206] Any change in bargaining power in the existing contracts would therefore have a very limited effect. The addition of new contracts in the factual represents an additional contracting mechanism available to minor PHIs and medical specialists, and not a change in bargaining power for an existing contract.[207]

177. Second, the proposed conduct would not result in a material change in bargaining power between PHIs and medical specialists because the best alternative to each agreement being reached remains broadly similar under both the factual and counterfactual.

178. I explain in paragraph 34 that MPPAs are contracts between PHIs and medical specialists. As such, the bargaining power should be assessed by considering each bilateral bargaining relationship, ie, between each minor PHI that may be part of the HH buying group and individual medical specialists. It is not appropriate to consider the bargaining power of the HH buying group because it will not be a party to contracts with medical specialists,[208] and it cannot compel its members to enter into contracts.

179. The degree of bargaining power that PHIs or medical specialists have depends upon each party's best outside option,[209] ie, the outcome if they fail to agree to an MPPA. The bargaining power of one party will increase if its best outside option improves, or the best outside option of the other party gets worse, and vice versa.[210]

180. For PHIs, their outside options under the factual and counterfactual are the same (assuming they can enter into MPPAs in the counterfactual). If a PHI does not agree to an MPPA with a medical specialist, it is able to:

a. procure services from other medical specialists through MPPAs or medical gap schemes;

b. provide customers access to the medical specialist in question through a medical gap scheme, ie:[211]

i. for major PHIs, the major PHI's medical gap scheme; and

ii. for minor PHIs, a buying group's medical gap scheme; and/or

c. contribute 25 per cent of the MBS rate should a customer choose to obtain treatment from the medical specialist in question outside of an MPPA or medical gap scheme.[212]

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[205] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 190.

[206] I understand that existing buying groups negotiate contracts with medical specialists to a limited extent and that Mr Du Plessis is not aware of any MPPAs between individual buying group members and medical specialists. See: Affidavit of David Malcolm Du Plessis, 13 June 2022, para 110.

[207] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 190.

[208] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 183(e).

[209] I explain in appendix A4 that bargaining power depends on each party's best outside option.

[210] I explain the framework for assessing bargaining power in appendix A4 and the balance of relative bargaining power in paragraph 241.

[211] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 190, 290.

[212] I note that this is a legislative requirement for the PHI. See paragraph 30.

181. Medical specialists also have the same outside options in the factual and counterfactual. Specifically, if a medical specialist does not enter into an MPPA with a PHI, the medical specialist can:[213]

    a. contract MPPAs or sign up for medical gap schemes with other PHIs (or buying groups);

    b. sign up for the medical gap scheme with the PHI (or buying group) in question; and/or

    c. charge patients gap fees over and above the MBS rate.

182. The fact that the outside options available to medical specialists and PHIs do not materially change under the proposed arrangements implies that the bargaining power of both parties would remain broadly similar if the proposed conduct were authorised.

183. The only difference between the proposed conduct and the counterfactual is that the proposed arrangements include the additional outside option for participating minor PHIs and medical specialists to utilise the HH buying group's medical gap scheme, whereas under the counterfactual minor PHIs and medical specialists had the outside options of the AHSA or ARHG medical gap schemes.

184. In my opinion, this will not materially reduce the value of the medical specialists' outside options because the minor PHIs will not have substantially more monopsony power and I understand that the HH buying group would neither discontinue its medical gap scheme nor reduce the payment rates under the factual.[214] Further, medical specialists retain other outside options under both the factual and counterfactual.[215]

185. It follows that the proposed conduct would not result in a material change in bargaining power between PHIs and medical specialists. As such, in my opinion the proposed conduct does not give rise to any public detriment as regards a change in bargaining power between PHIs and medical specialists.

5.3.2 No harm from inefficient provision of medical specialist services

186. The ACCC considered that a public detriment in the form of 'inefficient outcomes' in relation to the provision of medical specialist services would likely arise if the proposed conduct proceeded in a form that allowed major PHIs to participate in the HH buying group with respect to the BCPP.[216] In presenting its reasons for this conclusion, the ACCC states:[217]

> First, medical specialists would face fewer alternative healthcare payers with whom to negotiate payments than they would absent the Proposed Conduct. As a result, the Applicants will likely have the ability to secure the agreement of medical specialists to participate in the BCPP for a lower payment premium over existing gap scheme payments than absent the Proposed Conduct. This could raise the likelihood of the operation of the BCPP resulting in an inefficient underprovision of medical specialist services.
>
> Second, the ACCC is mindful that if HH attracted a large enough group of specialists to participate in the BCPP, then HH buying group insurers (including nib) might have incentives to abolish or reduce the generosity of their no and known gap scheme payments. This is because if insurers reduced their gap scheme payments, specialists will be constrained from raising out-of-pocket fees to customers because customers will have access to a large pool of other specialists who are committed to a no gap experience for customers. Those specialists who are not members of the

[213] See Figure 3.1.

[214] Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 190-191. See paragraph 152 for the reasons minor PHIs will not have increased monopsony power.

[215] See paragraph 181.

[216] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, paras 4.111-4.113.

[217] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, para 4.112.

> BCPP and are unwilling to join it may raise their gap fees, but perform fewer procedures. Reduced insurer gap scheme payments could thereby result in a contraction in the supply of medical specialists' services, which would likely be a public detriment.

187. In the remainder of this section, I examine the public detriment envisaged by the ACCC by:

    a. describing the conditions necessary for the ACCC's contemplated public detriment to arise;

    b. describing the difference between the outcomes under the proposed conduct and the counterfactual; and

    c. evaluating the public detriment contemplated in relation to the proposed conduct for each of the two reasons set out above by the ACCC.

188. For the reasons I elaborate below, I conclude that the proposed conduct will not result in a public detriment because it would not be expected to lead to a reduction in the quantity and/or quality of medical specialist services.

189. First, it is relevant to consider the conditions necessary for a detriment to arise in this context. The public detriment described by the ACCC concerns the potential 'inefficient' under provision of medical specialist services. It follows that, for a public detriment to arise, the proposed conduct must result in a reduction in the quality and/or quantity of one or more types of medical specialist services, as compared to the counterfactual.

190. Second, in relation to the difference between outcomes under the proposed conduct and the counterfactual, the ACCC states that 'medical specialists would face fewer alternative healthcare payers with whom to negotiate' in relation to major PHIs.[218] In my opinion, this is incorrect. Each of the major PHIs will still have their own medical gap scheme. Further, the major PHIs have the ability to use the BCPP under both the proposed conduct and the counterfactual. It follows that, under both the factual and counterfactual, the number of major PHIs (or their representatives) is the same.

191. Rather, the difference between the two scenarios (as they relate to major PHIs) is that, in the counterfactual, there would be no sharing of data and analytics between nib and participating major PHIs,[219] and the BCPP may not be as attractive to medical specialists.[220] This has no bearing on the number of healthcare payers with whom medical specialists are able to negotiate.

ACCC's first reason

192. In my opinion, the proposed conduct would not be expected to result in the 'inefficient' under provision of medical specialist services as contemplated in the first of the ACCC's reasons stated above, ie, a reduction in the quantity and/or quality of medical specialist services, because:

    a. the HH buying group could not reduce the BCPP premium over existing medical gap schemes; and

    b. PHIs face strong commercial incentives to maintain competitive no gap coverage for their customers.

[218] I note that medical specialists do not 'negotiate' medical gap schemes with PHIs. Rather, PHIs publish contract with standard terms and conditions, which medical specialists can choose whether or not to sign up for. See paragraph 152.

[219] Affidavit of David Malcolm Du Plessis, 13 June 2022, para 293(d).

[220] See paragraph 82; Affidavit of David Malcolm Du Plessis, 13 June 2022, paras 242-245.

193. Irrespective of the number of PHIs and medical specialists who participate in the HH buying group, the HH buying group could not secure the agreement of medical specialists to participate in the BCPP for a lower premium over existing medical gap schemes,[221] because:

    a. under both the factual and counterfactual, medical specialists retain the outside options I describe in paragraph 181 – the BCPP must pay sufficient premiums to attract and retain medical specialists, otherwise medical specialists may utilise their outside options and reduce the coverage of the BCPP; by consequence, the proposed conduct would not alter the output of medical specialist services; and

    b. if the BCPP premium over medical gap schemes reduces, each individual major PHI that was part of the HH buying group could gain a competitive advantage over its rivals by switching to using its own, more generous medical gap scheme – it follows that the major PHIs' medical gap schemes pose competitive constraints on the prices struck under the BCPP.

194. I explain above that participating major PHIs face strong commercial incentives to maintain no gap coverage for their customers.[222] By consequence, the proposed conduct could not be expected to result in a reduction in the quantity and/or quality of medical specialist services.

ACCC's second reason

195. In my opinion, there is no clear basis on which to conclude that any detriment would arise from member PHIs abolishing or reducing the amount paid under their medical gap schemes, thereby giving rise to a reduced ability of medical specialists who do not participate in the BCPP to charge gap fees because:

    a. as indicated by the ACCC, in this scenario patients have 'access to a large pool of other specialists who are committed to a no gap experience' – such circumstances would appear to be a benefit to consumers, since it would increase demand for private health insurance and its associated benefits to patients and, commensurately, increased medical specialists providing services through the private system;

    b. under both the factual and counterfactual, PHIs are competing to provide a 'no gap' experience to their customers so that, even with many specialists participating in the BCPP, under the proposed conduct PHIs still have an incentive to offer medical gap schemes in order to offer a better no gap experience than their rivals;[223]

    c. to the extent that medical specialists have a reduced ability to charge gap fees, this is because many customers can access a good no gap experience – in my opinion, it is incorrect to imply that a detriment arises because consumers cannot be charged very high prices by medical specialists; rather, there is a benefit that patients can access more no gap services, with this likely giving rise to an increase in demand for private health insurance;

    d. there is no economic basis for the ACCC's statement that '[t]hose specialists who are not members of the BCPP and are unwilling to join it may raise their gap fees' – rather, in this scenario more patients have access to a no gap service, which would be likely to reduce demand for medical services that involve gap fees, thereby making increased gap fees less likely; and

[221] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, para 4.112(a).

[222] See paragraph 169.

[223] I explain in section 5.3.1 that PHIs have a commercial incentive to maintain competitive medical gap schemes.

e. consistent with the different, more likely outcome I describe above, the ACCC states in the previous sentence that '…specialists will be constrained from raising out-of-pocket fees to customers because customers will have access to a large pool of other specialists who are committed to a no gap experience for customers', an outcome that is inconsistent with the suggestion that specialists 'may raise their gap fees'; and

f. the BCPP is not the only constraint on setting prices for medical gap scheme – if an individual PHI were to reduces premiums payable under their medical gap scheme, medical specialists could reallocate their services to:

   i. the BCPP;

   ii. other PHIs' medical gap schemes; and/or

   iii. public sector treatment.

5.3.3 No other detriment

196. The applicants contend that the proposed conduct will:[224]

   a. restrict medical specialist freedom with performance targets or PHI guidelines, which is inconsistent with patients' best interests;

   b. induce medical specialists to behave in a manner that is contrary to the best clinical outcome for patients; and

   c. lead to the disclosure of confidential information,[225] which would be detrimental for patients.

197. First, the freedom of medical specialists to act in the best interest of patients will remain in the factual. As noted by the ACCC in its final determination,[226] the *Private Health Insurance Act* prevents PHIs from limiting the professional freedom of medical practitioners.[227] Specifically, the *Private Health Insurance Act* states:[228]

> If a private health insurer enters into an agreement with a medical practitioner for the provision of treatment to persons insured by the insurer, the agreement must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments.

198. I assume PHIs are compliant with their obligations under the *Private Health Insurance Act 2007* in the factual and counterfactual, including not limiting the professional freedom of medical specialists who elect to enter into MPPAs (including under the BCPP).

199. The ACCC also notes medical practitioners can seek assistance from the Commonwealth Ombudsman or the Commonwealth Department of Health[229] in order to resolve matters where their professional freedom is inappropriately affected by PHIs.

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[224] NAPP, *Applicant's statement of facts, issues and contentions*, 4 April 2022, paras 86-88 and 92-98; RMSANZ, *Applicant's statement of facts, issues and contentions*, 4 April 2022, paras 102-111 and 117-120.

[225] NAPP, *Applicant's statement of facts, issues and contentions*, 4 April 2022, paras 89-91; RMSANZ, *Applicant's statement of facts, issues and contentions*, 4 April 2022, paras 112-116.

[226] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, para 4.161.

[227] *Private Health Insurance Act 2007* (Cth), section 172-5(1).

[228] *Private Health Insurance Act 2007* (Cth), section 172-5(1).

[229] ACCC, *Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group - Authorisation number: AA1000542*, Final determination, 21 September 2021, pp 3, 34.

200. Second, in my opinion, medical specialists will not be induced to behave in a manner that is contrary to the best clinical outcome for patients because:

    a. as set out above, the professional freedom of medical specialists will remain;

    b. the code of conduct for doctors in Australia requires doctors not to allow any financial or commercial interest in a hospital or other healthcare organisation or company providing or manufacturing healthcare services or products to adversely affect the way patients are treated[230] – I assume the code of conduct applies and is followed both in the presence or absence of the proposed arrangements; and

    c. it is not in the interest of a PHI to have agreements with medical specialists that result in worse outcomes for its customers[231] – I expect this would lead to a loss of customers to rival PHIs.

201. Third, the *Privacy Act 1988* (Cth) and equivalent state and territory legislation imposes obligations on PHIs to safeguard patient information.[232] I assume this sufficiently protects customer information in the factual. Further, PHI offerings that do not meet legislative requirements and community expectations or are unfavourable to customers and patients with respect to confidential information would likely lose customers to rival PHIs.

[230] Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia*, October 2020, para 10.12.9.

[231] See section 5.3.1.

[232] *Privacy Act 1988* (Cth), APPs 3, 6 and 11; *Health Records Act 2001* (Vic), HPPs 1, 2 and 4; *Health Records and Information Privacy Act 2002* (NSW), HPPs 1, 2, 5, 10 and 11; *Health Records (Privacy and Access) Act 1997* (ACT), Privacy principles 1, 3, 4, 9 and 10.

6. Declaration

202. In accordance with the requirements of the Code:

a. I acknowledge I have read and complied with the code and agree to be bound by it, and that my opinions are based wholly or substantially on specialist knowledge arising from my training, study, or experience; and

b. I declare that I have made all inquiries that I believe are desirable and appropriate, and that no matters of significance that I regard as relevant have, to my knowledge, been withheld from the Court.

Greg Houston
14 June 2022

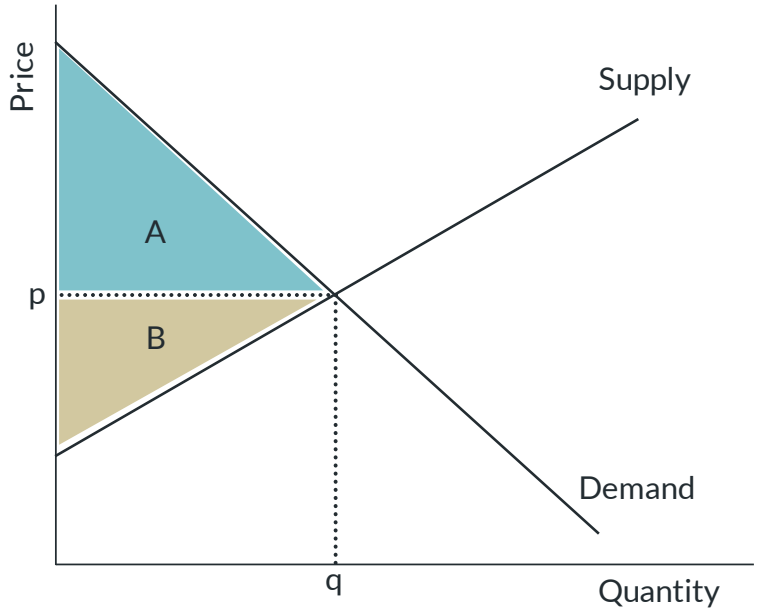
A1. Economic surplus

203. To assess the total economic surplus or welfare derived from the production and consumption of a good or service, economists consider the surplus that buyers and sellers receive from participating in a market.[233]

204. The benefit that consumers receive from participating in the market is known as consumer surplus.[234] The consumer surplus for each buyer is defined as the value that the buyer receives from consuming a product (ie, the maximum amount that a buyer would be willing to pay for a product) less the price paid.[235]

205. In Figure A1.1 I depict a demand curve (labelled 'Demand') representing the willingness to pay of all consumers for given quantities of a product. The area below the demand curve but above the price paid measures the consumer surplus, assuming that the price paid is given by the value p (ie, the area labelled 'A' in Figure A1.1 below).[236]

Figure A1.1: Consumer and producer surplus



206. Similarly, the benefit that producers receive from participating in the market is known as producer surplus.[237] Producer surplus is defined as the price that a producer receives less the cost to produce those products.[238] The supply curve in Figure A1.1 (labelled 'Supply') represents the sellers' costs for

[233] Gans, J, King, S and Mankiw, N, *Principles of microeconomics*, Nelson, Victoria, 2003, p 134.
[234] Gans, J, King, S and Mankiw, N, *Principles of microeconomics*, Nelson, Victoria, 2003, p 135.
[235] Gans, J, King, S and Mankiw, N, *Principles of microeconomics*, Nelson, Victoria, 2003, p 135.
[236] Gans, J, King, S and Mankiw, N, *Principles of microeconomics*, Nelson, Victoria, 2003, p 136.
[237] Gans, J, King, S and Mankiw, N, *Principles of microeconomics*, Nelson, Victoria, 2003, p 140.
[238] Gans, J, King, S and Mankiw, N, *Principles of microeconomics*, Nelson, Victoria, 2003, p 140.

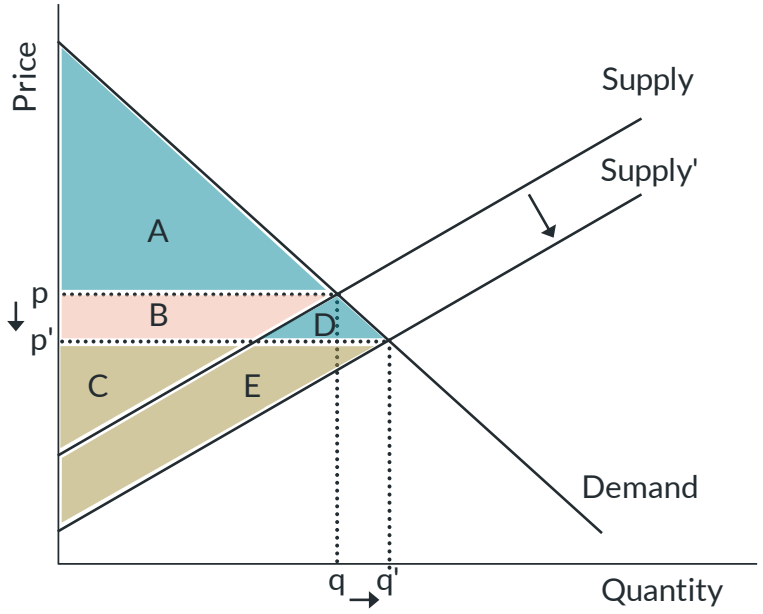
a given quantity supplied. The area below the price and above the supply curve therefore measures the producer surplus (ie, the area labelled 'B' in Figure A1.1 above).[239]

207. The sum of consumer and producer surplus is the known as the total surplus or welfare and is given by the sum of areas 'A' and 'B' in Figure A1.1.[240]

208. The effect of changes in legislation or conduct can be analysed by reference to this framework. For example, one benefit of a change may be more efficient operations on the part of producers, which results in improvements to productive efficiency. Productive efficiency refers to a market outcome whereby products and services are provided at the lowest possible cost, using facilities of optimal scale, over the long run, with existing technology.[241]

209. An improvement in productive efficiency would mean that, for a given quantity of inputs, more (or higher quality) output could be produced; or that for a given quantity (or quality) of output, fewer inputs are required.[242] An improvement in productive efficiency via cost savings would be represented graphically by the supply curve shifting outwards (to the curve labelled 'Supply''). The effect of an improvement in productive efficiency on total surplus is shown in Figure A1.2.[243]

Figure A1.2: Change in economic surplus due to improvement in productive efficiency



210. Figure A1.2 shows that:

[239] Gans, J, King, S and Mankiw, N, *Principles of microeconomics*, Nelson, Victoria, 2003, pp 141-142.

[240] Gans, J, King, S and Mankiw, N, *Principles of microeconomics*, Nelson, Victoria, 2003, p 144.

[241] Pass, C, Lowes B, and Davies L, *Economics (Collins Internet-Linked Dictionary of),* HarperCollins Publishing, June 2014, p 45 of 64 in 'P' section; Motta, *Competition Policy: Theory and Practice,* Cambridge University Press, United States, 2009, p 45; and Morgan, M Katz, and Rosen, H, *Microeconomics*, McGraw-Hill Education, United Kingdom, 2006, p 428.

[242] Motta, M, *Competition Policy: Theory and Practice,* Cambridge University Press, United States, 2009, p 45.

[243] The same effect (an outward shift of the supply curve from S to S') could occur from a shift in market or bargaining power. For example, if the supplier can procure inputs to production at a lower cost, the supply curve can shift to the right even though there has been no improvement in efficiency. Instead, this change reflects a transfer of benefits – whilst there is an increase in consumer and producer welfare in this market, there is an equivalent decline in producer welfare in another.

a. the improvement in productive efficiency results in increased production (q to q'), which leads to an increase in the total surplus (ie, by 'E' plus 'D'), with this benefit being shared by both consumers (who receive 'D') and producers (who receive 'E'); and

b. the improvement in productive efficiency also results in a transfer (of 'B') from producers to consumers.

211. Although transfers do not involve an increase in the production of goods and services, it may be that one particular distribution of benefits is held to be preferable to another. This involves the application of judgement as to the relative importance of benefits to different parties. In the above example, if welfare for consumers is deemed to be of greater value than welfare for producers, then the transfer of 'B' may be regarded as a net benefit.

A2. Economic principles of competition

212. In this appendix, I describe why increased competition can be expected to lead to greater efficiency and so economic surplus.

213. Competition leads to economic efficiency, which is attained when given resources are allocated in such a way to maximise the welfare, or economic surplus, of all individuals.[244] The Harper review set out a number of benefits that increased competition brings, ie:[245]

> More competitive markets can lead to: lower resource costs and overall prices; better services and more choice for consumers and businesses; stronger discipline on businesses to keep costs down; faster innovation and deployment of new technology; and better information, allowing more informed choices by consumers.

214. Economists recognise three types of efficiency that can be enhanced or improved as a result of increased competition, ie:[246]

    a. productive efficiency, which refers to a market outcome whereby products and services are provided at the lowest possible cost, using facilities of optimal scale, over the long run, with existing technology;[247]

    b. dynamic efficiency, which refers to the achievement of efficient levels and types of investment in new and improved products and production processes;[248] and

    c. allocative efficiency, which refers to a market outcome whereby prices and profit levels are consistent with the real resource cost of supplying each product, including a normal profit reward to suppliers – where this is the case, society's resources will be allocated between end uses in an optimal way such that goods and services that are produced best accord with consumer demand.[249]

215. Competition acts to increase each of these forms of efficiency.

216. Productive efficiency is increased as a result of greater competition because:[250]

    a. firms have an incentive to cut their costs so that they can reduce prices and increase sales; and

    b. firms that have lower costs grow, whilst others shrink.

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[244] Morgan, M Katz, and Rosen, H, *Microeconomics*, McGraw-Hill Education, United Kingdom, 2006, pp 434-435; and Productivity Commission, *On efficiency and effectiveness: some definitions*, May 2013, p 2.

[245] Competition Policy Review Panel, *Competition Policy Review Issues Paper*, 14 April 2014, p 8, para 1.2.

[246] See also, ACCC, *Submission to Harper Review*, 25 June 2014, p 14.

[247] Pass, C, Lowes B, and Davies L, *Economics (Collins Internet-Linked Dictionary of),* HarperCollins Publishing, June 2014, p 45 of 64 in 'P' section; Motta, M, *Competition Policy: Theory and Practice,* Cambridge University Press, United States, 2009, p 45; and Morgan, W, Katz, M, and Rosen, H, *Microeconomics*, McGraw-Hill Education, United Kingdom, 2006, p 428.

[248] Morgan, W, Katz, M, and Rosen, H, *Microeconomics*, McGraw-Hill Education, United Kingdom, 2006, p 428.

[249] Pass, C, Lowes B, and Davies L, *Economics (Collins Internet-Linked Dictionary of),* HarperCollins Publishing, June 2014, p 15 of 32 in 'A' section; and Morgan, W, Katz, M, and Rosen, H, *Microeconomics*, McGraw-Hill Education, United Kingdom, 2006, p 424.

[250] Motta, M, *Competition Policy: Theory and Practice,* Cambridge University Press, United States, 2009, p 52; and Vickers, J, *Concepts of Competition*, Oxford Economic Papers, vol. 97, 1995, p 1.

217. Dynamic efficiency is increased because competition pushes firms to invest, in order to improve their product or service offering and so their competitive position relative to rivals.[251]

218. Allocative efficiency is increased because the lower prices brought about by competition can be presumed to lead to higher levels of output, ie, consumers will buy more when prices are lower. Similarly, a reduction in competition leads to higher prices and so less output, thereby reducing allocative efficiency and welfare.

219. An increase in efficiency in a market leads to greater total surplus in that market because the total output is valued more highly for the same inputs, or the same output is maintained with fewer inputs.

220. It follows that any change in legislation or conduct that gives rise to an increase in competition is likely to give rise to an increase in efficiency, and therefore economic surplus.

[251] Motta, M, *Competition Policy: Theory and Practice,* Cambridge University Press, United States, 2009, p 56. A 2011 study by the Productivity Commission and Australian Bureau of Statistics, using data from the Business Longitudinal Database, found that firms are more likely to innovate if they face stronger competition, and that innovation is associated with better productivity outcomes – see Soames, L, Brunker D, and Talgaswatta, T, *Competition, Innovation and Productivity in Australian Businesses,* 9 September 2011. Further, the empirical evidence collated by the OECD across economies shows a positive correlation between product market competition, innovation and economic growth. For further discussion of competition and incentives for dynamic efficiency see: ACCC, *Submission to Harper Review*, 25 June 2014, p 14.

A3. Monopsony

221. In this appendix, I explain the concept of monopsony power, the detriment it can cause and when it is appropriate to use this framework.

A3.1 What is a monopsony?

222. A monopsony is a single buyer purchasing from many sellers that is capable of affecting the market price of the good or service being purchased.[252] As described by Perloff:[253]

> A monopsony is the mirror image of monopoly, and it exercises its market power by buying at a price below the price that competitive buyers would pay.

223. More generally, monopsony power is the ability of a buyer to affect the market price by changing the quantity purchased.[254]

224. A distinction can be drawn between monopsony power and bargaining power. Bargaining power is determined by the extent to which a buyer is able to extract surplus from a supplier in circumstances where there are relatively few suppliers and buyers, and the terms of trade are determined by bilateral bargaining.[255] As described by the OECD:[256]

> Differences in bargaining power are reflected in differences in individually negotiated discounts. Bargaining power refers to the bargaining strength that a buyer has with respect to its suppliers.

225. A monopsony framework may be appropriate in markets where there is one large buyer accounting for a large proportion of the input market, and where the extent of its market power is such that it can affect market output (for example by making all or nothing offers) or reducing market output to drive down the price.[257]

A3.2 Effect of a monopsony

226. In making production decisions, a firm will find it profit maximising to keep purchasing more input units until the last unit purchased provides a value by way of contribution to its production decisions (the marginal value) that is equal to the cost of that last input unit (the marginal cost).[258] The additional cost of buying one more unit of a good is the marginal expenditure.[259]

227. A buyer that is competing with many others will generally not be able to influence the price of the good or service being purchased, and so will not be able to affect the marginal expenditure.[260] Instead, a buyer competing with many others is likely to pay the same market price for each unit, so that its marginal expenditure is equal to the average expenditure, which is the price.[261]

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[252] See Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, pp 357 and 382.

[253] Perloff, J M, *Microeconomics*, Addison-Wesley, Boston, 2012, p 533.

[254] OECD, *Monopsony and buyer power*, Roundtables on competition policy 38, 2008, p 9; and Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, p 382.

[255] OECD, *Monopsony and buyer power*, Roundtables on competition policy 38, 2008, p 9.

[256] OECD, *Monopsony and buyer power*, Roundtables on competition policy 38, 2008, p 9.

[257] Roger, D Blair and Jeffery L Harrison, *Antitrust Policy and Monopsony*, Cornell Law Review, vol 76, 1991, p 306.

[258] Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, p 382.

[259] Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, p 383.

[260] Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, p 383.

[261] Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, p 383.

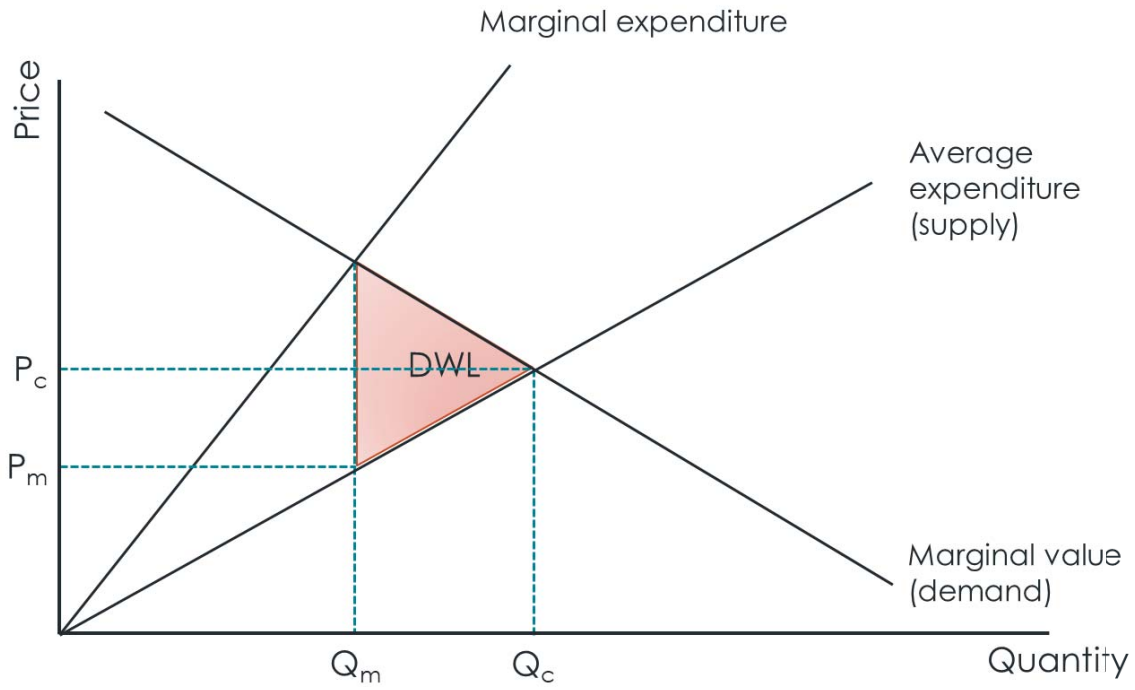
228. In contrast, a monopsonist seeking to maximise its profits will purchase an amount of the relevant input such that the marginal value it obtains is equal to the marginal cost. The crucial difference between a buyer facing competition from others and a monopsonist is that the monopsonist can reduce the price it pays by reducing the amount it purchases. A competitive buyer cannot achieve this outcome.

229. Figure A3.1 shows the quantity Q_m that the monopsonist will purchase, ie, where the marginal expenditure meets the marginal value (ie, demand for the input).[262] The average expenditure line is the supply curve, ie, the cost of producing one more unit of output. Consistent with the usual economic principles, I assume this is upward sloping, ie, the cost of producing one more unit increases as more units are produced.[263]

230. If a buyer is competing with others, quantity will equal Q_C because the buyer will purchase a quantity such that the marginal value of purchasing another unit was equal to the average expenditure (or the supply curve), since the buyer is unable to alter the price.[264]

231. A monopsonist has an incentive to pay a lower price and purchases less than a competitive buyer – because the monopsonist is able to reduce the price by purchasing less (whereas the competitive buyer is not). In that circumstance, the reduction in quantity sold under monopsony causes a dead weight loss (ie, loss of economic surplus), marked by DWL in Figure A3.1.[265]

Figure A3.1: Quantity purchased by monopsonist and competitive buyer



Source: Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012*, p 384.*

[262] The marginal expenditure line is above that of average expenditure because the average expenditure line is upward sloping.

[263] See for example: Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, figure 10.14, p 384.

[264] Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, p 384.

[265] This assumes there is no price discrimination. See also: OECD, *Monopsony and buyer power*, Roundtables on competition policy 38, 2008, p 9.

232. The reduction in input prices paid to suppliers by a monopsonist is generally not passed on in the form of lower prices to customers of the monopsonist's product, ie:[266]

> In fact, when the monopsonist has market power in its output market, the reduced input prices cause higher output prices.

A3.3 Assessing monopsony power

233. The degree of monopsony power refers to the extent to which a buyer can change the price by purchasing fewer inputs. Assessing monopsony power is analogous to the assessment of market power.[267] This typically can involve an assessment of:

    a. the market structure, because this can identify the strength of the competitive constraints on the firm or firms in question;

    b. the conduct of the firms in the market in question, because firms that use market power will act in a different way to those in a workably competitive market; and

    c. market outcomes, because firms using monopsony power are likely to set lower prices and/or purchase a lower quality and quantity of products.

234. In particular, buyers are likely to have very limited or no market power when there are many of them. In that instance, no particular buyer will be able to influence the price a great deal by purchasing less.[268] The OECD has said:[269]

> If sellers can easily find other buyers, then a buyer will have limited monopsony power.

[266] Roger, D Blair and Jeffery L Harrison, *Antitrust Policy and Monopsony*, Cornell Law Review, vol 76, 1991, p 306.

[267] Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, p 386.

[268] Pindyck, R S and Rubinfeld, D L, *Microeconomics*, Eighth edition, Prentice Hall, 2012, p 387.

[269] OECD, *Monopsony and buyer power*, Roundtables on competition policy 38, 2008, p 10.

A4. Bargaining framework

235. In this section I describe when it is appropriate to apply a bargaining framework to the assessment of competition and the considerations that determine outcomes in that framework.

236. Bargaining power has been described by the OECD as follows:[270]

> Bargaining power is typically defined as the strength of a buyer in its negotiations with sellers. Bargaining power is applicable to understanding the nature of trade between input suppliers and downstream firms when the interface or framework between trading partners involves bilateral negotiations. In this framework there are relatively few upstream and downstream firms and firms negotiate bilaterally over terms and conditions of supply.

237. The economic framework concerning bargaining therefore applies when two firms are negotiating bilaterally over the supply of some good or service.

238. Parties enter into bilateral bargaining and come to an agreement because both parties can realise benefits from a deal.[271] If one party did not benefit, then it would not voluntarily bargain with the other party. The benefits that each party derives from an agreement depends on the terms and conditions reached, which is in turn is governed by how the parties divide the amount of total net benefit or 'joint surplus' arising from a bargain.[272]

239. Bargaining power in a bilateral bargaining relationship is exercised where a party threatens to impose a cost, or to withdraw a benefit if the other party does not grant a concession, such as a price discount.[273]

240. An important result from the economic considerations applying under a bargaining framework is that the outcome depends on the best outside options for both parties, ie, the effect on each party of not reaching an agreement.[274] The more attractive is a party's outside option, the better outcome that party may receive from bargaining.

241. The value of the buyer's outside option depends on its ability and willingness to substitute alternative suppliers. Similarly, the value of the seller's outside option depends on its ability and willingness to substitute alternative buyers.[275] The more attractive is a party's outside option, the more bargaining power a party has, and the better outcome that party may receive from bargaining.

242. It follows that when assessing the bargaining power that may be gained from a threat, the effect on both parties, ie, the buyer and the seller, needs to be considered.

[270] OECD, *Monopsony and buyer power*, Roundtables on competition policy 38, 2008, p 22.
[271] ACCC, *Report of the ACCC inquiry into the competitiveness of retail prices for standard groceries*, July 2008, p 311.
[272] ACCC, *Report of the ACCC inquiry into the competitiveness of retail prices for standard groceries*, July 2008, p 312.
[273] ACCC, *Report of the ACCC inquiry into the competitiveness of retail prices for standard groceries*, July 2008, p 312.
[274] ACCC, *Report of the ACCC inquiry into the competitiveness of retail prices for standard groceries*, July 2008, p 513.
[275] OECD, *Monopsony and buyer power*, Roundtables on competition policy 38, 2008, p 10.

243. In the box below I provide is a simple theoretical bargaining model once described by the ACCC,[276] explaining how joint net profit will be shared between two bargaining parties.

> Two parties, the seller, S, and the buyer, B, are negotiating over the sale price of an item. If the deal is completed, the mutual benefit from the trade gives rise to a joint gross surplus (or profit) that S and B can jointly realise. This joint gross surplus has the value Z.
>
> The question is: how will S and B divide this joint surplus Z between them? The key concept in the economic theory of bargaining is the notion of the 'outside option' pay-off, or the value of the next best alternative outcome that each party, S and B, can achieve if they walk away from the deal—for example, by finding the best alternative buyer or seller. The value of these outside walk away options can be regarded as the minimum that the respective parties will accept in bargaining between S and B.
>
> To continue with the simple stylised example, let the values of these best outside options be V_S and V_B for S and B, respectively. This means that the joint net profit from the deal, shared between S and B, will be $Z-V_S-V_B$.
>
> The amount of this joint net profit that each party will receive will be determined by way of negotiation between them. The relative bargaining power of each party, S and B, will significantly determine this outcome.
>
> If S and B share the joint net surplus equally,
>
> - S will receive the value $V_S+0.5\times(Z-V_S-V_B) = 0.5\times(Z+V_S-V_B)$
>
> - B will receive $V_B+0.5(Z-V_S-V_B) = 0.5(Z+V_B-V_S)$.
>
> Further, if one of the parties has greater relative bargaining power, then that party will be able to capture a commensurately greater share of the joint net surplus.

[276] ACCC, *Report of the ACCC inquiry into the competitiveness of retail prices for standard groceries*, July 2008, p 513.

A5. Minor PHIs' hospital policy offerings

244. In this section I set out a summary of minor PHIs' hospital policy offerings, based on their websites. All websites were accessed on 10 June 2022.

245. Table A5.1 below sets out the hospital policy offerings for each minor PHI at each of the four policy tiers. A tick (✓) denotes that the PHI offers that policy tier, while a cross (✗) denotes that the PHI does not offer that policy tier.

Table A5.1: Hospital policy offerings for each minor PHI

Hospital fund	Buying group	Gold	Silver	Bronze	Basic
ACA Health Benefits Fund https://acahealth.com.au/hospital-only/	AHSA	✓	✗	✓	✓
AIA Health Insurance https://health.aia.com.au/quote/select-plan	AHSA	✗	✓	✓	✓
Australian Unity Health Limited https://www.australianunity.com.au/health-insurance/hospital-only-covers	AHSA	✓	✓	✓	✓
CBHS Corporate Health Pty Ltd https://www.cbhscorporatehealth.com.au/for-individuals/hospital-cover	AHSA	✓	✓	✓	✓
CBHS Health Pty Ltd https://www.cbhs.com.au/health-insurance/hospital-cover	AHSA	✓	✓	✓	✓
CUA Health Pty Ltd https://www.cuahealth.com.au/hospital-cover	AHSA	✓	✓	✓	✓
Defence Health https://www.defencehealth.com.au/health-insurance-for-adf-members/compare-covers	AHSA	✓	✓	✓	✓
GMHBA https://www.gmhba.com.au/health-insurance/quote?step=2&view=all	AHSA	✓	✓	✓	✓
HBF Health Ltd https://www.hbf.com.au/health-insurance/hospital-insurance	AHSA	✓	✓	✓	✓

Hospital fund	Buying group	Gold	Silver	Bronze	Basic
Health Care Insurance Limited https://www.hciltd.com.au/hospital-cover/	AHSA	✓	✓	✓	✓
Health Insurance Fund of Australia Limited https://www.hif.com.au/health-insurance/hospital-cover/hospital-cover-table	AHSA	✓	✓	✓	✓
Health Partners https://www.healthpartners.com.au/quote/hp-62a33de1077996.07859505/hospital	AHSA	✓	✓	✓	✓
Navy Health https://quote.navyhealth.com.au/compare/hospital	AHSA	✓	✓	✓	✗
Onemedifund https://www.onemedifund.com.au/siteassets/documents/cover-descriptions/gold-hospital-$250-excess--comprehensive-extras.pdf	AHSA	✓	✗	✗	✗
Peoplecare Health Insurance https://www.peoplecare.com.au/health-insurance/hospital-and-extras-cover/	AHSA	✓	✓	✓	✓
Phoenix Health Fund https://phoenixhealthfund.com.au/hospital-cover/	AHSA	✗	✓	✓	✗
Police Health Limited https://policehealth.com.au/products	AHSA	✓	✗	✗	✗
Queensland Country Health Fund Ltd https://www.queenslandcountry.health/cover-options/	AHSA	✗	✓	✓	✗
Reserve Bank Health Society Ltd https://www.myrbhs.com.au/health-insurance/hospital-cover/	AHSA	✓	✗	✗	✗
Teachers Health Fund https://www.teachershealth.com.au/insurance/health-insurance/hospital-cover/	AHSA	✓	✓	✗	✓
The Doctors' Health Fund Pty Ltd https://www.doctorshealthfund.com.au/our-cover	AHSA	✓	✗	✗	✓

Hospital fund	Buying group	Gold	Silver	Bronze	Basic
TUH https://tuh.com.au/your-quote/choose	AHSA	✓	✓	✓	✓
Westfund https://www.westfund.com.au/health-insurance/westfund-hospital-cover/	AHSA	✓	✓	✓	✓
Mildura Health Fund https://www.mildurahealthfund.com.au/Cover-Options/Compare-Hospital-Cover	ARHG	✓	✗	✗	✓
St Lukes Health https://stlukes.com.au/health-insurance/hospital-cover	ARHG	✓	✓	✓	✓
Latrobe Health Services https://www.latrobehealth.com.au/health-cover/healthy-start-hospital-package/	ARHG	✗	✓	✓	✓
Hunter Health Insurance https://www.hunterhi.com.au/products/#hospital-cover	ARHG	✗	✓	✓	✓

Annexure A – Letter of instructions

MinterEllison.

13 May 2022

PRIVATE AND CONFIDENTIAL

Mr Greg Houston
Partner
HoustonKemp Economics
BY EMAIL: greg.houston@houstonkemp.com

Dear Greg

Instructions for expert report

ACT 4 of 2021: National Association of Practising Psychiatrists Application for review of Authorisation AA1000542 Determination made on 21 September 2021
ACT 5 OF 2021: Rehabilitation Medicine Society of Australia and New Zealand Application for review of Authorisation AA1000542 Determination made on 21 September 2021

1. Background

1.1 We act for nib Health Fund Ltd (**nib**) and Honeysuckle Health Pty Ltd (**HH**) (collectively, the **Authorisation Applicants**).

1.2 In December 2020, the Authorisation Applicants sought authorisation from the ACCC under the Competition and Consumer Act 2010 (Cth) (**CCA**) for HH to form a joint buying group (**HH Buying Group**) and provide a number of contracting services to private health insurers (**PHIs**) and other healthcare payers [**Tabs 10-13**].

1.3 In September 2021, the ACCC issued authorisation of the conduct proposed by the Authorisation Applicants (**Proposed Conduct**), for a 5 year term and on the condition that the contracting services not be provided to Medibank Private Limited, Bupa HI Pty Ltd, Hospitals Contribution Fund of Australia Limited, or HBF Health Limited in Western Australia (collectively the **Major PHIs**) (**Authorisation**) [**Tab 15**].

1.4 On 8 October 2021, the National Association of Practising Psychiatrists (**NAPP**) and the Rehabilitation Medicine Society of Australia and New Zealand (**RMSANZ**) (together, the **Applicants**) filed separate applications seeking review of the Authorisation before the Australian Competition Tribunal (**Tribunal**) [**Tabs 1-4**].

The Authorisation Applicants

1.5 nib is a major private health insurer which supplies private health insurance policies to Australian and New Zealand residents. Currently, nib has an approximately 9.7% share of the Australian private health insurance market.

1.6 HH is a health services and data science company founded in December 2019 as a joint venture between nib and Cigna Corporation (**Cigna**), a global health services company. nib and Cigna each own 50% of HH. HH acts independently of its owners with its own Board and separate management.

1.7 In October 2020, nib appointed HH to provide contract negotiation and drafting, data analytics, contract administration and management, dispute resolution and performance and compliance assessment services for nib's contracts and arrangements with healthcare providers (**Providers**).

Application for review

1.8 The Applicants filed separate applications seeking review of the Authorisation before the Tribunal. The Applicants did not object to the Proposed Conduct insofar as it relates to hospital contracting but expressed concerns with medical specialist contracting, specifically in relation to nib's Clinical Partners Program.

1.9 Under this program, nib has entered into medical purchaser provider agreements (**MPPAs**) with orthopaedic surgeons, anaesthetists and assistant surgeons for the provision of orthopaedic joint replacements provided to customers free of any gap payments, and the Authorisation Applicants propose to broaden the Clinical Partners Program to cover other forms of surgery (**Broad Clinical Partners Program** or **BCPP**).

1.10 In their statement of facts, issues and contentions (**SOFIC**) filed on 4 April 2022, RMSANZ sought orders from the Tribunal in relation to terms of the MPPAs for the BCPP, specifically in relation to the terms pertaining to rehabilitation medicine including that the assessment of the appropriateness of rehabilitation care in the home should only be undertaken by a rehabilitation medicine physician [**Tab 6**].

1.11 In their SOFIC filed on 4 April 2022, NAPP also sought orders from the Tribunal in relation to terms of the MPPAs for the BCPP, and requested that in the event the orders are not made in relation to all contractual arrangements, that they be made in relation to contractual arrangements with practising psychiatrists [**Tab 5**].

1.12 Over 400 entities and individuals who made submissions to the ACCC were given notice of the review and none applied for leave to intervene.

1.13 The Authorisation Applicants filed their SOFIC on 19 April 2022 [**Tab 7**]. They submitted that the proposed conduct would give rise to substantial public benefits including:

(a) increasing competition between buying groups;

(b) improving services to buying group participants and customers by:

(i) improving access to data analytics and information for smaller PHIs;

(ii) extending the no gap experience to more customers and increasing certainty of cost for customers;

(iii) expanding value based contracting; and

(iv) transaction cost savings and increased efficiencies; and

(c) countervailing hospital bargaining power.

1.14 The Authorisation Applicants contended that the public benefits of the Proposed Conduct outweigh the public detriments asserted by the Applicants and the Proposed Conduct accordingly satisfied the net public benefits test in section 90(7) of the CCA.

1.15 The Authorisation Applicants sought orders from the Tribunal that it should affirm the ACCC decision to authorise the Proposed Conduct and otherwise amend the Authorisation such that:

(a) the period of Authorisation is extended from 5 to 10 years; and

(b) the condition preventing Major PHIs from joining the HH Buying Group is removed in respect of medical specialist contracting.

1.16 On 29 April 2022, the ACCC requested of the Tribunal that the interested parties who made submissions to the ACCC be given a further opportunity to apply to intervene in the proceedings because the condition and duration of the Authorisation had not previously been raised as issues in these proceedings before the Tribunal.

1.17 On 11 May 2022, Justice O'Bryan made an order that any interested parties seeking to intervene in the proceedings must file an application for intervention by 24 May 2022 [**Tab 9**]. The Australian Medical Association has already expressed that they intend to submit such an application [**Tab 8**].

2. Instructions

2.1 You are retained to prepare an expert report which:

(a) identifies and explains the key economic principles that should be applied in assessing the Proposed Conduct in this context for the purpose of identifying and assessing whether and to what extent net public benefits would arise from the Proposed Conduct;

(b) applying the principles identified in 2.1(a), provides your opinion on whether and to what extent net public benefits would arise from the Proposed Conduct, having regard to, inter alia;

(i) which markets are relevant to the assessment of net public benefits in this context;

(ii) whether and to what extent public detriments would arise from the Proposed Conduct in a future in which the Proposed Conduct is authorised compared to a future in which the Proposed Conduct is not authorised;

(iii) whether and to what extent public benefits would arise from the Proposed Conduct in a future in which the Proposed Conduct is authorised compared to a future in which the Proposed Conduct is not authorised.

3. Material

3.1 You have been provided with the documents attached at **Annexure 1** for the purpose of your report.

3.2 A link to the ACCC's public register for the application is here: Honeysuckle Health and nib | ACCC

3.3 Links to the Tribunal's public register for the applications for review are here: Application by National Association of Practising Psychiatrists (NAPP) - ACT 4 of 2021 (competitiontribunal.gov.au), Application by Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ) - ACT 5 of 2021 (competitiontribunal.gov.au)

4. Timing

4.1 The Authorisation Applicants are required to file written evidence by 6 June 2022, though we are seeking an extension in relation to our expert evidence. We require a report as soon as practicable and prior to 10 June 2022.

5. Other comments

5.1 We request that the report be prepared in accordance with the current Expert Evidence Practice Note from the Federal Court of Australia dated 25 October 2016 (including the Harmonised Expert Witness Code of Conduct annexed to that Practice Note). A copy of the Practice Note is attached as **Annexure 2.**

5.2 In particular, as part of any report please state, specify or provide:

(a) your name and address;

(b) an acknowledgment that you have read the Code of Conduct and agree to be bound by it;

(c) your qualifications to prepare the report;

(d) the assumptions and material facts on which each opinion expressed in the report is based (noting a letter of instructions may be annexed);

(e) the reasons for and any literature or other materials utilised in support of such opinion;

(f) (if applicable) that a particular question, issue or matter falls outside your field of expertise;

(g) any examinations, tests or other investigations on which the expert has relied, identifying the person who carried them out and that person's qualifications;

(h) the extent to which any opinion which you haves expressed involves the acceptance of another person's opinion, the identification of that other person and the opinion expressed by that other person;

(i) a declaration that you have made all the inquiries which the expert believes are desirable and appropriate (save for any matters identified explicitly in the report), and that no matters of significance which the expert regards as relevant have, to the knowledge of the expert, been withheld from the Court;

(j) any qualifications on an opinion expressed in the report without which the report is or may be incomplete or inaccurate;

(k) whether any opinion expressed in the report is not a concluded opinion because of insufficient research or insufficient data or for any other reason; and

(l) where the report is lengthy or complex, a brief summary of the report at the beginning of the report.

5.3 In addition, you should:

(a) acknowledge in the report that (i) you have read and complied with the Practice Note and agree to be bound by it, and (ii) your opinions are based wholly or substantially on specialised knowledge arising from the expert's training, study or experience;

(b) identify in the report the questions that you have been asked to address;

(c) sign the report and attach or exhibit to it copies of: (i) documents that record any instructions given to you; and (ii) documents and other materials that you have been instructed to consider.

6. Confidentiality

6.1 Please ensure that you and your staff maintain strict confidentiality including any information provided to you in relation to this matter as it contains material that is commercially sensitive (**confidential information**). Please also ensure that you do not disclose any confidential information to any person other than staff immediately involved in assisting you in the preparation of your report and who have been made aware of, and have agreed to comply with, these confidentiality requirements.

We look forward to hearing from you.

Yours faithfully
MINTERELLISON

Geoff Carter
Partner
geoff.carter@minterellison.com

Annexure 1 – Relevant documents

Tab No	Description	Date
Australian Competition Tribunal documents		
A. Applications for review		
1.	Application for review from National Association of Practising Psychiatrists (**NAPP**)	8 October 2021
2.	Annexures to NAPP application	8 October 2021
3.	Application from Rehabilitation Medicine Society of Australia and NZ (**RMSANZ**)	8 October 2021
4.	Annexures to RMSANZ application	8 October 2021
B. Statements of facts, issues and contentions (SOFICs)		
5.	SOFIC from NAPP	4 April 2022
6.	SOFIC from RMSANZ	4 April 2022
7.	SOFIC from Authorisation Applicants	19 April 2022
C. Letter from Australian Medical Association (AMA)		
8.	Letter from AMA contesting Authorisation Applicants' contentions	6 May 2022
D. Tribunal Directions		
9.	Tribunal's Directions in relation to the proceedings timetable	12 May 2022
ACCC Authorisation documents		
E. Application to the ACCC for authorisation		
10.	Application for authorisation	23 December 2020
11.	Amended application for authorisation	8 April 2021
12.	Response to ACCC information request and further amended application for authorisation	21 April 2021
13.	Final amended application for authorisation	6 May 2021
F. Decision of ACCC		
14.	Draft determination	21 May 2021
15.	Final determination	21 September 2021
G. Submissions – before draft determination		
16.	Letter from ACCC to interested parties re consultation process	12 January 2021
17.	Submission from RMSANZ	5 February 2021
18.	Applicants' response to interested party submissions (Part 1)	19 February 2021
19.	Applicants' response to interested party submissions (Part 2)	9 March 2021
20.	Applicants' response to AHSA submission	28 April 2021
21.	Applicants' response to ACCC request for further information	28 April 2021
H. Submissions – post draft determination		
22.	Letter from ACCC to interested parties re draft determination	21 May 2021
23.	First submission from NAPP	25 May 2021
24.	Second submission from NAPP	June 2021

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Tab No	Description	Date
25.	Applicants' response to interested party submissions (Part 1)	30 June 2021
26.	Applicants' response to interested party submissions (Part 2)	14 July 2021
27.	Third submission from NAPP (not taken into account)	6 September 2021
I. Pre-decision conference		
28.	Letter from ACCC to interested parties re pre-decision conference	24 June 2021
29.	Submission from National Association of Practising Psychiatrists	23 July 2021
30.	Applicants' response to interested party submissions	9 August 2021
J. Other relevant correspondence and documents		
31.	Medical networks value diagram provided to the ACCC	21 April 2021
32.	Letter from Applicants to ACCC re MPPAs and HPPAs	22 July 2021
33.	Example MPPA provided by Applicants to ACCC	28 July 2021
34.	Email from ACCC to Applicants re proposed condition	24 August 2021
35.	Letter from Applicants to ACCC responding to proposed condition	27 August 2021
36.	Letter from Applicants to ACCC confirming condition of authorisation	22 September 2021
37.	Letter from ACCC to Applicants clarifying condition of authorisation	24 September 2021

Annexure 2 – Expert Evidence Practice Note

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FEDERAL COURT OF AUSTRALIA

EXPERT EVIDENCE PRACTICE NOTE (GPN-EXPT)

General Practice Note

1. INTRODUCTION

1.1 This practice note, including the *Harmonised Expert Witness Code of Conduct* ("**Code**") (see **Annexure A**) and the *Concurrent Expert Evidence Guidelines* ("**Concurrent Evidence Guidelines**") (see **Annexure B**), applies to any proceeding involving the use of expert evidence and must be read together with:

(a) the Central Practice Note (CPN-1), which sets out the fundamental principles concerning the National Court Framework ("**NCF**") of the Federal Court and key principles of case management procedure;

(b) the Federal Court of Australia Act 1976 (Cth) ("**Federal Court Act**");

(c) the *Evidence Act 1995* (Cth) ("**Evidence Act**"**),** including Part 3.3 of the Evidence Act;

(d) Part 23 of the *Federal Court Rules 2011* (Cth) ("**Federal Court Rules**"**)**; and

(e) where applicable, the Survey Evidence Practice Note (GPN-SURV).

1.2 This practice note takes effect from the date it is issued and, to the extent practicable, applies to proceedings whether filed before, or after, the date of issuing.

2. APPROACH TO EXPERT EVIDENCE

2.1 An expert witness may be retained to give opinion evidence in the proceeding, or, in certain circumstances, to express an opinion that may be relied upon in alternative dispute resolution procedures such as mediation or a conference of experts. In some circumstances an expert may be appointed as an independent adviser to the Court.

2.2 The purpose of the use of expert evidence in proceedings, often in relation to complex subject matter, is for the Court to receive the benefit of the objective and impartial assessment of an issue from a witness with specialised knowledge (based on training, study or experience - see generally s 79 of the Evidence Act).

2.3 However, the use or admissibility of expert evidence remains subject to the overriding requirements that:

(a) to be admissible in a proceeding, any such evidence must be relevant (s 56 of the Evidence Act); and

(b) even if relevant, any such evidence, may be refused to be admitted by the Court if its probative value is outweighed by other considerations such as the evidence

being unfairly prejudicial, misleading or will result in an undue waste of time (s 135 of the Evidence Act).

2.4 An expert witness' opinion evidence may have little or no value unless the assumptions adopted by the expert (ie. the facts or grounds relied upon) and his or her reasoning are expressly stated in any written report or oral evidence given.

2.5 The Court will ensure that, in the interests of justice, parties are given a reasonable opportunity to adduce and test relevant expert opinion evidence. However, the Court expects parties and any legal representatives acting on their behalf, when dealing with expert witnesses and expert evidence, to at all times comply with their duties associated with the overarching purpose in the Federal Court Act (see ss 37M and 37N).

3. INTERACTION WITH EXPERT WITNESSES

3.1 Parties and their legal representatives should never view an expert witness retained (or partly retained) by them as that party's advocate or "hired gun". Equally, they should never attempt to pressure or influence an expert into conforming his or her views with the party's interests.

3.2 A party or legal representative should be cautious not to have inappropriate communications when retaining or instructing an independent expert, or assisting an independent expert in the preparation of his or her evidence. However, it is important to note that there is no principle of law or practice and there is nothing in this practice note that obliges a party to embark on the costly task of engaging a "consulting expert" in order to avoid "contamination" of the expert who will give evidence. Indeed the Court would generally discourage such costly duplication.

3.3 Any witness retained by a party for the purpose of preparing a report or giving evidence in a proceeding as to an opinion held by the witness that is wholly or substantially based in the specialised knowledge of the witness[1] should, at the earliest opportunity, be provided with:

(a) a copy of this practice note, including the Code (see Annexure A); and

(b) all relevant information (whether helpful or harmful to that party's case) so as to enable the expert to prepare a report of a truly independent nature.

3.4 Any questions or assumptions provided to an expert should be provided in an unbiased manner and in such a way that the expert is not confined to addressing selective, irrelevant or immaterial issues.

[1] Such a witness includes a "Court expert" as defined in r 23.01 of the Federal Court Rules. For the definition of "expert", "expert evidence" and "expert report" see the Dictionary, in Schedule 1 of the Federal Court Rules.

4. ROLE AND DUTIES OF THE EXPERT WITNESS

4.1 The role of the expert witness is to provide relevant and impartial evidence in his or her area of expertise. An expert should never mislead the Court or become an advocate for the cause of the party that has retained the expert.

4.2 It should be emphasised that there is nothing inherently wrong with experts disagreeing or failing to reach the same conclusion. The Court will, with the assistance of the evidence of the experts, reach its own conclusion.

4.3 However, experts should willingly be prepared to change their opinion or make concessions when it is necessary or appropriate to do so, even if doing so would be contrary to any previously held or expressed view of that expert.

Harmonised Expert Witness Code of Conduct

4.4 Every expert witness giving evidence in this Court must read the *Harmonised Expert Witness Code of Conduct* (attached in Annexure A) and agree to be bound by it.

4.5 The Code is not intended to address all aspects of an expert witness' duties, but is intended to facilitate the admission of opinion evidence, and to assist experts to understand in general terms what the Court expects of them. Additionally, it is expected that compliance with the Code will assist individual expert witnesses to avoid criticism (rightly or wrongly) that they lack objectivity or are partisan.

5. CONTENTS OF AN EXPERT'S REPORT AND RELATED MATERIAL

5.1 The contents of an expert's report must conform with the requirements set out in the Code (including clauses 3 to 5 of the Code).

5.2 In addition, the contents of such a report must also comply with r 23.13 of the Federal Court Rules. Given that the requirements of that rule significantly overlap with the requirements in the Code, an expert, unless otherwise directed by the Court, will be taken to have complied with the requirements of r 23.13 if that expert has complied with the requirements in the Code and has complied with the additional following requirements. The expert shall:

(a) acknowledge in the report that:

(i) the expert has read and complied with this practice note and agrees to be bound by it; and

(ii) the expert's opinions are based wholly or substantially on specialised knowledge arising from the expert's training, study or experience;

(b) identify in the report the questions that the expert was asked to address;

(c) sign the report and attach or exhibit to it copies of:

(i) documents that record any instructions given to the expert; and

(ii) documents and other materials that the expert has been instructed to consider.

5.3 Where an expert's report refers to photographs, plans, calculations, analyses, measurements, survey reports or other extrinsic matter, these must be provided to the other parties at the same time as the expert's report.

6. CASE MANAGEMENT CONSIDERATIONS

6.1 Parties intending to rely on expert evidence at trial are expected to consider between them and inform the Court at the earliest opportunity of their views on the following:

(a) whether a party should adduce evidence from more than one expert in any single discipline;

(b) whether a common expert is appropriate for all or any part of the evidence;

(c) the nature and extent of expert reports, including any in reply;

(d) the identity of each expert witness that a party intends to call, their area(s) of expertise and availability during the proposed hearing;

(e) the issues that it is proposed each expert will address;

(f) the arrangements for a conference of experts to prepare a joint-report (see Part 7 of this practice note);

(g) whether the evidence is to be given concurrently and, if so, how (see Part 8 of this practice note); and

(h) whether any of the evidence in chief can be given orally.

6.2 It will often be desirable, before any expert is retained, for the parties to attempt to agree on the question or questions proposed to be the subject of expert evidence as well as the relevant facts and assumptions. The Court may make orders to that effect where it considers it appropriate to do so.

7. CONFERENCE OF EXPERTS AND JOINT-REPORT

7.1 Parties, their legal representatives and experts should be familiar with aspects of the Code relating to conferences of experts and joint-reports (see clauses 6 and 7 of the Code attached in Annexure A).

7.2 In order to facilitate the proper understanding of issues arising in expert evidence and to manage expert evidence in accordance with the overarching purpose, the Court may require experts who are to give evidence or who have produced reports to meet for the purpose of identifying and addressing the issues not agreed between them with a view to reaching agreement where this is possible ("**conference of experts**"). In an appropriate case, the Court may appoint a registrar of the Court or some other suitably qualified person ("**Conference Facilitator**") to act as a facilitator at the conference of experts.

7.3 It is expected that where expert evidence may be relied on in any proceeding, at the earliest opportunity, parties will discuss and then inform the Court whether a conference of experts and/or a joint-report by the experts may be desirable to assist with or simplify the giving of expert evidence in the proceeding. The parties should discuss the necessary arrangements for any conference and/or joint-report. The arrangements discussed between the parties should address:

(a) who should prepare any joint-report;

(b) whether a list of issues is needed to assist the experts in the conference and, if so, whether the Court, the parties o r the experts should assist in preparing such a list;

(c) **t**he agenda for the conference of experts; and

(d) arrangements for the provision, to the parties and the Court, of any joint-report or any other report as to the outcomes of the conference ("**conference report**").

Conference of Experts

7.4 The purpose of the conference of experts is for the experts to have a comprehensive discussion of issues relating to their field of expertise, with a view to identifying matters and issues in a proceeding about which the experts agree, partly agree or disagree and why. For this reason the conference is attended only by the experts and any Conference Facilitator. Unless the Court orders otherwise, the parties' lawyers will not attend the conference but will be provided with a copy of any conference report.

7.5 The Court may order that a conference of experts occur in a variety of circumstances, depending on the views of the judge and the parties and the needs of the case, including:

(a) while a case is in mediation. When this occurs the Court may also order that the outcome of the conference or any document disclosing or summarising the experts' opinions be confidential to the parties while the mediation is occurring;

(b) before the experts have reached a final opinion on a relevant question or the facts involved in a case. When this occurs the Court may order that the parties exchange draft expert reports and that a conference report be prepared for the use of the experts in finalising their reports;

(c) after the experts' reports have been provided to the Court but before the hearing of the experts' evidence. When this occurs the Court may also order that a conference report be prepared (jointly or otherwise) to ensure the efficient hearing of the experts' evidence.

7.6 Subject to any other order or direction of the Court, the parties and their lawyers must not involve themselves in the conference of experts process. In particular, they must not seek to encourage an expert not to agree with another expert or otherwise seek to influence the outcome of the conference of experts. The experts should raise any queries they may have in relation to the process with the Conference Facilitator (if one has been appointed) or in

accordance with a protocol agreed between the lawyers prior to the conference of experts taking place (if no Conference Facilitator has been appointed).

7.7 Any list of issues prepared for the consideration of the experts as part of the conference of experts process should be prepared using non-tendentious language.

7.8 The timing and location of the conference of experts will be decided by the judge or a registrar who will take into account the location and availability of the experts and the Court's case management timetable. The conference may take place at the Court and will usually be conducted in-person. However, if not considered a hindrance to the process, the conference may also be conducted with the assistance of visual or audio technology (such as via the internet, video link and/or by telephone).

7.9 Experts should prepare for a conference of experts by ensuring that they are familiar with all of the material upon which they base their opinions. Where expert reports in draft or final form have been exchanged prior to the conference, experts should attend the conference familiar with the reports of the other experts. Prior to the conference, experts should also consider where they believe the differences of opinion lie between them and what processes and discussions may assist to identify and refine those areas of difference.

Joint-report

7.10 At the conclusion of the conference of experts, unless the Court considers it unnecessary to do so, it is expected that the experts will have narrowed the issues in respect of which they agree, partly agree or disagree in a joint-report. The joint-report should be clear, plain and concise and should summarise the views of the experts on the identified issues, including a succinct explanation for any differences of opinion, and otherwise be structured in the manner requested by the judge or registrar.

7.11 In some cases (and most particularly in some native title cases), depending on the nature, volume and complexity of the expert evidence a judge may direct a registrar to draft part, or all, of a conference report. If so, the registrar will usually provide the draft conference report to the relevant experts and seek their confirmation that the conference report accurately reflects the opinions of the experts expressed at the conference. Once that confirmation has been received the registrar will finalise the conference report and provide it to the intended recipient(s).

8. CONCURRENT EXPERT EVIDENCE

8.1 The Court may determine that it is appropriate, depending on the nature of the expert evidence and the proceeding generally, for experts to give some or all of their evidence concurrently at the final (or other) hearing.

8.2 Parties should familiarise themselves with the *Concurrent Expert Evidence Guidelines* (attached in Annexure B). The Concurrent Evidence Guidelines are not intended to be exhaustive but indicate the circumstances when the Court might consider it appropriate for

concurrent expert evidence to take place, outline how that process may be undertaken, and assist experts to understand in general terms what the Court expects of them.

8.3 If an order is made for concurrent expert evidence to be given at a hearing, any expert to give such evidence should be provided with the Concurrent Evidence Guidelines well in advance of the hearing and should be familiar with those guidelines before giving evidence.

9. FURTHER PRACTICE INFORMATION AND RESOURCES

9.1 Further information regarding Expert Evidence and Expert Witnesses is available on the Court's website.

9.2 Further information to assist litigants, including a range of helpful guides, is also available on the Court's website. This information may be particularly helpful for litigants who are representing themselves.

J L B ALLSOP
Chief Justice
25 October 2016

Annexure A

HARMONISED EXPERT WITNESS CODE OF CONDUCT[2]

APPLICATION OF CODE

1. This Code of Conduct applies to any expert witness engaged or appointed:

   (a) to provide an expert's report for use as evidence in proceedings or proposed proceedings; or

   (b) to give opinion evidence in proceedings or proposed proceedings.

GENERAL DUTIES TO THE COURT

2. An expert witness is not an advocate for a party and has a paramount duty, overriding any duty to the party to the proceedings or other person retaining the expert witness, to assist the Court impartially on matters relevant to the area of expertise of the witness.

CONTENT OF REPORT

3. Every report prepared by an expert witness for use in Court shall clearly state the opinion or opinions of the expert and shall state, specify or provide:

   (a) the name and address of the expert;

   (b) an acknowledgment that the expert has read this code and agrees to be bound by it;

   (c) the qualifications of the expert to prepare the report;

   (d) the assumptions and material facts on which each opinion expressed in the report is based [a letter of instructions may be annexed];

   (e) the reasons for and any literature or other materials utilised in support of such opinion;

   (f) (if applicable) that a particular question, issue or matter falls outside the expert's field of expertise;

   (g) any examinations, tests or other investigations on which the expert has relied, identifying the person who carried them out and that person's qualifications;

   (h) the extent to which any opinion which the expert has expressed involves the acceptance of another person's opinion, the identification of that other person and the opinion expressed by that other person;

   (i) a declaration that the expert has made all the inquiries which the expert believes are desirable and appropriate (save for any matters identified explicitly in the report), and that no matters of significance which the expert regards as relevant have, to the

[2] Approved by the Council of Chief Justices' Rules Harmonisation Committee

knowledge of the expert, been withheld from the Court;

(j) any qualifications on an opinion expressed in the report without which the report is or may be incomplete or inaccurate;

(k) whether any opinion expressed in the report is not a concluded opinion because of insufficient research or insufficient data or for any other reason; and

(l) where the report is lengthy or complex, a brief summary of the report at the beginning of the report.

SUPPLEMENTARY REPORT FOLLOWING CHANGE OF OPINION

4. Where an expert witness has provided to a party (or that party's legal representative) a report for use in Court, and the expert thereafter changes his or her opinion on a material matter, the expert shall forthwith provide to the party (or that party's legal representative) a supplementary report which shall state, specify or provide the information referred to in paragraphs (a), (d), (e), (g), (h), (i), (j), (k) and (l) of clause 3 of this code and, if applicable, paragraph (f) of that clause.

5. In any subsequent report (whether prepared in accordance with clause 4 or not) the expert may refer to material contained in the earlier report without repeating it.

DUTY TO COMPLY WITH THE COURT'S DIRECTIONS

6. If directed to do so by the Court, an expert witness shall:

(a) confer with any other expert witness;

(b) provide the Court with a joint-report specifying (as the case requires) matters agreed and matters not agreed and the reasons for the experts not agreeing; and

(c) abide in a timely way by any direction of the Court.

CONFERENCE OF EXPERTS

7. Each expert witness shall:

(a) exercise his or her independent judgment in relation to every conference in which the expert participates pursuant to a direction of the Court and in relation to each report thereafter provided, and shall not act on any instruction or request to withhold or avoid agreement; and

(b) endeavour to reach agreement with the other expert witness (or witnesses) on any issue in dispute between them, or failing agreement, endeavour to identify and clarify the basis of disagreement on the issues which are in dispute.

ANNEXURE B

CONCURRENT EXPERT EVIDENCE GUIDELINES

APPLICATION OF THE COURT'S GUIDELINES

1. The Court's Concurrent Expert Evidence Guidelines ("**Concurrent Evidence Guidelines**") are intended to inform parties, practitioners and experts of the Court's general approach to concurrent expert evidence, the circumstances in which the Court might consider expert witnesses giving evidence concurrently and, if so, the procedures by which their evidence may be taken.

OBJECTIVES OF CONCURRENT EXPERT EVIDENCE TECHNIQUE

2. The use of concurrent evidence for the giving of expert evidence at hearings as a case management technique[3] will be utilised by the Court in appropriate circumstances (see r 23.15 of the *Federal Court Rules 2011* (Cth)). Not all cases will suit the process. For instance, in some patent cases, where the entire case revolves around conflicts within fields of expertise, concurrent evidence may not assist a judge. However, patent cases should not be excluded from concurrent expert evidence processes.

3. In many cases the use of concurrent expert evidence is a technique that can reduce the partisan or confrontational nature of conventional hearing processes and minimises the risk that experts become "opposing experts" rather than independent experts assisting the Court. It can elicit more precise and accurate expert evidence with greater input and assistance from the experts themselves.

4. When properly and flexibly applied, with efficiency and discipline during the hearing process, the technique may also allow the experts to more effectively focus on the critical points of disagreement between them, identify or resolve those issues more quickly, and narrow the issues in dispute. This can also allow for the key evidence to be given at the same time (rather than being spread across many days of hearing); permit the judge to assess an expert more readily, whilst allowing each party a genuine opportunity to put and test expert evidence. This can reduce the chance of the experts, lawyers and the judge misunderstanding the opinions being expressed by the experts.

5. It is essential that such a process has the full cooperation and support of all of the individuals involved, including the experts and counsel involved in the questioning process. Without that cooperation and support the process may fail in its objectives and even hinder the case management process.

[3] Also known as the "hot tub" or as "expert panels".

CASE MANAGEMENT

6. Parties should expect that, the Court will give careful consideration to whether concurrent evidence is appropriate in circumstances where there is more than one expert witness having the same expertise who is to give evidence on the same or related topics. Whether experts should give evidence concurrently is a matter for the Court, and will depend on the circumstances of each individual case, including the character of the proceeding, the nature of the expert evidence, and the views of the parties.

7. Although this consideration may take place at any time, including the commencement of the hearing, if not raised earlier, parties should raise the issue of concurrent evidence at the first appropriate case management hearing, and no later than any pre-trial case management hearing, so that orders can be made in advance, if necessary. To that end, prior to the hearing at which expert evidence may be given concurrently, parties and their lawyers should confer and give general consideration as to:

   (a) the agenda;

   (b) the order and manner in which questions will be asked; and

   (c) whether cross-examination will take place within the context of the concurrent evidence or after its conclusion.

8. At the same time, and before any hearing date is fixed, the identity of all experts proposed to be called and their areas of expertise is to be notified to the Court by all parties.

9. The lack of any concurrent evidence orders does not mean that the Court will not consider using concurrent evidence without prior notice to the parties, if appropriate.

CONFERENCE OF EXPERTS & JOINT-REPORT OR LIST OF ISSUES

10. The process of giving concurrent evidence at hearings may be assisted by the preparation of a joint-report or list of issues prepared as part of a conference of experts.

11. Parties should expect that, where concurrent evidence is appropriate, the Court may make orders requiring a conference of experts to take place or for documents such as a joint-report to be prepared to facilitate the concurrent expert evidence process at a hearing (see Part 7 of the Expert Evidence Practice Note).

PROCEDURE AT HEARING

12. Concurrent expert evidence may be taken at any convenient time during the hearing, although it will often occur at the conclusion of both parties' lay evidence.

13. At the hearing itself, the way in which concurrent expert evidence is taken must be applied flexibly and having regard to the characteristics of the case and the nature of the evidence to be given.

14. Without intending to be prescriptive of the procedure, parties should expect that, when evidence is given by experts in concurrent session:

(a) the judge will explain to the experts the procedure that will be followed and that the nature of the process may be different to their previous experiences of giving expert evidence;

(b) the experts will be grouped and called to give evidence together in their respective fields of expertise;

(c) the experts will take the oath or affirmation together, as appropriate;

(d) the experts will sit together with convenient access to their materials for their ease of reference, either in the witness box or in some other location in the courtroom, including (if necessary) at the bar table;

(e) each expert may be given the opportunity to provide a summary overview of their current opinions and explain what they consider to be the principal issues of disagreement between the experts, as they see them, in their own words;

(f) the judge will guide the process by which evidence is given, including, where appropriate:

(i) using any joint-report or list of issues as a guide for all the experts to be asked questions by the judge and counsel, about each issue on an issue-by-issue basis;

(ii) ensuring that each expert is given an adequate opportunity to deal with each issue and the exposition given by other experts including, where considered appropriate, each expert asking questions of other experts or supplementing the evidence given by other experts;

(iii) inviting legal representatives to identify the topics upon which they will cross-examine;

(iv) ensuring that legal representatives have an adequate opportunity to ask all experts questions about each issue. Legal representatives may also seek responses or contributions from one or more experts in response to the evidence given by a different expert; and

(v) allowing the experts an opportunity to summarise their views at the end of the process where opinions may have been changed or clarifications are needed.

15. The fact that the experts may have been provided with a list of issues for consideration does not confine the scope of any cross-examination of any expert. The process of cross-examination remains subject to the overall control of the judge.

16. The concurrent session should allow for a sensible and orderly series of exchanges between expert and expert, and between expert and lawyer. Where appropriate, the judge may allow for more traditional cross-examination to be pursued by a legal representative on a particular issue exclusively with one expert. Where that occurs, other experts may be asked to comment on the evidence given.

17. Where any issue involves only one expert, the party wishing to ask questions about that issue should let the judge know in advance so that consideration can be given to whether

arrangements should be made for that issue to be dealt with after the completion of the concurrent session. Otherwise, as far as practicable, questions (including in the form of cross-examination) will usually be dealt with in the concurrent session.

18. Throughout the concurrent evidence process the judge will ensure that the process is fair and effective (for the parties and the experts), balanced (including not permitting one expert to overwhelm or overshadow any other expert), and does not become a protracted or inefficient process.

Annexure B – Curriculum vitae

Greg Houston

Partner

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Overview

Greg is a founding partner of HoustonKemp. He is an expert in the application of economics to assist high stakes decision-making in competition, finance, policy and regulatory matters.

In the antitrust sphere, Greg is regularly sought to advise on the competitive effects of proposed merger transactions, and to provide expert testimony in antitrust enforcement proceedings. His evidence has been cited favourably in numerous proceedings before the Federal Court, the Competition Tribunal and in the decisions of Australian and international arbitrators. For many years, Greg has been listed by Who's Who Legal as one of the world's leading competition economists. More recently, Greg has been recognised in WWL's Thought Leaders – Competition for his contributions to competition economics.

On regulatory matters, Greg has played a substantial role in shaping the development of economic regulatory regimes governing communications, energy, transport and water services infrastructure in Australia and the Asia Pacific region. His clients in this area include governments, regulators, infrastructure service providers and trade associations.

Greg is also the foremost expert in the region on the application of economics to critical questions arising in securities class actions, insider trading and market manipulation. He has filed expert reports in numerous proceedings concerning the adequacy and effect of disclosures in relation to listed and unlisted securities, in both Australia and New Zealand. Greg's evidence was accepted in the only two wrongful disclosure matters for which final judgment on substantive elements was informed by economic evidence before the Federal Court.

In April 2014, Greg – together with Adrian Kemp – founded HoustonKemp, a firm dedicated to applying economic analysis to bring clarity and focus to complex problems arising in competition, finance, policy and regulation.

Greg holds a first class honours degree in economics from the University of Canterbury, and is a member of the Competition and Consumer Committee of the Law Council of Australia.

Qualifications

1982	**University of Canterbury, New Zealand** B.Sc. (First Class Honours) in Economics

Prizes and scholarships

1980	University Junior Scholarship, New Zealand

Career details

2014-	**HoustonKemp Economists** Partner, Sydney, Australia
1989-2014	**NERA Economic Consulting** Director (1998-2014) London, United Kingdom (1989-1997) Sydney, Australia (1998-2014)
1987-89	**Hambros Bank, Treasury and capital markets** Financial Economist, London, United Kingdom
1983-86	**The Treasury, Finance sector policy** Investigating Officer, Wellington, New Zealand

Project experience[1]

Competition, access and mergers

2020-22	**Chapman Tripp & DLA Piper/Foodstuffs** **Competition market study** Advice, analysis and expert reports prepared in relation to the New Zealand Commerce Commission's market study of the retail grocery sector.
2021	**Clayton Utz/Port of Newcastle Operations** **Collective bargaining authorisation review** Expert report and evidence given before the Competition Tribunal in the context of its review of the decision by the Australian Competition and Consumer Commission to authorise collective bargaining for port access services by Hunter Valley coal producers.
2021	**Ashurst, King & Wood Mallesons/Ovato-Are Media** **Merger clearance** Advice and expert reports submitted to the Australian Competition and Consumer Commission and the New Zealand Commerce Commission in relation to attaining clearance in Australia and New Zealand for magazine publisher Are Media to acquire the magazine distribution business of Ovato.
2017-21	**Gilbert + Tobin/Confidential client** **Alleged cartel conduct** Advice and analysis in relation to an Australian Competition and Consumer Commission investigation and then prosecution of alleged cartel conduct.
2020	**Allens/Confidential client** **Alleged misuse of market power** Advice and analysis in relation to Federal Court proceedings brought by a private party in relation to below cost pricing of a fast moving consumer good.

[1] Past ten years only.

2020	**Ashurst/ASN** **Exclusive dealing** Expert report on the competitive effects of the exclusive dealing notification to the ACCC by the dedicated TV shopping channel retailer TVSN, proposing to be able to acquire products from suppliers on an exclusive basis.
2019-20	**King & Wood Mallesons/Confidential client** **Merger authorisation** Advice and preparation of expert report for use in a potential application for authorisation to the Australian Competition and Consumer Commission.
2018-20	**Squire Patton Boggs/Confidential client** **Market power provision** Advice and expert report prepared on the application of an industry-specific regulation directed at limiting a firm's pricing conduct in circumstances where it has market power.
2018-20	**Queensland Rail** **Access to facilities** Advice in relation to the Queensland Competition Authority's review of the declared status of services provided by QR's five rail networks, as well as the QCA's simultaneous review of the access undertaking applying to those networks.
2018-20	**DLA Piper/DBCT Management** **Access to facilities** Expert reports submitted to the Queensland Competition Authority's review of the declared status of services provided by the Dalrymple Bay Coal Terminal.
2017-19	**Johnson Winter & Slattery/Ramsay Healthcare** **Alleged misuse of market power** Expert reports and testimony in context of Federal Court proceedings brought by the Australian Competition and Consumer Commission against Ramsay Healthcare in relation to conduct by Coffs Harbour-based surgeons.
2017-19	**Wilson Harle/Wilson Parking** **Competitive effects of merger** Expert report submitted in High Court of New Zealand proceedings (settled shortly before trial) brought by the Commerce Commission concerning the competitive effects of an already completed merger transaction.
2017-20	**King & Wood Mallesons** **Competition analysis** Advice to a major digital platform service provider on competition matters arising in the Australian Competition and Consumer Commission's digital platforms inquiry, and the development of the news media and digital platforms bargaining code.
2015-20	**Port of Newcastle Operations** **Access to facilities** Advice and expert reports submitted to the National Competition Council on matters arising in applying the criteria for declaration under Part IIIA, in the context of applications by Glencore and the NSW Minerals Council seeking recommendation that navigation service be declared, and PNO's application for recommendation that the declaration of services be revoked.

2018	**Westpac Banking Corporation** **Competition analysis** Expert report prepared for the Productivity Commission in response to the draft finding in its banking competition inquiry that each of Australia's banks holds substantial market power.
2017-19	**Ashurst/Confidential client** **Anti-competitive bundling** Advice in relation to an Australian Competition and Consumer Commission's investigation of bundled discounts that were alleged to have had an anti-competitive effect.
2017	**Minter Ellison Rudd Watts/Complete Office Supplies** **Competitive effects of merger** Expert reports submitted in High Court of New Zealand proceedings concerning the proposed acquisition of OfficeMax by Platinum Equity injunction.
2017	**Minter Ellison/CrownBet** **Merger authorisation** Expert reports and testimony in Competition Tribunal proceedings concerning the proposed acquisition of Tatts by Tabcorp.
2016	**Bird & Bird/Generic Health** **Competitive effects of patent infringement** Expert reports and testimony in Federal Court proceedings concerning the damages arising from infringement of a pharmaceutical patent in relation to a pharmaceutical patent.
2016	**Manildra Group** **Competition analysis** Advice and preparation of an expert report assessing competitive constraints in the supply of fuel grade ethanol.
2016	**Clayton Utz/Anglo American** **Competitive effects analysis** Expert reports assessing the economic impact on the equine critical industry cluster if certain thoroughbred breeding operations were to leave the Upper Hunter.
2014-16	**Ashurst and Gilbert + Tobin/Confidential client** **Competitive effects of agreements** Analysis and advice prepared in context of an Australian Competition and Consumer Commission investigation of agreements between a supplier and its major customers that are alleged to harm competition.
2015	**Corrs/Confidential client** **Merger clearance** Analysis, advice and expert report submitted to the Australian Competition and Consumer Commission in the context of a proposed acquisition in the office products sector.
2014-15	**Australian Government Solicitor/Commonwealth of Australia** **Competition and trade analysis** Expert report on competition and trade in tobacco products, prepared in the context of the World Trade Organisation dispute settlement proceedings concerning Australia's tobacco plain packaging legislation.

2014-15	**King & Wood Mallesons/Confidential client** **Competitive effects of agreement** Analysis and advice prepared in context of an Australian Competition and Consumer Commission investigation of agreements between a supplier and its major customers that were alleged to harm competition.
2013-14	**Corrs/Australian Competition and Consumer Commission** **Effect of cartel conduct** Expert report filed in the Federal Court on the price effects of an alleged market sharing arrangement in relation to the supply of forklift gas, prepared in the context of proceedings brought against Renegade Gas (Supagas).
2013-14	**Australian Competition and Consumer Commission** **Merger clearance** Expert report and testimony before the Competition Tribunal in the context of the Australian Competition and Consumer Commission's decision to oppose the acquisition of Macquarie Generation by AGL Energy.
2013-14	**Ashurst/BlueScope** **Merger clearance** Expert reports submitted to the Australian Competition and Consumer Commission in the context of the clearance of three approved transactions in the domestic steel industry.
2013-14	**Australian Government Solicitor/ACCC** **Merger clearance** Analysis and advice prepared in the context of the Australian Competition and Consumer Commission review of the proposed acquisition of petrol retailing sites in South Australia.
2013	**Corrs/Generic Health** **Patent damages estimation** Expert report on the nature and extent of the analysis necessary to estimate damages in a patent infringement proceeding**.**
2012-13	**Minter Ellison/Confidential client** **Merger clearance** Expert reports submitted to the Australian Competition and Consumer Commission in the context of a confidential application for clearance of a proposed acquisition in the industrial gases industry.
2011-12	**Gilbert + Tobin/Pact Group** **Merger clearance** Expert reports submitted to the Australian Competition and Consumer Commission on the competitive implications of the proposed acquisition of plastic packaging manufacturer Viscount Plastics by Pact Group.
2011	**Gilbert + Tobin/Caltex** **Access to facilities** Expert report submitted to the National Competition Council on matters arising in the applying the criteria for declaration under Part IIIA, in the context of the application by the Board of Airline Representatives of Australia for the declaration of services provided by the Caltex jet fuel pipeline serving Sydney airport.

2010-12	**Mallesons/APA** **Merger clearance** Expert reports submitted to the Australian Competition and Consumer Commission on the competitive implications of the proposed acquisition of the gas pipeline assets of Hastings Diversified Utilities Fund by APA Group.

Regulatory analysis

2021	**Barrenjoey Capital Partners** **Regulatory due diligence** Advice and preparation of a vendor due diligence report in the context of the sale by Australian Super of a stake in the NSW electricity network service provider, Ausgrid. This work focused on the regulatory framework for regulation of electricity network services and its likely evolution in the face of the transition towards a lower carbon energy sector.
2021	**ESCOSA** **Review of regulatory determination** Conducted a formal review of ESCOSA's final determination of maximum allowed revenue for the licensed drinking water services provider, Robusto Investments, serving customers at Compass Springs, following application for review by Robusto.
2021	**Brookfield Asset Management** **Regulatory due diligence** Advice and preparation of a regulatory due diligence report and advice on competition matters arising in the context of Brookfield's acquisition of the Victorian electricity and gas network service provider, AusNet Services.
2021	**Barrenjoey Capital Partners** **Regulatory due diligence** Advice and preparation of a regulatory due diligence report in the context of the acquisition of the electricity network service provider, Spark Infrastructure Group by a consortium of KKR, OTPP and PSP.
2020-2022	**DLA Piper/Perth Airport** **Quantum meruit determination** Expert reports and evidence given in proceedings before the Supreme Court of Western Australia on the appropriate methodology and its application in a quantum meruit application to determine the fair and reasonable price for aeronautical services provided by Perth Airport Pty Ltd to Qantas Group during 2018, the price for which was in dispute.
2019-21	**DLA Piper/Dalrymple Bay Infrastructure** **Review of access undertaking** Advice and expert reports prepared in the context of the Queensland Competition Authority's review of the access undertaking for users of the Dalrymple Bay coal terminal.
2019	**Brookfield Asset Management/Bank of America** **Regulatory due diligence** Vendor due diligence report on all regulatory aspects of the arrangements – and potential developments therein – applying to the Dalrymple Bay coal terminal.

2018	**Johnson Winter & Slattery/Queensland Competition Authority** **Apprehension of bias claim** Expert reports submitted to the Queensland Supreme Court showing the chain of causation necessary for a connection between the QCA's Aurizon draft decision and the economic interests of the Port of Newcastle.
2017-18	**King & Wood Mallesons/Tasmania Gas Pipeline** **Gas pipeline arbitration arrangements** Expert reports on economic aspects of the Part 23 regime arbitration with Hydro Tasmania on the terms of access to the Tasmanian Gas Pipeline.
2017-18	**Victorian and South Australian electricity distribution networks** **Productivity adjustments** Expert report on the conceptual and empirical basis for pre-emptive productivity adjustments to DNSPs' projected operating expenditure.
2017-18	**Jemena** **Gas pipeline arbitration arrangements** Advice and analysis in relation to the new rules for arbitration of prices for services provided by non-scheme gas pipelines.
2016-18	**APA Group** **Gas market reform** Expert reports submitted to the Gas Market Reform Group in the context of its review of the gas pipeline coverage criteria, and the proposal to introduce the compulsory auction of contracted but unnominated gas pipeline capacity.
2016-17	**Minter Ellison Rudd Watts/Trustpower, New Zealand** **Transmission pricing methodology** Expert reports submitted to the Electricity Authority and to the High Court of New Zealand in relation to proposed reforms to the transmission pricing methodology and the distributed generation pricing principles.
2016	**Johnson Winter & Slattery/Australian Gas Networks** **Materially preferable decision** Expert report reviewing whether aspects of the Australian Energy Regulator's (AER's) draft access arrangement decision would be likely to result in a materially preferable decision in terms of achievement of the national gas objective.
2015-17	**Government of New South Wales** **Economic regulation for privatisation** Advisor to government of New South Wales on all economic regulatory aspects of the proposed partial lease the electricity transmission and distribution entities, TransGrid, AusGrid and Endeavour Energy.
2014-16	**Powerco** **Input methodologies review** Advice and several expert reports prepared in the context of the Commerce Commission's reviews of cost of capital and others aspects of the Input Methodologies governing the determination of maximum prices for New Zealand electricity and gas distribution networks.

2015	**ActewAGL** **Regulatory price review** Expert report on the economic interpretation of provisions in the national electricity law and rules in relation to the application of the national electricity objective to the entire price determination of the Australian Energy Regulator.
2014-16	**Atco Gas** **Access price review** Expert reports on the economic interpretation of provisions in the national gas law and rules in relation to depreciation and the application of the national gas objective to the entire draft decision, submitted to the Economic Regulation Authority of WA.
2014-16	**Government of Victoria** **Economic regulation for privatisation** Advisor to government of Victoria on the design, development and application of the framework for economic regulation of the Port of Melbourne Corporation in the context of the privatisation of the port by way of long term lease.
2013	**Actew Corporation** **Interpretation of economic terms** Advice on economic aspects of the decision of the Independent Competition and Regulatory Commission in relation to the price controls applying to Actew.
2012-13	**Ashurst/Brisbane Airport Corporation** **Draft access undertaking** Advice, analysis and expert reports in the context of the preparation of a draft access undertaking specifying the basis for determining a ten year price path for landing charges necessary to finance a new parallel runway at Brisbane airport.
2012	**King & Wood Mallesons/Origin Energy** **Interpretation of economic terms** Expert reports and testimony in the context of judicial review proceedings before the Supreme Court of Queensland on the electricity retail price determination of the Queensland Competition Authority.
2012	**Contact Energy, New Zealand** **Transmission pricing methodology** Advice on reforms to the Transmission Pricing Methodology proposed by Electricity Authority.
2011-12	**Energy Networks Association** **Network pricing rules** Advice and expert reports submitted to the Australian Energy Market Commission on wide-ranging reforms to the network pricing rules applying to electricity and gas transmission and distribution businesses, as proposed by the Australian Energy Regulator.
2010-12	**QR National** **Regulatory and competition matters** Advisor on the competition and regulatory matters, including: a range of potential structural options arising in the context of the privatisation of QR National's coal and freight haulage businesses, particularly those arising in the context of a 'club ownership model' proposed by a group of major coal mine owners.

2002-12	**Orion New Zealand Ltd, New Zealand** **Electricity lines regulation** Advisor on regulatory and economic aspects of the implementation by the Commerce Commission of the evolving regimes for the regulation of New Zealand electricity lines businesses, including the provision of expert reports, and the giving of expert evidence before the Commission.

Securities and finance

2022	**Madison Marcus/Galactic** **Appropriate litigation funding** Expert report and evidence before the Federal Court in proceedings seeking approval of the funding commission to be paid upon settlement of group proceedings brought against the franchisor of 7-Eleven stores.
2021-22	**HWL Ebsworth/iSignthis** **Materiality of information** Expert reports submitted in the context of Federal Court proceedings brought by ASIC alleging that iSignthis and/or failed to notify the ASX of information that was material to the price of its securities and thereby breached its continuous disclosure obligations.
2021	**Maurice Blackburn Lawyers/Representative proceeding** **Appropriate litigation funding commission** Expert reports prepared in the context of proceedings before the Supreme Court of Victoria seeking approval of a group costs order (CGO) for application in representative proceedings brought against ANZ and Westpac banks concerning the application of flex commissions in the sale of motor vehicles.
2020-21	**SBA Law/Pitcher Partners** **Valuation of damages** Expert reports and sworn evidence in the context of Federal Court proceedings brought against Pitcher Partners in its role as group auditor of consumer law firm Slater & Gordon and alleging it failed to recognise the need for an impairment of Slater & Gordon's UK subsidiary in light of poorer than expected financial performance and pending regulatory changes.
2020-21	**Australian Securities and Investments Commission** **Breach of disclosure obligations** Expert reports submitted in the context of Federal Court proceedings brought by ASIC in relation to the materiality for the price of its securities of the January 2013 disclosure by Rio Tinto Limited of an impairment to the value of Rio Tinto Coal Mozambique assets.
2019-21	**Shine Lawyers/Representative proceeding** **Breach of disclosure obligations** Expert reports submitted in the context of proceedings before the Federal Court concerning the effect of certain disclosures on the price of ASX listed securities in Iluka Limited.

2020	**Corrs/Balance Legal Capital** **Appropriate litigation funding commission** Expert report prepared in the context of proceedings to approve the settlement of a consumer class action brought against Swann Insurance, on the reasonable range of and return on investment implied by historically observed funding commission rates in previous class action proceedings in Australia.
2020	**Johnson Winter & Slattery/Representative proceeding** **Group cost order application** Expert report prepared in the context of an application to be brought before the Supreme Court of Victoria to make a group cost order (GCO), under which the legal costs and funding commission for a representative proceeding would be set by reference to a percentage of the settlement amount.
2020	**McCabe Curwood/Lewer Corporation** **Economic interpretation of loan agreement** Expert report prepared for the Supreme Court of Victoria as to whether a US dollar loan could be interpreted, economically, as equivalent to the sum of an Australian dollar loan plus a foreign exchange forward contract.
2020	**JWS/Australian Securities and Investments Commission** **Breach of disclosure obligations** Expert report in reply submitted in the context of Federal Court proceedings brought by ASIC concerning the materiality for the price of its securities of information omitted from ASX disclosures made by GetSwift Limited.
2019-20	**Joint Action Funding/Representative proceeding** **Valuation of damages** Expert reports submitted to the New Zealand High Court in the matter of Eric Houghton versus parties associated with former listed entity, Feltex Carpets Ltd, on the extent of loss arising from the allotment of shares under an IPO for which the prospectus contained untrue statements.
2019-20	**Slater & Gordon/Representative proceeding** **Breach of disclosure obligations** Expert reports submitted in the context of proceedings before the Federal Court concerning the effect of certain disclosures on the price of ASX listed securities in Spotless Limited.
2019-20	**Arnold Bloch Leibler/Australian Funding Partners** **Appropriate funding commission** Expert reports and sworn testimony in the proceedings before the Victorian Supreme Court concerning the appropriate level of funding commission to apply in the context of the 2018 settlement of representative proceedings brought against Banksia Securities Limited.
2017-20	**Portfolio Law/Representative proceeding** **Misleading and deceptive conduct** Expert reports and sworn testimony in representative proceedings before the Federal Court concerning the effect of certain disclosures on the price of ASX listed securities in Myer Ltd.

2019	**Norton Rose Fulbright/Directors of QRxPharma** **Breach of disclosure obligations** Advice and analysis of the extent of potential damages arising from a shareholder class action alleging breach of disclosure obligations of the former ASX-listed entity, QRxPharma.
2019	**Elliot Legal/Representative proceeding** **Breach of disclosure obligations** Expert reports submitted in the context of proceedings before the Federal Court concerning the effect of certain disclosures on the price of ASX listed securities in Murray Goulburn Co-operative Company Limited.
2018	**Maurice Blackburn/Representative proceeding** **Misleading and deceptive conduct** Expert reports prepared in relation to Federal Court representative proceedings concerning the effect of certain disclosures on the price of ASX listed securities in Sirtex Medical Ltd.
2018	**William Roberts/Representative proceeding** **Misleading and deceptive conduct** Preliminary analysis on the extent of liability and potential damages arising from a shareholder class action alleging breach of disclosure obligations.
2017-18	**Australian Pipelines and Gas Association** **Allowed rate of return** Advice in relation to the rate of return guideline review being undertaken by the Australian Energy Regulator, including participation in the AER's concurrent expert evidence session one.
2017	**Slater and Gordon/Gasmere Ltd** **Share portfolio valuation** Expert report prepared in relation to Supreme Court of Victoria proceedings brought against Shaw and Partners concerning the appropriate valuation of a share portfolio, the subject of a damages claim following the collapse of Opus Prime.
2016-17	**Allens/QBE** **Shareholder class action** Advice and analysis on the extent of liability and potential damages arising from a shareholder class action alleging breach of QBE's ASX disclosure obligations**.**
2016	**Elliot Legal/Representative proceeding** **Misleading and deceptive conduct** Expert reports in representative proceedings in the Supreme Court of Victoria concerning the effect of certain disclosures on the price of ASX listed securities in Downer EDI Ltd.
2015-16	**Maurice Blackburn/Representative proceeding** **Misleading and deceptive conduct** Expert reports submitted to the Federal Court assessing the effect of alleged misstatements in relation to the annual accounts and associated going concern assumption in relation to Tamaya Resources Ltd (in liquidation).

2013-15	**Sydney Water Corporation** **Cost of capital estimation** Prepare three expert reports for submission to the Independent Pricing and Regulatory Tribunal (IPART) on the framework for determining the weighted average cost of capital for infrastructure service providers, and on estimation of an appropriate equity beta.
2012-15	**HWL Ebsworth/Confidential client** **Insider trading** Expert advice and analysis in the context of criminal proceedings alleging insider trading in certain ASX-listed securities (2012-13). Subsequent expert report filed in Supreme Court of Tasmania estimating price effects of inside information in context of 'proceeds of crime' proceedings.
2014	**Wotton Kearney/Genesys Wealth Advisors** **Misleading and deceptive conduct** Expert report submitted to the Supreme Court of Victoria assessing the accuracy of product disclosure statements and other information in relation to two fixed interest investment funds offered by Basis Capital.
2014	**TransGrid** **Cost of capital estimation** Preparation of an expert report for submission to the Australian Energy Regulator (AER) estimating the weighted average cost of capital for electricity network service providers.
2011-13	**Slater & Gordon/Modtech** **Shareholder damages assessment** Expert reports and testimony in representative proceedings before the Federal Court alleging misstatement and/or breach of the continuous disclosure obligations of the ASX-listed entity, GPT.
2011-12	**Freehills/National Australia Bank** **Shareholder damages assessment** Expert advice in connection with representative proceedings before the Federal Court alleging misstatement and/or breach of the continuous disclosure obligations of an ASX-listed entity.
2012	**Johnson Winter & Slattery/Victorian gas distributors** **Cost of equity estimation** Expert report submitted to the AER on the appropriate methodology for estimating the cost of equity under the capital asset pricing model.
2009-13	**Minter Ellison/Confidential client** **Misleading and deceptive conduct** Expert report and related advice in light of investor claims and pending litigation following the freezing of withdrawals from a fixed interest investment trust that primarily held US-denominated collateralised debt obligations (CDOs), as offered by a major Australian financial institution. Analysis undertaken included the extent to which the investment risks were adequately described in the fund documents, and the quantum of potential damages arising.

Economic impact analysis

2022	**Seyfarth Shaw/Svitzer** **Effect of industrial action by tugboat masters** Expert report and evidence before the Fair Work Commission assessing the economic effect of industrial action by tugboat masters affecting the provision of harbour towage services at container and bulk trade ports in Queensland, NSW, South Australia and Western Australia.
2021	**Seyfarth Shaw/Australian Fresh Produce Alliance** **Earnings of piece rate and hourly paid workers in horticultural sector** Expert reports submitted to the Fair Work Commission in the context of an application brought by the Australian Workers Union, assessing empirical evidence concerning both the level and relative earnings of piece rate and hourly paid workers in the horticultural sector.
2020	**Seyfarth Shaw/Patrick** **Effect of industrial action by stevedores** Expert report submitted to the Fair Work Commission assessing the economic impact on the Australian and NSW economies of notified protected industrial action by stevedores.
2020	**Seyfarth Shaw/DP World** **Effect of industrial action by stevedores** Expert reports submitted to the Fair Work Commission assessing the economic impact on the Australian and NSW economies of notified protected industrial action by stevedores.
2020	**Crown Solicitor for New South Wales** **Relative economic effects of government expenditure decisions** Expert reports and testimony before the NSW Industrial Relations Commission in relation to the relative effects on the NSW economy of salary increases for public sector employees, as compared with increased expenditure on infrastructure projects – in the context of the effects of the Covid-19 pandemic.
2019	**Seyfarth Shaw/Confidential client** **Effect of potential industrial action by stevedores** Analysis and draft expert report in the context of a potential application to the Fair Work Commission addressing the economic effect that various forms of industrial action by stevedores would be likely to have on the Australian economy.
2016-17	**Seyfarth Shaw/Confidential client** **Effect of potential industrial action by stevedores** Analysis and draft expert report in the context of a potential application to the Fair Work Commission addressing the economic effect that various forms of industrial action by stevedores would be likely to have on the Australian economy.
2015-16	**Airservices Australia** **Effect of potential industrial action by air traffic controllers** Analysis and draft expert report in the context of a potential application to the Fair Work Commission addressing the economic effect that certain forms of industrial

action by Air Traffic Controllers would be likely to have on passengers, businesses, and the Australian economy.

2014 — **Confidential client**
Effect of potential industrial action by tug boat operators
Analysis and draft expert report in the context of a potential application to the Fair Work Commission addressing the economic effect that certain forms of industrial action by tug boat operators would be likely to have on iron ore exports and the Australian economy.

2011 — **Freehills/Confidential client**
Effect of potential industrial action by stevedores
Analysis and draft expert report in the context of a potential application to the Fair Work Australia addressing the economic effect that various forms of industrial action by stevedores would be likely to have on the Australian economy.

Valuation and contract analysis

2018-2020 — **DLA Piper/Basslink Pty Ltd**
Damages valuation
Expert reports and testimony in arbitration proceedings concerning the extent of damages arising from the 2016 failure of the Basslink electricity interconnector cable between the Tasmanian and Victorian regions of the national electricity market.

2017-19 — **DLA Piper & Arnold Bloch Leibler/Coal terminal users**
Price review arbitration
Expert reports and testimony in arbitration proceedings concerning the application of the price review clauses in the standard user agreement for Adani Abbot Point coal terminal.

2016 — **SyCip Salazar Hernandez & Gatmaitan/Maynilad Water Services**
Concession contract dispute
Expert reports and testimony in arbitration proceedings concerning the application of the price review clauses in the Manila Water Concession agreements.

2015-16 — **Clyde and Co/Apache Corporation**
Contract dispute
Expert reports submitted in the context of Supreme Court of Victoria proceedings concerning the appointment of receivers for Burrup Fertilisers Pty Ltd, in relation to the market price of gas available to supply an anhydrous ammonia plant on the Burrup Peninsula.

2015-16 — **Raja, Darryl & Loh/Serudong Power Sdn Bhd (SPSB)**
Power purchase agreement arbitration
Expert reports submitted in the context of an international arbitration held in Kuala Lumpur concerning the interpretation of price indexation provisions in a power purchase agreement between SPSB and Sabah Electricity Sdn Bhd.

2015-16 — **Australian Government Solicitor/Commonwealth of Australia**
Native title compensation
Expert reports and testimony before the Federal Court in relation to the native title compensation claim against the Northern Territory for certain acts extinguishing native title in the town of Timber Creek.

2014-15	**Minter Ellison/Foxtel Management Pty Ltd** **Assessment of reasonable licence fee** Expert reports prepared in the context of proceedings before the Copyright Tribunal concerning the appropriate valuation of the rights to be paid by Foxtel for the broadcast and communication of commercial recordings licensed by the Phonographic Performance Company of Australia.
2014-15	**Rahmat Lim & Partners/Port Dickson Power Berhad, Malaysia** **Power purchase agreement arbitration** Expert reports submitted in the context of an arbitration held in Kuala Lumpur concerning the interpretation of the price indexation provisions in a power purchase contract between Port Dickson Power Berhad and Tenaga Nasional Berhad.
2013	**Johnson Winter & Slattery/Origin** **Gas supply agreement price review** Analysis and advice on the implications of certain contract terms for the price of gas, to be determined in a potential arbitration concerning the terms of a substantial long term gas supply agreement.
2013	**Herbert Smith Freehills/Santos** **Gas supply agreement price review** Analysis and advice on factors influencing the market price of gas in eastern Australia, to be determined in a potential arbitration concerning the terms of a substantial long term gas supply agreement.
2012-13	**Herbert Smith Freehills/North West Shelf Gas** **Gas supply agreement arbitration** Expert reports on the implications of certain contract terms for the price of gas under a substantial long term gas supply agreement.
2012-13	**Allens/BHP Billiton-Esso** **Gas supply agreement arbitration** Analysis, advice and expert report on the implications of certain contract terms for the price of gas under a substantial long term gas supply agreement.
2012-13	**Gilbert + Tobin/Rio Tinto Coal Australia** **Price review arbitration** Analysis and expert reports prepared in the context of an arbitration concerning the price to be charged for use of the coal loading facilities at Abbott Point Coal Terminal.
2012	**King & Wood Mallesons/Ausgrid** **Power purchase agreement arbitration** Expert report prepared and filed in an arbitration on the in relation to the effect of the government's newly introduced carbon pricing mechanism on the price to be paid under a long term power purchase and hedge agreement between an electricity generator and retailer.

Institutional and regulatory reform

2008-11	**Department of Sustainability and Environment** **Management of bulk water supply** Advice on the concept and merits of establishing market based arrangements to guide both the day-to-day operation of the bulk water supply system in metropolitan Melbourne, as well as the trading of rights to water between the metropolitan water supply system and those throughout the state of Victoria.

Sworn, transcribed evidence[2]

2022	**Expert evidence before the Federal Court on behalf of Galactic, in the settlement approval of group proceedings concerning 7-Eleven Stores Pty Ltd** Expert report and evidence, Sydney, 29 March 2022
	Expert evidence before the Fair Work Commission on behalf of Svitzer, in the matter of an application to suspend industrial action notified by the Australian Maritime Officers Union. Expert reports, sworn evidence, via videolink, Friday 18 February 2022
2021	**Expert evidence before the Federal Court on behalf of Pitcher Partners, in the matter of the representative proceedings Matthew Hall v Pitcher Partners** Expert reports, sworn evidence, via videolink, 14-16 December 2021
	Expert evidence before the Australian Competition Tribunal on behalf of Port of Newcastle Operations, in the matter of an application for redetermination of a collective bargaining authorisation decision by the Australian Competition and Consumer Commission Expert reports, sworn evidence, via videolink, 13 October 2021
	Expert evidence before the Supreme Court of Western Australia on behalf of Perth Airport, in the matter of Perth Airport v Qantas Group Expert reports, sworn evidence, via videolink, 5-8 October 2021
	Expert evidence before the Fair Work Commission on behalf of the Australian Fresh Produce Alliance, in the matter of an application by the Australian Workers Union to vary the Horticultural Workers Award 2020 Expert reports, sworn evidence, via videolink, 20 July 2021
	Expert evidence before the Federal Court on behalf of Aucham Superfund, in the matter of the Aucham Superfund v Iluka Resources Limited Expert reports, sworn evidence, via videolink, 8-9 April 2021
2020	**Expert evidence before the NSW Industrial Relations Commission on behalf of the Crown Solicitor for NSW, in the matter of the Crown Employees (Police Officers) and Paramedics and Control Centre Officers' awards** Expert reports, sworn evidence, Parramatta, 7-8 October and 13 November 2020

[2] Past ten years only.

Expert evidence before Hon Robert French AC on behalf of Basslink Pty Ltd, in the matter of the State of Tasmania and Hydro Electric Corporation v Basslink Pty Ltd
Expert reports, sworn evidence, via videolink, 13-14 October 2020

Expert evidence before the Supreme Court of Victoria on behalf of Australian Funding Partners, in the matter of Laurence John Bolitho v Banksia Securities Limited
Expert reports, sworn evidence, via videolink to Melbourne, 4 August 2020.

Expert evidence before the Supreme Court of Queensland on behalf of the QCoal group and Lake Vermont Resources, in the matter of Adani Abbot Point v QCoal, Sonoma Mine Management and Byerwen Coal (the QCoal Group), and Lake Vermont Resources
Expert reports, sworn evidence, Brisbane, 28 February 2020

2019

Expert evidence before the Federal Court on behalf of Ramsay Healthcare, in the matter of ACCC v Ramsay Healthcare
Expert reports, sworn evidence, Sydney, 9-10 December 2019

Expert evidence before Hon Michael McHugh AM, on behalf of the QCoal Group and Lake Vermont Resources, in the matter of Adani Abbot Point Terminal v QCoal, Sonoma Mine Management and Byerwen Coal (the QCoal Group), and Lake Vermont Resources
Expert reports, sworn evidence, Brisbane, 21 February 2019

2018

Expert evidence before the Federal Court on behalf of TPT Patrol, in the matter of TPT Patrol v Myer
Expert reports, sworn evidence, Melbourne 23 August 2018

Expert evidence before the Board of the Australian Energy Regulator, on behalf of the South Australian public lighting customers, in arbitration proceedings concerning public lighting charges
Expert reports, transcribed evidence, Melbourne, 7 May 2018

Expert evidence before the Board of the Australian Energy Regulator, on behalf of the Australian Pipelines and Gas Association, in the Review of Rate of Return Guidelines, Concurrent expert evidence session one
Joint expert report, transcribed evidence, Sydney, 15 March 2018

Expert evidence before the Federal Court on behalf of Changshu Longte Grinding Ball Co Ltd, in the matter of Changshu Longte v Anti-Dumping Review Panel and others.
Expert reports, sworn evidence, Sydney, 1 February 2018

2017

Expert evidence before the Competition Tribunal on behalf of CrownBet, in the application by Tabcorp for authorisation to acquire Tatts
Expert reports, sworn evidence, Melbourne, 30 May–1 June 2017

2016

Expert evidence before the Federal Court on behalf of Generic Health, in the matter of Bayer Pharma Aktiengesellschaft v Generic Health Pty Ltd
Expert reports, sworn evidence, Sydney, 14-15 December 2016

Testimony before an UNCITRAL arbitral tribunal on behalf of Maynilad Water Service Inc (MWSI), in the matter of MWSI v Republic of the Philippines
Report, sworn evidence, Singapore, 6 December 2016

Expert evidence on behalf of Powerco, at the Commerce Commission's Conference on the Cost of Capital matters
Transcribed evidence, public hearings, Wellington, 7 September 2016

Expert evidence before the Federal Court on behalf of plaintiffs, in the matter of HFPS v Tamaya
Expert reports, sworn evidence, Sydney, 13 May 2016

Expert evidence before an arbitral tribunal on behalf of Serudong Power Sdn Bhd (SPSB), in the matter of SPSB v Sabah Electricity Sdn Bhd (SESB)
Expert reports, sworn evidence, Kuala Lumpur, 27-28 April 2016

Expert evidence before the Federal Court on behalf of the Commonwealth of Australia, in the matter of Griffiths v Northern Territory
Expert reports, sworn evidence, Darwin, 24-25 February 2016

2015

Expert evidence before an arbitral tribunal on behalf of Port Dickson Power Berhad (PDP), in the matter of PDP v Tenaga Nasional Berhad (TNB)
Expert reports, sworn evidence, Kuala Lumpur, 28 January 2015

2014

Expert evidence before an UNCITRAL arbitral tribunal on behalf of Manila Water Corporation Inc (MWCI) in the matter of MWCI v Metropolitan Waterworks and Sewerage System (MWSS)
Expert reports, sworn evidence, Sydney (by videolink to Manila), 31 August 2014

Expert evidence before the Australian Competition Tribunal on behalf of the ACCC, in the matter of AGL Energy v ACCC
Expert reports, sworn evidence, Sydney, 10-11 June 2014

2013

Expert evidence before the Supreme Court of Victoria on behalf of Maddingley Brown Coal in the matter of Maddingley Brown Coal v Environment Protection Agency of Victoria
Expert reports, sworn evidence, Melbourne, 12 August 2013

Expert evidence before the Federal Court on behalf of Modtech in the matter of Modtech v GPT Management and Others
Expert reports, sworn evidence, Melbourne, 27 March 2013

2012

Expert evidence before the Supreme Court of Queensland on behalf of Origin Energy, in the matter of Origin Energy Electricity Ltd and Others v Queensland Competition Authority and Others
Expert reports, sworn evidence, Brisbane, 3 December 2012

Speeches and publications[3]

2019

RBC Renewables and energy transition forum
Economic and regulatory forces affecting the transition
Panel discussant, Sydney, 12 September 2019

Competition Matters conference
Competition issues for Digital platforms
Panel discussant, Auckland, 26 July 2019

[3] Past ten years only

Competition Law Conference
Proof of collusion, or optical illusion?
Speech, Sydney, 25 May 2019

Clayton Utz – Equitable briefing series
Expert joint conferencing and reports
Panel discussant, Sydney, 16 May 2019

2018

RBC Capital Markets Global Infrastructure Forum
Australian utilities: current policy issues and industry trends
Panel discussant, Sydney, 13 March 2018

GCR 7th Annual Asia Pacific Law Leaders Forum
The role of algorithms: cartel enforcement in the era of artificial intelligence
Panel discussant, Singapore, 10 March 2018

2017

IPART 25th Anniversary Conference
Electricity and Water: Mutual Lessons
Speech, Sydney, 27 October 2017

Competition Law Conference
ACCC v Flight Centre: What was going on?
Speech, Sydney, 6 May 2017

Association for Data-driven Marketing and Advertising
Driving Customers to you: Insights from Location Data
Speech, Melbourne, 5 April 2017

GCR 6th Annual Asia Pacific Law Leaders Forum
Roadblocks and Solutions in Cross Border Mergers
Panel discussant, Singapore, 2 March 2017

2016

NSW Planning Assessment Commission
Economic Effects of Drayton South Mine on Upper Hunter Industry
Presentation to public hearing, Muswellbrook, 16 November 2016

2015

Electricity Networks Association Regulation Seminar, Brisbane
Participant in Expert Plenary Panel
Speech, Brisbane, 5 August 2015

NZ Commerce Commission Input Methodologies Review, Wellington
'Allocation of Risk' and 'New Technologies'
Panel Discussant, Wellington, 29 July 2015

Competition Matters Conference, Wellington
Disruptive Technologies
Chair, Discussion Panel, Wellington, 24 July 2015

Competition Law Conference
The Public Interest in Private Enforcement
Speech, Sydney, 30 May 2015

Singapore Aviation Academy, Singapore
Private Financing of Airport Infrastructure Expansions
Speech, Singapore, 5 March 2015

GCR 4th Annual Asia-Pacific Law Leaders Forum
Differences in using economics in EU and Asia Pacific
Speech, Singapore, 5 March 2015

AEMC Public Forum
East Coast Gas Market Review
Speech, Sydney, 25 February 2015

2014

Competition and Consumer Workshop, Law Council of Australia
An Economist's Take on Taking Advantage
Paper and Speech, Brisbane, 14 September 2014

Energy Networks 2014
Innovation and Economic Regulation
Speech, Melbourne, 1 May 2014

The Network Industries Quarterly, *Consumer Advocacy in Australian Regulatory Decision Making – 'Hard Choices Await',* Vol. 16, No 1, 2014
Ecole Polytechnique Federale de Lausanne, 31 March 2014

GCR 3rd Annual Law Leaders Asia Pacific
Role of Economists in Competition Law Enforcement in Asia-Pacific
Speech, Singapore, 6 March 2014

2013

University of South Australia – Competition and Consumer Workshop
Empirical test and collusive behaviour
Speech and participation game, Adelaide, 16 November 2013

Energy in WA Conference
Capacity Payments in the WEM – Time to Switch?
Panel Discussion, Perth, 21 August 2013

ACCC/AER Regulatory Conference
Designing Customer Engagement
Speech, Brisbane, 25 July 2013

Victorian Reinsurance Discussion Group
Australian Mining – When Opportunities and Risk Collide
Speech, Melbourne, 1 March 2013

NZ Downstream Conference
Investment and Regulation
Panel Discussion, Auckland, 25 July 2013

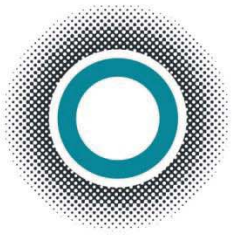
2012

Rising Stars Competition Law Workshop
Expert Evidence in Competition Cases
Speech, Sydney, 24 November 2012

KPPU – Workshop on the Economics of Merger Analysis
Theories and Methods for Measuring the Competitive Effects of Mergers
Speech, Bali, 19-21 November 2012

University of South Australia – Competition and Consumer Workshop
Reflections on Part IIIA of the Competition Act
Speech, Adelaide, 12 October 2012

NZ Downstream Conference
Lines company consolidation – what are the benefits and risks?
Panel discussion, Auckland, 6-7 March 2012



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