Draft Determination

Application for revocation of AA1000638 and the substitution of authorisation AA1000669
lodged by
the Australian Dental Association Inc
in respect of
agreements as to the fees to be charged for dental services provided within shared practices
Authorisation number: AA1000669

1 August 2024

Commissioners: Keogh
Carver
Williams

Summary

The ACCC proposes to grant authorisation to enable the Australian Dental Association and its members to continue to agree on 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 Australian Dental Association. A shared practice is one where the dental practitioners are independent businesses, but they operate at a particular premises in a way that presents to patients as a shared practice (for example by using a common practice trading name) with a common reception and shared staff, dental records, treatment of patients across the practice, dental equipment and supplies.

The ACCC has granted authorisation to the ADA in 2008, 2013 and 2023 for essentially the same conduct. The last authorisation was due to expire on 16 June 2024. The ACCC granted interim authorisation on 6 June 2024 to enable the arrangements to continue while the ACCC considered the substantive application.

The ACCC proposes to grant authorisation for 5 years.

The ACCC considers the conduct will continue to result in public benefits, including patient certainty of price and access to practitioners, practitioner co-operation improving efficiency in the provision and quality of dental services, and supporting flexible working arrangements for dental practitioners. The ACCC considers the conduct is unlikely to result in public detriment.

The ACCC invites submissions in relation to this draft determination before making its final decision.

1. The application for authorisation revocation and substitution

1.1. On 26 April 2024, the Australian Dental Association Inc (the **ADA**) lodged an application on behalf of itself and its members, to revoke authorisation AA1000638 and substitute authorisation AA1000669 for the one revoked with the Australian Competition and Consumer Commission (the **ACCC**). The ADA is seeking authorisation for 5 years to enable dental practitioners to agree on the fees to be charged for dental services provided within shared practices.

1.2. This application for revocation and substitution was made under subsection 91C(1) of the *Competition and Consumer Act 2010* (Cth) (the **Act**). If granted, an authorisation provides the relevant parties with protection from legal action under the specified provisions in Part IV of the Act in respect of the specified conduct. The ACCC has a discretion to grant authorisation, but must not do so unless it is satisfied in all the circumstances that the conduct would result, or be likely to result, in a benefit to the public and that benefit would outweigh the detriment to the public that would result, or be likely to result, from the conduct (ss 90(7) and 90(8) of the Act (the **authorisation test**)).

1.3. The ADA also requested interim authorisation to enable it to engage in the proposed conduct while the ACCC was considering the substantive application. On 6 June 2024, the ACCC granted interim authorisation in accordance with subsection 91(2) of the Act.[1] Interim authorisation will remain in place until the date the ACCC's final

[1] See ACCC decision 6 June 2024 available on the public register.

determination comes into effect, the application for revocation and substitution is withdrawn, or until the ACCC decides to revoke the interim authorisation.

The ADA

1.4. The ADA is a professional organisation representing dentists and is a not-for-profit membership organisation. Membership is voluntary and its members include practicing dentists, students of dentistry and retired dentists in Australia.

1.5. The ADA is a national organisation with branches in every state and territory of Australia. The branches provide education and face-to-face assistance to members, delivering public oral health advisory services, and advocating on issues impacting key stakeholders in a particular state or territory.

1.6. The ADA has approximately 16,670 members, including approximately 3,553 student members. The vast majority of ADA non-student members are practising dentists.

The Proposed Conduct

1.7. The ADA is seeking authorisation for the making of and giving effect to contracts, arrangements and understandings between 2 or more Dental Practitioners[2] as to the fees to be charged for Dental Services[3] 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 at a particular premises in a way that presents to patients as a shared practice (for example, by using a common practice trading name) being a practice in which independent practitioners at a common premises with a common reception share:

i. staff, for example, dental hygienists, administrative and support staff;

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

iii. dental equipment and supplies.

(the **Proposed Conduct**)

2. Background

The dental services industry

2.1. General practice dentists provide dental care to the public in both private and/or public sector dental health services. Dental specialists provide specialised services and include endodontists, oral and maxillofacial surgeons, orthodontists, forensic orthodontists, paediatric dentists, periodontists, prosthodontists, oral pathologists, special needs dentists, public health dentists, oral medicine specialists, oral surgeons and dental radiologists. Dental practitioners also include dental hygienists, therapists and prosthetists and oral health therapists.

2.2. The majority of dentists in Australia work in private practice and a significant portion work in group private practices. In 2020, there were 16,153 total employed dentists in

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[2] '**Dental Practitioner**' means a dental practitioner registered with the Dental Board of Australia from time to time.

[3] '**Dental Services**' means any services provided by a Dental Practitioner.

Australia, where 27% worked in solo private practice and 56% worked in group private practice.[4] Private dental clinics may be owned by large corporates, private health insurance companies, individual dentists or partnerships, and a range of legal structures may be used in these dental practices.

2.3. The ADA submits that in Australia, major cities and metropolitan areas have a higher concentration of dental practices due to a larger population base and higher demand. Some remote and very remote areas can have few or even no dental practices. Factors like lower population density, difficulty attracting and retaining dental professionals, and economic limitations contribute to scarcity in certain areas. Efforts to supply oral health treatment in addition to physical practices can include visiting dentists, mobile dental clinics, higher rates of dental therapists, use of the Royal Flying Doctor Service, telehealth consultations, and focus on preventative care.

2.4. The ADA understands that most of the Australian population has reasonable access to more than one physical general dental practice. Those who do not are likely to reside in remote or very remote areas.

2.5. The ADA notes that, since the previous authorisations were granted, there has been strong growth in contractual arrangements between dental practices and private health insurers under which the insurer sets fees (and other terms) in exchange for the right for the dental practice to participate in the insurer's 'preferred provider' network. The ADA submits that the majority of the largest private health insurers have some level of price capping for dental services.

Previous authorisations

2.6. Since 2008, the ACCC has granted authorisation to the ADA and its members for similar conduct on 3 occasions.[5] The ADA submits the underlying rationale for its applications for authorisation to date has recognised the diversity in the business structures utilised by dental practitioners in private practice who wish to work as a team, and the fact that, for most of these structures, intra-practice price setting is already permitted under competition law without authorisation. The ADA submits that ensuring that intra-practice price setting is consistently protected for all of these structures fundamentally benefits patients by allowing dental practitioners to choose the appropriate business structure for their needs and circumstances.[6]

2.7. The ACCC accepts 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). The essential features of a shared practice are:

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

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[4] Australian Institute of Health and Welfare, *Oral health and dental care in Australia*, Commonwealth of Australia, 21 November 2023, accessed 9 July 2024. A definition of a 'group private practice' is not provided. However, it is likely that a 'group private practice' is not necessarily the same as a 'shared practice'. For example, 'group private practices' could include shared practices that exhibit the features in paragraph 2.7 and need to be covered by the authorisation, and practices where dentists have entered into a partnership that may not need to be covered by the authorisation.

[5] In 2008, A91094 and A91095, available on the ACCC's public register. In 2013, A91340 and A91341, available on the ACCC's public register. In 2023, AA1000638, available on the ACCC's public register.

[6] The diversity of private practice business structures where dentists work as a team and the variation in the position with respect to price setting under competition law is summarised in Schedule 3 of the ADA's application for authorisation.

- a common reception and premises
- shared dental equipment and supplies.

2.8. The last authorisation (AA1000638) was granted on 25 May 2023 for 12 months. The ADA requested authorisation for 12 months while it completed a review of the definition of 'shared practice' to ensure it is accurate, contemporary and appropriate for a further longer-term authorisation, in light of developments relating to the application of payroll tax in shared practice settings.

2.9. The ADA has made changes to the Proposed Conduct since then, largely to provide greater clarity and ensure 'all circumstances of genuine intra-practice price setting are protected without 'opening the door' to price setting between practices'. These changes include:

- clarification that authorised intra-practice price setting is on a *premises-by-premises basis*
- introducing the defined terms 'Dental Practitioner' and 'Dental Services' to clarify the services that are covered by the Proposed Conduct
- grammatical clarification that a shared practice must have all the substantive elements described in paragraph 1.7(b)
- clarification that the Proposed Conduct relates to a practice presenting to patients as a shared practice, regardless of whether they do so by using a common practice trading name.

2.10. The ADA asked its members via a survey in late 2023 regarding the key benefits of the shared practice price setting arrangements, which attracted 379 responses. The ADA submits that almost 44% of total respondents indicated they had not been involved in intra-practice price setting (20% of respondents from larger practices), noting that this governs the response rates to the remaining questions. In particular, only the balance of dentists who *had been involved* (56%) were likely to recognise and indicate affirmatively one or more of the key benefits options which appeared. These results are discussed further in the Assessment section below.

3. Consultation

3.1. The ACCC invited submissions from a range of potentially interested parties including major relevant industry associations or peak bodies, consumer groups, private health insurance, state and federal government and relevant regulatory bodies.[7]

3.2. The ACCC received 3 submissions from interested parties in relation to the application.

3.3. Bupa Dental Care, a dental support organisation that operates 176 dental clinics, provided a submission on 10 May 2024 in support of the application.

3.4. Private Healthcare Australia, a private health insurance industry representative body, provided 2 submissions (on 10 May and 14 May 2024), where it submits that it has no objection to the ADA's application and request for interim authorisation. However, Private Healthcare Australia recommends that the ACCC impose a condition on authorisation that all dental clinics covered by the authorisation use price displays for common services, which will promote choice, competition and informed financial

[7] A list of the public submissions received is available from the ACCC's public register.

consent. Private Healthcare Australia also summarised data regarding the number of, and costs for, Australians with extras cover for dental, and data around Australians skipping or delaying dental care due to costs.

3.5. The ADA responded to Private Healthcare Australia's submission on 23 May 2024, and provided further information on 20 June 2024 in response to the ACCC's request for information.

3.6. Public submissions by the ADA and interested parties are on the Public Register for this matter.

4. ACCC assessment

4.1. The ADA has sought authorisation for Proposed Conduct in relation to Division 1 of Part IV of the Act (cartel conduct). Consistent with subsections 90(7) and 90(8) of the Act,[8] the ACCC must not make a determination granting authorisation unless it is satisfied, in all the circumstances, that the conduct would result, or be likely to result, in a benefit to the public and that benefit would outweigh the detriment to the public that would result, or be likely to result, from the conduct.

Relevant areas of Competition

4.2. To assess the likely effect of the Proposed Conduct, the ACCC identifies the relevant areas of competition likely to be impacted.

4.3. The ADA submits that the relevant area of competition impacted by the Proposed Conduct identified in the previous authorisations remains relevant to this application, namely the provision of private general and specialist dental services in localised geographic regions.

4.4. The ACCC considers that the relevant areas of competition are likely to be the provision of private general and specialist dental services in localised geographic regions.

Future with and without the Proposed Conduct

4.5. In applying the authorisation test, the ACCC compares the likely future with the Proposed Conduct that is the subject of the authorisation to the likely future in which the Proposed Conduct does not occur.

4.6. The likely future without the Proposed Conduct would be that dental practitioners operating in shared practices would set fees individually, which would potentially result in patients being charged different fees within the practice, or would otherwise require practitioners to incorporate or enter into a partnership.

Public benefits

4.7. The Act does not define what constitutes a public benefit. The ACCC adopts a broad approach. This is consistent with the Australian Competition Tribunal (the **Tribunal**) which has stated that in considering public benefits:

> … *we would not wish to rule out of consideration any argument coming within the widest possible conception of public benefit. This we see as anything of value to the community generally, any contribution to the aims pursued by the society including as*

[8] See subsection 91C(7).

one of its principal elements … the achievement of the economic goals of efficiency and progress.[9]

4.8. The ACCC has considered the following public benefits:

- patient certainty of price and access to practitioners in a shared practice
- practitioner co-operation improving quality of dental services
- efficiency in the provision of dental services through sharing costs
- supporting flexible working arrangements for dental practitioners.

Patient certainty of price and access to practitioners in a shared practice

4.9. The ADA submits that visiting a dentist within a shared practice structure allows patient certainty as to the availability of services and fees. Differing fees within a practice for the same service by different dental practitioners may create patient confusion and could ultimately undermine the level of cooperation between dental practitioners within a practice. It would also potentially inconvenience patients and interrupt patient care if a patient could only afford to access dental services from one dentist within the practice, but not from others who charge a higher rate.

4.10. The ADA submits that dentists within a shared practice are able to provide continuity of care such that patients can be seen by another dentist within the shared practice if a patient's regular dentist is unavailable due to holidays or other absence. The ADA also submits that having more than one dentist in a practice increases the chance that a patient will be able to be seen quickly in an emergency situation.

4.11. The ADA's member survey indicated that 46% of respondents considered 'pricing transparency for the patient', and 37% considered 'continuity of care', as key benefits of the shared practice price setting arrangements – noting that 44% of total respondents indicated that they *had not* been involved in intra-practice price setting.

4.12. Bupa Dental Care also submits that the Proposed Conduct will substantially benefit consumers by delivering certainty about price, reducing potential confusion and 'bill shock' and promoting transparency and choice, by permitting dentists to set and display standard fees for the services provided in a multi-practitioner clinic and therefore allowing consumers to evaluate the cost of a prospective treatment. Bupa Dental Care submits that, by knowing what their colleagues in a shared practice will charge, this will allow dentists to confidently refer patients to those colleagues based on the patients' needs and the expertise required, and at times when the dentist takes planned or unplanned leave.

4.13. Private Healthcare Australia submits that out-of-pocket dental-related expenses for people with health insurance have surged over the past 4 years and this trend could cause Australians to forego dental treatment. Private Healthcare Australia notes the findings that indicate 2.3 million Australians in 2022-23 skipped or delayed necessary dental care because of cost.[10]

4.14. 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 co-operation

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[9] *Re Queensland Co-operative Milling Association Ltd* (1976) ATPR 40-012 at 17,242; cited with approval in *Re 7-Eleven Stores Pty Limited* (1994) ATPR 41-357 at 42,677.

[10] Australian Bureau of Statistics, Commonwealth of Australia, *Patient experiences*, 21 November 2023, accessed 9 July 2024.

between dental practitioners within a practice and may limit access to other dental practitioners within the dental practice.

4.15. The ACCC considers the Proposed Conduct facilitates a co-operative approach between dental practitioners within a shared practice, whose patients will face the same initial cost for the same services irrespective of which dental practitioner they are treated by (before the impact of any private health insurance is taken into account). By knowing that their colleagues will charge the same prices, dental practitioners in a shared practice will be able to refer patients to those colleagues based on the patients' needs and the expertise and availability of their colleagues rather than the anticipated cost. The ACCC also considers that differing fees within a shared practice may cause patient confusion and inconvenience, particularly in cases where they are referred or otherwise seen by another dental practitioner within a shared practice who charges higher fees.

4.16. As such, the ACCC considers that a public benefit in the form of patient certainty of price and access to practitioners in a shared practice is likely.

Practitioner co-operation improving quality of dental services

4.17. The ADA submits that shared practices promote a culture of teamwork and improve the quality of dental services available to patients. A shared practice encourages high standards of patient care as the members of that practice have the ability to consult and confer with each other on all aspects of patient care. The ability to work as part of a team within a shared practice also gives dentists greater access to peer advice and review, clinical expertise and the camaraderie of other dentists.

4.18. The ADA submits that a shared practice structure increases the likelihood of a dentist within the practice having expertise or specialised knowledge in a particular area of clinical practice. For example, although all dentists in the practice may be general practitioners, one may have a particular interest in crown and bridge work and may be able to provide assistance to their colleagues in relation to any crown or bridge work that patients may require. This is particularly important for less-experienced dentists and helps improve standards of patient care.

4.19. The ADA also submits that visiting a dentist within a shared practice structure may allow for intra-practice referrals of patients, facilitating the efficient use of dentists' specific areas of specialisation. The ADA submits that such co-operative arrangements ensure continuity of care and encourage shared responsibility for ensuring that quality of patient care is paramount, and this co-operative approach adopted by a shared practice structure may be disturbed if each dentist were to charge different fees for the same services.

4.20. The ADA's member survey indicated that 42% of respondents considered 'working as a team' a key benefit of the shared practice price setting arrangements, noting that 44% of total respondents indicated that they *had not* been involved in intra-practice price setting.

4.21. Bupa Dental Care also submits that the Proposed Conduct will substantially benefit consumers by encouraging dentists at multi-practitioner clinics to take a collaborative and patient-centred approach to providing dental care. Bupa Dental Care submits that, by fostering collaboration between dentists in a shared practice, the authorisation will help create a more collegiate environment in which dentists can embrace a consultative, 'teamwork' based approach that raises their collective expertise for the benefit of all clinics' patients.

4.22. The ACCC considers that public benefit in the form of practitioner co-operation improving quality of dental services is likely. The ACCC considers that 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 through sharing costs

4.23. The ADA submits that a shared practice arrangement allows for greater efficiency in the provision of dental services by allowing sharing of the costs of practice, for example the cost of purchase or rent of major and specialist equipment, administration and other overheads, which ultimately lowers the cost of dental care to patients. Providing access to equipment 'in-house' removes the need for patients to make another appointment to see another health practitioner, thereby eliminating 'double handling' of the patient and the inconvenience and time delay associated with the patients needing to make another appointment to see another health practitioner.

4.24. The ADA's member survey indicated that 27% of respondents considered 'sharing costs' as a key benefit of the shared practice price setting arrangements, noting that 44% of total respondents indicated that they *had not* been involved in intra-practice price setting.

4.25. The ACCC considers that public benefit in the form of efficiency in the provision of dental services is likely. The ACCC considers the shared practice structure is likely to result in greater efficiency in the provision of dental services to patients due to the ability to share the costs of shared 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.

Supporting flexible working arrangements for dental practitioners

4.26. The ADA submits that providing increased flexibility in practice structures attracts more dentists to the profession and allows the profession to retain its workforce for longer. In particular, the shared practice structure is attractive to part-time dental practitioners, allowing dentists to share facilities and costs and provides a means by which dentists can remain in practice on a part-time basis if desired. The ADA submits that dentists may seek part-time work for a number of reasons, including to allow them to manage work and family commitments or if they are at a pre-retirement age.

4.27. The ADA also submits that the ability for dentists to practise in a shared practice structure has the potential to attract and retain practitioners in rural and remote areas by providing greater access to peer support and facilitating the sharing of costs without requiring practitioners to enter into partnership or practise only as an employee.

4.28. The ADA's member survey indicated that 23% of respondents considered 'flexible working arrangements' as a key benefit of the shared practice price setting arrangements. A higher proportion (25%) of respondents who considered it a key benefit are in regional areas.

4.29. Bupa Dental Care also submits that the Proposed Conduct will foster a 'teamwork' approach to care which may also enhance clinicians' work-life balance and promote greater workforce participation by those who require flexibility. Bupa Dental Care submits that dentists who can work in ways that suit their needs and lifestyle are also likely to be happier, resulting in them delivering better care for their patients and this, in

turn, promises to raise the standard of care delivered to all consumers of dental services.

4.30. The ACCC considers that some public benefit in the form of supporting flexible working arrangements for dental practitioners is likely. The ACCC notes that the shared practice structure is an attractive option for dental practitioners who may not consider sole ownership of a practice or entering into a formal partnership structure suitable (for example, due to increased complexities relating to the sharing of costs and revenues with full-time partners). The ACCC therefore considers that shared practices are likely to increase the feasibility of part-time, rural and remote work for dentists as a result of the ability to share facilities and costs and have greater access to peer support, which could lead to the attraction and retention of dental practitioners who require these forms of flexible working arrangements.

ACCC conclusion on public benefit

4.31. The ACCC considers that the Proposed Conduct is likely to result in public benefits from:

- patient certainty of price and access to practitioners in a shared practice, due to shared practices providing access to additional dental practitioners within a patient's usual dental practice without issues caused by differing fees within that practice
- practitioner co-operation improving quality of dental services due to shared practices improving the ability of dentists to work together and consult each other on aspects of patient care
- efficiency in the provision of dental services through sharing costs due to the ability to facilitate economies of scale and share the costs of a practice such as rent, leasing equipment, administration and other overheads
- supporting flexible working arrangements for dental practitioners due to shared practices likely increasing the feasibility of part time, rural and remote work for dentists as a result of the ability to share facilities and costs.

Public detriments

4.32. The Act does not define what constitutes a public detriment. The ACCC adopts a broad approach. This is consistent with the Tribunal which has defined it as:

> *… 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.*[11]

4.33. The ACCC has considered the public detriment of the potential for reduced competition in the provision of dental services to consumers.

4.34. Generally, the ACCC considers that agreements between competitors which influence the pricing decisions of market participants can raise significant competition concerns and can result in inefficiencies. For example, price agreements can move prices away from levels that would be set in a competitive market which can result in higher prices for consumers and send market signals which direct resources away from their most efficient use.

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

4.35. The ADA submits that the potential for public detriments remains low because authorisation is limited to agreements on price within 'shared practices' and not agreements on price between practices. Further, the competitive constraints on 'shared practices' continue to apply, namely that shared practices still have to compete with many other practices in such localised geographic regions. The ADA notes that the authorisation it seeks merely puts this one practice structure (shared practice) on the same footing as alternative practice structures with respect to *intra-practice* price setting allowing dental practitioners wanting to work as a team to choose the appropriate business structure for their needs and circumstances.

4.36. The ADA also notes the strong growth in contractual arrangements between dental practices and private health insurers under which the insurer sets fees (and other terms) in exchange for the right to participate in the insurer's 'preferred provider' network since the previous authorisations were granted. The ADA is aware of at least 11 private health insurers that have such arrangements, including the largest insurers.

4.37. The ADA submits it encourages its members to act in accordance with relevant legislation and regulations. For example, the ADA's policy statement regarding dental fees accessible on the ADA's website reminds members of their obligations under competition law with respect to setting their own fees (except as permitted under the shared practice authorisation).[12] The ADA submits that, should the authorisation application be successful, it would expect to announce the fact to members, and as part of this, remind members of their obligations under competition law, particularly with respect to the topic of pricing between dental practices.

4.38. The ACCC considers that the detriment from dental practitioners agreeing on the fees they will charge within a shared practice is likely to be limited. Significantly, the ACCC notes that the arrangements continue to be confined to agreements on fees within practices operating under a shared business structure (i.e. not between practices). Dental practitioners within a shared practice would continue to set their fees based on a range of factors including competition (where relevant) from nearby practices, noting that such constraint is likely to be greater in metropolitan areas where there are larger numbers of dental practices.

4.39. The ACCC considers that public detriment in the form of the potential for reduced competition is unlikely given that the arrangements are limited to within, and not between, practices and that the competitive constraints on 'shared practices' continue to apply. That potential for reduced competition is mitigated further by the ADA's planned communications to remind its members of their obligations under competition law, particularly with respect to the topic of pricing between dental practices. The ACCC also notes that such conduct does not fall within the scope of the Proposed Conduct for which authorisation is sought, and to the extent such conduct breached the Act it would not fall within the protection from legal action that authorisation would grant.

Balance of public benefit and detriment

4.40. For the reasons outlined in this draft determination, the ACCC is satisfied that the Proposed Conduct is likely to result in a public benefit and that this public benefit would outweigh any likely detriment to the public from the Proposed Conduct.

[12] Australian Dental Association, *Policy Statement 6.26 – Dental Fees*, November 2023, accessed 9 July 2024.

Condition proposed by Private Healthcare Australia

4.41. Private Healthcare Australia submits that the ACCC should impose a condition of authorisation that all dental clinics covered by the authorisation use price displays for common services, which will promote choice, competition and informed financial consent. Private Healthcare Australia submits that price displays should be posted on windows or other prominent areas of the clinic and on websites, so consumers can make informed decisions about whether to book an appointment. Price displays should also include clear, accurate fees for the most common dental services including a periodic check-up, a comprehensive examination, removal of calculus (plaque), an X-ray, and application of remineralising agent to teeth.

4.42. In response to the Private Healthcare Australia submission, the ADA submits:

- What is proposed by Private Healthcare Australia will not benefit consumers as private health insurers control the extent of the 'gap' due to the practice of differential rebates as between dental practices for the same service to the same patient. There is no transparency over differential rebates so consumers cannot properly understand what 'gap' will be payable as between different dental practices for a particular treatment item based on a price display by those dental practices.
- The merits of price displays in an industry are a complex equation (on the one hand transparency to consumers, on the other transparency to competitors). However, it is always something that must be considered at an industry level, and it is not something that can be done via an individual authorisation.
- A condition attached to this authorisation would only apply to one type of practice structure (shared practices) involving an ADA member and it would not deliver consumers (insured or uninsured) the ability to meaningfully compare across practices.
- Of relevance to the position of uninsured patients, a lot of people do not go to the dentist until they have a problem and treatment for problems is particularly hard to price without seeing the patient. Accordingly, in this context, uninsured patients would not be assisted by price displays. However, it is important to understand that the ADA encourages dental practices to provide transparency when the patient has been assessed and to obtain informed financial consent to proceed with treatment (see the ADA's policy statement 5.16).

4.43. The ACCC's power to grant authorisation is discretionary, and in particular cases the ACCC may consider it appropriate to grant authorisation subject to conditions specified in the authorisation rather than make a determination not to grant authorisation. In most cases, conditions are imposed by the ACCC to ensure that the authorisation test is met, or continues to be met, over the term of the authorisation. It is also possible for the ACCC to impose conditions where the authorisation test is met but, without the conditions, the ACCC would not otherwise be prepared to exercise its discretion in favour of authorisation.[13]

4.44. The ACCC is not proposing to impose a condition along the lines suggested by Private Healthcare. The ACCC considers:

[13] See *Application by Medicines Australia Inc* [2007] ACompT 4.

- The condition proposed by Private Healthcare Australia falls outside the scope of the Proposed Conduct and the ADA's application for authorisation, as the Proposed Conduct is focused on agreements on price *within* shared practices (rather than price communications across shared practices). The ACCC also notes the ADA's point that a condition of this nature would only apply to a subset of all dental practices.
- A condition of this nature may not assist in promoting choice, competition and informed financial consent given the current market design and the impact of an individual's circumstances as to whether they have private health insurance or not (and if so what rebate is offered to the patient by their private health insurance provider for a particular service).
- Ultimately, the condition proposed by Private Healthcare Australia is not necessary for the ACCC to be satisfied that the Proposed Conduct is likely to result in a public benefit and that this public benefit would outweigh any likely detriment to the public from the Proposed Conduct.

4.45. Accordingly, the ACCC considers that a condition along the lines suggested by Private Healthcare Australia is outside the scope of the Proposed Conduct and not appropriate or necessary for the ACCC to impose.

Length of authorisation

4.46. The Act allows the ACCC to grant authorisation for a limited period of time.[14] This enables the ACCC to be in a position to be satisfied that the likely public benefits will outweigh the detriment for the period of authorisation. It also enables the ACCC to review the authorisation, and the public benefits and detriments that have resulted, after an appropriate period.

4.47. In this instance, the ADA seeks authorisation for 5 years to preserve the public benefits of the Proposed Conduct over this period. The ADA submits that this would align the expiry of authorisation for intra-practice price setting by dental practitioners to shortly after the expiry of the current authorisation covering intra-practice price setting by medical practitioners (A91599), which expires in March 2028. The ADA submits that a 5-year authorisation would therefore allow the ACCC to consider the wider position, across both dental practitioners and medical practitioners, in around 4 to 5 years' time with the benefit of further developments that are likely to occur in relation to payroll tax over that period and the benefit of ongoing data from the ADA as to the structures being used by dental practitioners.

4.48. The ACCC proposes to grant authorisation for 5 years.

5. Draft determination

The application

5.1. On 26 April 2024, the ADA lodged an application to revoke authorisation AA1000638 and substitute authorisation AA1000669 for the one revoked. This application for authorisation AA1000669 was made under subsection 91C(1) of the Act.

[14] Subsection 91(1)

5.2. The ADA seeks authorisation for the making of and giving effect to contracts, arrangements and understandings between 2 or more Dental Practitioners as to the fees to be charged for Dental Services provided in a practice, where:

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

(d) the parties to the contract, arrangement or understanding operate at a particular premises in a way that presents to patients as a shared practice (for example, by using a common practice trading name) being a practice in which independent practitioners at a common premises with a common reception share:

i. staff, for example, dental hygienists, administrative and support staff;

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

iii. dental equipment and supplies.

(the **Proposed Conduct**)

5.3. Subsection 90A(1) of the Act requires that before determining an application for authorisation, the ACCC shall prepare a draft determination.

The authorisation test

5.4. Under subsections 90(7) and 90(8) of the Act, the ACCC must not make a determination granting an authorisation unless it is satisfied, in all the circumstances, that the Proposed Conduct would result, or be likely to result, in a benefit to the public and the benefit would outweigh the detriment to the public that would result, or be likely to result, from the Proposed Conduct.

5.5. For the reasons outlined in this draft determination, the ACCC is satisfied, in all the circumstances, that the Proposed Conduct would be likely to result in a benefit to the public and the benefit to the public would outweigh the detriment to the public that would result or be likely to result from the Proposed Conduct, including any lessening of competition.

5.6. Accordingly, the ACCC proposes to grant authorisation.

Conduct which the ACCC proposes to authorise

5.7. The ACCC proposes to revoke authorisation AA1000638 and grant authorisation AA1000669 in substitution.

5.8. The ACCC proposes to grant authorisation AA1000669 for the making of and giving effect to contracts, arrangements and understandings between 2 or more Dental Practitioners as to the fees to be charged for Dental Services provided in a practice, where:

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

(f) the parties to the contract, arrangement or understanding operate at particular premises in a way that presents to patients as a shared practice (for example, by using a common practice trading name) being a practice in which independent practitioners at a common premises with a common reception share:

i. staff, for example, dental hygienists, administrative and support staff;

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

iii. dental equipment and supplies.

5.9. The ACCC proposes to grant authorisation in relation to Division 1 of Part IV of the Act.

5.10. The ACCC proposes to grant authorisation AA1000669 for 5 years.

5.11. This draft determination is made on 1 August 2024.

6. Next steps

6.1. The ACCC now invites submissions in response to this draft determination. In addition, consistent with section 90A of the Act, the ADA or an interested party may request that the ACCC hold a conference to discuss the draft determination.