



Australian
Competition &
Consumer
Commission

Determination

Applications for authorisation

lodged by

Australian Dental Association Inc.

in respect of

**agreements as to the fees to be charged for
dental services provided within shared practices**

Date: 10 December 2008

Authorisation no.: A91094
A91095

Public Register no.: C2008/1170

Commissioners: Samuel
Schaper
Dimasi
Kell
King
Martin
Willet

Summary

The ACCC has decided to grant authorisation to the Australian Dental Association for the making of, or giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists who practice in a shared practice as to the fees to be charged for dental services provided in the practice.

The ACCC has decided to grant authorisation until 28 February 2013.

The authorisation process

The Australian Competition and Consumer Commission (ACCC) can grant immunity from the application of the competition provisions of the *Trade Practices Act 1974* (the Act) if it is satisfied that the benefit to the public from the conduct outweighs any public detriment. The ACCC conducts a public consultation process to assist it to determine whether a proposed arrangement results in a net public benefit.

The applications for authorisation

On 18 July 2008 the Australian Dental Association Inc. (ADA) lodged applications for authorisation A91094 and A91095 with the ACCC.

The ADA is seeking authorisation for the making of, or giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists who practice in a shared practice as to fees to be charged for dental services provided in the practice.

The ADA has sought authorisation for conduct that may be price fixing and may contain an exclusionary provision.

Public detriment

The ACCC considers that while there is the potential for anti-competitive detriment to result from price setting within a shared dental practice, any potential detriment is likely to be limited. In particular, the ACCC notes the arrangements are confined to agreements on price within practices operating under a shared business structure. There are various business structures through which dental services are provided. Further, dentists within a shared practice will continue to set their fees based on a range of factors including competition, where relevant, from nearby practices. Although the ACCC notes that such competition is likely to be greater in metropolitan areas where there are larger numbers of dental practices.

Public benefit

The ACCC is satisfied that the consistency of fees within a practice can assist with ensuring the predicability of costs for treatment within that practice and for the course of treatment required. This, in turn, assists with the continuity and consistency of patient care.

Balance of public benefit and detriment

Overall, the ACCC considers that in all the circumstances, the likely public benefit generated by allowing dentists and/or dental specialists within a shared practice to agree on fees, will outweigh the likely public detriment.

The ACCC grants authorisation to the ADA to enable agreements on the fees to be charged for dental services provided within shared practices with the following features:

- a common practice trading name
- shared staff, for example, dental hygienists, administrative and support staff
- shared dental records and treatment of patients by other members of the practice
- a common reception and premises
- shared dental equipment and supplies.

The ACCC considers that practitioners in these types of practices are more likely to have common administrative and operational costs which may limit the detriments and reinforce the benefits flowing from the authorisation.

Length of authorisation

The ACCC generally considers it appropriate to grant authorisation for a limited period of time, so as to allow an authorisation to be reviewed in the light of any changed circumstances.

In this instance, the ACCC considers that a four year time limit is appropriate.

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1. Introduction

Authorisation

- 1.1 The Australian Competition and Consumer Commission (the ACCC) is the independent Australian Government agency responsible for administering the *Trade Practices Act 1974* (the Act). A key objective of the Act is to prevent anti-competitive conduct, thereby encouraging competition and efficiency in business, resulting in a greater choice for consumers in price, quality and service.
- 1.2 The Act, however, allows the ACCC to grant immunity from legal action in certain circumstances for conduct that might otherwise raise concerns under the competition provisions of the Act. One way in which parties may obtain immunity is to apply to the ACCC for what is known as an 'authorisation'.
- 1.3 The ACCC may 'authorise' businesses to engage in anti-competitive conduct where it is satisfied that the public benefit from the conduct outweighs any public detriment.
- 1.4 The ACCC conducts a public consultation process when it receives an application for authorisation. The ACCC invites interested parties to lodge submissions outlining whether they support the application or not, and their reasons for this.
- 1.5 After considering submissions, the ACCC issues a draft determination proposing to either grant the application or deny the application.
- 1.6 Once a draft determination is released, the applicant or any interested party may request that the ACCC hold a conference. A conference provides all parties with the opportunity to put oral submissions to the ACCC in response to the draft determination. The ACCC will also invite the applicant and interested parties to lodge written submissions commenting on the draft.
- 1.7 The ACCC then reconsiders the application taking into account the comments made at the conference (if one is requested) and any further submissions received and issues a final determination. Should the public benefit outweigh the public detriment, the ACCC may grant authorisation. If not, authorisation may be denied. However, in some cases it may still be possible to grant authorisation where conditions can be imposed which sufficiently increase the benefit to the public or reduce the public detriment.

The application for authorisation

- 1.8 On 18 July 2008 the Australian Dental Association Inc. (ADA) lodged applications for authorisation A91094 and A91095 with the ACCC.
- 1.9 The ADA sought authorisation for the making of, or giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists who practice in a shared practice as to fees to be charged for dental services provided in the practice.

- 1.10 The ADA sought authorisation for conduct that may be price fixing and may contain an exclusionary provision.
- 1.11 The ADA sought authorisation for a period of five years.

Chronology

- 1.12 Table 1.1 provides a chronology of significant dates in the consideration of these applications.

Table 1.1: Chronology of applications for authorisation A91094 and A91095

DATE	ACTION
18 July 2008	Applications for authorisation lodged with the ACCC.
15 August 2008	Closing date for submissions from interested parties. Submissions were received until 27 August 2008.
5 September 2008	ACCC received the ADA's response to interested party submissions.
22 October 2008	Draft determination issued. Interested party consultations on the draft determination commence.
5 November 2008	Closing date for a request for a pre decision conference. No request was received.
12 November 2008	Closing date for submissions from interested parties. ADA invited to respond to interested party submissions.
10 December 2008	Determination issued

2. Background to the application

The applicant¹

- 2.1 The Australian Dental Association Inc. (ADA) is the peak professional organisation representing dentists. It is a national organisation with branches in all states and territories. Membership is voluntary and over 90% of dentists in Australia are members.
- 2.2 The aims of the ADA are to encourage the health of the public and promote the art and science of dentistry.

The industry

Dental sector

- 2.3 A dentist is a registered primary healthcare professional educated and specialised in the care of teeth, gums, bone support and the mouth. Dentists identify and treat dental diseases as well as provide preventative oral health services for teeth. General practice dentists provide dental care to the public in both private and/or public sector dental health services.
- 2.4 Dental specialists provide specialised services and include Endodontists, Oral and Maxillofacial Surgeons, Orthodontists, Paediatric dentists, Periodontists, Prosthodontists, Oral Pathologists and Dental Radiologists.

Dental practices

- 2.5 The majority of dentists in Australia work in private practice. The ADA advise that approximately 82% of practising dentists work in the private sector, 15% work in the public sector and 2% work in 'other' practice types.²
- 2.6 The ADA notes that there is a significant amount of diversity in the business structures utilised by dentists in private practice. These include:
- sole practitioner
 - a single dentist trading as an incorporated entity
 - one or more shareholder dentists in an incorporated entity
 - employment as an assistant in a practice i.e. being employed and receiving a salary from the practice
 - shared practices including:

¹ The majority of this information in this chapter is sourced from the ADA's supporting submission to the ACCC of 18 July 2008

² See Teusner, D.N. and Chrisopoulos, S (2006) 'Australian Dental Labour Force 2003', *Australian Dental Journal*, Vol. 51, No.2 p192

- partnership of two or more practitioners where expenses are shared and profits and losses allocated in agreed proportions
- dentists practising in conjunction with one or more other dentists, charging separately in accordance with an agreed fee schedule and featuring elements listed in paragraphs 2.7 and 2.8 below. The ADA notes that dentists practising in such a structure are often classified as being an 'associate dentist'.

2.7 Shared dental practices typically feature the following elements:

- two or more dental practitioners who may, but do not necessarily, practice in a partnership
- shared staff including dental hygienists, administrative and support staff
- treatment of patients of other members of the practice
- shared dental records
- shared premises and/or satellite offices
- a shared practice name
- a common reception
- shared dental equipment and supplies
- joint advertising.

2.8 Shared practices may also have:

- common billing and fee collection and other financial functions
- common policies and procedures and/or
- a common service entity.

2.9 In 2005, the ADA conducted a Dental Practice Survey of its members for the financial year ended 30 June 2004. The survey responses indicated the following types of business structures in private practice:

Type of practice	Percentage of respondents
Sole Practitioner	56%
Incorporated Practitioner	11%
Employing Practitioner	8%
Partnership Practitioner	14%
Specialist	11%

2.10 The ADA advise that shared practices exist in more than one of the 'types of practice' identified in the Dental Practice Survey, as dentists who practise in a shared practice may characterise themselves as either a sole practitioner, an incorporated practitioner, a partnership practitioner or a specialist, depending upon their individual circumstances.

- 2.11 The ADA notes that although the Dental Practice Survey did not quantify the number of dentists working in a shared practice, private practices were asked about their practice structure and 20% indicated that they had some form of 'associate relationship'.

Supply of dental services

- 2.12 Based on the most recent figures available in 2003 there were 11 404 registered dentists in Australia of which an estimated 9 678 were currently practising.
- 2.13 The number of dentists practising per head of population across the states and territories in 2003 is as follows:

Table: Number of dentists practising in Australian states and territories per 100,000 head of population

State/Territory	Major city	Inner regional	Outer regional	Remote/Very remote	Total
NSW	57.0	33.6	18.1	11.1	49.0
Vic	52.4	28.4	22.8	0.0	45.7
QLD	55.7	39.8	34.2	10.6	45.9
SA	66.0	23.5	28.1	27.1	54.7
WA	55.8	32.0	34.9	17.7	48.0
Tas	N/A	39.2	9.6	0.0	28.2
NT	N/A	N/A	36.6	13.8	26.1
ACT	56.0	0.0	N/A	N/A	55.9
<i>Total</i>	<i>56.2</i>	<i>33.6</i>	<i>26.6</i>	<i>22.9</i>	<i>47.4</i>

Source: ADA supporting submission dated 18 July 2008

- 2.14 In 2006 the Productivity Commission identified shortages in dentistry workforce supply³. The aggregate projected shortage in supply in 2010 has been estimated at approximately 3.8 million visits⁴. The ADA submits this shortage is throughout Australia, although it is more acute in outer metropolitan, rural and remote areas and indigenous areas.

³ Productivity Commission report into Australia's Health Workforce 2006, p XVI

⁴ Productivity Commission report into Australia's Health Workforce 2006, p XVI

3. The applications for authorisation

- 3.1 The ADA has sought authorisation for the making of, or giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists who practice in a shared practice as to fees to be charged for dental services provided in the practice.
- 3.2 The setting of fees within a shared practice potentially raises concerns under the anti-competitive conduct provisions of the Act. Consequently, the ADA has lodged the applications for authorisation with the ACCC.
- 3.3 The ADA's applications for authorisation extends to all contracts, arrangements or understandings in similar terms to the proposed conduct, to the extent that giving effect to the proposed conduct results in contracts, arrangements or understandings in similar terms.
- 3.4 The ADA advise that the authorisation with respect to an exclusionary provision was sought to ensure that any agreement with respect to fees within a shared practice could not potentially constitute a provision of a contract, arrangement or understanding between practitioners which is said to have the purpose of restricting or limiting the supply of dental services to patients in particular circumstances or on particular conditions, namely, other than in accordance with the agreed fee schedule.
- 3.5 Under section 88(6) of the Act, any authorisation granted by the ACCC is automatically extended to cover any person named in the authorisation as being a party or proposed party to the conduct.

4. Submissions received by the ACCC

- 4.1 A summary of the views of the ADA and interested parties is outlined below and are considered in the ACCC's evaluation of the proposed arrangements in Chapter 6 of this determination. Copies of public submissions are available from the ACCC website (www.accc.gov.au) by following the 'Public Registers' and 'Authorisations and Notifications Public Registers' links.

Prior to the draft determination

- 4.2 The ADA provided a supporting submission with its application for authorisation and has since provided a submission dated 5 September 2008 responding to the submissions received from interested parties.
- 4.3 The ACCC also sought submissions from around 35 interested parties potentially affected by the applications, including state and federal health departments, consumer groups, community and health services bodies and other relevant health entities. The ACCC received public submissions from:
- Centre for Oral Health Strategy NSW
 - Dental Board of the Northern Territory
 - Dental Board of Queensland
 - Dental Practice Board of Victoria
 - Rural Dental Action Group
 - South Australian Dental Service.

The ADA's supporting submission

- 4.4 The ADA submits that the authorisation, if granted, will allow dentists and dental specialists in a shared practice to agree on the fees to be charged to patients. The ADA argues that a shared practice cannot exist without the ability to agree on fees to be charged by the practice. The ADA notes that the authorised conduct will only apply within shared practices, and will not apply to conduct between other practices, and therefore will not adversely affect competition between dental practices.
- 4.5 The ADA notes that dentists work in diverse, complex and overlapping business structures. For dentists and dental specialists operating in the shared practice structure, authorisation would permit dentists working in a shared practice to agree on the fees that the practice charges patients, irrespective of their legal structure. The ADA noted that under other group business structures including partnerships and incorporated entities, dentists can collectively agree on the price they charge patients.
- 4.6 The ADA submits that the authorisation will ensure that the Act does not prevent a shared practice from existing in another form, namely a shared practice between two or more dental practitioners which possess the characteristics outlined at paragraph 2.7. The ADA further submits that it will provide dentists with flexibility to choose the

business structure that best suits their needs and has the potential to encourage competition.

- 4.7 The ADA submits that allowing dentists to agree on fees in a shared practice will improve the range of dental services offered by the practice and the efficiency of such services as the practice will be able to share costs and utilise economies of scale in the purchase of major equipment.
- 4.8 The ADA further submits that shared practices improve the availability of dental services for patients. The ADA also submits that shared practices promote a culture of teamwork and improve the quality of dental services available to patients.
- 4.9 The ADA submits that the authorisation will ensure continuity and consistency of patient care as different dentists within the practice will be able to access patient information and patient records.

Interested party submissions

Centre for Oral Health Strategy, NSW

- 4.10 The Centre for Oral Health Strategy NSW (the Centre) submits that the evidence to support the claimed benefits from the application is not strong, so a mechanism should be put in place to measure performance in achieving the claimed public benefits. Such performance evaluation should include the stated benefits, and a measure of improved public affordability of dental services.

Dental Board of the Northern Territory

- 4.11 The Dental Board of the Northern Territory supports the ADA's applications.

Dental Board of Queensland

- 4.12 The Dental Board of Queensland submits that, provided the dentists in their price fixing conduct do not behave in a way that constitutes unsatisfactory professional conduct, the matter would not come within the functions of the Board.

Dental Practice Board of Victoria

- 4.13 The Dental Practice Board of Victoria (DPBV) supports the application as it believes that multiple fee scales within the one practice could only increase the cost of dental services to the public in the long run.

Rural Dental Action Group

- 4.14 The Rural Dental Action Group supports the ADA's applications for authorisation.

South Australian Dental Service

- 4.15 The South Australian Dental Service (SADS) considers that any significant reduction in competition in the private dental sector that may result from price fixing conduct coupled with increased demand for dental services in the private sector could impact negatively on the future costs to the SADS in purchasing services from the private

sector. This would in turn affect the ability of the SADS to meet its public dental needs from the private sector, particularly in rural and remote areas.

- 4.16 The SADS agrees with the ADA that shared practice arrangements can benefit clients as claimed by the ADA, however the SADS notes that shared practice arrangements are already widespread, without common fee agreements in place. The SADS submits that it is questionable whether shared practice arrangements that allow these benefits to occur also require a common fee to be charged.

Response by the ADA to interested party submissions

- 4.17 In response to interested party concerns raised in relation to the current existence of shared practices, the ADA submits that shared practices currently in existence typically take the form of partnerships. The ADA notes that it is seeking authorisation for its members to set fees for shared practices that may include, but are not limited to, a partnership structure. The authorisation, if granted, will encourage the further use of the shared practice structure, which may make it easier for practitioners to offer a greater range and higher quality of services to patients.
- 4.18 The ADA notes the SADS concerns that the authorisation will result in a lessening of competition. In this regard, the ADA notes that the authorisation is in relation to conduct within a shared practice and will not adversely affect competition between dental practices.
- 4.19 The ADA submits that although the SADS recognise there is a shortage of dental services, the SADS has not recognised that the authorisation will help increase the availability and range of services, and in particular will increase the availability of dental services to meet the increased demand predicted by the SADS. The ADA submits that any potential for practitioners in a shared practice to increase fees in dealing with government purchasers of dental services will be offset by the bargaining power of State and Federal Governments in the acquisition of dental services.
- 4.20 The ADA submits that the expiry of the authorisation in five years will provide an opportunity to review the conduct, including the public benefits.

Following the draft determination

- 4.21 On 22 October 2008 the ACCC issued a draft determination in relation to the applications for authorisation. The draft determination proposed to grant authorisation to the arrangements for a period for four years.
- 4.22 A conference was not requested in relation to the draft determination.
- 4.23 The ACCC received five public submissions in response to the draft determination from the ADA, the DPBV, SA Health, the Australian Health Insurance Association and the Australian Dental Industry Association Inc.

The ADA's submission

- 4.24 The ADA asked that a modification be made to the draft determination in which the authorisation is expressed to apply to '*...agreements as to the fees to be charged for dental services provided within shared practices which operate as a team and share*

patient records, common facilities, a common trading name and common policies and procedures (paragraph 7.7). The ADA considers that the use of the words “which operate as a team” may result in some uncertainty as to the scope of the authorised conduct, as it is not a well understood legal concept and is covered by the other characteristics referred to by the ACCC (i.e. sharing patient records, common facilities, a common trading name and common procedures and policies).

Interested party submissions

SA Health

- 4.25 SA Health provided a submission on behalf of all its divisions and health regions, including SADS. SA Health continues to question the need to implement the conduct in order to achieve the public benefits.
- 4.26 SA Health submits that there is limited evidence to definitively support the claimed benefits. As such, there is a need to measure whether there is any improved affordability of dental services or at least the need for evidence demonstrating that competition has not been impeded by the conduct. SA Health submits the ACCC should document how it will measure the net public benefit including impacts on competition at the end of the four year period.
- 4.27 SA Health requests that the term ‘shared practice’ be defined, noting there is the potential for a shared practice to exist over multiple sites. SA Health submits the arguments made to support the authorisation are not necessarily relevant to a multi-site shared practice.
- 4.28 SA Health acknowledges that the overlap in services between dentists and specialists is likely to be minimal and as such any detriment in those shared practices is likely to be limited.

Australian Health Insurance Association

- 4.29 The Australian Health Insurance Association (the AHIA) submits that in general the draft determination is a reasonable commercial approach to allow dentists within shared practices to establish a common fee.
- 4.30 The AHIA notes that a significant number of dentists already engage in ‘preferred provider’ arrangements with some of the larger private health funds. The AHIA considers that in practical terms, these participating dental arrangements mean some funds will allow for providers within the one practice to utilise the same fee, presumably for using common billing systems with the intent of reducing overheads for the practice as a whole.
- 4.31 However, the AHIA notes that it would be concerned about an increase in dentists’ market power if practices were to increase in size in any uncontrolled fashion.
- 4.32 The AHIA also submits that it would be concerned if the movement to a common fee increased the overall charges for the set group of dentists establishing the common fee, for example, if all dentists moved to the same maximum common fee utilised by one dentist in the practice.

Dental Practice Board of Victoria

4.33 The Dental Practice Board of Victoria supports the draft determination.

Australian Dental Industry Association Inc

4.34 The Australian Dental Industry Association Inc supports the draft determination.

5. The net public benefit test

- 5.1 The ACCC may only grant authorisation where the relevant test in section 90 of the Act is satisfied.

Application A91094

- 5.2 The ADA lodged application for authorisation A91094 under section 88(1) of the Act to make and give effect to a contract, arrangement or understanding, a provision of which is or may be an exclusionary provision within the meaning of section 45 of the Act.
- 5.3 The relevant test is found in section 90(8) of the Act.
- 5.4 Section 90(8) states that the ACCC shall not authorise a proposed exclusionary provision of a contract, arrangement or understanding, unless it is satisfied in all the circumstances that the proposed provision would result or be likely to result in such a benefit to the public that the proposed contract, arrangement or understanding should be authorised.

Application A91095

- 5.5 The ADA lodged application for authorisation A91095 under section 88(1) of the Act to make and give effect to a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would have or might have the effect, of substantially lessening competition within the meaning of section 45 of the Act. The relevant tests for this application are found in sections 90(6) and 90(7) of the Act.
- 5.6 In respect of the making of and giving effect to the arrangements, sections 90(6) and 90(7) of the Act state that the ACCC shall not authorise a provision of a proposed contract, arrangement or understanding, other than an exclusionary provision, unless it is satisfied in all the circumstances that:
- the provision of the proposed contract, arrangement or understanding would result, or be likely to result, in a benefit to the public and
 - this benefit would outweigh the detriment to the public constituted by any lessening of competition that would result, or be likely to result, if the proposed contract or arrangement was made and the provision concerned was given effect to.

Application of the tests

- 5.7 There is some variation in the language in the Act, particularly between the tests in sections 90(6)/90(7) and 90(8).
- 5.8 The Australian Competition Tribunal (the Tribunal) has found that the tests are not precisely the same. The Tribunal has stated that the test under section 90(6) is limited

to a consideration of those detriments arising from a lessening of competition but the test under section 90(8) is not so limited.⁵

5.9 However, the Tribunal has previously stated that regarding the test under section 90(6):

[the] fact that the only public detriment to be taken into account is lessening of competition does not mean that other detriments are not to be weighed in the balance when a judgment is being made. Something relied upon as a benefit may have a beneficial, and also a detrimental, effect on society. Such detrimental effect as it has must be considered in order to determine the extent of its beneficial effect.⁶

5.10 Consequently, when applying either test, the ACCC can take most, if not all, public detriments likely to result from the relevant conduct into account either by looking at the detriment side of the equation or when assessing the extent of the benefits.

5.11 Given the similarity in wording between sections 90(6) and 90(7), the ACCC considers the approach described above in relation to section 90(6) is also applicable to section 90(7).

Definition of public benefit and public detriment

5.12 Public benefit is not defined in the Act. However, the Tribunal has stated that the term should be given its widest possible meaning. In particular, it includes:

...anything of value to the community generally, any contribution to the aims pursued by society including as one of its principle elements ... the achievement of the economic goals of efficiency and progress.⁷

5.13 Public detriment is also not defined in the Act but the Tribunal has given the concept a wide ambit, including:

...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.⁸

Future with-and-without test

5.14 The ACCC applies the 'future with-and-without test' established by the Tribunal to identify and weigh the public benefit and public detriment generated by arrangements for which authorisation has been sought.⁹

⁵ *Australian Association of Pathology Practices Incorporated* [2004] ACompT 4; 7 April 2004. This view was supported in *VFF Chicken Meat Growers' Boycott Authorisation* [2006] ACompT9 at paragraph 67.

⁶ *Re Association of Consulting Engineers, Australia* (1981) ATPR 40-2-2 at 42788. See also: *Media Council case* (1978) ATPR 40-058 at 17606; and *Application of Southern Cross Beverages Pty. Ltd., Cadbury Schweppes Pty Ltd and Amatil Ltd for review* (1981) ATPR 40-200 at 42,763, 42766.

⁷ *Re 7-Eleven Stores* (1994) ATPR 41-357 at 42,677. See also *Queensland Co-operative Milling Association Ltd* (1976) ATPR 40-012 at 17,242.

⁸ *Re 7-Eleven Stores* (1994) ATPR 41-357 at 42,683.

⁹ *Australian Performing Rights Association* (1999) ATPR 41-701 at 42,936. See also for example: *Australian Association of Pathology Practices Incorporated* (2004) ATPR 41-985 at 48,556; *Re Media Council of Australia* (No.2) (1987) ATPR 40-774 at 48,419.

- 5.15 Under this test, the ACCC compares the public benefit and anti-competitive detriment generated by arrangements in the future if the authorisation is granted with those generated if the authorisation is not granted. This requires the ACCC to predict how the relevant markets will react if authorisation is not granted. This prediction is referred to as the ‘counterfactual’.

Length of authorisation

- 5.16 The ACCC can grant authorisation for a limited period of time.¹⁰

Conditions

- 5.17 The Act also allows the ACCC to grant authorisation subject to conditions.¹¹

Future and other parties

- 5.18 Applications to make or give effect to contracts, arrangements or understandings that might substantially lessen competition or constitute exclusionary provisions may be expressed to extend to:

- persons who become party to the contract, arrangement or understanding at some time in the future¹²
- persons named in the authorisation as being a party or a proposed party to the contract, arrangement or understanding.¹³

¹⁰ Section 91(1).

¹¹ Section 91(3).

¹² Section 88(10).

¹³ Section 88(6).

6. ACCC evaluation

- 6.1 The ACCC's evaluation of the proposed arrangements is in accordance with the net public benefit tests outlined in Chapter 5 of this determination. As required by the tests, it is necessary for the ACCC to assess the likely public benefits and detriments flowing from the proposed arrangements.

The market

- 6.2 The first step in assessing the effect of the conduct for which authorisation is sought, is to consider the relevant market(s) affected by that conduct.
- 6.3 For the purpose of assessing these applications, the ACCC accepts the submission by the ADA that the relevant areas of competition affected by the proposed conduct is the provision of private general and specialist dental services in localised geographic regions.
- 6.4 The ACCC notes that the ADA's applications relate to the provision of general and specialist dentistry services through shared dental practices. Such practice types exist in the private sector. Further, the ACCC notes that, as with other medical services, where possible patients are most likely to seek primary care in a fairly localised and convenient geographic region. The geographic boundaries may be larger for specialist services or in rural and regional areas.

The counterfactual

- 6.5 As noted in Chapter 5 of this determination, in order to identify and measure the public benefit and public detriment generated by conduct, the ACCC applies the 'future with-and-without test'.
- 6.6 The ADA submits that in the absence of authorisation, it does not follow that a dentist will instead establish a competing practice. The ADA submits that in rural and regional areas it is more likely that the practitioner would not establish a practice at all. Even in the case of specialists practicing in metropolitan areas, it is possible that the practitioner would instead join a shared practice in the form of a partnership.
- 6.7 The SADS questioned whether a shared practice needs to have agreed fees for services within the practice. The SADS submits that shared practices currently exist without authorisation and can continue without the need to require a common fee to be charged.
- 6.8 A single company, sole natural person, legal partnership with no corporate partners, or trust is a single legal entity. All dentists/specialists practising within a single legal entity in any of these forms – either as directors, employees or partners – are considered part of the same entity. They are therefore not in competition with each other for the purposes of the Act and are able to agree on the fees to be charged by that entity, without breaching the Act.
- 6.9 Dentists/specialists practising through separate legal entities, or within a legal partnership with at least one corporate partner, are considered competitors for the purposes of the Act.

- 6.10 Therefore the structure of the shared dental practice and the practitioners operating within the practice is significant to determining whether, absent authorisation, a common fee can be agreed. For example, the ADA submits that to the extent that shared practices already exist with common fees being charged, they are typically structured as partnerships. Within such practices competition in relation to fees is non-existent. This is the case with or without the authorisation in the ADA's view.
- 6.11 The ACCC considers that shared dental practices where practitioners operate as separate legal entities must not reach agreement on fees absent authorisation. In particular the ACCC notes a recent decision in the Federal Court of Australia that found three orthodontic businesses operating as separate legal entities in the same premises had engaged in price fixing and market sharing conduct in breach of the Act.¹⁴ The ACCC considers that absent authorisation, dentists/specialists in this situation must set their fees individually or re-structure their corporate arrangements to avoid breaching the Act.

Anti-competitive detriment

- 6.12 The ADA believes the proposed conduct will give rise to minimal public detriment. The ADA submits that the applications for authorisation are confined only to the making of or giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists who work in a shared practice, as to fees to be charged for dental services provided in that practice. The authorised conduct will only apply within shared practices, and will not apply to conduct between other practices, and therefore will not adversely affect competition between dentist practices.
- 6.13 The main detriment raised by interested parties is the potential for reduced competition which may lead to increased prices for consumers.
- 6.14 An assessment of the public detriment generated by the proposed arrangements follows.

Potential for reduced competition

Interested parties' view

- 6.15 The SADS notes that due to the significant demand for public dental services and insufficient public sector dentists to meet the increased demand, the SADS purchases around \$5 million worth of dental services (for example, emergency general restorative and denture services) annually from the private sector.
- 6.16 The SADS submits that any significant reduction in competition in the private dental sector that may result from price fixing conduct coupled with the increased demand for dental services in the private sector could impact negatively on the future costs to the SADS of purchasing services from the private sector. The SADS submits that this would in turn affect the ability of the SADS to meet its public dental needs from the private sector, particularly in rural and remote areas.

¹⁴ ACCC v Ranu Pty Ltd & Ors [2007] FCA 1777

- 6.17 SA Health noted that if there is a significant reduction in competition there will be impacts in relation to the future cost to SADS of purchasing services from the private sector.
- 6.18 The AHIA is concerned that an ability by dentists to set common fees across practices would have a significant inflationary impact on premiums, resulting in possible higher out of pocket charges for patients, adversely affecting those consumers with private cover.

The ADA's submission

- 6.19 The ADA submits that the authorisation is in relation to conduct within a shared practice and will not adversely affect competition between dental practices.
- 6.20 The ADA submits that in metropolitan and some larger rural areas, patients are free to select which practice and which dentist they attend. The ADA notes that given that shared practices already exist in the form of partnerships and incorporated entities, the authorised conduct will not lessen competition, but will increase the opportunities for practitioners to operate in a shared practice.
- 6.21 The ADA further submits that in rural areas where there may not be the same level of competition, the demand for dental visits is likely to be greater than the supply of dental services. The ADA submits that accordingly, there is far less likelihood of competition between practices. The ADA submits that it is unlikely that a dentist who is denied the ability to practise in a shared practice will establish a competing practice in a rural or remote area.
- 6.22 The ADA submits that it is unlikely that current fee levels will increase if the authorisation is granted. In particular the ADA submits that as the demand for dental services currently exceeds the supply of those services Australia wide, all dentists are likely to be working at capacity.

ACCC's view

- 6.23 Generally, the ACCC considers that agreements between competitors which influence the pricing decisions of market participants can raise significant competition concerns and can result in inefficiencies. For example, price agreements can move prices away from levels that would be set in a competitive market which can result in higher prices for consumers and send market signals which direct resources away from their most efficient use.
- 6.24 The ADA submits that the level of actual competition between dentists and specialists within shared practices is already limited due to the team approach adopted in such practices. Further the ADA submits that shared practices that currently exist typically take the form of partnerships and within such practices competition in relation to fees is non-existent. The ADA therefore submits that the authorisation will have no effect on price competition within existing shared practices.
- 6.25 The ADA submits that the following factors operate as a constraint on the fees charged by dentists and dental specialists:

- a number of dentists enter into preferred provider agreements with private health funds which set the fees payable for patients who have insurance with the relevant provider
 - the Department of Veterans Affairs sets the level of fees chargeable for treatments to patients who hold a Repatriation Health Card and
 - the ADA has submitted that government purchasers of dental services have substantial bargaining power in determining the fees payable to dental practitioners supplying government funded services.
- 6.26 The ACCC considers that to the extent that dentists and specialists operating within a shared practice remain as separate legal entities and retain their own patients and the incomes derived from them there is potential that different fees will be charged between practitioners as a means of attracting and maintaining customers.
- 6.27 However, the ACCC considers that the detriment from dentists and specialists agreeing on the fees they will charge within a shared practice is likely to be limited.
- 6.28 Significantly, the ACCC notes that the arrangements are confined to agreements on fees within practices operating under a shared business structure. While there does not appear to be a standard definition of a shared practice, the ACCC considers that there are a number of features which are necessary to create, from the patient's perspective, a single dental practice (regardless of the legal structure). The essential features of a shared practice are:
- a common practice trading name
 - shared staff, for example, dental hygienists, administrative and support staff
 - shared dental records and treatment of patients by other members of the practice
 - a common reception and premises
 - shared dental equipment and supplies.
- 6.29 The ADA estimates that approximately 20% of dentists operate in such a shared practice structure. Many of these shared practices can already reach an agreement on fees without breaching the Act.
- 6.30 Dentists and specialists within a shared practice will also continue to set their fees based on a range of factors including competition, where relevant, from nearby practices. Although the ACCC notes that such constraint is likely to be greater in metropolitan areas where there are larger numbers of dental practices.
- 6.31 That being said, the ACCC notes that the proposed arrangements contain an exclusionary provision, meaning that should a shared dental practice choose to agree on fees, the dentists operating within that practice may be limited in deciding what fee to charge for dental services. Should a dentist decide not to participate in the common fee schedule for example, by discounting their fee in particular circumstances, they may be excluded from operating within that practice. Although again the ACCC notes that

many existing shared practices can already limit the ability of practitioners within the practice from charging different fees without breaching the Act.

- 6.32 It is also relevant that the proposed authorisation does not provide for any arrangements to allocate customers within the shared practice and customers remain able to select one practitioner over others within the shared practice.

Public benefit

- 6.33 The ADA submits the proposed conduct will deliver public benefits, including through:

- continuity of patient care
- improvements in the availability and quality of dental services
- efficiency in the provision of dental services.

- 6.34 An assessment of the public benefits follows.

Continuity of patient care

The ADA's submission

- 6.35 The ADA submits that the authorisation will ensure continuity and consistency of patient care as different dentists within the practice will be able to access patient information and patient records. In particular, the ADA submits that those dentists will be able to effectively cover for each other so that patients will be able to see other dentists in the practice if they require dental services and their usual dentist is unavailable.
- 6.36 In this regard, the ADA also notes that patients can embark upon a course of treatment with certainty regarding the availability of services and fees as shared practices allow cross-utilisation of other dentists within the practice for a particular patient. For example, if a patient requires a particular type of dental work, in which one of the dentists who is not the patients usual dentist specialises, it would be possible to include treatment by that dentist in the treatment plan while providing certainty about the fee for that work at the outset so that the patient can provide informed financial consent.
- 6.37 The ADA submits that these co-operative arrangements ensure continuity of care and encourage shared responsibility for ensuring that quality of patient care is maintained over time. The co-operative approach inherent in a shared practice may be disturbed by differential fees. Differential fees may also create real and/or perceived barriers for patients. From a patient's perspective, the shared practice is one business. It is consistent with this perception for dentists operating in such practices to have the ability to agree fees for the practice. It would also potentially inconvenience patients and interrupt patient care if a patient could only afford to access dental services from one dentist within the practice and not from others.

The SADS/ SA Health

- 6.38 The SADS notes the benefits claimed by the ADA and while they agree that shared practice arrangements benefit clients and the shared practices in these ways, the SADS

notes that these arrangements are already widespread, without common fee agreements in place. The SADS submits that it is questionable whether shared practice arrangements that allow these benefits to occur also require a common fee to be charged.

- 6.39 Following the draft determination, SA Health advised that it continued to question whether there is an overwhelming need to implement the conduct in order to achieve the benefits.

ACCC's view

- 6.40 The ACCC considers that consumers may experience some benefit from consistent, predictable pricing among dentists operating in a shared practice. Whilst those dentists operate under separate legal entities within the one practice, the shared business structure means that amongst other things dentists work as a team, have a common practice name, share dental records and have a common reception. Therefore they would appear to consumers to be one business and have the ability to charge a common price.
- 6.41 The ACCC accepts that the cooperative arrangements will ensure continuity of care and encourage shared responsibility for ensuring the quality of patient care is maintained. In this regard, the ACCC understands that the ability of a patient to see another dentist in the same practice is important to ensure continuity of care is maintained.
- 6.42 The ACCC considers that the consistency of fees within a practice can assist with ensuring the predictability of costs for treatment within that practice and for the course of treatment required. Although this does not suggest that the only way shared practices can operate effectively and achieve the benefits of continuity of care is through having a common fee.
- 6.43 The ACCC further considers that in these circumstances, authorisation would provide certainty that all dentists working in a shared practice where they operate as a team can agree on the fee they charge patients, if they chose to, irrespective of their business structure. The authorisation does not prevent a shared practice from existing in another form or from deciding not to have a common fee structure.

Availability and quality of dental services

The ADA's submission

- 6.44 The ADA submits that shared practices promote a culture of teamwork and improve the availability and quality of dental services available to patients. The ADA submits that shared practices encourage high standards of patient care as the members of that practice can readily access peer advice and review, clinical expertise and the camaraderie of other dentists. The ADA further submits that shared practices allow longer and more flexible opening hours thereby improving access to dental services for patients. Having more than one dentist in the practice also increases the chance that a patient will be able to be seen quickly in an emergency situation.
- 6.45 The ADA further submits that shared practices give dentists the opportunity to work around family and other commitments and reduces the pressure on dentists to be personally available to see patients whenever required.

- 6.46 The ADA submits that increased flexibility of work practices including working hours and on-call roster are important factors in attracting women and part-time dentists to the profession generally and in attracting dentists to rural areas.

ACCC's view

- 6.47 The ACCC notes the submission by the SADS that many of the benefits identified by the ADA, including promotion of teamwork and improvement of the availability and quality of dental services available, may be achievable without the need for common fees.
- 6.48 The ACCC considers that many of the benefits would be generated by one or more of the shared practice structures, including partnerships which are already likely to promote a culture of teamwork without the need to agree on fees within the practice.

Efficiency in the provision of dental services

The ADA's submission

- 6.49 The ADA submits that allowing dentists to agree fees in a shared practice will improve the range of dental services offered by the practice and the efficiency of such services as the practice will be able to share costs and utilise economies of scale for example, in the purchase of major equipment.
- 6.50 The ADA further submits that shared practices create an alternative to the corporate model of dental practice. In particular, the ADA notes that corporate practices which pursue profit in an attempt to maximise their shareholders' return may not provide dental services of a discount nature such as services to Department of Veterans Affairs patients or pro bono services. The ADA considers that shared practices ensure that dentists have a primary duty to the patient but allow the dentist to access the economies of scale available to practitioners who practise in a corporate model.

Interested parties' view

- 6.51 The SADS submits that an increase in the productivity of a dental practice gained through economies of scale does not rely on a common fee agreement.
- 6.52 The Dental Practice Board of Victoria (DPBV) supports the application as it believes that multiple fee scales within the one practice could only increase the cost of dental services to the public in the long run.

ACCC's view

- 6.53 The ACCC considers that in terms of efficiency in the provision of dental services, dentists operating in the relevant business structures are likely to experience some efficiency savings in administrative functions from agreeing on a common fee structure, as opposed to pricing their services individually.
- 6.54 The ACCC accepts that dentists may accrue some benefit in this regard.
- 6.55 There is a range of business structures through which dental services are provided. The ACCC makes no comment on the benefits or desirability of one structure over another.

Balance of public benefit and detriment

- 6.56 The ACCC may only grant authorisation if it is satisfied that, in all the circumstances, the proposed conduct is likely to result in a public benefit that will outweigh any public detriment.
- 6.57 In the context of applying the net public benefit test at section 90(8)¹⁵ of the Act, the Tribunal commented that:
- ... something more than a negligible benefit is required before the power to grant authorisation can be exercised.¹⁶
- 6.58 The ACCC considers that while there is the potential for anti-competitive detriment to result from price setting within a shared dental practice, any potential detriment is likely to be limited. In particular, the ACCC notes the arrangements are confined to agreements on price within practices operating under a shared business structure. There are various business structures through which dental services are provided. Further, dentists within a shared practice will continue to set their fees based on a range of factors including competition, where relevant, from nearby practices.
- 6.59 The ACCC is satisfied that the consistency of fees within a practice can assist with ensuring the predicability of costs for treatment within that practice and for the course of treatment required. This assists with the continuity and consistency of patient care.
- 6.60 On balance, the ACCC considers the public benefit is likely to outweigh the public detriment.
- 6.61 The ACCC grants authorisation to enable agreements on the fees to be charged for dental services provided within shared practices where the practitioners operate as a team and share patient records and common facilities, have a common trading name and common policies and procedures. The ACCC considers that practitioners in these types of practices are more likely to have common administrative and operational costs which may limit the detriments and reinforce the benefits from the authorisation.
- 6.62 The ACCC also grants authorisation to the proposed exclusionary provision.

Length of authorisation

- 6.63 The ACCC generally considers it appropriate to grant authorisation for a limited period of time, so as to allow an authorisation to be reviewed in the light of any changed circumstances.
- 6.64 In this instance, ADA seeks authorisation for a period of five years. The ADA submits that a five year period will allow the authorisation to be reviewed in light of any changed circumstances.

¹⁵ The test at 90(8) of the Act is in essence that conduct is likely to result in such a benefit to the public that it should be allowed to take place.

¹⁶ Re Application by Michael Jools, President of the NSW Taxi Drivers Association [2006] ACompT 5 at paragraph 22.

- 6.65 The ACCC considers that a four year time limit is appropriate. This is consistent with the time period imposed in a similar authorisation granted to the Royal Australian College of General Practitioners for intra-practice price setting arrangements.¹⁷ The ACCC therefore grants authorisation to the proposed conduct until 28 February 2013.
- 6.66 The ACCC notes that SA Health and the Centre for Oral Health Strategy (NSW) has requested the ACCC identify how it will measure the net public benefit, including the impacts on competition of the proposed arrangements at the end of the four year period. Should the ADA seek authorisation to continue the conduct after the expiry of this authorisation, the ACCC would expect the ADA to, among other things:
- provide examples of where the conduct has been implemented
 - demonstrate the benefits/detriments that have resulted from the conduct.
- 6.67 This would enable the ACCC to consider the impact, if any, of the authorisation on:
- the availability and cost of dental services generally, and particularly in rural and regional areas
 - public expenditure on dental care through the purchasing of services from private clinics.

¹⁷ ACCC Determination dated 23 May 2007, in respect of the application for revocation of authorisation A90795 and substitution with A91024 lodged by the Royal Australian College of General Practitioners.

7. Determination

The application

- 7.1 On 18 July 2008 the ADA lodged applications for authorisation A91094 and A91095 with the Australian Competition and Consumer Commission (the ACCC).
- 7.2 Applications A91094 and A91095 were made using Form A and Form B, Schedule 1, of the Trade Practices Regulations 1974. The applications were made under subsection 88 (1) of the Act to:
- to make and give effect to a contract, arrangement or understanding, a provision of which is or may be an exclusionary provision within the meaning of section 45 of the Act (A91094).
 - to make and give effect to a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would have or might have the effect, of substantially lessening competition within the meaning of section 45 of the Act (A91095).
- 7.3 In particular, the ADA seeks authorisation for the making of or giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists who practice in a shared practice as to fees to be charged for dental services provided in the practice.
- 7.4 The ADA advise that it seeks authorisation with respect to an exclusionary provision to ensure that any agreement with respect to fees within a shared practice could not potentially constitute a provision of a contract, arrangement or understanding between practitioners which is said to have the purpose of restricting or limiting the supply of dental services to patients in particular circumstances or on particular conditions, namely, other than in accordance with the agreed fee schedule.

The net public benefit test

- 7.5 For the reasons outlined in Chapter 6 of this determination:
- in respect of the conduct the subject of A91094, the ACCC considers that in all the circumstances the arrangements for which authorisation is sought are likely to result in a public benefit that would outweigh the detriment to the public constituted by any lessening of competition arising from the arrangements.
 - in respect of the conduct the subject of A91095, the ACCC is satisfied that the arrangements for which authorisation is sought are likely to result in such a benefit to the public that the arrangements should be allowed to take place.
- 7.6 The ACCC therefore **grants** authorisation to applications A91094 and A91095.

Conduct for which the ACCC proposes to grant authorisation

- 7.7 The ACCC grants authorisation to the Australian Dental Association Inc for agreements as to the fees to be charged for dental services provided within shared practices with the following features:
- a common practice trading name
 - shared staff, for example, dental hygienists, administrative and support staff
 - shared dental records and treatment of patients by other members of the practice
 - a common reception and premises
 - shared dental equipment and supplies.
- 7.8 Authorisation is granted until 28 February 2013.
- 7.9 This determination is made on 10 December 2008.

Conduct not proposed to be authorised

- 7.10 The authorisation is limited to conduct within shared practices, and will not apply to any price agreements or exclusionary provisions between practices.
- 7.11 Authorisation was not sought, and is not granted, to extend to any arrangements or agreements to allocate customers within shared practices.

Date authorisation comes into effect

- 6.68 This determination is made on 10 December 2008. If no application for review of the determination is made to the Australian Competition Tribunal (the Tribunal), it will come into force on 1 January 2009.