23 July 2026

Tanya Hobbs
A/Director
Competition Exemptions Branch
Australian Competition and Consumer Commission
Level 17, 2 Lonsdale Street
Melbourne VIC 3000

Dear Ms. Hobbs,

AA1000733-1 - Honeysuckle Health Pty Limited and nib Health Funds Limited - Interested party submission

We refer to the application (**Application**) made to the Australian Competition and Consumer Commission (**ACCC**) under section 88(1) of the *Competition & Consumer Act 2010* (Cth) (**CCA**) by Honeysuckle Health Pty Ltd (**HH**) in its own right and on behalf of nib Health Funds Limited (**nib**) (**Applicants**) seeking to revoke authorisation AA1000542 and substitute authorisation AA1000733 in its place. We note the Application is made with a view to continuing to maintain and operate the 'HH Buying Group' and to undertake contracting services in relation to hospitals, medical specialists, general practitioners, allied health professionals and other general treatment providers for nib and other healthcare payers who join as Participants (as defined) on the condition the Applicants not supply services to any of the Major PHIs (as defined) (**Proposed Conduct**).

The Australian Society of Anaesthetists (**ASA**) was established in 1934 and is the peak body representing the professional interests of specialist anaesthetists. Its mission is to support, represent and educate Australian anaesthetists, in order to assist them to provide best possible patient care.

The ASA lodged an objection to the previous authorisation AA1000542. For the reasons in that objection, and for further reasons articulated below, the ASA remains concerned about the Proposed Conduct sought to be authorised by the Application and believes an authorisation for HH to continue to operate a buying group to collectively negotiate and administer contracts with healthcare providers (including medical specialists and specifically anaesthetists) will substantially lessen competition and may lead to other breaches of Part IV of the CCA.

The ASA strongly believes that approval of the Application:

a) would not enhance the welfare of Australians through the promotion of competition and fair trading, contrary to the object of the CCA (section 2: CCA);

b) would not provide consumer protection;

c) would result in a significant increase in market power for nib and the other major health insurers; and

d) would result in public detriment, by way of lower quality healthcare, which will outweigh any possible benefits arising from purported transaction cost savings and efficiencies.

While the ACCC authorised similar conduct in 2021, the assessment should not simply be repeated. The Applicants' own evidence demonstrates that many of the expected public benefits have not materialised. The ACCC should undertake a fresh assessment based on present market conditions and based on the actual outcomes over the previous five years.

The ASA sets out its concerns below.

1. The Australian Healthcare System

1.1. Australian consumers have access through Medicare to a world class free public health system which provides high quality and safe healthcare. Those who choose to be treated as public patients incur no direct costs. Those who choose to be treated as private patients pay substantial premiums and out-of-pocket costs to obtain private health care. The question that arises therefore is: why do they do this?

1.2. The ASA submits that three primary factors account for the popularity of private health care in Australia:

a) choice;

b) access; and

c) quality.

1.3. These factors are acknowledged by the private health insurance industry. The website of Private Healthcare Australia (who represents health funds) (https://www.privatehealthcareaustralia.org.au/consumers/find-a-health-fund/) lists the following reasons to have private health insurance:

a) Access to timely care;

b) Avoiding long public hospital wait lists;

c) Choosing your doctor;

d) Continuity of care with a fully trained specialist; and

e) Relieving pressure on the public system, leaving it for those who need it most.

1.4. These attributes of private health care are threatened by a healthcare system that is controlled by healthcare payers who direct patients to specific healthcare providers who are required to care for those patients in designated hospital facilities using procedures determined by the healthcare payers rather than medical professionals. This is the type of insurer-controlled managed care system which is enabled by the Proposed Conduct for which re-authorisation is sought in the Application.

1.5. The ASA acknowledges the benefits to Australian consumers of a no gap (or known gap) scheme whereby Australian consumers clearly understand the costs involved with their

medical treatment. Under the current system, it is already the case that close to 90% of medical services in the private healthcare sector involve no out-of-pocket (**OOP**) expense to patients (https://www.apra.gov.au/news-and-publications/quarterly-private-health-insurance-statistics). A further 4-5% are provided under a "known gap" arrangement, in which there are specific limitations placed on the level of OOP expense. Therefore, any argument that OOP expenses are a significant issue across the sector is false.

1.6. The ASA believes it is essential that patients, whenever possible, know the cost of their medical care in advance. It is inaccurate to infer that doctors are responsible for OOP expenses. Where they do exist, OOP expenses are due to the inadequacy of medical rebates. Medicare and health fund rebates have failed to be indexed in line with the CPI for the last 45 years. In contrast, the Australian Medical Association (**AMA**) List of Medical Services and Fees has been indexed in line with the CPI. Doctors whose charges are guided by the AMA have found their patients incurring OOP expenses. If health insurers and Medicare refuse to index their rebates in line with the CPI, then OOP expenses become inevitable.

1.7. For this and other reasons, the Application is misleading when it asserts that the benefits of the Proposed Conduct to the Australian public outweigh the public detriments.

1.8. The Application sets out that the Proposed Conduct is to enable the streamlining of contract negotiation, procurement and management procedures, which will improve efficiencies by virtue of reduced transactional and administrative costs, and increase information sharing and data analytical capabilities - resulting in better health outcomes and reduced premiums for customers. This is disputed by the ASA. The ASA submits there is no evidence that any reduced transactional and administrative costs will reduce premiums or result in better health outcomes.

1.9. The ASA also submits that in addition to considering the impact of the Proposed Conduct on Australian consumers within the Australian healthcare system, the ACCC must also consider the position of medical professionals - including medical specialists, general practitioners and allied health professionals (referred to as Providers in the Application). The Proposed Conduct as set out in the Application will make it increasingly difficult for doctors to determine their own fees, which is fundamental in a competitive and well-regulated market. The present system whereby doctors compete on quality and cost will be lost. In this regard, we note one of the ACCC's purposes is to protect the interests and safety of consumers, and to support fair trade in markets affecting consumers and small business.

2. Public benefits

2.1. The ACCC must be satisfied that the benefit to the public from the Proposed Conduct outweighs any public detriment (see section 90(7) CCA). The ASA submits that any public benefit would be no more than negligible and that the benefit to the public will not outweigh the public detriment.

2.2. With regard to HH's submission that reduced transactional and administrative costs are a public benefit, the ASA submits this is in fact only a business benefit to the Applicants (and

other health insurers). They are not a public benefit unless the reduced costs result in reduced insurance premiums and/or reduced gap payments by consumers. There is no evidence to suggest that these cost savings will be passed on to consumers.

3. Public detriment (including likely competitive effects)

3.1. The ASA understands that the ACCC gives a broad meaning to 'public detriment' to the extent that it includes:

...any impairment to the community generally, any harm or damage to the aims pursued by the society...

3.2. We reiterate that Australian consumers expect:

a) safe and good quality healthcare;

b) ready availability of healthcare services;

c) to be able to choose their own doctor; and

d) that their chosen doctor can select the appropriate treatment for them, at the healthcare institution best suited to that treatment, in the opinion of their doctor.

3.3. The ASA submits that contrary to the arguments set out in the Application there will not be an improvement in health outcomes if the Proposed Conduct is authorised. Instead, there is likely to be a reduction in choice of Provider and a limitation in availability of private health care. There will also be a substantial lessening of competition in the market for medical specialists.

Lack of Choice

3.4. Should a patient be insured by nib (or a member of the HH Buying Group) but their medical specialist has not entered into a contract with the HH Buying Group, then favourable rebates will not be available to that patient if they continue to attend their chosen Provider, and they will otherwise need to pay OOP expenses to be treated by that chosen Provider. While patients theoretically retain freedom of choice, that choice may be constrained by the significant additional OOP costs associated with receiving treatment from non-participating providers.

3.5. Paying different rebates for the same service depending upon whether a Provider is participating in the HH network has the potential to influence both patient and Provider behaviour. There is a clear disadvantage to patients who pay the same premium but may get lower rebates (and thus have more OOP expenses) when they choose to receive treatment from a Provider outside the relevant network or contracting arrangement. The ACCC should carefully consider whether the continuation and potential expansion of these arrangements over a further ten-year period may strengthen purchaser power and reduce the ability of medical specialists to compete independently of insurer-supported networks.

Provider benchmarking and performance assessment

3.6. The Application proposes the ongoing collection, aggregation and analysis of data relating to quality, efficiency, utilisation, compliance and treatment outcomes. This information will be used to benchmark Providers, assess performance and inform future contracting decisions. The ASA does not oppose the use of data to improve quality and transparency. However, the Application provides very limited detail regarding the methodology by which Providers will be assessed, benchmarked or ranked, including how differences in patient complexity, co-morbidities and demographics (for example) will be taken into account. There is a risk that Provider assessments developed primarily for contracting and purchasing purposes may not accurately reflect clinical complexity or individual patient circumstances. The ASA submits that the ACCC should consider whether the proposed benchmarking and performance measures may distort competition between Providers and create incentives that favour standardised treatment pathways over independent clinical decision-making, which the ASA submits would lead to poorer patient outcomes.

Availability of Providers / Rural and Regional Australia

3.7. The ACCC also must consider the potential impact of the Proposed Conduct on competition and patient access in regional and rural areas. There is already a desperate need for more medical specialists in rural and regional areas. According to the National Rural Health Alliance's 'Rural Health in Australia Snapshot 2025' (https://www.ruralhealth.org.au/wp-content/uploads/2025/02/NRHA-Rural-Health-in-Australia-Snapshot-2025.pdf), those in regional and remote communities are less likely to have private health insurance, and 18,405 people in remote and very remote Australia have no access to primary healthcare services within an hour drive time from their home. For these communities, there is likely to be only one local private health facility, or no practical alternative within reasonable travelling distance. If a medical specialist is unable to enter into an arrangement with HH (or another major health insurer) it is likely they will not be able to work in the private healthcare facility in that regional town. In those circumstances, the aggregation of purchaser power through collective contracting, preferred provider arrangements and differential rebate structures may have a more pronounced effect than in metropolitan markets. Where patients face materially higher out-of-pocket costs for treatment by non-participating specialists, there is a risk that insurer-supported networks will influence patient choice and referral patterns to a greater extent in regional areas where alternatives are limited.

3.8. The ASA submits there is a crisis unfolding with the closure of private services across regional and remote Australia due to lack of financial viability, with insurer funding pressures as a dominant driver, underscoring the fragility of non-metropolitan essential services provision. Operators are forced to prioritise commercial viability over continuation of essential but workforce-intensive services like maternity, mental health, rehabilitation and paediatrics. A number of regional or rural services have recently closed, for example:

(a) **Maternity** - Bunbury (St John of God Bunbury Maternity - June 2024), Gosford (Gosford Private Maternity - March 2025), Darwin (Darwin Private Maternity - June 2025), Hobart (Hobart Private Hospital Maternity Service - August 2025), Gladstone (Mater Gladstone - October 2018), Cairns (Cairns Private - November 2023)

(b) **Mental health** – Hobart (The Hobart Clinic - October 2025, St Helen's Private Hospital - July 2023), Toowoomba (The Toowoomba Clinic - May 2024), Mt Alban/Sunshine (Sunshine Private - May 2024), Cockburn (Bethesda Clinic - February 2024), Cooroy (Eden Private Hospital - February 2024)

(c) **Rehabilitation** - Ivanhoe (North Eastern Rehab Centre - April 2026)

(d) **Hospital wide** – Mackay (Mackay Private - June 2026), Canberra (Canberra Private - expected to close in September 2026), Victor Harbor (Victor Harbor Private April 2024)

With the closure of the Dawin and Hobart private maternity units, it was reported that hundreds of women were left with little option for where they would give birth, likely inundating nearby public hospitals: Why HealthScope maternity closures are an 'absolute crisis' and a symptom of a bigger problem - ABC News (https://www.abc.net.au/news/2025-02-21/srt-maternity-closures-insurance-private-health/104959630). Indeed, articles published referencing such closures often refer to financial difficulties due to negotiation with private health insurers, for example: Victor Harbor Private Hospital to close with beds to be transferred to public system - ABC News (https://www.abc.net.au/news/2024-02-20/sa-victor-harbor-private-hospital-closure-/103484110); Health insurers accused of 'aggressive' and 'almost bullying' tactics in private hospital dealings - ABC News (https://www.abc.net.au/news/2026-04-28/health-insurers-aggressive-tactics-accusations-private-hospitals/106598450).

3.9. The ASA submits that amalgamated buying groups further concentrate market power with the likely effect of stronger leverage over suppliers and payers without any enforceable obligation to maintain regional, remote, obstetric, paediatric, or mental health services. Rural and remote maternity closure literature shows consistent harms from travel, safety concerns, emotional burden, and fragmented care. Public hospitals are left to absorb displaced births and other complex or low-margin care, creating a more difficult case mix and greater pressure on public capacity, which is harder to absorb in regional and remote locations with existing workforce limitations.

3.10. The Applicants have not provided any meaningful assessment of the potential impact of the proposed conduct on competition for specialist services in regional and rural markets or on patient access to specialist care in those areas and the ASA notes that there is no evidence that during the time authorisation AA1000542 has been in effect there has been any positive impact on access in vulnerable markets. Conversely, the observed pattern is of increasing closures of low-margin services and transfer of demand into public hospitals, with worsening access for regional and remote communities.

Substantial lessening of competition / Significant increase in market power

3.11. HH intends to negotiate one set of terms and conditions including price schedules, business rules for payment of benefits and quality and performance targets for all providers (see paragraph 5.25: Application). It wishes to do this with a buying group representing nib and other Participants. The Proposed Conduct will therefore result in an

enhanced ability for HH, nib and other health insurers to increase prices and profits and increase barriers to entry in the localised and national market for medical specialists.

3.12. Paragraph 5.25 of the Application describes a highly coordinated collective purchasing arrangement that extends well beyond the purpose of administrative efficiencies. Under the proposal, HH will aggregate claims and utilisation data across competing healthcare payers, establish common benchmarks for price, quality and service delivery, and then use that aggregated information to negotiate a single set of commercial terms, pricing schedules, performance metrics and business rules on behalf of multiple purchasers. In practical terms, this replaces independent negotiations between healthcare payers and Providers with a centralised purchasing mechanism that reduces competition in the acquisition of specialist medical services. The Proposed Conduct increases buyer concentration and bargaining power and creates a significant risk that providers will be compelled to contract on standardised terms determined by a collective of Purchasers rather than through competitive, bilateral negotiations. The ACCC should closely scrutinise whether the claimed efficiencies could be achieved through less competition-restrictive means, particularly given the Applicants' proposal to share data, develop common benchmarks, and negotiate uniform contractual and pricing arrangements across Participants. These features are characteristic of coordinated purchasing conduct that would otherwise raise serious concerns under sections 45 and 45AD(2) of the CCA and require clear and compelling evidence of public benefit before authorisation could be justified (if it can be authorised at all in light of the provisions of section 90(8)(a) of the CCA).

3.13. The market power that will be held by HH will be significant and an individual Provider will be at a substantial disadvantage and, realistically, be unable to negotiate on his or her own behalf. HH will instead be setting the terms and conditions of any medical purchaser provider agreement (**MPPA**).

3.14. If authorisation is granted, the reality is that the practical ability of many medical specialists to decline participation may be significantly constrained by commercial realities, particularly where a substantial proportion of privately insured patients are covered by Participants. HH would be in a position to exert considerable pressure on medical specialists to engage in the collective negotiations and if they do not the likelihood is that the medical specialist will not be able to practice at a specified healthcare facility or provide healthcare services to any HH and nib member.

3.15. Whilst the ASA acknowledges that the Proposed Conduct will not prevent Providers from offering healthcare services to other insurers, buying groups or healthcare payers that are not participating in the HH buying group, and will not restrict the terms and conditions on which the Provider is entitled to enter those agreements , it would be incorrect to state this means that Providers are not at any disadvantage or there is not a substantial lessening of competition in the market.

3.16. There will also be a significant impact upon Providers in relation to the proposed data analytic services which it is said will be part of contract negotiations (see paragraph 5.32: Application). HH proposes to collect, aggregate, analyse and disseminate provider-specific information including, but not limited to, cost information, adverse incident information,

breach of contract information and discovery of fraudulent claims (see paragraph 5.33: Application). This information will presumably be shared without the knowledge of the Provider - resulting in a lack of procedural fairness and, unless consent is provided, in breach of the Provider's privacy and privacy obligations. This information may then be used in benchmarking exercises, contract negotiations and purchasing decisions across multiple Participants. The Application provides limited detail regarding how Providers will be able to challenge, correct or respond to adverse information held or distributed by HH, particularly where allegations remain disputed or untested. The likelihood of any Provider willingly consenting to the sharing of such information is negligible but again, realistically, the Provider will be unable to negotiate, and considerable pressure will be exerted to extract consent. Further, these arrangements would give participating purchasers access to a centralised repository of detailed Provider information that would not otherwise be available to competing healthcare payers. This has the potential to increase information asymmetries, facilitate coordinated purchasing behaviour and further strengthen the collective bargaining position of Participants in negotiations with Providers while the Provider will not be fully informed about the information available to Participants.

3.17. The Applicants correctly acknowledge at paragraph 5.35 that the proposed conduct engages several core competition law prohibitions, including cartel provisions, concerted practices, misuse of market power, arrangements that may substantially lessen competition and exclusive dealing. Against that background, the rationale advanced at paragraph 5.36 is insufficient to justify the breadth of the proposed conduct. Much of the claimed benefit is expressed at a high level and remains speculative, particularly given the Applicants' acknowledgment elsewhere in the application that the HH Buying Group has attracted only one participant over the course of the existing authorisation and has not delivered many of the benefits originally anticipated. The asserted efficiencies from collective negotiations, information sharing and aggregated data analytics must be weighed against the very real competitive consequences of reducing independent purchasing decisions, standardising contractual terms and pricing approaches, and increasing collective buyer power in negotiations with Providers. The application does not adequately explain why these objectives could not be achieved through less restrictive arrangements that preserve competition between purchasers, nor does it provide compelling evidence that the significant competition risks identified in paragraph 5.35 are outweighed by demonstrable public benefits. In those circumstances, the rationale advanced for the proposed conduct falls short of establishing that authorisation is warranted.

3.18. Finally on this topic, the ASA disagrees with the final sentence of paragraph 5.42(b) of the Application. The GapSure scheme simply provides nib greater control over doctors' billing.

4. Period of Authorisation sought

4.1. The ACCC previously concluded that participation by Major PHIs in collective specialist contracting arrangements was capable of generating public detriment through an imbalance in bargaining power between insurers and medical specialists. That concern remains relevant to the current application and supports scrutiny of the substantially longer authorisation period now sought.

4.2. The ACCC intentionally chose a five-year authorisation period so that it could assess the actual operation and consequences of the HH Buying Group before considering any further authorisation. The evidence from the first five years demonstrates that many of the anticipated benefits have not materialised and uptake has remained limited. Against that background, there is no persuasive basis for the ACCC to depart from its earlier reasoning and grant the substantially longer ten-year authorisation now sought.

4.3. Perhaps the most compelling reason why the Application should not be granted is because the 2021 authorisation was granted largely on the basis that HH Buying Group would create a meaningful alternative buying group, increase competition among buying groups, stimulate innovation and create efficiencies for smaller health funds. After nearly five years:

a) no meaningful number of private health insurers has joined;

b) HH Buying Group has failed to achieve the scale originally forecast;

c) the overwhelming majority of potential participants remain members of Australian Health Service Alliance or Australian Regional Health Group; and

d) many claimed efficiencies remain speculative rather than demonstrated.

4.4. The ASA submits that the ACCC should be cautious about relying on projected future benefits which have not emerged despite a substantial authorisation period already having elapsed. In effect, the Applicants are seeking a further 10 year authorisation for anti-competitive conduct based largely on purported benefits that remain hypothetical.

4.5. In that regard, the Applicants seek to attribute the limited growth of the HH Buying Group to the shortness of the initial authorisation period. However, that assertion is not supported by any compelling evidence. The fact remains that, after almost five years of operation, the HH Buying Group has attracted only one additional participant, QBE, and no additional private health insurers. The ACCC should therefore be cautious about accepting the proposition that a further ten-year authorisation is warranted on the basis of public benefits that have yet to materialise. If the participation, scale and benefits of the HH Buying Group have remained limited during the existing authorisation period, that points away from granting a substantially longer authorisation and instead supports a fresh and rigorous reassessment of both the claimed public benefits and the competition risks associated with the conduct. Equally, if the Applicants are correct that a longer authorisation period will facilitate significant expansion of the HH Buying Group, wider participation by health funds, greater aggregation of data and more extensive collective contracting arrangements, then the potential competition impacts of the conduct will become more significant, not less. In either case, the ASA submits that the Applicants have not established a persuasive basis for the ACCC to move from a five-year authorisation to the ten-year period now sought (noting that the ASA's primary position is that there should be no authorisation at all).

4.6. Paragraphs 8.23 to 8.26 of the Application acknowledge an important aspect of the ACCC's 2021 determination, namely that collective bargaining arrangements of this kind can create an imbalance in bargaining power between health insurers and medical specialists and lead to inefficient outcomes in the acquisition of specialist medical

services. While the Applicants emphasise that the ACCC addressed this concern through the exclusion of Major PHIs from participation in the BCPP, the existence of that condition should not be treated as conclusively resolving all competition concerns arising from the proposed conduct. The ACCC's earlier findings recognised the potential for collective purchasing arrangements to reduce the alternative contracting options available to medical specialists and enhance insurer bargaining power. The current application seeks a further ten-year authorisation during which the Applicants expressly intend to expand participation in the HH Buying Group, broaden their contracting activities, increase the aggregation of claims and performance data, and extend no-gap and other collective contracting programs. In those circumstances, the ACCC should not assume that the competition assessment undertaken in 2021 remains unchanged. Rather, it should carefully reassess whether the cumulative effect of expanded participation and more sophisticated collective contracting arrangements may increase purchaser power and further constrain the ability of medical specialists to negotiate independently. The fact that a condition was required in 2021 to address identified public detriments highlights the need for continued caution and close scrutiny, particularly where a substantially longer authorisation period is now being sought.

5. Clarification regarding alleged engagement with ASA

5.1. Paragraph 7.6 of the Application overstates the nature and significance of the ASA's interactions with HH, nib and related entities. While representatives of the ASA have attended meetings and discussions with nib and HH from time to time, those engagements occurred for the purpose of receiving information, raising concerns and advocating on behalf of anaesthetists affected by insurer contracting arrangements. The ASA did not collaborate in the development of, support, endorse or approve HH's contracting models, the nib MediGap Scheme, the GapSure scheme, any fee schedules, billing rules, unit values, gap caps or other product features. HH's presentation of its proposals to the ASA comprised a one hour conference session at the ASA Manager’s Conference on 1 December 2023 in Sydney. This consisted of a panel discussion, plus a Q&A with one representative each from nib / Honeysuckle, Bupa and Medibank Private. It was for information purposes only and the Committee's attendance at those meetings should not be characterised as endorsement or support for any aspect of the conduct for which authorisation is sought. To the extent that the Applicants seek to rely upon discussions with the ASA as evidence of acceptance of, or support for, the proposed conduct, that reliance is misplaced. Further, the Applicants' reference to changes to the GapSure scheme and related products does not reflect the fact that aspects of those arrangements arose from discussions with individual Newcastle-based anaesthetists acting in their personal capacities, rather than through the ASA or any of its Committees or office holders. The ACCC should therefore place little weight on paragraph 7.6 as evidence of industry support for the Proposed Conduct.

6. Changes since 2021 Application

6.1. The Applicants seek to rely on a broad range of public benefits. However, the ACCC's 2021 determination accepted only a relatively narrow range of claimed benefits and expressly declined to conclude that the conduct would result in more efficient hospital

pricing or significant additional transaction cost savings. To the extent those claims are re-advanced in the current application, they should be treated cautiously.

6.2. The ACCC's earlier assessment of governance, incentives and information-sharing occurred in circumstances where HH was jointly owned by nib and Cigna. The position has materially changed following nib's acquisition of Cigna's interest. The ACCC should therefore undertake a fresh assessment rather than relying on conclusions reached in a substantially different ownership environment.

6.3. Importantly, the ACCC previously recognised that nib's ownership interest in HH created at least the appearance of a potential conflict of interest but accepted the Applicants' assurances in circumstances where HH was jointly owned by nib and Cigna and where the commercial success of the Buying Group depended upon attracting participants. The ACCC also noted that a significant change in HH's ownership structure may warrant review of the authorisation. The Applicants now seek to characterise nib's acquisition of Cigna's interest as immaterial, but the ACCC should carefully reconsider whether the assumptions that underpinned its 2021 assessment remain valid now that HH is wholly owned and controlled by nib.

7. Summary

7.1. The ASA submits the real purpose of the conduct described in the Application is to decrease payments to Providers and to seek to standardise the healthcare services given by Providers in order to minimise overall costs for health insurers and thereby increase profits. Consumers will not benefit from authorisation of this Proposed Conduct.

7.2. The ASA would be happy to provide further information if required by the ACCC and is willing to participate in any Conference.

Yours sincerely,

Matthew Fisher PhD DHlthSt (honoris causa)
Chief Executive Officer
Australian Society of Anaesthetists