Determination

Application for authorisation

lodged by

Australian Society of Ophthalmologists

in respect of

agreements to set fees for ASO members in shared practices for ophthalmology services

Date: 19 September 2013

Authorisation number: A91360

Commissioners: Sims
Rickard
Schaper
Cifuentes
Court
Walker

Summary

The ACCC has decided not to authorise application A91360 lodged by the Australian Society of Ophthalmologists Limited (ASO) for ASO's members to reach agreements as to the fees to be charged for ophthalmic services provided within a shared practice.

On 26 February 2013, the Australian Society of Ophthalmologists (ASO) lodged an application for authorisation A91360 on behalf of its members. The application sought authorisation to enable registered ASO members to agree on, and set, fees in shared practices for ophthalmology services. For the reasons outlined in this determination, the ACCC is not satisfied that the proposed conduct meets the statutory tests for granting authorisation.

The ACCC considers that generally, agreements between competitors in relation to fees will reduce competition, resulting in increased prices or reduced quality and availability of goods or services. Outcomes of this nature are associated with significant public detriment. For the ACCC to consider granting authorisation for such a serious breach of the *Competition and Consumer Act* 2010, applicants need to show that substantial public benefits are likely to result from the proposed arrangements, as well as the existence of sufficient mitigating factors to limit the resulting detriment. The onus is on the Applicant to put forward the factual basis to enable the ACCC to be satisfied that public benefits are likely to result, and that those benefits outweigh the likely public detriments.

The ACCC considers that common fee setting by professionals in shared practices is likely to result in significant detriment, except where there are a number of competitors in each area that provide a real competitive constraint to the shared practice. In terms of benefit, the ACCC considers the primary potential benefits from common fee setting by professionals within shared practices will arise from the cost savings, efficiencies and greater teamwork and collaboration from operating as a shared practice. As a result, common fee setting will typically only deliver significant benefits where it results in a greater number of shared practices than would otherwise be the case.

The ASO represents approximately 60% of all ophthalmologists within Australia. There are around 810 practising ophthalmologists in Australia with the majority working in major cities. There are significantly fewer ophthalmology service providers in regional and remote areas. Training to qualify as an ophthalmologist is lengthy and few places are made available, making entry into the profession difficult, even in comparison with other medical specialists. The ACCC understands that demand for ophthalmologists' services is currently high and likely to increase.

Public detriment

The ACCC considers that, given the likelihood of relatively small numbers of competitors for the provision of ophthalmic services in many geographic areas, the lack of substitutability for many ophthalmic services and the height of barriers to entry, the effects of any horizontal agreements between competitors in relation to price would be likely to significantly reduce existing price competition, resulting in higher prices paid by consumers for ophthalmic services and substantial detriment.

For example, in a given area, many of the limited number of ophthalmic practices may be shared practices run by ASO members. In these areas, the Proposed Conduct is

likely to significantly reduce any price competition that currently occurs by reducing the number of competitors from the number of individual ophthalmologists practising within a region, to the relatively small number of shared practices within a region.

While the ASO submits that ophthalmic practices generally tend to cluster around facilities such as hospitals, in the absence of any geographic data as to the location of ophthalmic practices the ACCC is not satisfied that shared practices, in moving to common fees, would be adequately constrained by other competitors within their local region.

The ACCC has previously authorised similar conduct within the medical industry, such as for shared practices of dentists and general practitioners, and for ophthalmologists within clinics operated by the Vision Group. In these instances, however, there were a number of factors that substantially lowered the likely anti-competitive detriment which are not present in the current application or are present to a more limited extent.

In the case of general practitioners and dentists, for example, these professions have a significantly larger number of practices in each region and a substantially higher number of practitioners overall, which lowers the likely detriment arising from intra-practice fee setting, because there are other practices to act as a competitive constraint.

In the case of the Vision Group authorisation, the majority of the ophthalmologists affected by the authorisation were employees of the Vision Group, which could already freely set a common fee for them prior to the authorisation. Further, the Vision Group provided information that satisfied the ACCC that each affected clinic was subject to an adequate level of competitive constraint from surrounding ophthalmic practices.

Public benefits

The ASO submits the conduct would give rise to a range of public benefits from improved patient outcomes through improved communication and teamwork within practices, competition based on quality of service rather than price, increased intra-practice referrals and improved efficiency in providing ophthalmic services.

The ACCC considers that most of these claimed benefits arise from the operation of shared practices – which the ASO submits the majority of ophthalmologists are already operating within and more will likely move to, with or without the fee setting conduct due to the very high capital costs of setting up an ophthalmic practice. To the extent that common fee setting will further incentivise ophthalmologists to operate in shared practices, the ACCC considers the conduct will result in some benefits.

In the case of applications by GPs and dentists to engage in similar conduct, the ACCC considered the likely benefits were greater due to the importance of common fee setting to the establishment of shared practices within the profession. As discussed above, the ACCC considers that the high capital costs of setting up an ophthalmology practice is the driving factor in shared ophthalmology practices, and that common fee setting is less important.

In assessing the Vision Group application, the ACCC considered that benefits would arise due to the business structure of the Vision Group, which created a greater consumer expectation of consistent pricing within each Vision Group clinic, because more than half of ophthalmologists engaged by Vision Group were employees (and therefore could already charge common fees), and Vision Group clinics were specifically branded to create the impression of a single business to consumers.

Conclusion

For these reasons the ACCC considers that the level of likely detriment arising from the ASO's proposed conduct is more significant than in previously authorised arrangements in other professions, and that the public benefits arising from the conduct are likely to be more limited.

The ACCC considers that the public benefits are not likely to outweigh the detriments from the proposed arrangements, and therefore the ACCC denies authorisation.

Contents

The application for authorisation

1. On 26 February 2013 the Australian Society of Ophthalmologists (ASO) lodged an application for authorisation (A91360) with the ACCC on behalf of its current and future members, seeking to allow its members to reach agreements as to the fees to be charged for ophthalmic services provided within a shared practice.

2. Authorisation is a transparent process where the ACCC may grant protection from legal action for conduct that might otherwise breach the *Competition and Consumer Act 2010* (the Act). 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. The ACCC conducts a public consultation process when it receives an application for authorisation, inviting interested parties to lodge submissions outlining whether they support the application or not. Before making its final decision on an application for authorisation the ACCC must first issue a draft determination.[1]

Draft determination

3. On 20 June 2013, the ACCC issued a draft determination proposing to deny authorisation to the ASO's application.

4. The ASO called a pre-decision conference to enable public discussion of the draft determination. The conference was attended by representatives of the ASO and RACS.[2]

The Conduct

5. The ASO is seeking authorisation to enable its members to agree on the fees to be charged for ophthalmology services within shared practices. Specifically for:

    - the making of or giving effect to contracts, arrangements or understandings between two or more ophthalmologists who are members of the ASO and practice in a shared practice as to the fees to be charged for ophthalmology services provided in the practice (**Proposed Conduct**).[3]

6. The ASO submits that a 'shared practice' consists of the following attributes for the purposes of the Application:

    - a partnership of two or more ophthalmologists; or

    - an associateship of two or more ophthalmologists:

[1] Detailed information about the authorisation process is contained in the ACCC's Authorisation Guidelines available on the ACCC's website **www.accc.gov.au**.
[2] Minutes of the pre-decision conference are available on the public register on the ACCC website at **www.accc.gov.au**.
[3] ASO Submission dated 26 February, p. 11 at [17].

- who are co-located or operate as a branch practice; and
- which has a common service entity, in which each of the ophthalmologists must either have an interest; have contracted with the service entity; or be employed or otherwise engaged by the service entity to provide ophthalmology services on the service entity's behalf; and
- the service entity is responsible for managing and/or maintaining a common reception, common fee collection, common bank account, common trading name, common medical records and, except for branch practices, common policy and procedures.

7. The ASO submits that it is expected that ophthalmologists in shared practices would implement uniform consultation fees for the most commonly utilised item numbers covered by the Medicare Benefits Schedule (ie. those for initial consultation and follow up consultation), and that the same fees would be charged regardless of the practitioners' age and experience.[4]

8. The ASO expects exceptions would be made for professional fees charged by certain sub-specialists, such as those associated with neuro ophthalmic consultations or paediatric consultations, which would be expected to be set at a higher level. Further, the ASO expects there would be uniform discounts applicable to pensioners.[5]

9. The ASO submits that shared practices of ophthalmologists do not generally grow to involve more than six to eight practitioners, as practices with more than this number tend to put a strain on the shared practice model.[6]

10. The ASO submits that the Proposed Conduct is voluntary and would not relate to any other staff, services or suppliers in a shared practice, that is, only ASO members who are ophthalmologists would be covered by the authorisation.

11. Following the ACCC's draft determination, the ASO proposed confining the scope of the Proposed Conduct to apply only to clinics which have a competing ophthalmic practice within 10 kilometres.

12. The ASO is not seeking authorisation for any exclusionary provisions.

13. The ASO seeks authorisation of the Proposed Conduct for five years.

The Australian Society of Ophthalmologists

14. The ASO is the peak organisation representing ophthalmologists. Ophthalmologists are specialist medical practitioners who specialise in eye-related disease, injuries and deficiencies. They are also known as eye specialists or eye surgeons.

[4] ASO Submission dated 3 June, p6 at [22].
[5] ASO Submission dated 3 June, p6-7 at [23-24].
[6] ASO Submission dated 26 February, p11 at [16].

15. The ASO advises that over 60% of ophthalmologists across all States and Territories in Australia are currently ASO members. The ASO states that the main objectives for which it is established are to:

    - promote, represent, and secure the interests in relation to medico-political and medico-industrial issues of all ASO members within Australia;
    - represent members' patients in relation to public and private care, and Medicare issues that may arise due to Federal or State government policy, legislation and/or regulation;
    - provide advice and information to individual members on industrial issues, and identify appropriate representation if necessary or required; and
    - provide business development and business improvement advice to members.

16. ASO membership is voluntary and is open to current practising ophthalmologists, ophthalmologists in training, retired ophthalmologists and business associates.[7] Membership fees for current practising ophthalmologists range between $170 and $750 per annum depending on level of seniority.[8]

Background

17. Further discussion of the structure and features of the provision of ophthalmic services follows.

Referrals

18. A referral from a GP, optometrist or current specialist is required before an initial consultation with an ophthalmologist in order to receive a Medicare benefit for that consultation. Patients may still visit an ophthalmologist without a referral but a Medicare benefit will not be paid towards the cost of that visit.[9] The difference in cost for patients is significant and therefore the ACCC understands that it is uncommon for patients to attend an ophthalmologist without a referral for a service covered under the Medicare Benefits Schedule.

19. Due to the highly specialised nature of ophthalmology, a primary carer may refer a patient to a generalist ophthalmologist, who may then refer the patient onwards to a sub-specialist ophthalmologist depending on the patient's condition (for example, for glaucoma, paediatric or refractive issues). The ASO advises that this secondary referral increasingly occurs between ophthalmologists within

[7] Business Associates covers clinical, administrative and business professionals working within an ophthalmology practice (ASO website: **www.aso.asn.au**, accessed 15 April 2013).
[8] ASO website: **http://www.aso.asn.au**, accessed 15 April 2013.
[9] Royal Australian and New Zealand College of Ophthalmologists (RANZCO) website: **http://member.ranzco.edu/eyehealth/referral.php**, accessed 7 May 2013.

shared practices as the profession becomes increasingly sub-specialised due to technological and medical advances.[10]

20. At the pre-decision conference the ASO indicated that primary carers (such as GPs) will usually refer a patient to a particular ophthalmologist within a practice, but that about 10-20% of referrals are to the practice only and do not specify a particular ophthalmologist. The ASO also advised at the pre-decision conference that, whether a patient is referred to a particular doctor or the practice in general, in the case of urgent referrals which need to be seen the same day, a practice will often determine which ophthalmologist will see the patient based on availability of doctors and the appropriate subspecialisations.[11]

Training

21. Entry into the specialist training program with a medical degree is difficult. For the 2011/2012 intake, of the 96 doctors who applied, 35 were selected as first year ophthalmology trainees across Australia and New Zealand in 2011 (2 in South Australia, 1 in Western Australia, 4 in Queensland, 11 in Victoria, 11 in New South Wales and 6 in New Zealand).[12] Becoming fully qualified as an ophthalmologist requires a minimum of 12 years' training in total.

22. The ACCC understands that entry into the ophthalmologist training program is inhibited by several structural factors and sunk costs including government funding of registrar training, a suitable candidate with the requisite skill base, an available consultant willing to train a student in a location with a large population base for training and available hospital equipment to facilitate that training.

23. The ACCC understands barriers to entry into the profession are high as a result of these factors, even when compared to other medical specialties.

Increasing demand

24. The ACCC understands that bulk billing ophthalmology practices are available in some public sector hospitals including regional and rural areas. The ACCC understands that wait times in the public system are extensive. In addition, ophthalmological services have the longest average wait time (74 days) for elective surgery of all surgical specialities.[13]

25. At the pre-decision conference, the ASO submitted that the elective surgery wait time is due to the level of public hospital funding and is not due to the supply of ophthalmologists. The ASO submitted that, within the private system, most patients requiring ophthalmic surgery will be treated within a week, and the wait time from referral to initial consultation is also relatively immediate.[14]

[10] See ASO Submission dated 26 February, p13 at [32], and Minutes of the Pre-Decision Conference, p5.
[11] See Minutes of the Pre-Decision Conference, p4-5.
[12] RANZCO, Annual Report 2011-2012, p.12.
[13] Australian Institute of Health and Welfare (AIHW), *Australian Hospital Statistics 2011-12: elective surgery waiting times*, Figure 44.
[14] See Minutes of the Pre-Decision Conference, p4.

26. The ASO submits that demand for the services of eye health professionals in the foreseeable future is likely to increase due to the ageing population and the increase in prevalence of chronic disease such as diabetes, which is a risk factor for a variety of eye diseases and disorders.[15]

Applicant's submissions

27. Broadly, the ASO submits that the Proposed Conduct is likely to result in a number of public benefits arising from: improved communication and teamwork within practices, which would in turn deliver improved patient outcomes; competition based on quality of service rather than price; increased occurrence of intra practice sub-speciality referrals; an increase in the number of shared practices; certainty of price for patients; and improved efficiency in providing ophthalmic services.

28. The ASO submits that there would be minimal public detriment arising from the Proposed Conduct as ASO members in shared practices are subject to a number of constraints including strong competition between shared practices and from other eye health care providers, and pressure from private health funds to enter into "no gap" or "known gap" agreements. The ASO submits the conduct would be voluntary. The ASO submits that the Proposed Conduct is unlikely to result in an increase of fees or any other anti-competitive detriments, and in fact that patients would be more likely to obtain treatment faster and for a lower price.

29. The views of the ASO are considered in more detail in the evaluation section of this determination.

Interested party submissions

30. The ACCC tests the claims made by the applicant in support of an application for authorisation through an open and transparent public consultation process.

31. The ACCC sought submissions from approximately 35 interested parties potentially affected by the ASO's application for authorisation. Potentially interested parties included various medical industry associations and training colleges, hospitals, government agencies, industry participants and consumer groups.

32. The ACCC received one submission from The Royal Australasian College of Surgeons (RACS) who held no concerns with the ASO's application for authorisation.

33. The ASO provided submissions on 4 and 6 June 2013 following requests for further information from the ACCC. The ASO made further submissions on 25 July and 15 August in response to the ACCC's draft determination and called a pre-decision conference to enable public discussion of the draft determination. The conference was attended by representatives of the ASO and RACS.

[15] AIHW, *Eye Health labour force in Australia*, 2009, p2.

34. Copies of public submissions, along with the minutes of the pre-decision conference,may be obtained from the ACCC's website **www.accc.gov.au/authorisationsregister.**

ACCC evaluation

Previous relevant authorisations

35. The ACCC has previously authorised intra-practice fee setting arrangements in the medical industry and has considered the range of public benefits and detriments which may result from fee setting arrangements within certain contexts.

RACGP 2007 Authorisation (A91024) and 2002 (A90795)

36. The ACCC granted authorisation to the Royal Australian College of General Practitioners (**RACGP)** in 2002 and reauthorised the arrangements in 2007. Broadly, these authorisations permitted General Practitioners to engage in intra-practice price setting and collective bargaining (as single practices) over VMO services to public hospitals. Authorisation was most recently granted for four years and lapsed on 14 June 2011.

Vision Group 2010 Authorisation (A91217)

37. In 2010, the ACCC granted authorisation to Vision Group Holdings Limited, its employees and ophthalmologists engaged as contractors at Vision Group clinics (**Vision Group**) to discuss and agree and implement fees to be charged to patients for ophthalmology services supplied at Vision Group clinics.

ADA 2013 Authorisations (A91340 and A91341) and 2008 (A91094 and A91095)

38. The ACCC granted authorisation to the Australian Dental Association Inc (**ADA**) in 2008, and again in 2013. These authorisations enabled dental practitioners to reach agreements as to the fees charged for dental services provided within a shared practice. Authorisation was most recently granted for ten years.

AMA 2013 authorisation (A91334)

39. The ACCC granted authorisation to the AMA in 2013, permitting general practitioners who operate within certain team based practice structures to engage in intra-practice price setting and collective bargaining with VMO Service Purchasers and Medicare Locals. Authorisation was granted until 2018.

Public benefits and detriments in previous authorisations

40. In the case of the ADA and AMA authorisations, the ACCC accepted that price or fee agreements within shared practices were likely to increase the incidence of shared practices of dentists and GPs. Importantly, it is participation in a shared

practice that results in a number of public benefits rather than the fee setting conduct itself.[16]

41. In the case of the ADA, AMA and RACGP authorisations, involving the dental and general practice professions, the ACCC recognised benefits arising from the conduct through providing consistent, predictable pricing among GPs or dentists operating within one practice and by facilitating access to additional medical practitioners within a patient's usual practice.[17] The ACCC notes the generalist nature of the services the subject of these authorisations, in that many patients are likely to be able and willing to substitute the services of one practitioner for another within the practice, should a patient be unable to see their regular practitioner at the required time. Further, patients attending these services will often have urgent concerns, which would require being seen by a different practitioner if their regular practitioner were unavailable. The ACCC notes that these benefits may not arise, or may not arise to the same extent, in the case of more specialised and sub-specialised professions, or specialties treating conditions which less frequently have conditions that require urgent treatment.

42. Generally, the ACCC considers that agreements between competitors which influence the pricing decisions of market participants have the potential to result in allocative inefficiencies. However, in the ADA, AMA and RACGP authorisations the ACCC was satisfied that potential anti-competitive detriment resulting from the conduct was mitigated by a significant level of inter-practice competition, given the large number of practices providing comparable services within any given geographic area.[18] The ACCC understands the number of practitioners in the relevant professions in these authorisations to have been close to 12,000[19] in the case of dentists, and 19,000[20] for general practitioners in 2013.

43. In assessing the likely impact on competition in granting Vision Group's application for authorisation, the ACCC considered the mitigating effect of local competition constraining each Vision Group clinic.[21] In support of its application, Vision Group provided information listing competing ophthalmic practices nearby each of its clinics and their distance.[22] Almost all of the clinics operated in metropolitan areas with a number of other providers of private ophthalmic services in the local area.[23] Significantly, the ophthalmologists in practices near each Vision Group clinic set their prices individually, providing a greater number of competitors.

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[16] ACCC Determination, Australian Dental Association Inc, A91340-A91341, 27 March 2013 (ADA Determination), p5 at [32]; and ACCC Determination, Australian Medical Association Limited, A91334, 21 February 2013 (AMA Determination) p5 at [19].

[17] AMA Determination, p5 at [19]; ADA Determination, p6 at [33-34]; and ACCC Determination, Royal Australian College of General Practitioners, A90795, 23 May 2007 (RACGP Determination), p36 at [6.42].

[18] AMA Determination, p5 at [21]; ADA Determination, p7 at [42]; RACGP Determination, p34 at [6.29].

[19] ADA, Submission in support of application for authorisation, A91340-A91341, p11.

[20] **www.racgp.org.au**, accessed 13 June 2013.

[21] ACCC Determination, Vision Group Holdings Limited, A91217, 8 September 2010, p10 at [4.25-4.26].

[22] Vision Group Holdings Limited, Submission in support of application, Attachment 1.

[23] Noting that a number of the clinics which formed part of the Vision Group at the time of the application were no longer open at the time authorisation was granted. See Minutes of the Pre-Decision Conference, p3.

44. Another important factor considered by the ACCC in granting authorisation to the Vision Group was the business structure of Vision Group, in which ophthalmologists working at the same Vision Group-branded clinic may be either employees or contractors.[24] Specifically, of the 54 ophthalmologists engaged at that time by the Vision Group, 39 were associates or employees,[25] and hence able to set common fees without raising competition concerns. The remaining 15 were independent contractors. Further, in its application Vision Group linked its claimed public benefits with its brand, citing the public image of Vision Group as one clinic, creating an expectation by patients that ophthalmologists at the clinic would have consistent pricing and the team approach employed by Vision Group to enhance its image as a single practice.[26]

45. The ACCC was satisfied that, while the benefits flowing from the conduct may be more confined than in the case of more generalist professions, the detriment to competition would be sufficiently mitigated by competition from other ophthalmologists within the same geographic area of each of the Vision Group practices to result in a net public benefit. The ACCC noted in the Vision Group matter that the public benefit from the conduct may not outweigh the detriment if, for example, the level of competition provided by other providers of ophthalmology services were to significantly reduce, such as if Vision Group were to acquire competing businesses which currently constrain the pricing of Vision Group's services.[27]

ACCC approach to the current application

46. The ACCC's evaluation of the Proposed Conduct is in accordance with the relevant net public benefit tests contained in the Act.[28] In broad terms, under the relevant tests the ACCC shall not grant authorisation unless it is satisfied that the likely benefit to the public would outweigh the detriment to the public constituted by any lessening of competition that would be likely to result.

47. The ACCC has used the same analytical framework it applied in the previous authorisations in its consideration of the Proposed Conduct in the ASO's application for authorisation.

48. Broadly, the ACCC considers that common fee setting by professionals in shared practices is likely to result in significant detriment, except where there are a number of competitors in each area that provide a real competitive constraint to the shared practice. In terms of benefit, the ACCC considers the primary potential benefits from common fee setting by professionals within shared practices will arise from the cost savings, efficiencies and greater teamwork and collaboration from operating as a shared practice. As a result, common fee setting will typically only deliver significant benefits where it results in a greater number of shared practices than would otherwise be the case.

[24] Employees and associates of Vision Group may have common pricing, but for contractors to agree on pricing would likely be in breach of the Act and therefore require authorisation.
[25] Vision Group submission in support of application for authorisation, p3.
[26] See Vision Group submission in support of application for authorisation, pp3 and 7.
[27] Vision Group Determination, p10 at [4.27].
[28] Subsections 90(6), 90(7), 90(5A) and 90(5B). The relevant tests are set out in Attachment A.

49. In this case, the ACCC considers there are significant differences in the circumstances of the Proposed Conduct compared to previously authorised conduct. This includes the overall number and proportion of all practitioners potentially affected by the Proposed Conduct, the current and likely future structure of practices, the height of barriers to entry into the profession, and the referral-based nature of the specialty.

50. In order to assess the effect of the Proposed Conduct and the public benefits and detriments likely to result the ACCC first identifies the relevant areas of competition and the likely future without the conduct.

The relevant areas of competition

51. The ASO submits that the relevant markets are the regional and metropolitan markets for the supply of ophthalmology services to patients in Australia.[29]

52. The ASO submits that there are currently 812 practising ophthalmologists in Australia.

	STATE								TOTAL
AREA	NSW	ACT	NT	VIC	QLD	SA	WA	TAS	
Metro*	246 *(76%)*	12 *(100%)*	3 *(75%)*	168 *(87%)*	73 *(54%)*	52 *(84%)*	52 *(75%)*	8 *(57%)*	614 (76%)
Non-Metro**	76 *(24%)*	0 (0%)	1 *(25%)*	26 *(13%)*	62 *(46%)*	10 *(16%)*	17 *(25%)*	6 *(43%)*	198 (24%)
TOTAL	322	12	4	194	135	62	69	14	**812**

Source: ASO Submission, p 12 at Table 1.

53. The ACCC is aware of differing figures as to the percentage of ophthalmologists practising in metropolitan and non-metropolitan (regional and rural) areas. Figures provided by the ASO in its submission dated 26 February 2013, sourced from the Royal Australian and New Zealand College of Ophthalmologists and reproduced above, indicate 24% of ophthalmologists operated in a non-metropolitan area.[30] A report by the Australian Institute of Health and Welfare indicated that in 2006 17.5% of ophthalmologists worked in regional and remote areas.[31] In its submission dated 3 June 2013, the ASO advises that 42% of ophthalmologists practice in rural and regional Australia.[32] While there is some discrepancy in the numbers from various sources, the ACCC considers it is clear that disproportionately few ophthalmologists currently practise in non-metropolitan areas.

54. The ASO has not provided any further geographic data to indicate the location of ophthalmic practices, and advises there were complicating issues with obtaining this data such as ophthalmologists working across multiple locations and

[29] ASO application A91360 for authorisation, p 5 at [5] and ASO Submission dated 26 February, p. 12 at [25].
[30] RANZCO, Annual Report 2011-2012.
[31] AIHW, *Eye Health labour force in Australia*, 2009, p9.
[32] ASO Submission dated 3 June, p7 at [25].

changes to the location and working arrangements of ophthalmologists over time.[33]

55. The ASO submits that 50%[34] or 65%[35] of ophthalmologists currently practise within a shared practice, and has advised the numbers are unclear because individual ophthalmologists will often operate in a number of practices which may have different types of arrangements.[36]

56. The ASO advises that ophthalmic practices tend to cluster around health facilities such as public and private hospitals and day theatres, and estimates that 90-95% of shared practices would have one or more other private ophthalmic practice within 10 kilometres.[37] However, as noted above the ASO has not provided any geographic data to support this.

57. In terms of demand, the ASO submits that, in 2009, 67% of Australians with eye disorders lived in metropolitan areas.

58. The ASO submits that the demand for ophthalmologist services is increasing due to population growth, an ageing populating, cultural and linguistic diversity factors and the increasing prevalence of chronic diseases affecting eye health, such as diabetes.[38]

59. The ASO estimates that 95% of ophthalmologists work in private practices.[39]

60. The ACCC considers that ophthalmologists who are ASO members may compete with each other (whether in the same or in different practices), with non-ASO members (between 30 and 40% of ophthalmologists), for some business with optometrists, and to an extent with public health services.

61. There are several sub-categories of services in which ophthalmologists may specialise, including medical retina, surgical retina, glaucoma, neuro ophthalmology and others. Complex cases requiring diagnosis and or treatment in these sub-categories may be referred to sub-specialists in these areas by ophthalmologists in the same practice. The ACCC notes the ASO's submission that currently approximately 10-15% of ophthalmologists practise exclusively in a sub-specialty, with the majority of these practising in metropolitan areas,[40] and that sub-specialities are increasing with technological and medical advances.[41]

62. The ACCC considers the relevant areas of competition for the purposes of assessing the Proposed Conduct are likely to be the supply of ophthalmologist services in local areas within States and Territories around Australia. These areas may be further narrowed by demand for specific subcategories of ophthalmological services.

[33] Minutes of the Pre-Decision Conference, p7.
[34] ASO Submission dated 3 June, p7 at [29].
[35] ASO Submission dated 26 February, p11 at [14].
[36] Minutes of the Pre-Decision Conference, p4.
[37] Minutes of the Pre-Decision Conference, pp3 and 5.
[38] ASO Submission dated 26 February, p12 at [26-27].
[39] ASO Submission dated 26 February, p13 at [34].
[40] ASO Submission dated 3 June, p7 at [27].
[41] ASO Submission dated 26 February, p13 at [32].

The future with and without

63. The ACCC considers the *likely future with-and-without* the conduct to identify and weigh the public benefit and public detriment generated by conduct for which authorisation has been sought.[42] The ACCC compares the public benefit and anti-competitive detriment generated by arrangements in the future with the conduct with those generated without the conduct.

64. The ASO submits that most ophthalmologists currently practise within a shared practice, and advises the number of shared practices is likely to increase regardless of whether or not the Proposed Conduct is authorised, mainly because the shared practice model is generally viewed as providing the most effective way to achieve overhead efficiencies and flexibility for practitioners.[43]

65. At the pre-decision conference, the ASO further noted that due to the high and increasing costs of setting up a practice, all ophthalmologists now commencing practice will set up in a shared practice. The ASO also observed that it did not expect authorisation of the Proposed Conduct to motivate those ophthalmologists who currently remain solo practitioners to move into shared practice.[44]

66. On other occasions the ASO has nonetheless submitted that common fees would further increase the attractiveness of shared practices for ophthalmologists and would therefore encourage the formation of shared practices as opposed to solo practices, and will result in a real and appreciable increase in the number of shared practices.[45]

67. The ACCC concludes that, given considerable incentives for ophthalmologists to participate in shared practices will continue to exist in any event, and consistent with the ASO's submissions, the number of shared practices is likely to continue to increase with or without the Proposed Conduct. At best, the Proposed Conduct might be argued to accelerate the trend to shared practices. The ACCC considers that, absent the Proposed Conduct, ASO members are likely to continue to operate separate fee schedules at shared practices.

68. For this reason the ACCC will examine the likely public benefits arising from the ability to agree on a common fee structure, compared to a situation in which shared practices continue without agreement on a common fee structure within practices.

Public benefit

69. 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:

[42] *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.
[43] ASO Submission dated 26 February, p19 at [69].
[44] Minutes of the Pre-Decision Conference, pp3-4 & 8.
[45] ASO Submission dated 25 July 2013, p7 at [23].

> …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.[46]

70. The onus is on the Applicant to put forward the factual basis to enable the ACCC to be satisfied that public benefits are likely to result from the proposed conduct.

71. The ASO submits the Proposed Conduct will deliver public benefits, including:

    - improved quality of ophthalmology services through the promotion of a teamwork culture and collaboration between specialists;
    - continuity and availability of patient services;
    - range of ophthalmology services to meet demand;
    - certainty and predictability in price of ophthalmic care within shared practices;
    - efficiency in providing ophthalmology services, which it expects to lead to lower prices for patients;
    - new technology; and
    - encouraging more shared practices.

72. The ACCC has previously acknowledged that public benefits may arise in relation to intra-practice fee setting arrangements in the medical industry.[47] The ACCC recognised that the intra-practice fee setting arrangements were likely to lead to increased instances of shared practices for GPs and dentists, and the greater efficiencies and team culture arising from this.

73. However, in this instance the ACCC considers that the number of shared ophthalmology practices will continue to increase regardless of the Proposed Conduct. Therefore the ACCC proposes to only recognise public benefits that arise from the proposed intra-practice fee setting arrangements rather than any benefits that arise from operating as a shared practice.

74. The ACCC's assessment of the likely public benefits from the Proposed Conduct follows.

Improved quality of ophthalmology services

75. The ASO submits that the quality of ophthalmology services may be improved by allowing ophthalmologists within a shared practice to discuss models of care without restrictions imposed as to discussions about fee structures. The ASO submits the Proposed Conduct will assist in creating an atmosphere of open communication and teamwork, leading to improved patient outcomes.[48]

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[46] *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.
[47] See ADA Determination and also RACGP Determination.
[48] ASO Submission dated 26 February, p15 at [39] and p16 at [42-45].

76. Further, the ASO submits the Proposed Conduct will facilitate a greater degree of cross-referral of patients between ophthalmologists within a shared practice, reflecting a stronger teamwork culture and collaboration between practitioners.[49] However, at the pre-decision conference, the ASO advised that cross-referrals between ophthalmologists in a shared practice are already increasing with the level of subspecialisation within the profession, and in the case of patients with urgent conditions when necessary due to specialist availability or appropriateness due to sub-specialty.[50] The ASO has not set out any ways in which differing fees constitute a substantial barrier to cross-referral and how common fees would materially increase the number of cross-referrals. The ACCC recognises that barriers to cross-referral may be slightly lower where there are common fees, but is not satisfied that any resultant benefit is substantial, particularly where patients are most commonly referred to a particular ophthalmologist by their primary carer and there is little choice or transparency in relation to fees.

77. The ACCC has previously accepted that there are benefits to medical practitioners and consumers (including error management and reduction) from an open, team-based structure in shared practices.[51] In these matters, the ACCC has recognised fee setting within medical practices is likely to lead to an increased incidence of shared practices by increasing the attractiveness and benefits of shared practices. The ACCC has recognised that much of the public benefit flowing from common fee setting is a result of the likelihood that it will lead to an increased number of shared practices, rather than the fee setting arrangements themselves.

78. In the current matter, the ASO submits that a majority of ophthalmologists are currently operating within a shared practice due to the very high costs associated with establishing an ophthalmic practice and undesirable aspects of alternative partnership models, including joint medico legal liability and business costs/profit attribution difficulties.[52] Further, the ASO submits that the number of shared practices will continue to increase, regardless of whether the Proposed Conduct is authorised.[53]

79. Therefore, to the extent the proposed fee setting conduct would further enhance the capability of shared practices to operate as a team, the ACCC considers it may deliver some public benefit in terms of improved quality of ophthalmology services. However, the ACCC understands that the bulk of the teamwork benefits will be achieved in any event without the Proposed Conduct or can be – and apparently are being - achieved without transgressing competition laws, for example discussion of improvements to medical procedures and/or administrative procedures, and cross-referral of patients to the most appropriate specialist within a practice.

[49] ASO Submission dated 3 June, p3 at [10.1].
[50] Minutes of Pre-Decision Conference, p5.
[51] RACGP Determination, p36 at [6.39]; ADA Determination, p6 at [35].
[52] ASO Submission dated 3 June, p7 at [29]; ASO Submission in support of application, p11 at [14].
[53] ASO Submission dated 26 February, p19 at [69].

Continuity and availability of patient services

80. The ASO submits that the Proposed Conduct will enable ophthalmologists within a shared practice to offer common fees throughout the practice ensuring a patient is satisfied in accessing the services of an alternative specialist if their initial treating specialist is unavailable, particularly in an emergency situation or when a patient requires treatment at fixed time intervals. The ASO submits the Proposed Conduct has the potential to facilitate cross referral of patients between sub-specialties as decisions would be based on the skill and experience of the specialist rather than on cost,[54] and would remove customer concern about uncertainty of cost which constitutes a barrier to cross referral.[55]

81. The ASO submits that such an arrangement would improve non-price competition between members of a shared practice based on quality of service, experience and skill of a specialist, and may increase the occurrence of intra practice sub-specialty referrals, ensuring patients access highly specialised care.

82. The ASO further submits that co-operative arrangements will encourage shared responsibility for ensuring the quality of patient care is maintained.[56]

83. The ACCC has previously accepted that differing fees within a practice of dentists or GPs for the same service may create issues for some patients and ultimately undermine the level of cooperation between medical practitioners within a practice. As such a public benefit may be derived from improved continuity and consistency of patient care should a common fee structure be adopted by a practice.[57]

84. To the extent that ophthalmologists within a practice charge uniform fees for particular procedures or consultations, the ACCC considers this may provide some benefit by providing for a more seamless transition between specialists within a practice.

85. The ACCC notes the ASO's submission that pricing currently varies between specialists depending on their level of experience or degree of sub-specialisation, but that following authorisation it would expect ophthalmologists to implement uniform consultation fees for the most commonly utilised item numbers covered by the Medicare Benefits Scheme – those for initial consultations and follow up consultations, and that it is expected that the same fees will be charged for such items, regardless of the practitioners' age and experience. The ASO advises that it nonetheless would expect ophthalmologists of some sub-specialties to charge different fees from others in the same practice.[58]

86. The ACCC considers that the public benefits from common fees will be significantly lower in the case of medical professions in which there is a high proportion of patient referrals to specific individual specialists, and/or in which the medical conditions treated are typically non-urgent. This is because many of the benefits in arrangements of this type arise through situations in which patients need to see a practitioner other than their usual or current practitioner, and hence

[54] ASO Submission dated 26 February, p15 at [41].
[55] ASO Submission dated 3 June, p3 at [9.2].
[56] ASO Submission dated 3 June, p5 at [16.2].
[57] See ADA Determination, p6 at [34] and RACGP Determination, p38 at [6.54-6.55].
[58] ASO Submission dated 3 June, p6 at [22-23].

benefits of patient certainty of price, or ease of cross-referral between practitioners, may arise.

87. In preparing the draft determination, the ACCC understood that patients will typically need to visit an ophthalmologist about issues which are less likely to be urgent when compared to GPs and dentists.[59]

88. The ASO asserts that a busy ophthalmologist would see between three and six urgent cases per day of consultations, and that this is not less than GPs or dentists and may in fact be more.[60] At the pre-decision conference, the ASO noted the proportion of urgent cases will vary by individual ophthalmologist depending on the individual work mix and the type of practice, but estimated between 10 and 30% of an ophthalmologist's patients may be urgent – ie. requiring examination on the same day.[61]

89. The ACCC accepts that the proportion of urgent appointments seen by ophthalmologists may be higher than it previously understood, but notes a lack of any evidence or data provided to indicate the proportion of urgent appointments in a typical ophthalmology practice.

90. Nonetheless, the ACCC considers that patients' expectations that different ophthalmologists within a practice will charge the same fees will be lower than in the case of GP or dentist practices. This is largely due to the system of referrals from primary carers (GPs and optometrists) which means patients are typically less aware of the fees, and that GPs and dentists offer more generic services – which means a patient will more readily see a different practitioner should their regular practitioner be unavailable. As a result, the potential benefits from common fee setting by ophthalmologists are likely to be lower than in the case of GP or dentist practices. Further, in the case of those conditions which are non-urgent, the ACCC considers that ophthalmologists in shared practices will often not have an incentive to on-refer patients to other ophthalmologists within a shared practice due to excess demand for their services; rather, ophthalmologists could add incoming patients to the end of their waiting list.

91. The ACCC considers therefore that the Proposed Conduct may result in some benefit in relation to continuity and availability of patient services, but that this benefit is likely to be very limited in practice.

Range of ophthalmology services to meet demand

92. The ASO submits a public benefit will be derived from the Proposed Conduct through the provision of a greater range of ophthalmology services to meet demand, because as the number of ophthalmologists in a practice grows, the pool of expertise available to patients also grows.

93. The ACCC considers that this benefit is a result of the shared practice arrangement rather than from any fee setting conduct within a shared practice. The ACCC notes that, while the ASO submits the Proposed Conduct would

[59] ACCC, Draft Determination in relation to application for authorisation A91360 lodged by the Australian Society of Ophthalmologists, 20 June 2013 (ASO draft determination), p12 at [70] and p13 at [78].
[60] ASO Submission dated 25 July, pp1-2 at [2-3].
[61] Minutes of the Pre-Decision Conference, p4.

enhance the attractiveness of shared practices and therefore lead to an appreciable increase in the number of shared practices, it is likely that the number of shared practices will continue to increase, regardless of whether the Proposed Conduct is authorised. The Proposed Conduct could therefore at best be described as arguably accelerating the formation of shared practices, and the ACCC therefore considers the Proposed Conduct delivers little public benefit in regard to providing a greater range of ophthalmology services to meet demand.

Certainty and predictability in price of ophthalmic care

94. The ASO submits that the Proposed Conduct will improve certainty and predictability of price for patients ensuring comfort and prior awareness of the likelihood of expenditure required when receiving specialist services, and reduce patient confusion and anxiety relating to the uncertainty of fees.[62]

95. The ACCC has previously accepted that there is likely to be public benefit from consistent, predictable pricing among health practitioners operating in a shared practice where they work as a team, share patient records, common facilities, a common trading name and common policies and procedures, in circumstances where, to consumers, they may often appear to be one business with the ability to charge a common price.[63]

96. The ACCC accepted certainty and predictability of price as providing a public benefit in granting authorisation A91217 which permitted ophthalmologists operating within Vision Group clinics to agree on fees. The ACCC notes that, in the case of Vision Group, the clinics were specifically "branded" so as to appear to consumers to be a single business[64] and further had a large proportion of ophthalmologists employed by Vision Group (and therefore able to have common pricing) compared to ophthalmologists engaged as consultants (who could not agree on pricing and therefore whose fees would likely differ).[65]

97. Consistent with previous decisions the ACCC considers that there is likely to be some benefit to the public from enabling ophthalmologists within shared practices to provide consistent and predictable pricing for their patients, but notes that this is likely to provide less benefit than in the case of the Vision Group authorisation, in which patients were more likely to have a greater expectation of consistent pricing. The ACCC considers that, in the case of a non-branded ophthalmic shared practice, patients are more likely to expect different specialists to charge different fees depending on their level of experience and sub-specialty.

98. Further, the ACCC considers that much of the benefit could be captured without the Proposed Conduct, for example, by disclosing to patients the fees charged by the various practitioners within a shared practice in the form of a fee schedule.[66] Such a disclosure would not require any agreement on fees between ophthalmologists within a shared practice.

99. In response to this observation by the ACCC in the draft determination the ASO submitted that a fee schedule with individual prices for all practitioners is less

[62] ASO Submission dated 26 February, p17 at [51-52].
[63] Vision Group Determination, p8 at [4.14]; RACGP Determination, p38 at [6.54].
[64] Vision Group submission in support of application, p 2 at [2.2].
[65] Vision Group submission in support of application, p7 at [6.3].
[66] See ASO Submission dated 3 June, p7-8 at [31].

administratively efficient and will require regular updating. The ACCC considers that, while these points relate to the efficiency benefits of the Proposed Conduct, they do not have a bearing on the benefit provided to consumers by certainty of price.[67] The ACCC remains of the view that certainty of price for consumers can, to a large extent, be obtained by wider and more public disclosure of ophthalmologists' fees to patients and referrers, and that certainty of price is unlikely to be perceived by consumers to be a benefit if the uniform price is higher than the price they would otherwise have paid.

Efficiency in providing ophthalmology services

100. The ASO submits that the Proposed Conduct will save time for administration staff in billing procedures and continuously communicating to patients why differences in fees occur between practice specialists.[68]

101. The ASO further submits that efficiencies would arise from the conduct in relation to "informed financial consent" (**IFC**) processes and procedures. The Australian Medical Association encourages practitioners to adhere to IFC principles by providing cost disclosures to patients regarding potential fees and rebates for medical procedures and obtaining consent to these fees and charges. The ASO submits that these cost disclosures are provided by the vast majority of ophthalmologists to their patients, but are also customarily sought by primary carers from ophthalmology practices prior to referring patients. The ASO submits that shared ophthalmology practices tend to receive a large number of fee-related enquiries on this basis.[69]

102. The ASO submits that the Proposed Conduct would give rise to efficiencies in relation to IFC processes, as it would eliminate the need for (or greatly reduce the frequency with which) patient referrers enquire about fees charged by practitioners in shared practices, and would simplify the IFC process for referrals between ophthalmologists within shared practices.[70]

103. The ASO therefore expects that the Proposed Conduct will lead to lower prices for patients due to the resulting efficiency savings.

104. The ACCC considers the Proposed Conduct, while not necessarily increasing the number of cross-referrals between ophthalmologists within a shared practice,[71] may make the cross-referral of patients within a practice more efficient.

105. The ACCC has previously accepted that efficiency savings may arise to some extent through members of a shared practice agreeing on one price structure, as opposed to pricing their services individually.[72] The ACCC further accepts that some efficiencies may arise in relation to minimising or simplifying processes necessary for compliance with IFC requirements.

[67] For discussion of efficiency benefits, see [100-108].
[68] ASO Submission dated 26 February, p17 at [54].
[69] ASO Submission dated 3 June, p2 at [4].
[70] ASO Submission dated 3 June, p3 at [9.1].
[71] See discussion at [78].
[72] See: RACGP Determination; Vision Group Determination and; AMA Determination.

106. However, the ACCC considers that any resulting benefit will be lower in practices of specialists than in general practice and dentist practices, where the ACCC understands patients will typically be more likely to attend different practitioners within a practice over time due to the broad nature of health complaints for which a patient will attend a generalist practice.

107. In its submission of 25 July, the ASO questioned the consistency of the ACCC's view in this regard, citing that in the case of previously authorised GPs and dentists the conduct was voluntary and therefore practitioners may not necessarily agree to charge uniform fees for particular services. The ACCC notes that, in these previous authorisations, the efficiency savings from the proposed conduct were likely to be greater given the conduct was accepted to be likely to increase the number of shared practices. In the current matter, the ACCC considers the efficiency benefits are likely to be more marginal and therefore any inconsistency in fees is likely to reduce any minor benefits arising from the Proposed Conduct in this regard.

108. The ACCC accepts that, should members of a shared practice agree on a uniform fee structure to operate across the practice, there may be some minor administrative and overhead cost savings as a result. The ACCC also notes, however, that the process of agreeing on common fees will itself impose some new costs which would, to an extent, erode these benefits. On balance the ACCC considers that it is unlikely costs would reduce to any significant extent as a result of efficiency savings from the Proposed Conduct.

New technology

109. The ASO submits the Proposed Conduct would deliver benefits in relation to the delivery of ophthalmology services remotely through the use of new technology, which creates the opportunity for patients to be able to access the most competent or expert doctor regardless of time or place. For example, the ACCC is aware of equipment installed in some remote health clinics which allow images of a retina to be taken without the presence of an ophthalmologist, thus facilitating diagnosis and treatment management of a patient by a specialist who is not physically present.[73]

110. The ASO submits such technology requires a seamless approach to fee setting because:

- if treatment were to be provided via a system of rostered practitioners, patients would pay differing fees depending on which practitioner was rostered on. Therefore, the Proposed Conduct would provide patients with certainty of price, removing an element of complexity from the system which may otherwise undermine the success of the technology; and

- the Proposed Conduct would deliver efficiencies in relation to the delivery of remote services using technology by simplifying the process associated with cost disclosures as part of IFC processes to patients by ophthalmologists.

[73] Source: **www.irisprogram.com.au**, accessed 4 June 2013.

111. It is unclear to the ACCC, based on the ASO's submissions, how the use of remote technology by a shared practice of co-located ophthalmologists to treat patients would require greater use of rosters or more frequent IFC disclosures than the treatment of patients attending in person at the practice.

Authorisation will encourage more shared practices

112. The ASO submits that authorisation would encourage the formation of shared practices as opposed to solo practices and benefits in broader treatment options and efficiencies they bring for patients.[74]

113. As discussed previously,[75] the ACCC is not satisfied that the Proposed Conduct will result in any significant benefit by encouraging more shared practices, as significant incentives already exist for ophthalmologists to form shared practices, due largely to the significant capital costs of setting up a practice.

ACCC conclusion on public benefits

114. The ACCC is satisfied that some public benefits are likely to arise as a result of the Proposed Conduct, but considers that these are likely to be limited.

115. The ACCC considers that the public benefits in this instance are likely to be less substantial than in previously authorised fee setting arrangements within the medical industry due to:

- the large percentage of ophthalmologists already operating within a shared practice, which the ACCC considers is likely to increase in the future with or without the conduct. This means that most of the benefits that flow from operating shared practices will be achieved with or without the Proposed Conduct;
- similarly, most of the teamwork benefits of operating in shared practices will be achieved without the Proposed Conduct or can be achieved without transgressing competition laws;
- it being likely that patients seeing specialists will typically attend the practice less frequently and will less often have an urgent condition that requires being seen by another specialist if their specialist is unavailable on a given day;
- patients being more likely to expect ophthalmologists within a shared practice to charge different fees based on their level of experience or sub-specialty, thereby reducing any benefit to be gained from certainty and predictability of price.

[74] ASO Submission dated 26 February, p18 at [63].
[75] See discussion at [65-70] above.

Public detriment

116. 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.[76]

117. The ASO submits that the Proposed Conduct will not result in any material detriment because:

- the Proposed Conduct would occur only within shared practices and hence will not adversely affect the strong competition which exists between ophthalmology practices;
- in inner regional, outer regional, remote and very remote areas, where the rate of ophthalmologists per head of population is much lower than in metropolitan areas, ophthalmologists are likely already working at capacity and therefore the Proposed Conduct would not lessen competition or result in increases to fees;
- alternative services are offered by public hospitals, optometrists and other eye health care providers;
- the Proposed Conduct would encourage the formation of shared practices and the benefits and efficiencies these bring;
- the Proposed Conduct would be voluntary and no ophthalmologist would be bound to take part;
- ophthalmologists are constrained by: “no gap” or “known gap” arrangements with private health insurers; discounts to pensioners, veterans and other special interest groups; particular arrangements with large clients; and other informal arrangements, such as discounts provided based on financial hardship.

118. The ACCC considers that generally, agreements between competitors in relation to price will reduce competition, resulting in increased prices or reduced quality and availability of goods or services. In any market where competitive constraints are reduced, the ACCC would expect prices to increase. The ACCC would therefore expect significant public detriment to occur as a result of price agreements between competitors.

119. In this case, the ACCC is concerned that the Proposed Conduct is likely to result in increased fees for ophthalmic services than would otherwise be the case, because it removes the competitive constraint which would otherwise exist between members of the shared practice.

120. The following sections examine the extent of any detriment from the conduct facilitating price increases and the various constraints which may limit the extent of any such detriment.

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

121. The factors considered include:

- the level of competition between ophthalmologists, both between shared practices and within shared practices, including the impact of the referral system and patient preferences for non-price aspects of ophthalmic services on the level of competition
- the extent to which ophthalmic services may be substitutable, and the height of barriers to entry for the profession
- any pressure on ophthalmologists from private health insurers as a possible constraint
- the level of demand for ophthalmic services,.

Level of competition between ophthalmologists

122. The number of ophthalmologists practicing in each geographic area differs. The ACCC has not been provided with a breakdown of numbers of practising ophthalmologists by geographic region, but understands that a large majority of ophthalmologists practice in metropolitan areas.[77]

123. The ASO advises that ophthalmic practices tend to cluster around health facilities such as public and private hospitals and day theatres, and estimates that 90-95% of shared practices would have one or more other private ophthalmic practice within 10 kilometres.[78] At the pre-decision conference the ASO advised that, while most ophthalmologists work in metropolitan areas, larger regional centres also have multiple ophthalmic practices.[79] As previously noted the ASO has not provided any geographic data or other evidence to support these observations.

124. However, given the overall small number of ophthalmologists practising within Australia, in some areas there will be few if any competing practices. This effect is compounded given the extent of sub-specialisation within the profession.[80] The extent of this impact will vary by geographic region, and considering the ASO's submission about the clustering effect around metropolitan health facilities, the ACCC considers the impact is likely to be greatest in regional, rural and remote areas where there is a lower density of ophthalmologists practising per head of population.

    The ASO has indicated that some competition currently exists between ophthalmologists within a shared practice: for example, the ASO submits as a public benefit improved competition based on quality of service rather than on price.[81] Further, the ACCC understands based on ASO submissions that there is some degree of price disclosure to primary carer referrers who seek information about the fees charged by different ophthalmologists. The ASO advised it

[77] See discussion at [53] above.
[78] Minutes of the Pre-Decision Conference, pp3 and 5.
[79] Minutes of the Pre-Decision Conference, p7.
[80] The ACCC notes the ASO's Submission that, of the 10-15% of ophthalmologists who practise exclusively in a sub-specialty, the vast majority practise within metropolitan areas: ASO Submission dated 3 June, p7 at [27-28].
[81] ASO Submission dated 26 February, p16 at [49].

understands that GPs and optometrists, in choosing a specialist to whom to refer a patient, will look for safety and quality first but price after that.[82]

125. These statements imply that there is currently some level of price competition between ophthalmologists within, as well as between, shared practices. This is different to the Vision Group circumstances, as in that case more than half of the ophthalmologists affected were employees who already charged common fees, and Vision Group clinics were specifically branded to create the impression of a single business to consumers.

126. The Proposed Conduct covers all ophthalmologist members of the ASO who are members of a shared practice. The ASO reports more than 60% of ophthalmologists are currently members of the ASO, and that the majority of ophthalmologists currently operate within a shared practice, with this proportion likely to increase in the future. Further, the ACCC considers that the inclusion of ophthalmologists who operate as a branch practice within the definition of "shared practice" potentially broadens the scope of the Proposed Conduct to include ophthalmologists practising over large geographic areas.

127. In the draft determination, the ACCC expressed the view that the concentrated nature of the provision of ophthalmological services means the anti-competitive effects from the proposed fee setting will be higher than in the other medical fee setting authorisations the ACCC has considered. Specifically, in the case of previous authorisations such as the AMA and the ADA, the number of competing practices in any given market would be relatively large. By way of indication, the number of practitioners in the relevant professions in these authorisations were close to 12,000[83] in the case of dentists, and 19,000[84] for general practitioners, compared to only 812 currently practising ophthalmologists.[85] The ACCC's concern, therefore, is that the current application involves an industry which may have few constraining practices in each of the various geographic areas of competition. Further, the Proposed Conduct covers up to 60% of all ophthalmologists, compared to the Vision Australia authorisation which covered only approximately 7% of ophthalmologists in Australia.

128. The ASO has questioned the relevance of this point as, although there are more dentists and GPs than ophthalmologists in Australia, there is a correspondingly smaller number of patients seeking the services of ophthalmologists. Further, the ASO submits the comparison drawn by the ACCC between the scope of the Proposed Conduct and that conduct authorised in Vision Group is erroneous, as each shared practice which would be permitted to agree on fees constitutes less than 1% of all ophthalmologists within Australia, compared to the vastly greater application of the Vision Group authorisation which related to 7% of ophthalmologists.

129. The ACCC's concern in relation to the smaller number of ophthalmologists in this context is not related to the supply of particular medical practitioners compared to demand for their services. Rather, a small number of practitioners nationally indicates that, in any given area, there are likely to be few other ophthalmic practices to provide a competitive constraint on a shared practice which chooses to engage in the Proposed Conduct.

[82] Minute of Pre-Decision Conference, p7.
[83] ADA, Submission in support of application for authorisation, A91340-A91341, p11.
[84] **www.racgp.org.au**, accessed 13 June 2013.
[85] ASO Submission dated 26 February, p12 at Table 1.

130. Further, the relevance of the comparison with the Vision Group authorisation for the ACCC is, again, the level of competitive constraint operating on each practice which would be permitted to set fees under the application within each regional market. In the case of the Vision Group authorisation, the applicant presented data on the ophthalmic practices likely to be constraining each clinic affected by the conduct. The ACCC was able to assess the likely constraint on a practice by practice basis and was satisfied that the likely benefits outweighed the likely detriments in those circumstances.

131. In the case of the current application, 60% of ophthalmologists are currently members of the ASO, the majority of these are in shared practices, and the number of shared practices is likely to increase in the future absent the Proposed Conduct. It therefore seems likely that any ophthalmologists in current or future shared practices that would otherwise constrain a competing practice may also engage in the Proposed Conduct. In this way, competition between individual ophthalmologists within any given area is likely to be reduced from current levels (which will likely be competition between individual ophthalmologists) to competition between shared practices, each setting its own fees. The ACCC considers this reduction in competition is likely to constitute a significant detriment.

ASO proposal to limit the scope of the conduct

132. Following the draft determination, the ASO proposed confining the scope of the Proposed Conduct to apply to shared practices which have a competing private ophthalmic clinic within a 10 kilometre radius. The ASO noted the ACCC's observation in the Vision Group authorisation determination that it was comforted by the presence of a competitor within 10 kilometres of each clinic.

133. In assessing the likely detriment to competition in the Vision Group authorisation, the ACCC considered a range of factors based on material presented by Vision Group, on which basis the ACCC concluded that each Vision Group clinic was subject to adequate competitive constraint. The presence of competitors in the local area of each clinic was one relevant factor in assessing the level of competition to which each clinic was subject, but the decision was not taken on this basis alone.

134. In the current matter the ACCC is not satisfied that the presence of a competitor within 10 kilometres would, on its own, provide a sufficient level of constraint in all circumstances to provide comfort to the ACCC that the detriment to competition would be mitigated such that the likely benefits would outweigh the likely detriment.

135. As already noted, other relevant factors in authorisation of the Vision Group's application included the corporate structure, the number of ophthalmologist employees and the corporate branding. In this case, the loss of competition even under ASO's proposal to limit the scope of the conduct is likely to still be substantial. The Proposed Conduct could, for example, reduce the range of patient choice in an area from 10 individual ophthalmologists setting prices individually within two shared practices, to only two shared practices each setting fees within the practice.

Impact of referral system on price competition

136. The ACCC considers that the nature of the referral system by which ophthalmologists generally gain access to new patients may impact on the nature of competition between ophthalmologists. Under the Medicare program, ophthalmologists gain access to new patients on a referral basis from a primary carer such as a GP or current specialist. The referral system may currently limit the extent to which ophthalmologists in shared practices compete (particularly on price) for new patients and therefore mitigate to some extent the detriment from a lessening in competition from the Proposed Conduct.

137. This effect will be reduced to the extent that referring doctors take account of the fees charged by particular ophthalmologists in choosing which specialist to refer patients to. The ASO notes the operation of the IFC process whereby referring primary carers make inquiries of ophthalmologists' likely fees on behalf of patients prior to referring patients,[86] which suggests that referring doctors take price into account in choosing a specialist to refer to.[87]

138. Further, the ACCC understands from the pre-decision conference that local GPs and optometrists regularly seek price information from ophthalmic practices before referral.[88]

139. Therefore the ACCC considers that referring doctors are likely to take price into account in selecting which ophthalmologist to refer patients to, and in doing so may compare the fees of various ophthalmologists including those operating within shared practices. Such competition would be lost if common fees were permitted.

Impact of patient preference for non-price aspects of service on price competition

140. The ACCC understands that patients may value highly specialised patient care and non-price aspects of an ophthalmologist specialist.[89] Patients are unlikely to be aware of what other ophthalmologists charge.[90] Patients may not be aware of the fees of a particular specialist when they are referred to them, and in any case may not select between different ophthalmologists based on price. This may reduce the extent to which ophthalmologists compete on price.

141. However, as discussed above, the ACCC understands from ASO submissions that general practitioners, in referring patients to ophthalmologists, may take price into account on behalf of their patients in selecting a specialist. Again, such competition would be lost if common fees were permitted.

Substitutability for ophthalmic services

142. The ASO has submitted that the Proposed Conduct will not result in detriments (in part) because of competition for some services from public hospitals and

[86] ASO Submission dated 3 June, p2 at [4.1].
[87] Minute of Pre-Decision Conference, p7.
[88] Minute of Pre-Decision Conference, p7.
[89] IBISWorld, *Specialist Medical Services in Australia*, November 2012, pp19-20.
[90] ASO Submission dated 3 June, p3 at [7].

other medical professionals, such as optometrists.[91] The ASO submits that an increasing proportion of the work of ophthalmologists is able to be undertaken by optometrists, such as aspects of the treatment of glaucoma.[92]

143. The ACCC considers that ophthalmologists are more likely to be constrained in relation to services which are also offered by optometrists, and that the proposed fee setting conduct is likely to be less detrimental in relation to these services.

144. However, many ophthalmic services are only available from ophthalmologists and are not substitutable by services from other professionals. The ACCC considers that for most services provided by ophthalmologists patients would have few, if any, alternatives available and would therefore be unable to avoid any price increases resulting from intra-practice fee setting agreements, and therefore that the services of other professions such as optometrists would provide little competitive constraint on the fees charged by ophthalmologists.

145. The ACCC accepts that ophthalmological services provided to patients at public hospitals may provide some competition to those provided by private ophthalmologists. However, the small proportion of ophthalmological services provided at public hospitals and long waiting times mean that they are unlikely to provide significant competitive discipline.

Height of barriers to entry

146. In markets in which it is relatively easy for new parties to enter and compete, these potential new entrants can be expected to constrain or provide downward pressure on price increases within the market. In response to the draft determination, the ASO submitted that barriers to entry are not as high as the ACCC perceives and have been getting progressively lower for some time.[93] However the ACCC maintains the view that, in the current matter, barriers to entry are very high due to the lengthy training required to specialise and then sub-specialise, as well as the limited availability of training places. As a result new market entrants are unlikely to provide downward pressure on prices above efficient levels and are therefore unlikely to mitigate any tendency for price increases resulting from the Proposed Conduct.

Other constraints on price

147. The ASO submits there are a number of other constraints on the prices charged by ophthalmologists, including preferred provider arrangements with private health funds, discounts to pensioners, veterans and other special interest groups, particular arrangements with large clients, and informal arrangements such as discounts provided to individual patients based on financial hardship.[94]

148. In relation to the arrangements offered by ophthalmologists to special interest groups, large clients and individuals experiencing financial hardship, the ACCC does not regard these as constraining the price of ophthalmic services, as these are voluntarily offered by ophthalmologists.

[91] ASO Submission dated 26 February, p18 at [61-62].
[92] ASO Submission dated 25 July 2013, pp4-5 at [11-18].
[93] ASO Submission dated 25 July 2013, p9 at [38].
[94] ASO Submission dated 25 July 2013 p5 at [19] and ASO Submission dated 15 August 2013, p3 at [8].

149. In relation to the level of constraint provided by preferred provider arrangements, the ACCC notes the ASO's submission that private health insurers are able to exert significant pressure on ophthalmologists to accept "no gap" or "known gap" treatment, in which an ophthalmologist undertakes to charge fees set by the insurance fund.[95]

150. However, at the pre-decision conference the ASO advised that very few ophthalmologists have preferred provider arrangements with health insurers. Rather ophthalmologists will generally make arrangements with individual patients rather than a specific insurer. In this context, the ACCC considers it unlikely that private health insurers are providing a significant degree of constraint.

151. In the case of some previous applications for authorisation in relation to similar conduct, the ACCC has considered that the potential detriments have been likely to have been mitigated by bulk billing or 'no gap' services.[96] Unlike the GP shared practices, for approximately 85 to 95% of all ophthalmologists (being those in private practice) the ACCC understands from the Department of Health and Ageing that few ophthalmology services are bulk billed.

152. Accordingly, the ACCC considers that the public detriments arising from the Proposed Conduct are unlikely to be mitigated by bulk billing or 'no gap' ophthalmological services.

High demand compared to supply

153. The ASO submits that, in regional and remote areas, ophthalmologists are likely already working at capacity and therefore the Proposed Conduct would not lessen competition or result in increases to fees.[97]

154. The ACCC understands that demand for ophthalmologists in private practice is likely to increase due to an ageing population and an increase in the prevalence of chronic disease.[98]

155. While the ACCC accepts that demand may currently be higher than supply in non-metropolitan areas, this does not mitigate the anti-competitive detriment resulting from the Proposed Conduct. Excess demand suggests that prices could rise and the Proposed Conduct may facilitate this.

156. There would also be substantial detriment in removing the potential for greater price competition between ophthalmologists in the future if demand or other market circumstances were to change.

The conduct is voluntary

157. The ASO submits that the Proposed Conduct would not result in any detriments in part because the proposed arrangements would be voluntary – that is ophthalmologists could choose whether or not to participate in common fee

[95] ASO Submission dated 25 July 2013, p4 at [4].
[96] For example, AMA Determination, p5 at [21].
[97] ASO Submission dated 26 February, p18 at [60].
[98] AIHW, *Eye health labour force in Australia,* p2.

setting within a shared practice. The ASO further submits that it is expected exceptions will be made for fees charged by certain sub-specialists, who would be expected to set a higher professional fee.[99]

158. The ACCC would expect ophthalmologists to choose to participate in the Proposed Conduct if they expect to be able to capture greater efficiencies or reduce costs. It is unlikely that any ophthalmologist would choose to participate if it meant their fees would be reduced – particularly where they are able to capture the bulk of the benefits from participating in a shared practice without needing to set common fees. In any market, the ACCC would expect prices to increase above competitive levels where market participants have the ability to do so because there is not sufficient competitive constraint to prevent this.

159. Nonetheless, the ACCC acknowledges that the fact that ophthalmologists joining a practice would not be forced to charge a particular fee would mitigate the detriment to some extent.

160. Further, ophthalmologists may choose to deviate from agreed fee schedules for particular patients or in particular circumstances, such as for low-income earning patients or to attract new patients. Indeed, the ASO submits that it is expected that there will be discounts applicable to pensioners.[100] While this may mitigate the detriment, the ACCC notes that to the extent ophthalmologists deviate from an agreed fee structure, this would also reduce the claimed benefits from having consistent fees within a shared practice.

ACCC conclusion on public detriments

161. Price fixing conduct generally results in considerable detriment within a concentrated market with few substitutable services available and high barriers to entry.

162. The ACCC considers that, given the likelihood of relatively small numbers of competitors for the provision of ophthalmologist services in many geographic areas, the lack of substitutability for many ophthalmic services and the height of barriers to entry, the effects of any horizontal agreements between competitors in relation to price would be likely to significantly reduce any existing price competition, resulting in higher prices paid by consumers for ophthalmic services and result in substantial detriment.

163. While the level of price competition between ophthalmologists may be higher than the ACCC understood in preparing the draft determination, the ACCC has not been provided with information to support the view that this competition exists only between, rather than within, shared practices.

164. Further, due to the relatively small number of ophthalmologists in some regional and rural areas, many of the ophthalmic practices within any given region may be shared practices run by ASO members. In these areas, the Proposed Conduct is likely to significantly reduce any price competition that currently occurs by reducing the number of competitors from the number of individual ophthalmologists practising within a region, to the relatively small number of shared practices within a region.

[99] ASO Submission dated 3 June, p6 at [23].
[100] ASO Submission dated 3 June, p7 at [24].

165. The ACCC understands that price competition between ophthalmologists in some geographic markets may currently be limited, particularly within regional, rural and remote areas where few ophthalmologists practice. However, these ophthalmologists currently set their own fees and in moving to common agreed fee structures, it is likely that fees would increase on average.

166. In geographic areas in which price competition does currently exist, or may exist at some time in the future due to new entrants, the ACCC considers the Proposed Conduct is likely to result in a significant reduction, removal or prevention of this price competition over time.

167. The ACCC considers that the loss of price competition between ophthalmologists in shared practices is a significant detriment.

Balance of public benefit and detriment

168. In general, the ACCC may grant authorisation if it is satisfied that, in all the circumstances, the Proposed Conduct is likely to result in a public benefit, and that public benefit will outweigh any likely public detriment, including any lessening of competition.

169. In the context of applying the net public benefit test in subsection 90(8)[101] of the Act, the Tribunal commented that:

> … something more than a negligible benefit is required before the power to grant authorisation can be exercised.[102]

170. For the reasons outlined in this determination the ACCC is not satisfied that the likely limited benefit to the public would outweigh the detriment to the public including the significant detriment constituted by the lessening of competition that would be likely to result.

171. Accordingly, the ACCC is not satisfied that the relevant net public benefit tests are met.

Determination

The application

172. On 26 February 2013 the Australian Society of Ophthalmologists Incorporated (**ASO**) lodged application for authorisation A91360 with the ACCC. Application A91360 was made using Form B Schedule 1, of the Competition and Consumer Regulations 2010. The application was made under subsections 88(1) and (1A) of the Act for current and future ASO members who are registered ophthalmologists and who practice in a shared practice to make and/or give

[101] The test at subsection 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.

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

effect to contracts, arrangements or understandings as to the fees to be charged for ophthalmology services provided by the shared practice.

173. For the purposes of the application, a 'shared practice' consists of the following attributes:

- a partnership of two or more ophthalmologists; or
- an associateship of two or more ophthalmologists:
  - who are co-located or operate as a branch practice; and
  - which has a common service entity, in which each of the ophthalmologists must either have an interest; have contracted with the service entity; or be employed or otherwise engaged by the service entity to provide ophthalmology services on the service entity's behalf; and
  - the service entity is responsible for managing and/or maintaining a common reception, common fee collection, common bank account, common trading name, common medical records and, except for branch practices, common policy and procedures.

The net public benefit test

174. For the reasons outlined in this determination, the ACCC is not satisfied that the proposed conduct for which authorisation is sought is likely to result in a public benefit that would outweigh the detriment to the public constituted by any lessening of competition arising from the conduct. Therefore the ACCC is not satisfied that the relevant tests in subsections 90(5A), 90(5B), 90(6) and 90(7) of the Act are met.[103]

175. The ACCC therefore **denies** authorisation to application A91360.

[103] See Attachment A for a summary of the relevant statutory tests.

Attachment A - Summary of relevant statutory tests

Subsections 90(5A) and 90(5B) provide that the ACCC shall not authorise a provision of a proposed contract, arrangement or understanding that is or may be a cartel provision, unless it is satisfied in all the circumstances that:

- the provision, in the case of subsection 90(5A) would result, or be likely to result, or in the case of subsection 90(5B) has resulted or is likely to result, in a benefit to the public; and

- that benefit, in the case of subsection 90(5A) 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 were made or given effect to, or in the case of subsection 90(5B) outweighs or would outweigh the detriment to the public constituted by any lessening of competition that has resulted or is likely to result from giving effect to the provision.

Subsections 90(6) and 90(7) 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 in the case of subsection 90(6) would result, or be likely to result, or in the case of subsection 90(7) has resulted or is likely to result, in a benefit to the public; and

- that benefit, in the case of subsection 90(6) 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 was given effect to, or in the case of subsection 90(7) has resulted or is likely to result from giving effect to the provision.