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AUSTRALIAN COMPETITION TRIBUNAL

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Lodgment and Details

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File Title:	RMSANZ APPLICATION FOR REVIEW OF AUTHORISATION AA1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
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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.

COMMONWEALTH OF AUSTRALIA

Competition and Consumer Act 2010 (Cth)

IN THE AUSTRALIAN COMPETITION TRIBUNAL

File No: ACT 4 of 2021 and ACT 5 of 2021

Re: Application for review of authorisation AA1000542 lodged by nib Health Funds Ltd and Honeysuckle Health Pty Ltd and the determination made by ACCC on 21 September 2021.

Applicants: National Association of Practising Psychiatrists and Rehabilitation Medicine Society of Australia and New Zealand

SUBMISSIONS OF NIB HEALTH FUNDS LTD AND HONEYSUCKLE HEALTH PTY LTD

PART A: OVERVIEW

1. On 21 September 2021, the Australian Competition and Consumer Commission (**ACCC**) authorised nib Health Funds Ltd (**nib**) and Honeysuckle Health Pty Ltd (**HH**) (the **Authorisation Applicants**) to form and operate a buying group (the **Buying Group**) to supply contracting services to private health insurers (**PHIs**) and other healthcare payers, other than "Major PHIs".[1] The **Proposed Conduct**, including the meaning of contracting services, is described in **Part B** below**.** HH currently supplies those services to nib.

2. The National Association of Practising Psychiatrists (**NAPP**) and the Rehabilitation Medicine Society of Australia and New Zealand (**RMSANZ**) (the **Applicants**) seek review of the ACCC's determination (the **Authorisation**). The Australian Medical Association (**AMA**) has leave to intervene. The statutory framework for that review is set out in **Part C** below. A brief summary of the evidence is set out in **Part D**.

3. The Applicants and the AMA are concerned with the specific terms of the contracts that the Buying Group has negotiated with medical specialists under its Broad Clinical Partners Program (**BCPP**), being terms directed to achieving a value based contracting model (as opposed to the existing fee for service model). Value based contracting is intended to lead to better *value* care (that is better *or equitable* health outcomes for equitable or lower costs (c.f. NAPP/RMSANZ [8]). The BCPP has been in operation since 2019. At present, it comprises 35 specialists who have agreed to provide hip and knee joint replacement surgery and to refer clinically appropriate patients to an at-home rehabilitation program, with no out of pocket costs to nib's customers.[2] The "value" derives from at-home rehabilitation which, for appropriate patients following hip and knee joint replacement, achieves better or equitable health outcomes for lower costs than in-patient rehabilitation. The BCPP is facilitated through medical purchaser provider agreements (**MPPAs**) with medical specialists that include, amongst other terms, target percentages for referrals to at-home rehabilitation. The Authorisation Applicants propose to offer the BCPP to Buying Group participants and ultimately to extend and adapt the contracting model for other procedures and specialty areas.

4. In their statements of facts, issues and contentions (**SOFICs**), the Applicants sought by this review to vary the Authorisation by adding conditions that the Authorisation Applicants be precluded from including in MPPAs terms they say may undermine the clinical

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1 Medibank Private Limited, Bupa HI Pty Ltd, Hospitals Contribution Fund of Australia Limited, or HBF Health Limited in Western Australia (collectively the **Major PHIs**). All other PHIs are referred to as **Minor PHIs**. The Authorisation Applicants, and the application for authorisation are described fully in Part D of the affidavit of David Du Plessis dated 13 June 2022 (**Du Plessis affidavit**) [8]-[11] and [165]-[172].

2 Du Plessis affidavit [84].

independence of medical specialists.[3] The Applicants maintain that claim in their submissions (NAPP/ RMSANZ [4], [5(c)]). The AMA in its application for leave to intervene also sought to vary the Authorisation to add such conditions and to require the Authorisation Applicants to continue to offer a gap scheme to medical specialists no less favourable than existing schemes.[4]

5. In a departure from their SOFICs, and despite not taking issue with most of the conduct authorised by the Authorisation,[5] the Applicants now seek to have the entirety of the Authorisation set aside (NAPP/ RMSANZ [3]). Alternatively, the Applicants seek to exclude psychiatrists and rehabilitation medicine specialists from the scope of the conduct the subject of the Authorisation.[6] Nevertheless, it is apparent from the Applicants' submissions that their concern remains, in substance, the terms of the MPPA for the BCPP (NAPP/RMSANZ [6], [9]).

6. Many of the Applicants' concerns about the MPPA misunderstand the effect of its terms in relation to clinical independence, guidelines, and confidentiality. The Applicants also incorrectly assume that the terms of the template MPPA can or will be applied *ceteris paribus* to other procedures or specialty areas, despite the evidence to the contrary. It should be recalled that the Authorisation Applicants do not oppose the conditions proposed by the Applicants and AMA, other than in relation to targets.[7] Those conditions put beyond any doubt that the MPPAs do not have the effect alleged.

7. The Applicants' concern about the use of targets to facilitate value based contracting fails to appreciate the purpose of the authorisation[8] and the fact that PHIs can, do, and will unilaterally negotiate contracts with medical specialists and other health providers containing such terms in the absence of authorisation. The Applicants describe the inclusion of such terms in medical contracts as "unprecedented" (NAPP/RMSANZ [101]). To the contrary, nib has included such terms in contracts for the BCPP since 2019. In the absence of authorisation, it is open to all PHIs to negotiate such terms in contracts with

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3 NAPP SOFIC [137(b)]; [138]; RMSANZ SOFIC [163(b)].

4 AMA submission p 17.

5 The Applicants do not object to the Buying Group supplying contracting services for hospital contracting, medical gap schemes or general treatment networks: see NAPP/RMSANZ [2]. The AMA does not object to the Buying Group engaging in hospital contracting other than to the extent it imposes conditions on medical specialists: statement of Omar Khorshid dated 14 June 2022 (**Khorshid statement**) [13].

6 NAPP/RMSANZ [5(b)]. The Authorisation Applicants assume by this, the Applicants intend to exclude the Authorisation Applicants from supplying to Buying Group participants medical specialist contracting services in relation to the BCPP for psychiatrists and rehabilitation medicine specialists.

7 Authorisation Applicants' SOFIC [95].

8 That is, to engage in conduct that would breach the prohibitions against cartel conduct, anti-competitive agreements and exclusive dealing in, respectively, Division 1 of Part IV and ss 45 and 47 of the Act.

medical specialists if they have the resources to do so, including access to sufficient data and data analytics to negotiate and manage those contracts.

8. To date, only Major PHIs have had those resources at sufficient scale. Allowing the collective negotiation and management of those contracts (and the other proposed contracting services) will allow the Buying Group to compete with existing buying groups and offer an alternative contracting model, including the BCPP, underpinned by better data and data analytics. The relevant markets and key features of those markets are summarised in **Part E**. For the reasons explained in **Part F**, the conduct proposed by the Authorisation Applicants is likely to increase competition in the market for the supply of health provider contracting services (particularly to Minor PHIs) and will have flow on benefits in the market for private health insurance by increasing the take-up and quality of private health insurance. In particular, it will result in pass-through of higher quality or lower cost private health insurance policies, increase the competitive constraint on Major PHIs and increase cost certainty for consumers.

9. In addition, the Authorisation Applicants submit that the Tribunal should **vary** the Authorisation to allow Major PHIs to join the Buying Group (for the BCPP only). This will further benefit competition in the market for health provider contracting services and increase the scale of the public benefits in other dependent markets for the reasons explained in **Part F** below. The Authorisation Applicants also submit that the Tribunal should extend the period of authorisation from five to 10 years to allow the public benefits of the proposed conduct to be fully realised, as set out in **Part G** below. The Applicants oppose those variations (NAPP/RMSANZ [10]).

10. Although it is for the Tribunal to be satisfied of the statutory test in respect of the whole of the conduct, it is appropriate for the Tribunal to focus on the matters in issue between the parties on the review: see paragraph 17 below. Accordingly, these submissions address those matters, having regard to the Applicants' submissions. For the reasons set out in these submissions, the Tribunal should be satisfied that the proposed conduct (in comparison with the likely future without the proposed conduct) would likely result in public benefits and no material detriments to the public and accordingly should **affirm** the Authorisation with the variations proposed by the Authorisation Applicants.

PART B: THE PROPOSED CONDUCT

11. The Authorisation described the conduct authorised as "the formation and operation of the HH buying group by HH, including the BCPP, involving the provision of services to Authorised Entities" and "the acquisition of contracting services by Authorised Entities from

HH".[9] The "Authorised Entities" were PHIs (other than Major PHIs), international medical and travel insurance companies, government and semi-government payers of healthcare services and any other payer of healthcare services notified to the ACCC.[10]

12. The meaning of "contracting services" was explained in the ACCC's determination (the **Determination**)[11] and the Authorisation Applicants' application as meaning:[12]

    (a) the following services:

        (i) contract negotiations and drafting;

        (ii) contract administration and management;

        (iii) dispute resolution;

        (iv) data analytics;

        (v) administration and management of medical gap schemes and general treatment networks;

        (vi) performance and compliance assessment of providers;

    (b) supplied in relation to arrangements for funding health services between Buying Group participants and:

        (i) hospitals (by way of hospital purchaser provider agreements);

        (ii) medical specialists (by way of medical gap schemes and MPPAs, including the BCPP);

        (iii) general practitioners, allied health professionals or other health providers (by way of general treatment networks).

13. HH currently supplies all of the contracting services to nib.[13]

14. Participants in the Buying Group (except the Major PHIs) will be able to purchase some or all of the contracting services; Major PHIs will only be permitted to purchase the contracting services in relation to the BCPP[14] (together with the formation and operation of the Buying Group, the **Proposed Conduct**).

PART C: STATUTORY FRAMEWORK FOR THE TRIBUNAL'S REVIEW

Nature of the Tribunal's review

15. Section 88 of the Act empowers the ACCC to grant an authorisation to a person to engage in conduct, specified in the authorisation, to which one or more provisions of Pt IV specified

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9 ACCC Determination [5.7].
10 ACCC Determination [5.6].
11 ACCC Determination [1.24] to [1.36].
12 Du Plessis affidavit [168] and DD-59; in relation to the BCPP specifically see Du Plessis affidavit [183]-[195].
13 Du Plessis affidavit [11].
14 Du Plessis affidavit at [174]-[176]; DD-59.

in the authorisation would or might apply. In this case, the Authorisation is in respect of the cartel provisions in Division 1 of Part IV of the Act and the anti-competitive agreement provisions of ss 45 and 47 of the Act. While the authorisation remains in force, those provisions do not apply to the authorised conduct.

16. Section 101 of the Act provides that a person dissatisfied with such a determination may apply to the Tribunal for a review of the determination. Section 102 provides that, on review, the Tribunal may make a determination affirming, setting aside or varying the determination of the ACCC and, for the purposes of the review, may perform all the functions and exercise all the powers of the ACCC. The review is a review *de novo*. In *Application by Port of Newcastle Operations Pty Limited (No 2)* [2022] ACompT 1 (***PNO No 2***) (O'Bryan J, Mr D Abraham and Ms D Eilert) at [20] the Tribunal summarised the nature of the review in the following terms:

> As the Tribunal observed in *Application by Flexigroup Ltd (No 2)* [2020] ACompT 2 (***Flexigroup***) at [107], a review under s 101 is a de novo review, meaning that the Tribunal conducts a fresh hearing and determination of the authorisation. The Tribunal must "make its own findings of fact and reach its own decision as to whether authorisation should be granted or not and, if so, any conditions to which it is to be subject": *Application by Medicines Australia Inc* [2007] ACompT 4; ATPR 42-164 (***Medicines Australia***) at [135] (French J, Mr G Latta and Prof C Walsh); *Flexigroup* at [135]. That function is not performed by considering "whether the ACCC was right or wrong in the conclusion it reached or whether it could have better formulated its determination". Rather, the Tribunal must "assess the applications for authorisation on their merits and by reference to the information and evidence given to the ACCC and any material that the parties wish to put before the Tribunal": *Medicines Australia* at [138].

17. The Tribunal is not confined by the issues raised by the parties, but is nevertheless required to determine an application within the context of those issues and the issues otherwise raised by the Tribunal: *PNO No 2* at [21]. As explained by the Tribunal in *Re 7-Eleven Stores Pty Ltd* [1998] ACompT 3; ATPR 41-666 at 41,453:

> where the applicants and other parties participating in proceedings before the Tribunal agree with findings on factual matters set out in the Commission's published reasons for determination, the Tribunal would ordinarily be justified in treating those findings as common ground which significantly limits the areas of primary fact which the Tribunal is itself required to examine in detail; see *Re Herald & Weekly Times Ltd (Media Council of Australia (No 1))* (1978) ATPR ¶40-058 at 17,601; (1978) 17 ALR 281 at 296 where the Tribunal (Deane J, President, Shipton and Walker, Members) observed that fairness and common sense combine to require that the Tribunal determine an application for review within the context of matters which can properly be seen to be in issue between the parties or which the Tribunal itself raises or indicates that it regards as being at large.

Statutory precondition for authorisation

18. The precondition for the grant of authorisation is that stated in s 90(7)(b) of the Act, namely that the conduct would result, or be likely to result, in a benefit to the public and the benefit would outweigh the detriment to the public that would result, or be likely to result, from the conduct (**net public benefit**). Thus, the statutory test requires the ACCC, and the Tribunal

on review, to compare the future with the conduct and without the conduct: *Flexigroup* at [137]; *Medicines Australia* at [117].

19. The satisfaction of the statutory precondition does not oblige the Tribunal on review to grant authorisation: *Medicines Australia* at [106]; however, if the Tribunal were so satisfied, ordinarily authorisation would be granted: *Flexigroup* at [138].

20. In *PNO (No 2)* at [27] the Tribunal summarised the meaning of public benefit and detriment in the following terms:

> A benefit to the public includes "anything of value to the community generally, any contribution to the aims pursued by society including as one of its principal elements (in the context of trade practices legislation) the achievement of the economic goals of efficiency and progress": [*Re Queensland Co-operative Milling Association Ltd* (1976) 8 ALR 481] at 507-8; *Medicines Australia* at [107]. The relevant "public" is the Australian public: *Re Qantas Airways Ltd* [2004] ACompT 9; (2005) ATPR 42-065 (***Qantas Airways***) at [196] citing *Re Howard Smith Industries Pty Ltd* (1977) 28 FLR 385 at 392. Similarly, a detriment to the public includes "any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency": *Re 7-Eleven Stores Pty Ltd* [1994] ATPR 41-357 at 42,683 (Lockhart J, Prof M Brunt and Dr B Aldrich).

21. In assessing whether an increase in economic efficiency constitutes a public benefit, the total welfare or surplus standard of economic efficiency applies: *Qantas Airways* at [187]-[189]. As the Tribunal explained in *PNO No 2*, this means that cost savings (productive efficiency gains) will constitute a public benefit even if the efficiency gain is captured in the first instance by the (private) parties to the proposed conduct.

22. The important public detriments will tend to be the anti-competitive effects (if any) of the proposed conduct. As the Tribunal explained in *Medicines Australia* at [108]:

> Although "detriment" covers a wider field than anti-competitive effects in many cases the important detriments will have that character. The relevant detriment will flow from the anti-competitive effect of the conduct to which authorisation is sought. This does not exclude consideration of other detriments which may be incidental to and therefore detract from a claimed public benefit. To that extent such detriment will be relevant in weighing the public benefit.

PART D: THE EVIDENCE

23. The Authorisation Applicants rely on the Du Plessis affidavit and the expert evidence of Mr Greg Houston (the **Houston report**).

24. Mr Du Plessis is the head of health contracting services at HH; he previously held the same position for nib.[15] He has been responsible for hospital and health contracting for the Authorisation Applicants for six years. By reason of his position, and his experience in

15 Du Plessis affidavit [1], [12].

the health services industry, he is able to give evidence about the relevant markets, health services contracting, and other services provided by PHIs and buying groups.[16]

25. Mr Houston is an experienced economist. He holds a BSc(Hons) in Economics, is a founding partner of the economic consulting firm HoustonKemp, and has over thirty years' experience in the economic analysis of markets.[17]

26. Mr Du Plessis's and Mr Houston's evidence will be subject to cross-examination. There are no challenges to the admissibility of their evidence.

PART E: RELEVANT MARKETS

27. The Authorisation Applicants submit, consistently with Mr Houston's analysis, that the primary market in which the Proposed Conduct is to be considered is an Australia-wide market for the supply of health provider contracting services. [18] The Proposed Conduct is also likely to have flow on effects in other dependent markets: a national market for private health insurance (and separately for international medical and travel insurance); local markets for medical services for each medical speciality; and local markets for hospital services.[19] Key features of the relevant markets are set out below.

Health provider contracting services market

28. There is a national market for health provider contracting services.[20] Health provider contracting services are supplied by the Major PHIs, HH and two buying groups that engage in collective negotiation on behalf of their members. The Major PHIs supply their own contracting services internally; nib purchases contracting services from HH; 23 Minor PHIs purchase contracting services from the Australian Health Services Alliance (**AHSA**) and 4 Minor PHIs purchase contracting services from the Australian Regional Health Group (**ARHG**).[21]

29. In the counterfactual, HH will continue to supply contracting services to nib. HH will also offer contracting services in relation to the BCPP to other Major PHIs on a unilateral basis (it will not collectively bargain or share data and analysis across participating PHIs).[22] HH

16 Du Plessis affidavit [16].
17 Houston report [10]-[13].
18 Houston report [7]-[9]; [86]-[88].
19 Given the issues in dispute between the parties, these submissions do not address effects in the markets for international medical and travel insurance and hospital services.
20 Houston report [94]-[100]; see also ACCC Determination [4.7].
21 Du Plessis affidavit [103]-[104].
22 Du Plessis affidavit [293].

is unlikely to offer contracting services to Minor PHIs other than for general treatment networks (again, on a unilateral basis).[23]

Private health insurance market

30. PHIs compete in a national market for private health insurance.[24] Both Mr Houston and the ACCC reached this conclusion, given that each PHI is registered to operate on a national basis[25] and offers similar private health insurance products across Australia.[26] There are geographic variations in the market share of PHIs in this national market.[27]

31. The market is highly regulated.[28] PHIs must classify products into pre-defined tiers of minimum clinical categories,[29] PHIs must notify customers of detrimental changes to coverage,[30] and insurance premium increases require ministerial approval.[31]

32. PHIs compete with each other in relation to price and additional services covered above minimum clinical categories.[32] Customers can (and do) switch PHIs without incurring detriments in the form of waiting times or exclusions.[33]

Medical specialist services market

33. Medical specialists compete in local markets for each medical specialty.[34] There are approximately 100,000 medical specialists in Australia across different specialties.[35] Of the specialties represented by the Applicants, there are approximately 1,653 psychiatrists and 170 rehabilitation medicine specialists in the private health system.[36]

34. PHIs can only pay for medical specialist services in hospital.[37] Currently, medical specialists are paid for services provided to private patients in hospitals in one of four ways: *first,* charging the Medicare Benefits Schedule Fee (**Schedule Fee**), of which 25 per cent is paid by the patient's PHI and 75 per cent by Medicare;[38] *second,* charging a fee higher than the Schedule Fee and collecting the "gap" from the patient or their PHI;[39]

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23 Du Plessis affidavit [293]-[297].
24 Houston report [105], [108]; ACCC Determination [4.6].
25 Du Plessis affidavit [33].
26 Du Plessis affidavit [41]-[43].
27 Du Plessis affidavit [34]-[35].
28 Houston report [139(c)].
29 Du Plessis affidavit [41]-[43].
30 Du Plessis affidavit [51]-[54].
31 Du Plessis affidavit [48]-[50].
32 Houston report [106]; Du Plessis affidavit [44]-[47] and DD-13.
33 Du Plessis affidavit [36]-[40].
34 Houston report [112].
35 Du Plessis affidavit [25].
36 Du Plessis affidavit [26].
37 Du Plessis affidavit [60].
38 Du Plessis affidavit [61]; see also [57]-[58].
39 Du Plessis affidavit [62].

third, accepting the amount offered by the patient's PHI under a medical gap scheme and charging the patient the gap (if any) allowed under that scheme;[40] or *fourth,* accepting an amount agreed with the patient's PHI under an MPPA.

35. All PHIs operate medical gap schemes: either "no gap" schemes (where the specialist cannot charge the patient an extra fee) or "known gap" schemes (where the specialist can charge the patient up to a fixed extra fee).[41] The terms and conditions of medical gap schemes are not negotiated; rather, PHIs publish their terms and conditions and specialists apply to register for the schemes.[42] Specialists who register for the schemes generally may opt in or out on a case by case basis per procedure or patient.[43]

36. Some PHIs (including nib) contract directly with specialists using other forms of MPPAs.[44] Commonly, Major PHIs use MPPAs to contract with radiologists and pathologists in the PHI's "hospital network".[45] More recently, some Major PHIs, including nib, have used MPPAs to establish programs like the BCPP.[46]

PART F: NET PUBLIC BENEFITS

Future with and without the Proposed Conduct

37. In applying the net public benefits test, the Tribunal must compare the future with and without the Proposed Conduct: see paragraph 18 above. Having regard to the scope of the issues in dispute, the difference between the future with and without the Proposed Conduct is that, in the future with the Proposed Conduct Minor PHIs will have the alternative option of joining the Buying Group for purchasing all health provider contracting services and Major PHIs will have the alternative option of joining the Buying Group for the BCPP.[47]

PUBLIC BENEFITS

Benefits of increased competition in the market for health provider contracting services

38. The establishment of the Buying Group will increase competition in the market for health provider contracting services, which will increase the quality of, and put downward pressure on the price of, health provider contracting services. These are public benefits under s 90(7)(b) of the Act.

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40 Du Plessis affidavit [62], [68].
41 Du Plessis affidavit [73] and Annexure DD-20.
42 Du Plessis affidavit [67]-[70].
43 Du Plessis affidavit [67], [69].
44 Du Plessis affidavit [81].
45 Du Plessis affidavit [81]-[83].
46 Du Plessis affidavit [84], [87]-[89].
47 Houston report [5]-[6]; [59]-[60].

39. As the ACCC correctly found,[48] and as explained in the Houston report,[49] the addition of a buying group with a differentiated model of contracting and funding will increase competition and thereby efficiency and total surplus. Mr Houston's conclusions are not contradicted by any other expert evidence.[50]

40. In Mr Houston's expert opinion, competition between buying groups is presently weak: there are only two buying groups, one of which (ARHG) does not impose a competitive constraint on the other (AHSA), given its small size and geographically limited coverage; there is no switching; and there are high barriers to entry.[51] In those circumstances, the addition of the Buying Group will significantly improve competition, which will improve the quality of, and put downward pressure on the price of, health provider contracting services.[52] Mr Du Plessis's evidence establishes efficiency gains for participants switching from existing buying groups in the form of a modelled [redacted] lower cost base (and hence membership fee) compared with AHSA at comparable scale)[53] and a broader scope of contracting services (c.f. NAPP/ RMSANZ [74]).

41. The Buying Group offers a differentiated service to existing market offerings in four key respects. [redacted] *Second*, it offers an alternative model of value based contracting, which smaller PHIs do not have the scale and capability to achieve on their own and existing buying groups do not have the resources and expertise to establish.[55] *Third,* it offers superior access to data and data analytics compared with existing buying groups.[56] *Fourth,* it offers a combination of hospital and medical specialist contracting, including for the BCPP and general treatment networks,[57] whereas existing buying groups focus on hospital contracting.[58] The Applicants' attempts to equate the BCPP with AHSA's offerings (NAPP/ RMSANZ [75]) are undermined by the lack of any evidence that AHSA operates similar models, AHSA's public statements,[59] and

48 ACCC Determination [4.19].
49 Houston report [125]-[135].
50 See Siolis report [62] and [24]-[26].
51 Houston report [125]-[129].
52 Houston report [130]-[134].
53 Du Plessis affidavit [234] and DD-60.
54 [redacted]
55 Du Plessis affidavit [211]-[212]; [219]-[222].
56 Du Plessis affidavit [216]-[225].
57 Du Plessis affidavit [297].
58 Du Plessis affidavit [110]; [212]-[214] and [234].
59 Authorisation Applicants' response to ACCC dated 9 March 2021 [1.9]-[1.10].

the Applicants' assertions in these proceedings about value based contracting and the "unprecedented" nature of the BCPP.

42. The Buying Group also offers a differentiated service for Major PHIs joining for the BCPP because of HH's superior data analytics and access to aggregated participant data.[60] Joining for the BCPP offers efficiencies for Major PHIs, given the time and cost of establishing such a model[61] (see paragraph 56 below; c.f. NAPP/ RMSANZ [78]).

43. If PHIs choose the Buying Group's services (including if Major PHIs choose the BCPP), it will be because the Buying Group offers better price or quality for PHIs than existing options.[62] This too, in Mr Houston's expert opinion, increases total surplus.[63]

44. The Applicants adopt Mr Siolis's opinion that the introduction of the Buying Group may reduce competitive pressures (NAPP/ RMSANZ [81]). That opinion appears to be based on the premise that Minor PHIs' lack of access to value based contracting is a competitive constraint on Major PHIs.[64] That premise is wrong: as the evidence establishes, and the ACCC correctly found, Major PHIs have developed, and are likely to continue to develop, such models.[65] The constraints on adopting those models arise not from the inability of the Minor PHIs to do so, but from cost and access to data.[66]

Lower cost and higher quality products in the private health insurance market

45. In turn, as the ACCC correctly recognised[67] and as explained in the Houston report,[68] increased competition in the market for health provider contracting services will have flow-on effects in the market for private health insurance, in the form of lower cost or higher quality private health insurance products and, consequently, increased demand for private health insurance. These are public benefits under s 90(7)(b) of the Act.

46. The Authorisation Applicants rely on Mr Houston's expert opinion that these benefits are likely to arise in the following three ways.

Consumer pass through

47. *First*, PHIs are likely to pass through health provider contracting cost savings to consumers (in the form of lower premiums or increases) and higher quality health insurance

60 Du Plessis affidavit [214]; see also [148]-[157].
61 Du Plessis affidavit [213], [233] and [249].
62 Houston report [133].
63 Houston report [134].
64 Siolis report [62], [45]-[47].
65 Du Plessis affidavit [84]-[85], [87]-[91] and [295]; ACCC Determination [4.163].
66 Du Plessis affidavit [219]-[221].
67 ACCC Determination [4.19] and [4.34]; see also [4.52] and [4.58].
68 Houston report [136]-[140].

products.[69] Mr Houston's opinion is that pass through of most savings can be presumed, given: *first,* the structure of the market implies competition is effective, which generally implies full pass through; *second,* savings will be in marginal costs because Buying Group fees will be based on PHIs' customer numbers; and *third,* the market is highly regulated.[70] Mr Houston's opinion is consistent with Mr Du Plessis's evidence that reduced costs put downward pressure on premiums or premium increases.[71]

48. The Applicants contend that cost savings are likely to be captured rather than passed through to consumers (NAPP/ RMSANZ [55], [62]). That contention should be rejected: it misunderstands the nature, and ignores the evidence, of the likely costs savings, and its premise of ineffective competition is not made out. In any event, even captured cost savings would be a public benefit in the relevant sense: see paragraph 21 above.

49. At the outset, the Applicants adopt an incorrectly narrow view of cost savings: that is, only cost savings arising from the value based contracting model (NAPP/ RMSANZ [55]). Cost savings are not limited to the BCPP but extend to savings resulting from lower membership fees (see paragraph 40 above) and likely outcomes from the range of contracting services engaged in by the Buying Group (including for hospitals and gap schemes). That the Buying Group is likely to achieve competitive contracting outcomes compared with existing buying groups is evident from the comparable benefit outlays of nib and AHSA: on a per-procedure basis benefits paid by AHSA are routinely significantly (between 20 and 40 per cent) higher than benefits paid by nib.[72]

50. The Applicants attempt to undermine the weight of Mr Du Plessis's evidence, by submitting that he does not sufficiently explain the basis for his evidence that lower costs put downward pressure on premiums (NAPP/ RMSANZ [57]). That submission should be rejected. Mr Du Plessis is well placed to explain how PHI costs affect premium increases, given his position and experience. His evidence establishes that to increase premiums PHIs must establish both cost and saving pass through (including steps to reduce benefit inflation or improve the value of private health insurance).[73]

51. The Applicants' other attempts to undermine Mr Houston's expert evidence that the market is effectively competitive (NAPP/ RMSANZ [58]-[59]) do not withstand scrutiny, for the following reasons.

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69 Houston report [137].
70 Houston report [139].
71 Du Plessis affidavit [49], [120], [131]-[132] and [215].
72 See Khorshid statement [80] (AMA's 2021 Private Health Insurance Report Card, figure 6).
73 Du Plessis affidavit [48] and DD-14 at items 7 and 8.

52. *First,* none of the matters relied on by the Applicants as indicators of a lack of competition (an unspecified number of related entities, five unrelated major players, and geographic variations in market concentration: NAPP/ RMSANZ [59]) compel (or even suggest) a conclusion that the market is not competitive. Mr Houston's view of the effectiveness of competition is not contradicted by any other expert evidence. It is consistent with the evidence of Mr Du Plessis and Dr Omar Khorshid of premium and benefit competition between PHIs.[74] Further, Mr Houston explains that even if competition is less effective than he expects, pass through of a substantial portion of costs savings remains likely.[75] The market is not a monopoly (NAPP/ RMSANZ [61]).

53. *Second,* the Applicants, again relying on Mr Siolis's opinion, contend that collective bargaining is likely to further lessen competition (NAPP/ RMSANZ [60]). That contention ignores the fact that all Minor PHIs currently engage in collective bargaining, the vast majority through a single buying group. As Mr Siolis appears to recognise, there is no increase in those effects in the market unless collective bargaining occurs across a larger number of PHIs.[76] Even if all members of AHSA switched to the Buying Group (an outcome which is unlikely), the additional effect would be marginal and no more than that which existed prior to 2010 when nib was part of AHSA.[77]

Increasing competitive constraint

54. The Proposed Conduct will increase the competitive constraint Minor PHIs pose on Major PHIs in the private health insurance market.[78] In particular, Minor PHIs will gain access to a value based contracting model, and to aggregated participant data and HH's data analytics across the full suite of services offered by the Buying Group, to none of which they would have access in the counterfactual.

55. Minor PHIs do not have sufficient market share — and hence sufficient data — to generate statistically relevant analysis, or to develop data science matching models and machine learning.[79] Data sharing is not facilitated through existing buying group AHSA.[80] Nor do Minor PHIs alone, or through existing buying groups, enjoy access to the sophisticated data analytics available to HH.[81] Acquiring data analytics of this kind is unviable for Minor PHIs given it would cost in the millions of dollars to acquire the relevant skills, infrastructure

74 Du Plessis affidavit [47] and DD-13; Khorshid statement [80] (AMA's 2021 Private Health Insurance Report Card, figure 6).
75 Houston report [140].
76 Siolis report [42].
77 Du Plessis affidavit [108].
78 Houston report [141].
79 Du Plessis affidavit [146], [221].
80 Du Plessis affidavit [208].
81 Du Plessis affidavit [148], [219]-[222].

and technologies.[82] By aggregating data of all Buying Group participants and applying HH's data analytics, the Buying Group will give Minor PHIs significantly more information about the market than they currently have.[83] As the ACCC correctly recognised,[84] that will reduce information asymmetry and thereby assist minor PHIs to compete with Major PHIs more effectively.[85]

56. Given existing data constraints, Minor PHIs do not have the scale and capabilities to achieve the kind of value based contracting used in the BCPP, either unilaterally or through existing buying groups.[86] In addition, the development of such models is time and resource intensive: Mr Du Plessis's evidence is that establishing such models takes up to two years (to develop appropriate models of care with medical specialists, develop matching funding models, establish networks and test programs) and costs an estimated $1 to 1.5 million.[87] Further, to efficiently implement the models, specialists require a sufficient volume of patients to be covered by the relevant model and funding (estimated at 20 per cent of a specialist's patient volume).[88] Accordingly, there has been relatively limited uptake of value based contracting models amongst Major PHIs in the private healthcare system (and none amongst Minor PHIs).[89]

57. The Applicants assert that the benefits of HH's data analytics and access to data will be incremental, given existing market offerings (NAPP/ RMSANZ [65]). The Applicants' reliance on AHSA's submission to support that proposition (NAPP/RMSANZ [65]) is misguided: that submission is lacking in meaningful detail and is inconsistent with AHSA's public statements and with nib's experience as a member of AHSA.[90] By contrast, Mr Du Plessis deposes to the precise range of data analytic capabilities presently available to HH and that will be available to the Buying Group.[91] His uncontradicted evidence is that those capabilities — supplied by a major international health data sciences company[92] — are superior to those of other PHIs in Australia. The ACCC similarly had the benefit of AHSA's submission, and of hearing from AHSA and the Authorisation Applicants on a number of occasions prior to its Determination, and concluded that the data analytics offered by HH would not be available to Minor PHIs in the counterfactual.[93] The Tribunal

82 Du Plessis affidavit [220].
83 Du Plessis affidavit [217].
84 ACCC Determination [4.25], [4.28] and [4.34].
85 Du Plessis affidavit [223]-[224].
86 Du Plessis affidavit [212]-[213].
87 Du Plessis affidavit [236].
88 Du Plessis affidavit [243]-[245].
89 Du Plessis affidavit [84]-[91]; [130].
90 Du Plessis affidavit [208]; Authorisation Applicants' response to ACCC dated 9 March 2021 [1.10].
91 Du Plessis affidavit [148]-[157] and [193]-[194].
92 Du Plessis affidavit [9].
93 ACCC Determination [4.24], [4.27]-[4.28].

should prefer the evidence of Mr Du Plessis and the informed views of the ACCC in this regard over a submission by the Buying Group's principal competitor.

Expanding no gap experience and increasing certainty of cost

58. The Proposed Conduct will expand the availability of the BCPP's no gap experience to customers of more PHIs (increasing certainty of cost for those consumers). The Applicants accept that this is a public benefit, as did the ACCC in its Determination.[94] Mr Houston's expert opinion is that improving cost certainty for consumers will improve the quality of, and thus the demand for, private health insurance.[95]

59. Consumers value certainty of out of pocket costs.[96] Existing gap schemes do not ensure certainty of out of pocket costs, because specialists can opt in or out on a case by case basis[97] and there is no guarantee that all specialists involved in an episode of treatment will be registered for, and opt in to the scheme, for that treatment.[98] By contrast, the MPPAs that form the basis of the BCPP require participating specialists to treat all of nib's customers and ensure *all* medical specialists involved in the treatment agree not to charge a gap fee.[99] The benefit to consumers is neither speculative nor theoretical (c.f. NAPP/ RMSANZ [69]). It can be quantified by inference from the average out of pocket cost savings for consumers to date: the BCPP has saved consumers on average $1,850 per episode of treatment with total estimated out of pocket savings of $2.5 million over two years.[100] The benefit for consumers has been reflected in high consumer participation rates and positive feedback.[101]

60. The Authorisation Applicants agree that the extent of the benefit depends on the extent of the expansion of the BCPP (NAPP/RMSANZ [69]).[102] In particular, the benefit will be significantly greater if Major PHIs are authorised to join the Buying Group for the BCPP: this will extend the BCPP to more customers, and also increase efficiencies for specialists, thereby encouraging their participation.[103] Those efficiencies are not already realised through existing buying groups because those groups do not offer an equivalent contracting model (c.f. NAPP/ RMSANZ [76]-[77]).

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94 NAACP SOFIC [127]; RMSANZ SOFIC [154]; ACCC Determination [4.44]-[4.45].
95 Houston report [142].
96 Du Plessis affidavit [76]; see also Khorshid statement [41], [42(a)].
97 Du Plessis affidavit [78].
98 Du Plessis affidavit [79]-[80].
99 Du Plessis affidavit [86].
100 Du Plessis affidavit [228]-[229].
101 Du Plessis affidavit [137]-[139].
102 The same point was made by the ACCC: ACCC Determination at [4.45] and in the Siolis report at [64].
103 Du Plessis affidavit [235]-[236].

61. The benefit is not diminished by the existence of gap schemes[104] or the proportion of procedures presently provided under those schemes (c.f. NAPP/ RMSANZ [70]).[105] The data shows that gap payments were required on average in at least 10 per cent of all specialist services in all states and territories; gaps also vary significantly between specialty groups (for instance, gaps for orthopaedics constitute on average 27 per cent of the charge to patients; for anaesthesia, that figure is 20 per cent).[106]

PROPOSED CONDUCT NOT LIKELY TO RESULT IN PUBLIC DETRIMENTS

62. The Proposed Conduct is not likely to result in any public detriments. For the following reasons, the detriments alleged by the Applicants are not supported by the evidence.

No likely inefficiencies in the market for medical specialist services

63. Mr Houston's expert evidence is that the increase in demand for private health insurance resulting from an increase in the quality of those products will in fact likely *increase* demand in the market for medical specialist services, and in turn the prices paid to medical specialists and the quantity of such services.[107]

64. The Applicants instead contend that medical specialist services will be *under*-provided: relying on Mr Siolis's report, they say the Proposed Conduct will increase concentration in demand for medical services, resulting in lower fees for medical specialists and thereby under-provision of medical services and higher gaps charged to consumers.[108] Mr Siolis's theory fails to take into account the actual features of the market in the factual and counterfactual. In particular, PHIs will not abolish or diminish gap schemes: not only do they have no incentive to do so as a matter of economic theory or commercial reality,[109] the Authorisation Applicants have not and do not intend to do so and do not object to a condition of authorisation to prevent that outcome.[110]

65. Mr Houston explains that, even if the Buying Group secured a 30 per cent market share, the bargaining power of Buying Group participants will not increase significantly, given the existing market structure.[111] Further, competition from other PHIs would prevent any reduction in the quantity of medical specialists performing treatment under medical gap schemes: given the importance of no-gap treatment to customers, it would not be in the interest of Minor PHIs to use the Buying Group's gap scheme if it offered lower rates to

104 See the reference to steps taken to address gaps in the AHSA submission [50]-[52].
105 Khorshid statement [45].
106 See Du Plessis affidavit DD-4, p 9.
107 Houston report [144]-[145].
108 Siolis report [34].
109 Houston report [170]-[171]; Du Plessis affidavit [190]-[191].
110 Du Plessis affidavit [189]-[191]; Authorisation Applicants' SOFIC [95].
111 Houston report [164]-[166].

medical specialists, such that fewer of its customers had access to no gap services.[112] In relation to the BCPP, Mr Houston explains that the bargaining power of PHIs vis-à-vis specialists will remain broadly similar in the factual and counterfactual because their outside options do not materially change, and the effects, if any, of increased bargaining power would be limited given the confined scope of the BCPP.[113]

66. In those circumstances, Mr Houston concludes that the Buying Group must pay sufficient premiums to attract and retain specialists to use the BCPP over their outside option; if the premium over medical gap schemes reduces, each Major PHI that uses the BCPP could gain a competitive advantage by switching to its own gap scheme, thereby constraining prices under the BCPP.[114] Participants would not be incentivised to abolish or reduce gap schemes — but even if they did, the result for consumers would be increased access to no gap services (under the BCPP), which would in turn be likely to increase demand for private health insurance and reduce demand for medical services with gap fees, thereby constraining specialists from charging increased gap fees.[115]

67. Given the Applicants fail to establish that the bargaining power of PHIs vis-à-vis medical specialists is likely to increase, they also fail to establish that the alleged risks of value based contracting will increase (NAPP [107]-[110]/ RMSANZ [108]-[111]).

No detriments arising from value based contracting

68. The Applicants allege a range of detriments arising from value based contracting, all of which are premised upon the claim that it will limit the clinical independence of medical specialists to act in their patients' best interests. That premise cannot be made good.

69. *First,* even if value based contracting was likely to have the effects alleged by the Applicants (a proposition which is not supported by the evidence) those effects are not caused by the Proposed Conduct. Rather, as the ACCC recognised,[116] they are existing features of value based contracting in the private health insurance market. Accordingly, to the extent they are relevant at all, it is only in weighing any claimed benefit of expanding value based contracting: see *Medicines Australia* at [108].

70. *Second*, even if the Applicants' concerns about value based contracting could be substantiated (which they cannot) they are only likely to have any real effect in the absence

112 Houston report [168]-[170].
113 Houston report [180]-[182] and [176].
114 Houston report [193].
115 Houston report [195].
116 ACCC Determination [4.163].

of an attractive outside option for medical specialists.[117] As explained in paragraphs 64 and 65 above, medical gap schemes will be maintained in both the factual and counterfactual. Further, the BCPP is confined to a limited number of procedures, the identified opportunities for expansion of the BCPP to date are limited to cardiac procedures, obstetrics, ENT, gastroenterology and vascular surgeries,[118] and there are a range of specialist areas and treatments never likely to be covered.[119] In those circumstances, and as the Applicants' evidence suggests,[120] medical specialists are not likely to be practically compelled to participate in the BCPP.

71. *Third,* the detriments alleged by the Applicants are speculative and theoretical.[121] The Applicants' cases extrapolate terms of the template MPPA (developed for rehabilitation of patients following joint replacement surgery) to vastly different treatments and specialties (e.g. NAPP [99]). That is inconsistent with Mr Du Plessis's evidence of the limited current and intended scope of the BCPP (see paragraph 70 above) and his evidence that models of care will be adapted to those specialities and co-designed with relevant medical specialists.[122] The BCPP does not currently apply to psychiatry, nor is there any evidence that the Authorisation Applicants contemplate that it will. Even if it did, plainly any expansion of the BCPP to psychiatric specialists would not involve simply applying to psychiatric services the targets developed for at home rehabilitation following hip and knee replacements. Evidence of the effects of early discharge on psychiatric patients (NAPP [97]) has no connection with the likely effects of the BCPP in its current or contemplated form. Similarly, evidence about "managed care" in other countries is not relevant: these are not features of the BCPP.[123]

72. *Fourth*, and relatedly, the Applicants' suggestion that the Authorisation Applicants are required to detail precisely how value based care might be deployed in specialist areas that are not even contemplated for inclusion in the BCPP should be rejected (c.f. NAPP/ RMSANZ [91], [99]). *First*, the Authorisation Applicants do not contend that the Tribunal should treat value based care or the equitable or better health outcomes it is likely to achieve as a public benefit in itself. To the extent that the health outcomes of value based care (generally or specifically) fall to be considered by the Tribunal at all, it is in assessing the detriments raised by the Applicants. *Second*, the evidence establishes sufficiently how

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117 See, for instance, statement of Philip Morris dated 10 May 2022 (**Second Morris statement**) [23], [26]; Statement of John Estell dated 16 May 2022 (**Estell Statement**) [32].
118 Du Plessis affidavit [85] and [188].
119 Du Plessis affidavit [190].
120 Second Morris statement [23]; Statement of Gary Galambos dated 13 May 2022 [36]; Estell statement [31] – [32]; Statement of Stephen De Graaff dated 13 May 2022 [24]; Khorshid statement [64].
121 *Qantas* [156].
122 Du Plessis affidavit [236].
123 Du Plessis affidavit [255].

such a model will be expanded without giving rise to the detriments alleged by the Applicants. Relevantly, Mr Du Plessis explains that HH will approach the expansion of the BCPP to other specialty areas and procedures on a case by case basis in consultation with relevant medical specialists in the field,[124] that models of care are co-designed with relevant medical specialists[125] (c.f. NAPP/ RMSANZ [91(a)], outcome measures will be developed with relevant disciplines[126] (c.f. [91(b)]) and guidelines formulated by recognised bodies[127] (c.f [91(c]). His evidence is that the development of such models takes years and significant resources.[128]

73. *Fifth,* there is no basis to infer that the Authorisation Applicants' model of value based contracting is concerned only with cost reductions and not improving outcomes (NAPP [93]; RMSANZ [93], [98]). That inference is contradicted by Mr Du Plessis's evidence that the model is based on achieving better outcomes for the patient and that it is fundamentally inconsistent with that model to achieve worse health outcomes for patients.[129] Contrary to the Applicants' contentions (NAPP/ RMSANZ [54]), this is not a mere assertion: it is supported by HH's data analysis demonstrating previously high rates of inpatient admissions inconsistent with the National Rehabilitation Guidelines,[130] studies demonstrating equitable or improved health outcomes for at-home rehabilitation following joint replacement surgery (including but not limited to the example offered by Mr Du Plessis in his affidavit: c.f. RMSANZ [100]),[131] a 60 per cent reduction in rates of inpatient rehabilitation and 23 per cent reduction in acute stays under the BCPP,[132] and the value BCPP customers place on at-home rehabilitation.[133] In those circumstances there is no basis to conclude that risks of a model driven "primarily by reduction in costs" will arise (NAPP/ RMSANZ [94]): the evidence does not establish that the BCPP is or will be such a model. In any event, cost reductions (at improved, or even unchanged, quality of outcomes) are a *benefit*, not a detriment.

74. The Applicants contend that the inclusion of targets and requirements to follow clinical guidelines will limit clinical independence and override medical specialists' obligations to act in the best interests of patients (NAPP [101]/ RMSANZ [102]). The claim is entirely speculative and contrary to the evidence. As the Applicants recognise, it is contrary to the

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124 Du Plessis affidavit [190].
125 Du Plessis affidavit [236].
126 Du Plessis affidavit [263].
127 Du Plessis affidavit [271]-[272].
128 Du Plessis affidavit [236].
129 Du Plessis affidavit [254].
130 Du Plessis affidavit [257]; [153] and DD-49.
131 Du Plessis affidavit [122], DD-29; see also [134], DD-40 and DD-41 and [135], DD-42, DD-43; see also studies at Court Book pp 3253-3276.
132 Du Plessis affidavit [134].
133 Du Plessis affidavit [137]-[139] and DD-44.

statutory prohibition on PHIs limiting clinical autonomy — breach of which exposes PHIs to damages and adverse publicity orders, and their officers to personal pecuniary penalty orders.[134] It is also, as the Applicants recognise, contrary to the express terms of the existing MPPA: the targets and guidelines are expressly subject to the practitioner's determination of clinical appropriateness in any given case;[135] and the medical specialist would not comply with the MPPA if the specialist were to provide treatment that was not consistent with best clinical practice and in accordance with professional standards (c.f NAPP/ RMSANZ [88]).[136] The Authorisation Applicants do not oppose conditions to ensure the clinical independence of practitioners.[137] Finally, and fundamentally, participation in the BCPP is voluntary.[138] HH does not seek authorisation to engage in a collective boycott: participants cannot bypass or boycott specialists who decline to contract with the Buying Group.[139] There is no practical compulsion on specialists to participate in it because of its confined scope and because existing gap schemes will be maintained: see paragraph 70 above (c.f. NAPP [103], [105]/ RMSANZ [104]). If there is no such practical compulsion, it cannot have the substantive effect for which the Applicants contend (NAPP [103], [106]/ RMSANZ [104], [107]); that is, a specialist could simply elect not to participate in the BCPP and instead charge under a gap scheme. In those circumstances, the health risks alleged by the Applicants do not arise (e.g. NAPP [97],[99]; RMSANZ [99]).

75. RMSANZ (but not NAPP) contends that the target in the MPPA is arbitrary, unsubstantiated, and selected to reduce referral to inpatient rehabilitation following joint replacement surgery (RMSANZ [98], [100]). The Authorisation Applicants do not deny the target is intended to achieve that outcome, where clinically appropriate. The target was set, in light of the data and studies described in paragraph 73 above, at slightly below the average rate of inpatient rehabilitation of 33 per cent.[140] The target does not require specialists to make decisions without regard to individual patient characteristics (c.f. RMSANZ [97]). Nor does the target restrict or limit access to clinically appropriate care (c.f. RMSANZ [98]); to the contrary, it is expressly subject to clinical appropriateness.[141] The Authorisation Applicants do not contend that clinically appropriate inpatient rehabilitation is "low value care" (c.f RMSANZ [100]).

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134 Ss 172-5, 172-15, 185-5, 203-10, 203-15 and 203-20 of the *Private Health Insurance Act 2007* (Cth): Du Plessis affidavit [113]-[116].
135 Du Plessis affidavit [253]; Annexure DD-62 (see, for instance, clause 7.1(e); 7.1(g); 10.2; Schedule 2).
136 Du Plessis affidavit [253]; Annexure DD-62 (see for instance clauses 7.1 (b) and (c)).
137 Authorisation Applicants' SOFIC [95]; Du Plessis affidavit [272].
138 Du Plessis affidavit [185].
139 Du Plessis affidavit [186]; see ACCC Determination [1.23].
140 Du Plessis affidavit [258].
141 Du Plessis affidavit [261].

76. NAPP (but not RMSANZ) contends that the MPPA may cause harm by requiring medical specialists to keep their agreement confidential (NAPP [100]). That is plainly incorrect: the MPPA requires the medical specialist to notify the patient that they have an MPPA with the PHI.[142] The standard confidentiality clause in the contract is not intended to prevent any disclosure to the patient but to nib's competitors.[143] The MPPA and HH's data policies also require patients informed consent to any data disclosure.[144] In those circumstances the theoretical risk of harm alleged by NAPP does not arise.

PART G: PERIOD OF AUTHORISATION

77. Extending the period of authorisation to 10 years will allow the public benefits outlined in **Part F** above to be more fully realised. This would better demonstrate the benefits of the value based contracting model by allowing sufficient time to develop the models of care required to expand the BCPP and to improve outcomes or efficiency over multiple contracting cycles.[145] A 10 year period would also provide greater certainty for potential Buying Group participants, including Minor PHIs switching from existing buying groups, bearing in mind the difficulties and cost of switching.[146]

CONCLUSION

78. For the reasons set out above, the Proposed Conduct is likely to result in a net public benefit. No reason has been advanced as to why authorisation should be refused in the Tribunal's discretion. Accordingly, the Tribunal should affirm the ACCC's decision to grant authorisation with the variations proposed by the Authorisation Applicants.

15 July 2022

M Borsky

A Lord

142 Annexure DD-62 (see clause 7.1(h) of the MPPA).
143 Du Plessis affidavit [284].
144 Du Plessis affidavit [163], [277]-[278].
145 Du Plessis affidavit [286]-[287].
146 Du Plessis affidavit [205]-[207], [288].