
# Determination

Application for revocation of AA1000491 and the substitution of authorisation AA1000567 lodged by
the State of Victoria as represented by the Department of Health
in respect of
co-ordination of healthcare services in response to COVID-19

Date: 2 December 2021

Commissioners: Keogh
Rickard
Brakey
Ridgeway

# Summary

**The ACCC has decided to grant conditional re-authorisation to the State of Victoria, as represented by the Department of Health (the Department), and relevant healthcare providers, in relation to arrangements for the purpose of maximising healthcare capacity and ensuring Victoria-wide coordination of healthcare services while responding to issues arising from COVID-19.**

**In broad terms, the arrangements involve the Department, participating private healthcare providers, and public hospitals in Victoria sharing information about capacity and resources and, under the oversight and direction of the Department, coordinating their activities in relation to the provision of certain medical services or the treatment of particular groups of patients at particular hospitals. The arrangements also allow the coordination of the procurement of medical equipment and supplies and the sharing of resources to meet demand.**

**The arrangements for which re-authorisation was sought are the same as those previously authorised by the ACCC on 13 August 2020. The previous authorisation was due to expire on 30 September 2021.**

**The ACCC granted interim authorisation to allow the arrangements authorised in 2020 to continue while the ACCC completed its assessment of the application for re-authorisation.**

**The Department sought re-authorisation for a further 12 months. The ACCC notes there is inherent uncertainty as to the period of time COVID-19 will continue to impact the health system. Given the ACCC's consideration of the balance of public benefits and detriments likely to result from the Conduct, and the potential benefits in having certainty of ongoing authorisation, the ACCC has decided to grant re-authorisation of the Conduct until 24 June 2023.**

**Re-authorisation is granted with a condition which requires reporting of conduct engaged in under the authorisation, similar to the requirements of the previous authorisation.**

# 1. The application for authorisation

1.1. On 26 August 2021, the State of Victoria as represented by the Department of Health (the **Department**) lodged an application with the Australian Competition and Consumer Commission (the **ACCC**) to revoke authorisation AA1000491 and substitute authorisation AA1000567 for the one revoked (referred to as re-authorisation). The Department seeks re-authorisation for a further 12 months on behalf of itself and the following parties who are engaged, or propose to become engaged, in the Conduct:

- specified private healthcare providers operating in Victoria as listed in **Attachment 1** (and their related bodies corporate), as well as any other private healthcare providers notified to the ACCC by the Department from time to time (the **Participating Providers**), and
- all public hospitals operating in Victoria, as listed in **Attachment 2**, and any other healthcare facility owned or operated by the State of Victoria or an authority of the State of Victoria (**the Victorian Public Providers**).

1.2. This application for re-authorisation was made under subsection 91C(1) of the *Competition and Consumer Act 2010* (Cth) (the **Act**).

1.3. The ACCC may grant authorisation, which provides businesses with protection from legal action under the competition provisions in Part IV of the Act, for arrangements that may otherwise risk breaching those provisions in the Act but which are not harmful to competition and/or are likely to result in overall public benefits.

1.4. The Department seeks re-authorisation for the broad purpose of maximising healthcare capacity and ensuring the Victoria-wide coordination of healthcare services to facilitate the most efficient and effective allocation of healthcare services while responding to issues arising from COVID-19. To achieve this purpose, the Department has entered into separate but substantially similar agreements with the Participating Providers, and may enter into further agreements in the future (together, the **Agreements**) in order to achieve the Objectives defined at paragraph 1.8 below.

1.5. The Department also seeks re-authorisation for the formation of Cluster Planning Implementation and Operational Groups (**Cluster Groups**). These groups may include private healthcare providers who are notified to the ACCC but are not party to an Agreement with the Department, or cease to be a party to an Agreement with the Department. The Cluster Groups will plan for, and if necessary, coordinate responses to COVID-19 outbreaks in particular geographic regions of Victoria (**Clusters**).

1.6. The Department is seeking to continue the arrangements put in place under the previous authorisation AA1000491, which the ACCC granted on 13 August 2020. The previous authorisation was due to expire on 30 September 2021. As such, the Department requested the ACCC grant interim authorisation to enable the parties to continue to engage in the Conduct while the ACCC was considering the substantive application for re-authorisation.

1.7. On 28 September 2021, the ACCC suspended the operation of the previous authorisation and granted interim authorisation in substitution for that suspended authorisation, under subsection 91(2) of the Act.[1] The interim authorisation remains in place until it is revoked, the date the ACCC's final determination comes into effect, or when the application for authorisation is withdrawn.

## The Conduct

1.8. The Department's objectives include to:

(a) work cooperatively to ensure that the public and private healthcare sectors respond successfully to the COVID-19 pandemic;

(b) ensure the ongoing sustainability and operation of hospital facilities across Victoria;

(c) make available to the Department (and the Victorian public) the maximum amount of hospital facilities;

(d) ensure that hospital services are provided equitably, consistently and in accordance with clear standards (having regards, where appropriate, to the circumstances presented by the COVID-19 pandemic) in order to optimise health outcomes;

(e) ensure that the Department obtains access to additional hospital services required as a result of the COVID-19 pandemic at a reasonable cost and in a manner that achieves a cost-efficient solution for the Department; and

[1] See ACCC decision of 28 September 2021 available on the ACCC's Public Register.

(f) work together through a culture of mutual respect and cooperation and in an environment that fosters cost-efficiency, transparency and open, honest and timely communication,

(the **Objectives**).

1.9. The Department is seeking authorisation to:

(a) negotiate and enter into new Agreements;

(b) engage in conduct consistent with the Objectives to give effect to the Agreements, including (without limitation) by:

a. engaging in coordinated group discussions regarding healthcare operations, capacity and other matters required or contemplated by the Agreements; and sharing any information required or contemplated by the Agreements or otherwise reasonably necessary to facilitate the Objectives, including but not limited to:

i. information about the capacity or expected capacity of a hospital to provide care to patients or patients with particular conditions; and

ii. information about the availability of resources required to treat patients (including, but not limited to, hospital beds, staff, medicines and other equipment);

b. coordinating the following activities:

i. allocation of the provision of certain services or certain patients to particular healthcare providers and / or between certain healthcare facilities (e.g. designating specific categories of patients to particular hospitals);

ii. restriction of certain services that can be provided at particular healthcare facilities;

iii. sharing of resources (including staff and medical supplies and equipment) to meet demand at particular healthcare facilities; and

iv. procurement and supply of medical equipment and supplies in order to minimise supply chain disruption and ensure these resources are available to healthcare facilities on an as-needs basis

c. engaging in any other conduct that is necessary or desirable to give effect to the Agreements and facilitate the Objectives at the request or direction of the Department or one or more of the Victorian Public Providers; and

(c) engage in any other conduct that is related to the Agreements and necessary or desirable to meet the Objectives, including participating in and agreeing to co-

ordinate COVID-19 responses in Cluster Groups or similar coordination groups led by the Department or one or more of the Victorian Public Providers.

(the **Conduct**).

1.10. The key features of the Agreements entered into with the Participating Providers are:

(a) the Department will provide funding to the Participating Providers on condition they provide certain services to public patients, being:

i) any services which the Participating Provider performs or is authorised to perform immediately prior to the commencement of the Agreement,

ii) each Participating Provider making available to the Department its specified healthcare facilities (including beds, healthcare and other services required to support the operation of each of its healthcare facilities), and

iii) any other healthcare services reasonably necessary to respond to a patient who has been (or is suspected to have been) infected with the COVID-19 virus;

b) each Participating Provider will continue to hold operational control and operate their respective healthcare facilities;

c) each Participating Provider will be permitted to continue to provide healthcare services to private patients but only to the extent permitted by the Agreement or by the Department in accordance with principles to be agreed;

d) the Department will oversee and direct a 'Private Hospital Coordination Group' which is a group that will have a representative from some or all of the Participating Providers and which will be the forum for coordinating resources between the Participating Providers, each of their facilities and the Victorian Public Providers;

e) each Participating Provider will continue to maintain all categories of employees in the ordinary course of business with the provision of secondment of staff to public healthcare facilities in certain circumstances;

f) each Participating Provider will provide services under the Agreement on a purely cost recovery and non-profit basis;

g) public patients will not be required to pay any amount arising from or in connection with healthcare treatment by a Participating Provider; and

h) the parties participating in the Proposed Conduct will cooperate in respect of the procurement and supply of medical equipment.

1.11. The Agreements are not intended to, and do not extend to, coordination or any agreement between Participating Providers other than as necessary or desirable to give effect to the Agreements and facilitate the Objectives at the request or direction of the Department or one or more of the Victorian Public Providers.

1.12. The responsibilities and functions of the Cluster Groups are to:

(a) develop a pandemic Cluster Response Plan in accordance with the requirements set out by the Department, drawing on existing healthcare service preparedness plans and regional planning already underway;

(b) oversee the coordination of services in the Cluster in accordance with the Cluster Response Plan;

(c) assess local system capacity and capability and ensure optimum utilisation of services, facilities and workforce of all hospital sites within the Cluster in delivery of the COVID-19 response;

(d) implement clear and transparent bed coordination, management and (de-)escalation protocols, including equipment and workforce allocation;

(e) coordinate and prioritise the delivery of healthcare services within the Cluster in accordance with system design principles;

(f) use best endeavours to maintain delivery of critical COVID-19 and nonCOVID-19 healthcare within their Cluster through optimal utilisation of all available resources, whether public or private;

(g) oversee the implementation of care pathways, particularly for those vulnerable cohorts (e.g. Aboriginal, immuno-suppressed, aged care, etc.); and

(h) notify the Department as soon as practicable regarding emerging risks and barriers to the delivery of critical services within the Cluster.

1.13. The 'system design principles' referred to above are:

(a) Health services will be assigned to Clusters that will form under a hub and spoke model incorporating public and private hospitals.

(b) Each Cluster will have a lead health service that will have a significant role in coordination of all public and private hospitals within the Cluster, and in particular overseeing patient flows. Services will be designated as major COVID, COVID, or non-COVID centres.

(c) The lead health services will also be the major COVID centre for the Cluster providing critical care at scale (~100 beds) to support workforce efficiency and safety. (d) COVID and non-COVID activity will be separated and delivered at different campuses within each Cluster wherever possible.

(d) COVID focussed hospitals will be designed to enable step up/down care in place with critical care capable beds.

(e) Non-COVID streams will focus on ongoing management of chronic health conditions, medical management of emergency conditions, and streams such as maternity, renal dialysis, cancer treatments, trauma, cardiac and neurology.

1.14. A copy of the application for re-authorisation is available on the ACCC's Authorisations public register.

# 2. Background

2.1. The ACCC recognises the significant challenges that continue to exist as a result of the ongoing impact of COVID-19. There is risk that Australia's health services may continue to be put under pressure in responding to increasing COVID-19 case numbers as state and international borders re-open.

**The National Partnership on COVID-19 Response**

2.2. On 13 March 2020, the Commonwealth of Australia and each of the states and territories, signed the National Partnership on COVID-19 Response[2] (the **NPA**). The NPA is a commitment between the Commonwealth and the states and territories to respond to COVID-19.

2.3. The NPA provides that as system managers of public hospitals, each state will enter into agreements with existing private hospitals (including day hospitals) within their jurisdiction, through a consistent agreement, to ensure:

(a) increased capacity for the Commonwealth and states to rapidly respond to COVID-19; and

(b) the viability of private hospitals is maintained and they are able to resume operations once the COVID-19 response ends.

2.4. The Department advises that the application for re-authorisation forms part of the implementation of the NPA and funding commitments that have been made by the Australian Government and State and Territory Governments.

# 3. Consultation

3.1. A public consultation process informs the ACCC's assessment of the likely public benefits and detriments from the Conduct.

3.2. On 28 September 2021 the ACCC issued a draft determination proposing to grant authorisation, with a reporting condition, for 18 months.

3.3. The ACCC invited submissions in response to the draft determination from a range of potentially interested parties including relevant industry associations or peak bodies, consumer groups and state and federal government.[3] Two submissions were received, from the Australian Medical Association (**AMA**) and the Australian Society of Orthopaedic Surgeons (**ASOS**), responding in general terms to issues raised by this application and similar applications lodged by other jurisdictions.

3.4. The Australian Medical Association submits that public hospitals, in the absence of adequate funding, may be forced to shift a significant part of their workload to the private sector, which is potentially incentivised under the NPA due to the Commonwealth government's commitment to fund 50% of the costs of transferred patients. The AMA submits that, while it has been appropriate for arrangements to operate that support public hospitals to tap into the resources of the private sector to ensure patients can access care during the pandemic, this has not been without some public detriment. The AMA refers in its submission to detriments including:

- the loss of access to training opportunities for doctors in training
- in the case of some specialties in private practice, a significant reduction in procedural work, resulting in some private hospital operators offering contracts for the treatment of public patients that are inadequate
- potential impacts on the viability of some private medical practices, and

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2 See https://www.coag.gov.au/sites/default/files/communique/covid19-npa.pdf

3 A list of the parties consulted and the public submissions received is available from the ACCC's public register www.accc.gov.au/authorisationsregister .

- the displacement of private patients, growing private elective surgery backlogs, and a diminished value proposition for private health insurance.

3.5. The AMA says that despite adverse impacts, the profession has supported the arrangements, recognising the importance of providing surge capacity where it is genuinely required. However, the AMA considers that if the transfer of public patients to the private sector becomes routine because of inadequate public hospital funding, then the public detriment will become more pervasive. The AMA submits that there is potential to significantly distort the market. To the extent that the authorisation is needed, the AMA encourages the ACCC to consider conditions to ensure the authorisation is focused on supporting surge capacity in times of genuine need while also requiring regular reporting on demand for public hospital services, available capacity and what they are doing to satisfy unmet need within their own hospitals.

3.6. ASOS also raises concerns regarding the prosect of changes to the balance between private and public hospital sectors. ASOS submits this would be to the detriment of patients with private health insurance, and to the growth and resourcing of Australian public hospitals. ASOS submits that orthopaedic surgeons have accepted the need to ensure plans have been made for a worst-case scenario resulting from COVID-19, but that there is now an imperative to restore the ability of private hospitals to meet the demands of privately insured patients many of whom have had surgery delayed. ASOS is concerned that some public hospitals may have under-utilised elective surgery capacity, and that public-in-private arrangements are being extended beyond necessity. ASOS also submits that there are detriments to medical training, and that the arrangements result in additional detriments to rural specialist practice and patient care through fragmented treatment pathways.

3.7. ASOS submits that, should the ACCC decide to grant re-authorisation, that it do so for a further six months only and subject to a condition which provides the ACCC with the ability to revoke the authorisation should the arrangements be used for a purpose other than that sought.

3.8. In response, the Department submits that:

- the arrangements the Department has implemented are necessary and justified, and in accordance with health advice
- the current public-in-private patient treatment arrangements in Victoria are a necessary response to the current stage of the pandemic,
- given the ongoing presence of COVID-19 in Victoria, and the uncertainty around the potential for surging cases in the future, it is important that the Department has the continued ability to coordinate the state-wide provision of healthcare services, in order to maximise healthcare capacity and ensure the ongoing operation of hospital facilities, and
- the coordination measures put in place to date have operated as intended and have provided a clear public benefit to the people of Victoria.

3.9. Public submissions by the Department and interested parties are available on the Public Register for this matter.

# 4. ACCC assessment

4.1. The ACCC's assessment of the Conduct is carried out in accordance with the relevant authorisation test contained in the Act.

4.2. The Department has sought re-authorisation for the Conduct in relation to Division 1 of Part IV of the Act, and sections 45, 46 and 47 of the Act. Consistent with subsections 90(7) and 90(8) of the Act, the ACCC must not grant authorisation unless it is satisfied, in all the circumstances, 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 (the **authorisation test**).

4.3. The ACCC's assessment of AA1000567 is made in the context of the ongoing impacts of COVID-19. Consistent with the purpose of the Act which is to enhance the welfare of Australians by promoting fair trading and competition, when considering applications for authorisation in response to the issues arising from COVID-19, the ACCC is seeking to ensure that any changes to the competitive landscape are, wherever possible, temporary.

## Relevant areas of competition

4.4. To assess the likely effect of the Conduct, the ACCC will identify the relevant areas of competition likely to be impacted.

4.5. The ACCC considers that the relevant areas of competition are likely to include the supply of overnight and day hospital healthcare services to persons in the state of Victoria, in both the private and public healthcare system. The supply of surgical and other related healthcare services to persons in the state of Victoria is also likely to be relevant. These areas of competition encompass a diverse range of healthcare services.

## Future with and without the Conduct

4.6. In applying the authorisation test, the ACCC compares the likely future with the Conduct that is the subject of the authorisation to the likely future in which the Conduct does not occur.

4.7. In the future without the Conduct, the ACCC considers that the Victorian Government would be likely to enter into contracts with private healthcare providers on a bilateral basis. These contracts may be on broadly similar terms and would still seek to meet the NPA and any other requirements implemented as part of the response to COVID-19. However, in the future without the Conduct, the contracts would not establish the cooperation and coordination mechanisms between private healthcare providers provided for by the Conduct.

4.8. The ACCC considers that any incentives public hospitals may have to transfer patients to private facilities beyond what is necessary will exist with or without the Conduct.

## Public benefits

4.9. The Act does not define what constitutes a public benefit. The ACCC adopts a broad approach. This is consistent with guidance from the Australian Competition Tribunal (the **Tribunal**) which has stated that the term should be given its widest possible meaning, and includes:

> *…anything of value to the community generally, any contribution to the aims pursued by society including as one of its principal elements … the achievement of the economic goals of efficiency and progress.* [4]

4 Queensland Co-operative Milling Association Ltd (1976) ATPR 40-012 at 17,242; cited with approval in Re 7-Eleven Stores (1994) ATPR 41-357 at 42,677.

4.10. The Department submits that the Conduct will continue to result in the following public benefits:

- enabling the Participating Providers and the Victorian Public Providers to work together under the oversight and direction of the Department, to coordinate the medical response to the COVID-19 pandemic as effectively, efficiently and economically as possible;
- reducing the likelihood that private healthcare providers operating in the State of Victoria will have to partially or fully suspend or cease operations as a result of funding issues caused by any Commonwealth Government restrictions on their ability to provide certain surgeries;
- providing the Department with service capacity oversight to allow distribution of service delivery to meet periods of peak demand and minimise patient transfers between healthcare facilities which will allow patients to receive the best possible care available at the time;
- allowing the Participating Providers to be responsive to the needs of the overall healthcare system and coordinate with the Victorian Public Providers based on clinical priorities, recognising the need for continuity and quality patient care;
- allowing the Participating Providers to work in synchronisation with the public healthcare system and each other and prioritise capacity for COVID-19 patients, urgent care and other healthcare services;
- ensuring medical equipment (including ventilators), PPE, medical supplies and other relevant supplies are, to the extent possible, available where needed to respond to the COVID-19 pandemic;
- ensuring provision of additional intensive care facilities in response to the COVID-19 pandemic;
- ensuring the Participating Providers can remain operational, and retain staff under existing industrial arrangements during the COVID-19 pandemic; and
- ensuring the viability of Participating Providers during and following the COVID-19 pandemic which will help ensure that following the COVID-19 pandemic consumers will continue to have a choice of private or public care.

4.11. The Department advises that, under the previous authorisation, the authorised parties have entered into and given effect to the Agreements; established a Private Hospital Coordination Group; and formed and deployed Cluster Groups. In the future, the Department expects the Conduct will be critical to enable the continued response to potential pressure placed on the hospital system as the Victorian Government continues with the re-opening strategy.

4.12. As noted in paragraphs 4.7-4.8, the ACCC considers that, without the Conduct, the Victorian Government would be likely to enter into contracts with private healthcare providers to facilitate access to the private healthcare system's resources; and that such agreements would be on broadly similar terms and would seek to meet the NPA and other requirements implemented as part of the response to issues arising from COVID-19. In these circumstances it is likely that the some of the public benefits arising from the ongoing viability of the private healthcare system could be achieved without the Conduct.

4.13. However, the ACCC considers that the Conduct will allow the authorised parties to coordinate the medical response to COVID-19 in Victoria as efficiently and effectively

as possible, including by facilitating the swift response to outbreaks in Victoria. The ACCC considers that this is likely to contribute to public confidence in the response to COVID-19. The ACCC considers that the Conduct is likely to result in significant benefits to the public by supporting the timely deployment of critical resources.

4.14. In addition, the ACCC considers that there are likely to be some contracting efficiencies resulting from the Conduct, and these may be more difficult to achieve in the future without the Conduct.

### Conclusion on public benefits

4.15. The ACCC considers that the Conduct is likely to deliver significant public benefit through the enhanced coordination and improved responsiveness of the Victorian healthcare system to COVID-19.

## Public detriments

4.16. The Act does not define what constitutes a public detriment. The ACCC adopts a broad approach. This is consistent with guidance from the Tribunal which has defined it as:

> *…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.*[5]

4.17. The Department submits that it is not aware of any public detriments that have or may result from the Conduct.

4.18. The AMA and ASOS submit that reliance on public-in-private patient treatment arrangements is likely to result in public detriments (outlined at paragraphs 3.4 – 3.7 above), including by reducing opportunities for doctor training, threatening the viability of some private medical practices, and reducing the value proposition of private health insurance.

4.19. The ACCC notes that the response to COVID-19 continues to impact medical professionals, including private medical practices and the training of doctors. However, the ACCC notes that public-in-private patient treatment arrangements, along with any incentive which may exist to extend these beyond what is necessary to respond to COVID-19, would be likely to occur in the absence of the Conduct, in the form of bilateral arrangements between the Department and private providers. Therefore, any such detriments which may arise would be likely with or without the Conduct, rather than resulting from the Conduct itself.

4.20. While providing a mechanism for the healthcare system to coordinate its response to COVID-19, the ACCC considers that measures taken as part of the Conduct may restrict competition. For example, private patients with non-COVID-19 conditions may experience fewer options or longer wait times for healthcare services during these interventions, including because COVID-19 patients are prioritised over other patients. To a large extent, however, many of these detriments would be likely to arise due to increased demand on healthcare resources as a result of COVID-19, and by public policy decisions in response to it. In that sense, many of these detriments would occur with and without the Conduct.

5 Re 7-Eleven Stores (1994) ATPR 41-357 at 42,683.

4.21. The Conduct also allows for increased cooperation and coordination between competitors. Agreements between competitors can give rise to competition concerns if the horizontal agreement makes coordination (rather than competition) between firms beyond the terms of the authorised agreement more likely and also across the market more generally. In general, coordination between competitors can cause significant detriment to the public.

4.22. However, the ACCC considers that, in the current circumstances, the likely public detriment resulting from the Conduct is limited by a number of factors:

(a) to the extent that Participating Providers retain the capacity to do so, nothing in the Agreements is intended to affect the normal competitive process vis-à-vis the provision of healthcare services to private patients;

(b) the Conduct does not extend to any price agreements between private hospitals for non-COVID-19 services;

(c) the Conduct does not extend to any coordination or agreement between Participating Providers or between Participating Providers and the Victorian Public Providers other than as necessary or desirable to give effect to the Agreements and facilitate the Objectives. Coordination between the participating parties can only occur at the request or direction of the Department or one or more of the Victorian Public Providers;

(d) there will be continued transparency around the Conduct as the Department is required under the Conduct to notify the ACCC of additional Participating Providers, and the ACCC's condition requires the Department to provide regular updates to the ACCC;

(e) any information shared under the Conduct is likely to lose relevance following the cessation of the Conduct;

(f) the Conduct provides a temporary response to COVID-19, the measures are not designed or intended to provide a permanent restriction on competition; and

(g) the ACCC has the power to revoke authorisations in certain circumstances set out in s91B of the Act (for example, due to a material change in circumstances since the authorisation was originally granted).

4.23. The ACCC has considered requests by the AMA and ASOS to impose certain additional conditions on the authorisation (described at paragraphs 3.5 and 3.7 above) to ensure the Conduct is not being used beyond what is required for surge capacity in times of genuine need. Given the ACCC's view on the likely future without the Conduct (described at paragraphs 4.7 – 4.8 and 4.19 above), and its existing powers to revoke authorisations in certain circumstances (described at paragraph 4.22(g) above), the ACCC does not consider it necessary to impose these conditions. In particular, the ACCC considers that any incentive which may exist to extend public-in-private patient treatment arrangements beyond what is necessary to respond to COVID-19 would be likely to occur in any event in the absence of the Conduct.

## Conclusion on public detriments

4.24. The ACCC considers that the Conduct is likely to result in some public detriment in the short term because it is likely to reduce competition, including in the supply of overnight and day hospital healthcare services to particular patients in Victoria. However, there are a number of factors that mean the ACCC considers it unlikely that

the Conduct will significantly impact competition in the long term, including oversight by the Department and as a result of the transparency provided by the condition.

## Balance of public benefit and detriment

4.25. The ACCC considers that the Conduct is likely to result in significant public benefits through the enhanced coordination and improved responsiveness of the Victorian healthcare system to COVID-19.

4.26. The ACCC also considers that the Conduct is likely to result in some public detriment over the short term because it is likely to reduce competition in the supply of hospital healthcare services to certain patients in Victoria. In the circumstances, the ACCC considers that the potential reduction in competition is limited (see paragraph 4.22 above) and is not likely to continue in the long term. The ACCC also considers that the condition will provide important transparency over the arrangements.

4.27. Overall, the ACCC considers that the Conduct is likely to result in a public benefit and that this public benefit would outweigh any likely detriment to the public from the Conduct.

## Length of authorisation

4.28. The Act allows the ACCC to grant authorisation for a limited period of time.[6] This enables the ACCC to be in a position to be satisfied that the likely public benefits will outweigh the detriment for the period of authorisation. It also enables the ACCC to review the authorisation, and the public benefits and detriments that have resulted, after an appropriate period.

4.29. In this instance, the Department sought re-authorisation for a further 12 months from the date of a final determination by the ACCC, but it supports the ACCC's proposal in the draft determination, which proposed to grant authorisation for 18 months.

4.30. ASOS submits the arrangements should only be re-authorised for six months, given the detriments ASOS considers are likely to result.

4.31. The ACCC notes that there is inherent uncertainty as to the period of time COVID-19 will continue to impact the health system, and that this impact is likely to differ from that on other sectors of the economy. Given the ACCC's consideration of the balance of public benefits and detriments likely to result from the Conduct, and the potential benefits in having certainty of ongoing authorisation, the ACCC has decided to re-authorise the Conduct until 24 June 2023.

# 5. Determination

## The application

5.1. On 26 August 2021, the Department lodged an application to revoke authorisation AA1000491 and substitute authorisation AA1000567 for the one revoked (referred to as re-authorisation). This application for re-authorisation was made under subsection 91C(1) of the Act.

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[6] Subsection 91(1)

5.2. The Department seeks re-authorisation for the Conduct described at paragraph 1.9, on behalf of itself, Participating Providers and Victorian Public Providers, for the broad purpose of maximising healthcare capacity and ensuring the Victoria-wide coordination of healthcare services to facilitate the most efficient and effective allocation of healthcare in response to issues arising from COVID-19. As part of these arrangements, the Department will enter into Agreements with Participating Providers and form Cluster Groups to plan for and, if necessary, respond to outbreaks of COVID-19 in particular geographic regions in Victoria.

## The authorisation test

5.3. Under subsections 90(7) and 90(8) of the Act, the ACCC must not grant authorisation unless it is satisfied in all the circumstances that the Conduct would or is 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.

5.4. For the reasons outlined in this determination, the ACCC is satisfied, in all the circumstances, that the Conduct would be likely to result in a benefit to the public and the benefit to the public would outweigh the detriment to the public that would result or be likely to result from the Conduct.

5.5. Accordingly, the ACCC has decided to revoke authorisation AA1000491 and substitute authorisation AA1000567 for the one revoked.

## Condition of authorisation

5.6. The ACCC may specify conditions in an authorisation.[7] The legal protection provided by the authorisation does not apply if any of the conditions are not complied with.[8]

5.7. The ACCC may specify conditions in circumstances where, although the relevant public benefit test is met, without the conditions the ACCC would not be prepared to exercise its discretion in favour of the authorisation.[9]

5.8. In this instance, the ACCC has decided to grant authorisation with the following condition:

**Reporting Requirements**

(a) Subject to paragraph (b) below, the Department must provide updates to the ACCC on a quarterly basis (or as otherwise agreed with the ACCC), describing any conduct engaged in during that quarter in reliance upon this authorisation.

(b) If no conduct was engaged in during that quarter in reliance upon this authorisation, or if there has been no change in conduct since the last update was provided, the Department is not required to provide an update.

5.9. Under the condition, the ACCC may authorise a Committee or Division of the ACCC, a member of the ACCC or a member of the ACCC staff, to exercise a decision making function under the conditions of this authorisation on its behalf.

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7 Section 88(3) of the Act.

8 Section 88(3) of the Act.

9 Application by Medicines Australia Inc (2007) ATPR 42-164 at [133].

## Conduct which the ACCC has decided to authorise

5.10. With the condition, the ACCC has decided to revoke authorisation AA1000491 and substitute authorisation AA1000567 to enable the Department and Participating Providers and Victorian Public Providers to coordinate healthcare services to facilitate the most efficient and effective allocation of healthcare while responding to issues arising from COVID-19 as described in paragraph 1.9 and defined as the Conduct. The ACCC has decided to grant authorisation to the Conduct only in so far as it is for the sole purpose of dealing with the effects of COVID-19 in Victoria.

5.11. Authorisation is granted in relation to Division 1 of Part IV of the Act, and sections 45, 46 and 47 of the Act.

5.12. The ACCC has decided to grant conditional authorisation AA1000567 until 24 June 2023.

# 6. Date authorisation comes into effect

6.1. This determination is made on 2 December 2021. If no application for review of the determination is made to the Australian Competition Tribunal, it will come into force on 24 December 2021.

## Attachment 1 – Participating Providers

### 1. Specified private healthcare providers

- Cabrini Health Ltd
- Epworth Foundation t/a Epworth Health Care
- Healthe Care Specialty Holdings Pty Ltd
- Healthe Care Epping Pty Ltd (trading as Epping Private Hospital)
- Healthe Care Surgical Holdings Pty Ltd
- Healthscope Operations Pty Ltd
- Ramsay Health Care Investments Pty Ltd
- St John of God Health Care Inc
- St Vincent Private Hospital Ltd
- Ballan & District Soldiers' Memorial Bush Nursing Hospital and Hostel Inc
- Maryvale Private Hospital Proprietary Limited
- Euroa Health Inc.
- The Bays Healthcare Group Inc
- Kitaya Holdings Pty. Ltd. trading as Jessie McPherson Private Hospital
- Nagambie HealthCare Inc
- Neerim District Soldiers Memorial Hospital trading as Neerim District Health Service
- Stanlake Private Hospital Pty. Ltd. trading as Western Private Hospital
- Mildura District Hospital Fund Ltd
- Heyfield Hospital Incorporated
- IPHoA Management (Mt District) Pty Ltd
- Kitaya Holdings Pty. Ltd.
- Nexus Day Hospitals Pty Ltd
- GIH Access Endoscopy Pty Ltd as trustee for GIH Access Endoscopy Unit Trust
- Chelsea Heights Day Surgery and Endoscopy Pty Ltd as trustee for Chelsea Heights Day
- Surgery And Endoscopy Unit Trust
- Marie Stopes International
- Idameneo (No 123) Pty Ltd as trustee for Artlu Unit Trust trading as Greensborough Day Surgery
- North West Day Hospital Pty Ltd as trustee for North West Unit Trust
- Nunyara Centre Pty Ltd
- J & T Quach Holdings Pty. Ltd. as trustee for J & T Quach Family Trust & NNLE Pty Ltd as
- trustee for the A Le Trust No. 1 & Pascrear Nominees (Vic) Pty Ltd as trustee for Western

- General Specialist Medical Services Trust trading as Western Gastroenterology Services
- The Glen Endoscopy Centre Pty Ltd
- Bendigo Day Surgery Pty Ltd as trustee for Bendigo Day Surgery Unit Trust
- Berwick Eye Centre Pty. Ltd. as trustee for the Hauptman Family Trust
- Dr Natalie Krapivensky and Dr Andrey Brodsky trading as Melbourne MediBrain
- Monash House Private Hospital Pty Ltd as The Trustee for Monash House Private Hospital Unit
- Trust
- Open Endoscopy Pty Ltd
- Sunshine Private Day Surgery Pty Ltd
- Waverley Endoscopy Pty Ltd
- Wyndham Clinic Pty Ltd as trustee for Wyndham Clinic Unit Trust

**2. Any other private healthcare operator in Victoria who seeks to engage in conduct the subject of this application providing the ACCC is notified by the Department.**

## Attachment 2 - The Victorian Public Providers

The Victorian Public Providers, being those providers listed below and any other healthcare facility owned or operated by the State of Victoria or an authority of the State of Victoria.

Metropolitan

- Alfred Health
- Angliss Hospital
- Austin and Repatriation Hospitals
- Austin Health
- Austin Health - Austin Hospital
- Austin Health - Heidelberg Repatriation Hospital
- Box Hill Hospital
- Broadmeadows Health Service
- Bundoora Extended Care Centre
- Calvary Health Care Bethlehem Ltd.
- Caritas Christi Hospice Ltd
- Casey Hospital
- Caulfield Hospital
- Craigieburn Health Service
- Cranbourne Integrated Care Centre
- Dandenong Hospital
- Dental Health Services Victoria
- Eastern Health
- Frankston Hospital
- Healesville and District Hospital
- Kingston Centre
- Maroondah Hospital
- Melbourne Health
- Mercy Health - O'Connell Family Centre
- Mercy Hospital for Women
- Mercy Public Hospitals Inc.
- Monash Health
- Monash Medical Centre, Clayton Campus
- Monash Medical Centre, Moorabbin Campus

- Mount Eliza Rehabilitation, Aged and Palliative Care
- Northern Health
- PANCH Health Service
- Peninsula Health
- Peter James Centre
- Peter MacCallum Cancer Centre
- Queen Elizabeth Centre
- Rosebud Hospital
- Royal Melbourne Hospital - City Campus
- Royal Melbourne Hospital - Royal Park Campus
- Royal Talbot Rehabilitation Centre
- Sandringham Hospital
- St George's Health Service
- St Vincent's Health
- St Vincent's Hospital (Melbourne) Ltd
- Sunshine Hospital
- The Alfred
- The Northern Hospital
- The Royal Children's Hospital
- The Royal Victorian Eye and Ear Hospital
- The Royal Women's Hospital
- Tweddle Child and Family Health Service
- Wantirna Health
- Werribee Mercy Hospital
- Western Health
- Western Hospital
- Williamstown Hospital
- Yarra Ranges Health

Rural

- Albury Wodonga Health
- Alexandra District Hospital
- Alpine Health
- Bairnsdale Regional Health Service
- Ballarat Health Services

- Barwon Health
- Bass Coast Health
- Beaufort and Skipton Health Service
- Beechworth Health Service
- Benalla Health
- Bendigo Health Care Group
- Boort District Health
- Casterton Memorial Hospital
- Castlemaine Health
- Central Gippsland Health Service
- Cobram District Health
- Cohuna District Hospital
- Colac Area Health
- Djerriwarrh Health Services
- Dunmunkle Health Services
- East Grampians Health Service
- East Wimmera Health Service
- Echuca Regional Health
- Edenhope and District Hospital
- Gippsland Southern Health Service
- Goulburn Valley Health
- Heathcote Health
- Hepburn Health Service
- Hesse Rural Health Service
- Heywood Rural Health
- Inglewood and District Health Service
- Kerang District Health
- Kilmore and District Hospital
- Kooweerup Regional Health Service
- Kyabram and District Health Service
- Kyneton District Health Service
- Latrobe Regional Hospital
- Lorne Community Hospital
- Maldon Hospital
- Maryborough District Health Service
- Melton Health

- Mildura Base Hospital
- Moyne Health Services
- Nathalia District Hospital
- Northeast Health Wangaratta
- Numurkah District Health Service
- Omeo District Health
- Orbost Regional Health
- Otway Health and Community Services
- Portland District Health
- Robinvale District Health Services
- Rochester and Elmore District Health Service
- Rural Northwest Health
- Seymour Health
- South Gippsland Hospital
- South West Healthcare
- Stawell Regional Health
- Swan Hill District Health
- Tallangatta Health Service
- Terang and Mortlake Health Service
- Timboon and District Healthcare Service
- Upper Murray Health and Community Services
- West Gippsland Healthcare Group
- West Wimmera Health Service
- Western District Health Service
- Wimmera Health Care Group
- Yarram and District Health Service
- Yarrawonga Health
- Yea and District Memorial Hospital