Determination

Applications for authorisation A91340 and A91341

lodged by

Australian Dental Association Inc.

in respect of

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

Date: 27 March 2013

Authorisation numbers: A91340 and A91341

Commissioners: Sims
Rickard
Schaper
Court
Dimasi
Walker

Summary

The Australian Competition and Consumer Commission (ACCC) has decided to grant authorisations A91340 and A91341 for a period of 10 years to the Australian Dental Association Inc. (ADA). The authorisation will enable dental practitioners to reach agreements as to the fees to be charged for dental services provided within a shared practice where at least one party to the agreement is a member of the ADA.

The ACCC grants authorisation until 18 April 2023.

The applications for authorisation

1. On 29 October 2012, the Australian Dental Association Inc. (ADA) lodged applications for authorisation A91340 and A91341 on behalf of its members. The applications are substantially similar to authorisations A91094 and A91095 that were granted by the ACCC on 10 December 2008 (the 2008 Authorisation) and expired on 28 February 2013. The ADA also sought interim authorisation in the event that the ACCC's determination in respect of the applications was not made prior to the expiration date.[1]

2. Authorisation is sought to enable agreements as to the fees to be charged for dental services within shared practices, including where such conduct may be characterised as exclusionary conduct. Specifically, the ADA sought authorisation for:[2]

    - the making of or giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists who practise in a shared practice as to fees to be charged for dental services provided in the practice;

    - where at least one party to the contract, arrangement or understanding is a member of the ADA.

3. The ADA's application for authorisation extends to 'all contracts, arrangements or understandings in similar terms to the proposed conduct, to the extent that giving effect to the proposed conduct results in contracts, arrangements or understandings in similar terms'.[3]

4. The ADA advises that the authorisation with respect to an exclusionary provision was sought to ensure that any agreement with respect to fees within a shared practice could not potentially constitute a provision of a contract, arrangement or understanding between practitioners which is said to have the purpose of restricting or limiting the supply of dental services to patients in particular circumstances or on particular conditions, namely, other than in accordance with the agreed fee schedule.

1 ADA letter to ACCC, 21 November 2012.
2 Letter from the Australian Dental Association Inc., 18 December 2012.
3 ADA submission 26 October 2012, paragraph 2.6.

5. The ADA submits that shared practices typically include the following characteristics:

    - Two or more dental practitioners who may, but do not necessarily practise in a partnership (the applications for authorisation are relevant to shared practices other than those structured as a partnership)
    - Shared staff including dental hygienists, administration and other support staff
    - Treatment of patients of other members of the practice and shared dental records
    - Shared premises, practice name, dental equipment and supplies, reception, billing and advertising.

6. The ADA sought authorisation for a period of five years.

Draft determination

7. On 13 February 2013, the ACCC issued a draft determination that proposed to grant authorisation for a period of 10 years. The ACCC also decided to grant interim authorisation at that time.

8. No submissions were received after the draft determination.

The ADA

9. The ADA is the peak professional organisation representing dentists. It is a national organisation with branches in all states and territories. The ADA has two main aims being the encouragement of the health of the public and the promotion of the art and science of dentistry.[4]

10. Functions of the ADA include maintaining continuing communication with the membership, determining policy and generating expert advice, and responding to enquiries by the general public and other organisations.

11. The ADA notes that membership is voluntary and around 90% of practising dentists are currently members.

12. Applicants for membership must initially apply to their relevant State or Territory Branch. Membership fees vary between Branches with annual fees being $1286 in NSW/ACT; $964 in Victoria and $890 in Queensland. Members must also pay an additional annual fee of $660 to the national body.[5]

[4] ADA submission, 26 October 2012, p. 2.
[5] ADA letter to the ACCC dated 14 December 2012.

Previous authorisation – 2008

13. On 10 December 2008 the ACCC granted authorisation to the ADA in respect of agreements as to the fees to be charged for dental services provided within shared practices. This authorisation expires on 28 February 2013.

14. The ACCC considered that the consistency of fees within a practice can assist with ensuring the predictability of costs for treatment within that practice and for the course of treatment required. This was considered to assist with the continuity and consistency of patient care.

15. The ACCC considered that the potential for detriment was limited by the fact that the arrangements were confined to agreements on price within shared practices and because shared practices would continue to set their fees based on a range of factors including competition where relevant.

16. The ACCC considered that the likely public benefit generated by allowing dentists and/or dental specialists within a shared practice to agree on fees would outweigh the likely public detriment.

Applicant's submissions

17. Certain legal structures such as partnerships and incorporated entities permit dentists to agree on common fees without the need for authorisation. The ADA submits that the proposed conduct will provide dentists with increased flexibility to choose the business structure that best suits their needs.

18. The ADA submits that the authorisation of fee setting within a shared practice will promote a number of public benefits including:

    - improving the availability of dental services and providing continuity of patient care
    - increasing the quality of dental services available within a practice
    - encouraging efficiency in the provision of dental services
    - attracting and retaining dental practitioners in the workforce.

19. The ADA cited research that indicates an increase in the take up of the 'associate' structure (a form of shared practice) from 15% in 2007 to 18% in 2010.[6] The ADA submits that the rate of fee increases for all dental services has decreased in every financial year from 2008 to 2011, coinciding with the current authorisation. The ADA further submits that there is no reason to suggest that the renewal of authorisation would affect fee levels negatively in the years to come.

[6] ADA submission 26 October 2012, p.9.

Interested party submissions

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

21. The ACCC invited around 30 potentially interested parties to make submissions on the ADA's applications for authorisation. Potentially interested parties included various government agencies, industry associations and consumer groups. Prior to the draft determination, the ACCC received submissions from:

    - Consumers Health Forum of Australia
    - Consumers' Federation of Australia
    - SA Dental Service (Government of South Australia)
    - the South Australian Branch of the Australian Dental Association (ADASA).

22. Submissions received were broadly supportive of the ADA's applications for authorisation. However the Consumers Health Forum of Australia questioned whether the authorisation would apply to dental practitioners who are not members of the ADA. The Consumers Health Forum of Australia is of the view that the authorisation should cover all dental practitioners regardless of their ADA membership status.

23. The ACCC did not receive any submissions after the draft determination.

24. Copies of public submissions can be obtained from the ACCC's website www.accc.gov.au/authorisationsregister.

ACCC evaluation

25. The ACCC's evaluation of the proposed conduct is in accordance with the relevant net public benefit tests[7] contained in the Act. 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, including the detriment constituted by any lessening of competition that would be likely to result.

Relevant Area of Competition

26. The ADA submits that the relevant area of competition impacted by the proposed conduct concerns the provision of private general and specialist dental services in localised geographic regions. This description is consistent with the area of competition accepted by the ACCC in its 2008 Determination.[8] The ACCC accepts that this description remains appropriate.

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7 Subsections 90(5A), 90(5B), 90(6), 90(7) and 91C(7) of the Act). The relevant tests are set out in Attachment A.

8 ACCC Determination, Australian Dental Association Inc, A91094-A9105, 10 December 2008.

Future with and without

27. The ACCC considers a likely 'future with-and-without' to identify and weigh the public benefit and public detriment generated by conduct for which authorisation has been sought.[9]

28. In its 2008 Determination, the ACCC noted that dental practitioners operating as separate legal entities in shared practices must not reach agreement on fees in the absence of authorisation. The ACCC considered that in the absence of authorisation, dental practitioners operating as separate legal entities must set their fees individually or restructure their business structure to avoid competition concerns under the Act.[10]

29. Dental practitioners can collectively agree on the prices they charge patients where they operate under business structures such as partnerships and incorporated entities. However, the Act prevents dental practitioners from reaching agreements regarding the fees that they charge where they do not operate under these structures, such as in shared practices (other than a partnership). A partnership structure may not be suitable for all dental practitioners wishing to operate as part of a shared practice. For example, the ADA submits that partnership is less attractive to some dental practitioners for reasons that include the acceptance of liability for the actions of other partners in the practice.

30. The ACCC considers that the proposed conduct will provide dental practitioners with increased flexibility to choose the business structure that best suits their needs. The ACCC considers that if dentists are permitted to set fees within a shared practice, this will facilitate collaboration and collegiality between those dentists which is likely to encourage more dentists to operate within a shared practice environment.

31. The likely future should authorisation not be granted, would be that dental practitioners operating in shared practices would either not be able to agree on fees to be charged by the practice or would be required to incorporate or enter into partnership.

ACCC assessment of public benefits and detriments

Public Benefit

32. The ACCC considers that the conduct is likely to increase the incidence of shared practices, which has a number of benefits. The ACCC's assessment of likely public benefits associated with the shared practice structure is set out below.

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

10 See ACCC Determination, Australian Dental Association Inc, A91094-A9105, 10 December 2008, p.16.

Availability and continuity of patient care

33. Shared practices are likely to improve the availability and continuity of patient care by providing access to additional dental practitioners within a patient's usual dental practice. Circumstances where additional dental practitioners may be of benefit to patients include emergencies and continuity of care during an individual dentist's holiday leave and other absences. A shared practice may also facilitate the efficient use of dentists' specific areas of specialisation through intra-practice referrals.

34. The ADA submits that a cooperative approach expected in a shared practice may be disturbed by differential fees. The ACCC considers that differing fees within a practice for the same service may create issues for some patients and ultimately undermine the level of cooperation between dental practitioners within a practice.

Quality of dental services

35. Shared practices may be more conducive to greater quality of service owing to the enhanced ability of dentists to consult each other on aspects of patient care and the ability to work as part of a team. Peer review, advice and the ability to draw on the clinical experience or specific area of expertise of other dentists is likely to improve the quality of patient care. The ACCC considers that if dentists were to compete on the basis of price within shared practices, the team environment may be undermined to some extent, resulting in a lost opportunity to improve the quality of dental services.

Efficiency in the provision of dental services

36. The shared practice structure is likely to result in greater efficiency in the provision of dental services as a result of the ability to share the costs of practice such as rent, leasing equipment, administration and other overheads. The shared practice may also facilitate the realisation of economies of scale in the purchase of major equipment and the more efficient utilisation of certain assets.

37. The ADA also submits that providing access to equipment within a shared practice removes the need for patients to make another appointment to see another health practitioner and eliminates 'double handling' of the patient. The ACCC accepts that where the relevant circumstances apply, this is likely to result in public benefits.

Attraction and retention of dental practitioners

38. Shared practices are likely to increase the feasibility of part time work for dentists as a result of the ability to share facilities and costs. In its submission, the ADA described two demographic groups for whom access to part time work would be particularly beneficial: older dentists who may put off retirement by electing to work part time, and younger dentists with pressures to manage work and family commitments.

39. The ADA submits that a partnership structure is unlikely to be suitable for part time practitioners due to the increased complexities relating to the sharing of costs and revenues with full time partners.

40. The ACCC considers that the proposed conduct may lead to public benefits through increasing the flexibility of working arrangements for dentists, which in turn should improve the availability of dental care.

Public Detriments

41. The ADA submits that the existing authorisation has not resulted in any public detriment and that if the authorisation continues, it will not give rise to public detriment in the future. The ADA submits that there will be no lessening of competition between dental practices as a result of the proposed conduct.

42. In its 2008 Determination, the ACCC considered that the potential for public detriment was limited because the authorisation was limited to agreements on price within (not between) practices operating under a shared business structure. The ACCC considered that dentists within a shared practice would continue to set their fees based on a range of factors including competition (where relevant) from nearby practices.

43. The ACCC considers that these factors remain relevant to the current applications for authorisation.

44. The ADA submits that fee levels have not increased significantly since authorisation was granted in 2008 and that the rate of fee increases for all dental services has decreased in every financial year from 2008 – 2011.[11] However, the ACCC is cautious about relying on this data to infer that the current authorisation has not placed upward pressure on prices. The data represents the net result of many factors that affect fees, notwithstanding that one such factor may be the 2008 Authorisation.

45. At the time of considering the 2008 applications for authorisation, SA Dental Service raised concerns with the potential for reduced competition and increased costs of accessing dental services. However in relation to the current applications for authorisation, SA Dental Service submits that 'having reviewed the documentation provided, SA Dental Service concludes there may be potential public benefit and that there is no apparent public detriment in granting an extension of the existing arrangements'.[12]

46. The Consumers Health Forum sought clarification as to whether the authorisation is limited to ADA members only, submitting that it would be unable to support the authorisation if it is limited to ADA members only.[13] The ADA subsequently wrote to the ACCC to amend the scope of the applications such that authorisation is sought for:[14]

    - the making of or giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists who practise in a shared practice as to fees to be charged for dental services provided in the practice;

    - where at least one party to the contract, arrangement or understanding is a member of the ADA.

11 ADA submission 26 October 2012, p.10.
12 SA Dental Service submission, 12 November 2012.
13 Consumers Health Forum submission, 22 November 2012.
14 ADA letter to ACCC, 18 December 2012.

47. As the ADA's membership accounts for approximately 90% of Australian dentists, the ACCC considers there would be few shared practices where none of the dental practitioners would be existing members of the ADA. Further, where this is not the case membership of the ADA is generally accessible to dental practitioners and the relevant membership fees are unlikely to be cost prohibitive.

Balance of public benefit and detriment

48. The ACCC considers that the proposed conduct is likely to result in public benefits flowing from the increased availability of shared practices. The benefits that are likely to flow from an increase in the number of dentists practising in shared practices are the improved availability, continuity and quality of care, improved efficiency in the provision of dental services and greater flexibility for dental practitioners which may in turn also further improve the availability of dental care.

49. The ACCC considers that no significant public detriment is likely to arise from the proposed conduct given that the arrangements are limited to within and not between practices.

50. In its 2008 Determination, the ACCC noted that there 'does not appear to be a standard definition of a shared practice' and that 'there are a number of features which are necessary to create, from the patient's perspective, a single dental practice (regardless of legal structure)'.[15] The ACCC considers that these features continue to be relevant to the proposed conduct.

51. Accordingly, the ACCC considers it appropriate for authorisation to extend only to arrangements between dental practitioners in shared practices that exhibit the features described in paragraph 5.

52. For the reasons outlined in this determination the ACCC is satisfied that the likely benefit to the public would outweigh the detriment to the public including the detriment constituted by any lessening of competition that would be likely to result.

53. Accordingly, the ACCC is satisfied that the relevant net public benefit tests are met.

Length of authorisation

54. The ACCC notes that the proposed arrangements are substantially the same as those authorised in 2008 which are currently in place. The ACCC also notes that there have been no issues or complaints raised in relation to the continuation of the existing conduct. The ACCC also expects that the balance of likely benefits and detriments is likely to remain stable for the foreseeable future.

55. Although the ADA sought authorisation for five years, in the circumstances, the ACCC proposed to grant authorisation for a period of ten years and sought interested parties' views on this issue.

[15] ACCC Determination, 9 September 2008, p.18.

56. No submissions were received following the draft determination. Accordingly, the ACCC has decided to grant authorisation for a period of ten years.

Determination

The application

57. On 29 October 2012 the Australian Dental Association Inc. (ADA) lodged applications for authorisation A91340 and A91341 with the ACCC.

58. Application A91340 was made using Form A, Schedule 1, of the Competition and Consumer Regulations 2010.

59. Application A91341 was made using Form B, Schedule 1, of the Competition and Consumer Regulations 2010.

60. The ADA sought authorisation to permit dentists and dental specialists (where at least one of those dentists is an ADA member) who operate within shared practices (as described in paragraph 5) to engage in the conduct described in paragraphs 2 – 6.

The net public benefit test

61. For the reasons outlined in this determination, the ACCC considers that in all the circumstances 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.

62. Further, the ACCC is satisfied that the proposed conduct for which authorisation is sought is likely to result in such a benefit to the public that the conduct should be allowed to take place.

63. The ACCC therefore **grants** authorisation to applications A91340 and A91341.

Conduct for which the ACCC grants authorisation

64. The ACCC grants authorisation for the making of and giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists as to the fees to be charged for dental services provided in a practice, where:

    a. at least one party to the contract, arrangement or understanding is a member of the ADA; and

    b. the parties to the contract, arrangement or understanding operate a practice that shares:

        i. a common practice trading name

        ii. staff, for example, dental hygienists, administrative and support staff

iii. dental records and treatment of patients by other members of the practice

iv. a common reception and premises

v. dental equipment and supplies.

65. The ACCC grants authorisation for a period of ten years.

Conduct not authorised

66. The authorisation is limited to conduct within shared practices and will not apply to any price agreements or exclusionary provisions between practices.

Interim authorisation

67. On 21 November 2012, the ADA requested interim authorisation in relation to the setting of fees in shared dental practices. Existing authorisations A91094 and A91095 were granted on 10 December 2008 and expire on 28 February 2013. The ADA requested that interim authorisation take effect from 1 March 2013 until the ACCC's determination comes into force.

68. On 13 February 2013, at the time of issuing the draft determination, the ACCC granted interim authorisation under section 91(2) of the Act.

69. Interim authorisation commenced on 1 March 2013 and will remain in place until the date the ACCC's determination comes into effect or until the ACCC decides to revoke interim authorisation.

Date authorisation comes into effect

70. This determination is made on 27 March 2013. If no application for review of the determination is made to the Australian Competition Tribunal the authorisation will come into force on 18 April 2013.

Attachment A - Summary of relevant statutory tests

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

- that benefit, in the case of section 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 section 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.

Section 90(8) states that the ACCC shall not:

- make a determination granting:

    i. an authorization under subsection 88(1) in respect of a provision of a proposed contract, arrangement or understanding that is or may be an exclusionary provision; or

    ii. an authorization under subsection 88(7) or (7A) in respect of proposed conduct; or

    iii. an authorization under subsection 88(8) in respect of proposed conduct to which subsection 47(6) or (7) applies; or

    iv. an authorisation under subsection 88(8A) for proposed conduct to which section 48 applies;

  unless it is satisfied in all the circumstances that the proposed provision or the proposed conduct would result, or be likely to result, in such a benefit to the public that the proposed contract or arrangement should be allowed to be made, the proposed understanding should be allowed to be arrived at, or

the proposed conduct should be allowed to take place, as the case may be; or

- make a determination granting an authorization under subsection 88(1) in respect of a provision of a contract, arrangement or understanding that is or may be an exclusionary provision unless it is satisfied in all the circumstances that the provision has resulted, or is likely to result, in such a benefit to the public that the contract, arrangement or understanding should be allowed to be given effect to.