Thank you for inviting me to speak to your meeting today. I have been asked to speak on the relevance of the Commerce Act, or competition, for the health sector and DHBs in particular.

On receiving the invitation, I noted that I was placed near the end of what looked to be a very demanding agenda. And I wasn't sure whether this meant I was in a for an easy ride or whether this particular topic would keep people fired up to the end given the Commission's interventions in the industry over the past few years!

It is fair to say that very little attention had been paid to the medical field until more recently. Clearly this has changed with the Ophthalmology cases, close Commission scrutiny of mergers and more recent issues with tendering (which are now close to a resolution).

But I do not intend getting into a lot of detail today. Rather, I would like to make three key points:

- Firstly that the Commission does operate from the position that competition is healthy and good for the sector.
- Secondly that you as DHBs have a very important role in bringing the benefits of competition to the sector and ultimately to your patients.
- Thirdly that there are some specific things you can do to and look out for that will assist in delivering those benefits.

I do recognise, however, that many of the issues faced in health are complex, and that there are many incentives to co-operate. For today, however, I am going to take the high ground. It is always useful to remember that parties can come in for authorisation if their proposals are likely to raise competition issues but where the benefits to the public good outweigh the harm. In that context, you may be interested to know that the Commission is currently looking at how it can streamline its authorisation processes to deal with smaller cases more quickly and cheaply.

Competition generally brings the benefits of greater patient choice, innovation, competitive pricing and better quality (as doctors and DHBs strive to meet community demands and patient needs). These sorts of outcomes are particularly important in the health sector where funding is often scarce and quality of service matters greatly to patients.

Just by way of illustration, I'd like to start by asking how many of you are familiar with the Commission's ophthalmology case? This case clearly demonstrated how the Commission and funding authorities can work together to deliver the benefits of competition to the public

There have been two separate cases involving ophthalmologists but today I will cover the main case.

In Invercargill, there was one Ophthalmologist, Dr Rogers. He was in private practice but was also employed on a 6/10 basis by Southern Health which was experiencing a considerable backlog in operations with waiting times up to 18 months. If operations were not performed within an appropriate time, patients' vision could have been affected and they may ultimately have gone blind.

Complications from the operation were considered to be few when operations were conducted by a competent surgeon.

Dr Rogers was performing cataract operations for Southern Health for $NZ1, 100 per operation.

As a result of a government grant, additional money became available to reduce the queue. Southern Health doubted Dr Rogers' capacity to undertake the operations and also felt they could be performed at a cheaper rate. Because of difficulties in negotiating with Dr Rogers, Southern Health decided to contract with an Australian specialist to perform the surgery and the board passed a motion approving a contract with Dr Silva, one of Sydney's most eminent ophthalmologists.

The day after this motion was passed, Dr Rogers contacted one of the ophthalmic surgeons operating at Christchurch Hospital advising him of Southern Health's intentions. This set in train a series of events, including a meeting with six doctors at Christchurch Hospital (one of whom was the VP of the OSNZ) which led to the President of the Ophthalmological Society of NZ writing a letter to Southern Health stating, among other things, that:

- The practice of employing an itinerant surgeon was contrary to the College's guidelines and to general medical profession ethics
- The intended arrangement was ethically unacceptable and condemned by the Society, its Australian counterpart body and by the NZMA

- The additional cataract contract could have been performed by Dr Rogers with colleague assistance from Dunedin and Christchurch
- No general oversight by an ophthalmic surgeon was available.

A subsequent letter confirmed that no Christchurch ophthalmologist had agreed to provide a service for post-operative emergencies contrary to claims that Canterbury Health would do so. If this were the case, the Australian could not be registered to practice in NZ.

In the end, the Australian pulled out of the contract and Dr Rogers performed the surgery for $675 per operation, or a savings of nearly 40%.

So what was wrong with this conduct?

The Commission alleged that all the defendants (or any two of them) had entered into an arrangement or understanding that they would oppose surgery required to reduce public waiting lists for cataract operations. We said that this had the purpose of substantially lessening competition in the supply by ophthalmologists of routine cataract surgery in Southland. We also said that it was intended to hinder or prevent cataract surgery being carried out by Australian doctors and did, in fact, have this effect.

In the ultimate, the Commission was successful. So what conclusions can be drawn from this case?

- It could be argued that absent the threat of entry from an alternative (Australian) supplier, the cost to DHBs and ultimately the taxpayer, would have been much higher. The threat of competition, in this case, led to prices some 40% lower than otherwise. Had Dr Silva been contracted, it is possible that the fees would have been even lower as a figure of $600 had been discussed. Competition therefore works to the advantage of those procuring services.
- Imagine also what happens if societies have code of ethics provisions condemning “price discounting”. Disciplining competitors for pricing breaches has occurred in a number of professional associations and it is a sure fire method of ensuring price uniformity. If there had been a provision preventing the Australian doctor quoting below the relevant NZ recommended price, the effect on competition would be immediately obvious.

- DHBs play a very important role in ensuring that hospitals and consumers derive the benefits of competition – timely operations, reduced waiting lists, and reduced costs.

I'd be interested in knowing what impact you think this case has had in the sector? To what extent has this changed behaviour in your view? Have DHBs made any attempt to bring in overseas trained specialists since that time? With what effects? If not, why do you think this may not have been tried again?

This leads nicely onto the topic of co-operation. At certain times, a co-operative model can produce improvements, but there is a risk that co-operation can lead to more negative outcomes such as price fixing. This is particularly true when some of the parties involved in service provision are concerned with maximising profit. Issues around collaboration have come to the Commission's attention when investigating tendering practices.

So what do DHBs need to be alive to? They need to be very alive to the potential for bid rigging when engaging in public procurement. There may be efficiencies to achieve from joint tenders and they are not in of themselves in breach of the Act. However, they are likely to raise concerns.

DHBs can minimise their risks by doing a few simple things:

- In most cases, the best outcomes occur when purchasers of health services have a variety of providers to select from and you should seek to preserve choice.
- Try and put in safeguards to ensure that the providers do not have the opportunity to collude – negotiating with service providers individually rather than collectively will assist. And specifying collaboration in contracts is likely to lead to collusion.
- Avoid approaches from bidders to withdraw their tenders and form collaborative joint ventures.
- Be alert to evidence in tenders that competitors may have shared information.
- If parties indicate they would like to submit a joint tender, encourage them to apply to the Commission for clearance.
- If a joint venture is likely to raise competition concerns, it is preferable to prepare joint tenders only after Commission clearance has been granted and DHB timeframes should reflect this.

You can also encourage the tender parties to:

- Consider contracting the preparation of joint tenders out to external parties who can control the flow of sensitive information between competitors.
- Where this is not possible, have a confidentiality agreement in place that specifies the types of information to be shared, restricts the people who have access to the information and restricts the purposes for which the information can be used.
- Ensure the agreement covers the destruction of information at the end of the process.

In summary, I have attempted today to demonstrate some of the benefits of competition, to show you how you as DHBs can assist the competitive process and I have provided some tips on how this might happen through the public procurement process. I trust this also assists in your understanding of the Commission's concerns and its role of promoting competition for the benefit of all consumers.