Application for revocation of an authorisation for proposed conduct and substitution of a replacement

Information

Applicants

1. *Provide details of the applicants for revocation and substitution, including:*

1.1 *name, address (registered office), telephone number, and ACN*

Australian Dental Association Inc (**ADA**)
14-16 Chandos Street
St Leonards NSW 2065
(02) 8815 3333
contact@ada.org.au

1.2 *contact person's name, position, telephone number, and email address*

Damian Mitsch
Chief Executive Officer
[redacted]
[redacted]@ada.org.au

1.3 *a description of business activities*

The ADA is the peak professional organisation representing dentists.

The ADA is a not-for-profit membership organisation. Its members include practicing dentists, students of dentistry and a committed cohort of retired dentists in Australia. Membership of the ADA is voluntary.

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.

The ADA has two main aims:

(a) the encouragement of the health of the public; and

(b) the promotion of the art and science of dentistry.

The functions of the ADA include:

(a) maintaining a national body representing organized dentistry in Australia (the Federal Council of the ADA and its Federal Executive);
(b) maintaining a national headquarters for the Association;
(c) managing the Association's finances;
(d) determining policy, and generating expert advice through the Association's Committees;
(e) conducting seminars and workshops for policy generation;
(f) providing administrative support for the work of the Federal Council, Federal Executive and Committees;
(g) maintaining a continuing communication with the membership;
(h) maintaining the international relationships of the Australian dental profession;
(i) responding to enquiries by the general public and other organisations in Australia and overseas; and
(j) maintaining the records of Association activities and history.

The ADA is governed by the Federal Council which consists of 17 Councillors together with the President of each Branch or his/her nominee. The Federal Council is formed by five Councillors from New South Wales, three from Victoria, one from the Northern Territory and two from each of South Australia, Tasmania, Queensland and Western Australia.

The Federal Executive consists of 5 members elected from the Federal Council and is subject to the general control and direction of the Federal Council.

1.4 *email address for service of documents in Australia.*

Mark Fitzgerald / Hayley Bowman
Meridian Lawyers
[redacted]

copy to Rachel Trindade
Competition & Consumer Lawyer
[redacted]

Authorisation to be revoked (the existing authorisation)

2. *Provide details of the authorisation sought to be revoked including:*

2.1 *the registration number and date of the authorisation which is to be revoked*

The authorisations which are to be revoked are A91340 and A91341 dated 27 March 2013. These authorisations were granted for a period of 10 years to enable dental practitioners to reach agreements as to the fees to be charged for dental services within a 'shared practice' (intra-practice price setting) where at least one party to the agreement is a member of the ADA. The concept of a 'shared practice' is described in paragraph 4.5.

2.2 *other persons and/or classes of persons who are a party to the authorisation which is to be revoked*

Authorisations A91340 and A91341 were sought by the ADA on behalf of ADA members who are general practice dentists and dental specialists (current and future) and who practice in a 'shared practice'.

2.3 *the basis for seeking revocation, for example because the conduct has changed or because the existing authorisation is due to expire.*

Authorisations A91340 and A91341 are due to expire on 18 April 2023. The ADA wishes to maintain immunity for intra-practice price setting by 'shared practices' currently covered by these authorisations (temporarily preserving the status quo) while the ADA reviews the definition of 'shared practice' to ensure it is accurate, contemporary and appropriate for a further 10 year authorisation, as explained further in paragraph 4.5.

Authorisation to be substituted (the new authorisation)

3. *If applicable, provide details of any other persons and/or classes of persons who also propose to engage, or become engaged, in the proposed conduct and on whose behalf authorisation is sought. Where relevant provide:*

3.1 *name, address (registered office), telephone number, and ACN*

3.2 *contact person's name, telephone number, and email address*

3.3 *a description of business activities.*

The new authorisation seeks to preserve the status quo for current 'shared practices' covered by Authorisations A91340 and A91341 for a period of 12 months. It would also apply to any new 'shared practice' that commences during that 12 month period which would have been covered by those authorisations.

There is no register of how many dental practices are currently relying on Authorisations A91340 and A91341. However, the ADA believes that there would be a substantial number, sufficient to warrant preserving the status quo while it undertakes the work

summarised in paragraph 13. As explained in paragraph 13, part of that work includes establishing a confidential register that will allow on-going identification of all dental practices covered by authorisation for intra-practice price setting.

The proposed conduct

4. *Provide details of the proposed conduct, including:*

4.1 *a description of the proposed conduct and any documents that detail the terms of the proposed conduct*

The proposed conduct is a continuation of the intra-practice price setting currently authorised for 'shared practices' under Authorisations A91340 and A91342, namely the making of and giving effect to contracts, arrangements and 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.

4.2 *an outline of any changes to the conduct between the existing authorisation and the new authorisation*

No changes are proposed to the conduct between the existing authorisations and the new authorisation, for the reasons explained in paragraph 4.5.

4.3 *the relevant provisions of the Competition and Consumer Act 2010 (Cth) (the Act) which might apply to the proposed conduct*

The relevant provisions which might apply to the proposed conduct are those in Division 1 of Part IV (cartel conduct).

4.4 *the rationale for the proposed conduct*

The rationale for the proposed conduct is explained in paragraph 4.5.

4.5 *the term of authorisation sought and reasons for seeking this period.*

Authorisation for intra-practice price setting by dental practitioners who remain independent businesses (and thus in competition with each other for the purposes of the Act) but from the patient's perspective work as a team has been in place since 2008 (Authorisations A91094 and A91095 in 2008, and Authorisations A91340 and A91342 in 2013).

At the time of the initial 2008 authorisation, the ACCC noted that: "While there does not appear to be a standard definition of a shared practice, the ACCC considers that there are a number of features which are necessary to create, from the patient's perspective, a single dental practice (regardless of the legal structure)." At the time, the ACCC identified these essential features as being:

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

This definition has remained the basis for identifying, and authorising, beneficial intra-practice price setting since 2008.

Recent developments relating to the application of payroll tax in shared practice settings have caused significant uncertainty for dental practitioners about the implications of how traditional shared practices have operated to date, and the type of structures and arrangements that would be appropriate to use in the future (see further information in Schedule 2).

In relation to the expiry of Authorisations A91340 and A91342, these developments raise questions that the ADA is currently working through about the consistency and fairness of how a setting that involves independent practitioners, but from the patient's perspective operates like a single practice, is treated from the perspective of payroll tax and competition law. From the practitioners' perspective, it is unfair to be treated like employees in one context, but competitors in another.

The ADA wishes to avoid introducing on top of the stress caused by the payroll tax developments, additional cost, disruption and uncertainty around the legality of shared practice structures covered by the current authorisations if these

authorisations expire while these issues are still being worked through.

The ADA is therefore seeking a substitute authorisation under section 91C for a term of 12 months, and interim authorisation under section 91(2)(f), to preserve the status quo for existing shared practices relying on the current authorisations while the ADA completes a review of the definition of 'shared practice' to ensure it is accurate, contemporary and appropriate for a further 10 year authorisation.

The ADA expects to make a further more detailed revocation/substitution application seeking an authorisation term of 10 years once it has completed this review.

5. *Provide the name of persons, or classes of persons, who may be directly impacted by the proposed conduct (e.g. targets of a proposed collective bargaining arrangement; suppliers or acquirers of the relevant goods or services) and detail how or why they might be impacted.*
   The direct impact is on dental practices that currently rely on authorisation to permit intra-practice price setting, and the patients of those practices. As noted in paragraph 4.5, the purpose of seeking re-authorisation is to preserve the status quo for these practices and their patients for a 12 month period as the feedback to the ADA is that consumers are happy with this model.

Market information and concentration

6. *Describe the products and/or services, and the geographic areas, supplied by the applicants. Identify all products and services in which two or more parties to the proposed conduct overlap (compete with each other) or have a vertical relationship (e.g. supplier-customer).*
   Dental services of a general and specialist nature, provided throughout all states and territories of Australia that practice in a 'shared practice'.

7. *Describe the relevant industry or industries. Where relevant, describe the sales process, the supply chains of any products or services involved, and the manufacturing process.*
   A 'dentist' is a primary healthcare professional registered with the Dental Board of Australia, educated and specialising in the care of teeth, gums, bone support and the mouth. Dentists identify and treat dental diseases as well as provide preventative oral health services for teeth. General practice dentists provide dental care to the public in both private and/or public sector dental health services. Dental specialists provide specialised services and include Endodontists, Oral and Maxillofacial Surgeons, Orthodontists, Forensic Orthodontists, Pediatric dentists, Periodontists, Prosthodontists, Oral Pathologists, Special Needs dentists, Public health dentists, Oral Medicine specialists, oral surgeons and Dental Radiologists.

8. *In respect of the overlapping products and/or services identified, provide estimated market shares for each of the parties where readily available.*

   Background data about registered dentists is available in the Dental Board of Australia Registrant Data Report, current as at 31 December 2022, accessible on the DBA website at: https://www.dentalboard.gov.au/About-the-Board/Statistics.aspx

   The Australian Government Australian Institute of Health and Welfare Report (AIHW Report) includes relevant data on the use of dental services and the current dental workforce (last updated on 17 March 2022). This is accessible here:
   https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-care
   https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-workforce

9. *In assessing an application for authorisation, the ACCC takes into account competition faced by the parties to the proposed conduct. Describe the factors that would limit or prevent any ability for the parties involved to raise prices, reduce quality or choice, reduce innovation, or coordinate rather than compete vigorously. For example, describe:*

   9.1 *existing competitors*

   9.2 *likely entry by new competitors*

   9.3 *any countervailing power of customers and/or suppliers*

   9.4 *any other relevant factors.*

   The ADA believes that the relevant area of competition impacted by the 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. The ADA believes that the reasons why intra-practice price setting does not enable shared practices to raise prices, recognised in Authorisations A91340 and A91341, continue to apply, namely that shared practices still have to compete with plenty of other practices in such localised geographic regions.

   Further, the ADA notes that, since these 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 to participate in the insurer's "preferred provider" network. According to the latest IBIS report on health insurance (Industry Report K6321), BUPA, Medibank, HCF and HBF

combined make up 74.4% of the health insurance market. The ADA understands that all of these insurers have some level of price capping for services.

Public benefit

10. *Describe the benefits to the public that are likely to result from the proposed conduct. Refer to the public benefit that resulted under the authorisation previously granted. Provide information, data, documents or other evidence relevant to the ACCC's assessment of the public benefits.*

The ADA believes that the public benefits recognised in the previous authorisations relating to intra-practice price setting by dental practitioners who remain independent businesses, but from the patient's perspective work as a team like a single practice, continue to apply. The ADA is seeking to preserve these for the shared practices that fall within the existing definition of 'shared practice' for a 12 month period while the ADA completes a review of the definition of 'shared practice' to ensure it is accurate, contemporary and appropriate for a further 10 year authorisation. A more detailed analysis of public benefit beyond the next 12 months will be provided in the application for a further 10 year authorisation.

The previously recognised public benefits fall into the following 4 main areas, each of which is summarised below:

- availability and continuity of patient care:
- quality of dental services:
- efficiency in the provision of dental services:
- attraction and retention of dental practitioners

(1) Availability and continuity of patient care:

- A shared practice structure improves availability, continuity and consistency of patient care, facilitating access to patient information and records within a dental practice.
- Utilising a dentist within a shared practice structure allows patient certainty as to the availability of services and fees applicable. 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 at a higher rate.

- 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 patients regular dentist is unavailable due to holidays or other absence.
- Having more than one dentist in a practice also increases the chance that a patient will be able to be seen quickly in an emergency situation.
- Utilising a dentist within a shared practise structure may also allow for intra-practice referrals of patients, facilitating the efficient use of dentists' specific areas of specialisation. Such co-operative arrangements ensure continuity of care and encourage shared responsibility for ensuring that quality of patient care is paramount. 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.

(2) Quality of dental services:

- 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.
- A shared practice structure also 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 his/her 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.

(3) Efficiency in the provision of dental services:

- 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) Attraction and retention of dental practitioners

- 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. Dentists may seek part time work for a number of reasons, including for example:
  - pre-retirement age dentists that elect to continue to work but on a part time basis; and
  - dental practitioners that are working part time to allow them to manage work and family commitments.
- The ability to practice 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.

Public detriment including any competition effects

11. *Describe any detriments to the public likely to result from the proposed conduct, including those likely to result from any lessening of competition. Refer to the public detriment that may have resulted under the authorisation previously granted. Provide information, data, documents, or other evidence relevant to the ACCC's assessment of the detriments.*

    The ADA believes 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' explained in paragraph 9 will continue to apply.

Contact details of relevant market participants

12. *Identify and/or provide names and, where possible, contact details (phone number and email address) for likely interested parties such as actual or potential competitors, customers and suppliers, trade or industry associations and regulators.*

Names and contact details for likely interested parties are provided in Schedule 1.

Additional information

13. *Provide any other information or documents you consider relevant to the ACCC's assessment of the proposed application.*

    As explained in this application, the ADA is seeking to preserve the status quo for existing shared practices relying on the current authorisations which are due to expire on 18 April 2023, while the ADA completes a review of the definition of 'shared practice' to ensure it is accurate, contemporary and appropriate for a further 10 year authorisation.

    The next steps for the ADA, and anticipated timing, are:

    - The ADA is working on developing a proposed new framework for defining what is a genuine 'shared practice' that will allow clear delineation, for the purposes of both payroll tax and competition law, as to when dental practitioners are independent competitors (working as a team in a *shared* practice) and when they are employees of a *single* practice.
    - Once this has been developed, the ADA then proposes to conduct member surveys on the proposed new framework to confirm that it is accurate, contemporary and appropriate for how dental practices are likely to operate in the future.
    - The ADA anticipates that this will provide it with a revised definition of 'shared practice' that would be an appropriate basis for making a further more detailed revocation/substitution application seeking an authorisation term of 10 years. In particular, the ADA anticipates that this revised definition will allow clear identification of when intra-practice price setting requires authorisation and a more detailed assessment of the public benefit relating to intra-practice price setting by such practices.
    - The ADA anticipates being in a position to make that further more detailed revocation/substitution application around October 2023.
    - The ADA also proposes to establish a confidential register that will allow on-going identification of all dental practices covered by authorisation for intra-practice price setting.

Declaration by Applicant

The undersigned declares that, to the best of their knowledge and belief, the information given in response to questions in this form is true, correct and complete, that complete copies of documents required by this form have been supplied, that all estimates are identified as such and are their best estimates of the underlying facts, and that all the opinions expressed are sincere.

The undersigned undertakes to advise the ACCC immediately of any material change in circumstances relating to the application.

The undersigned is aware that giving false or misleading information is a serious offence and is aware of the provisions of sections 137.1 and 149.1 of the *Criminal Code* (Cth).

[redacted]

Signature of authorised person

Damian Mitsch
Chief Executive Officer, Australian Dental Association Inc

This 9th day of March 2023

Schedule 1: Contact Details for Interested Parties

Interested Party Name	Contact details
SA Dental Service, a division within the Central Adelaide Local Health Network	Mark Chilvers, Executive Director [redacted] HealthSADSPublic@sa.gov.au 1300 008 222 GPO Box 864, ADELAIDE SA 5001
Consumers Health Forum of Australia	Dr Elizabeth Deveny, Chief Executive Officer info@chf.org.au 02 6273 5444 7B/17 Napier Close, DEAKIN ACT 2600
Consumers Federation of Australia	Gerard Brody, Chair info@consumersfederation.org.au 03 9670 5088 PO Box 16193 Collins Street West VIC 8007
Australian Patients Association	Stephen Mason, Chief Executive Officer [redacted] info@patients.org.au 03 9274 0788 7/114 William Street, MELBOURNE VIC 3000
Australian Dental Association (New South Wales Branch) Limited	Bill O'Reilly - Acting Chief Executive Officer [redacted] adansw@adansw.com.au [redacted] Level 1, 1 Atchison Street, ST LEONARDS NSW 2065
Australian Dental Association (NT Branch) Incorporated	Emma Neibling, President [redacted] admin@adant.org.au [redacted] GPO Box 4496, DARWIN NT 0801
Australian Dental Association (WA Branch) Inc	Trevor Lovelle, Chief Executive Officer [redacted] adawa@adawa.com.au [redacted]

	ADA House 54-58 Havelock Street, WEST PERTH WA 6005
Australian Dental Association Tasmanian Branch Incorporated	Fiona Tann, Chief Executive Officer [redacted] admin@adatas.org.au [redacted] PO Box 9015, SOUTH YARRA VIC 3141
Australian Dental Association Victorian Branch Inc	Matt Hopcraft, Chief Executive Officer [redacted] ask@adavb.org [redacted] Level 3, 10 Yarra St, SOUTH YARRA VIC 3141
Australian Dental Association (Queensland Branch)	Lisa Rusten, Chief Executive Officer [redacted] adaq@adaq.com.au [redacted] 22-28 Hamilton Place, BOWEN HILLS, QLD 4006
Australian Dental Association South Australian Branch Inc	Bradley Abraham, Chief Executive Officer [redacted] admin@adasa.asn.au [redacted] 62 King William Rd, GOODWOOD SA 5034

Schedule 2: Explanation of payroll tax issue

The Thomas and Naaz case

In *Thomas and Naaz Pty Ltd (ACN 101 491 703) v Chief Commissioner of State Revenue* [2022] NSWCATAP 220 the appellant appealed a decision of the Tribunal which upheld the Chief Commissioner's decision to levy payroll tax on payments made by the appellant to various doctors who were treating patients at three medical centres operated by the appellant.

The written agreements between the appellant and the doctors provided for the doctors to use the centres as private practitioners and for the appellant to provide the doctors with rooms and shared administrative and support services. In return for these facilities and services the doctors agreed to pay to the appellant 30% of the Medicare benefits payable to them in respect of the patients seen at the medical centres.

Most of the doctors at the appellant's medical centres opted to direct Medicare to pay all benefits paid in respect of the services provided to their patients into a bank account held in the name of the appellant. The appellant would record and reconcile all Medicare benefits received for each doctor and would then pay 70% of those amounts to the doctor, with the remaining 30% retained by the appellant, representing the payment to be made to it by the doctor for the facilities and services referred to above.

The Chief Commissioner levied payroll tax under the *Payroll Tax Act 2007* on these payments on the basis that the agreements were "relevant contracts" and that the payments to the doctors were made "for or in relation to the performance of work relating to a relevant contract". While shared practice arrangements can be structured and documented in a myriad of ways, health practitioners and their service/management entities have generally considered these payments would not be subject to payroll tax.

The ADA understands that leave to appeal this decision is being sought.

The Queensland Revenue Office ruling

After the Thomas and Naaz case, peak medical bodies sought clarity from various state revenue offices. In December 2022, the Queensland State Revenue Office made *Public Ruling PTAQ000.6.1 Relevant contracts—medical centres* (a copy of which is attached).

The purpose of this public ruling is to explain the application of the relevant contract provisions in the *Payroll Tax Act 1971* (Qld) (the Act) to an entity that conducts a medical centre business

(referred to as a 'medical centre'), including dental clinics, physiotherapy practices, radiology centres and similar healthcare providers who engage medical, dental and other health practitioners or their entities ('practitioners') to provide patients with access to the services of practitioners.

Under paragraph 13 of this ruling, payroll tax is likely to be applied where "a medical centre engages a practitioner to practice from its medical centre **or holds out to the public that it provides patients with access to medical services of a practitioner**" (bold emphasis added).

The implications of this recent ruling, including the likely position of other state revenue offices, are still being worked through in the health sector. One concern that has been raised by the words highlighted above is that they go to the fundamental characterisation of shared practices by the ACCC in the authorisation context, namely that practitioners work as a team in a setting that creates, *from the patient's perspective*, a single practice (this also being the basis for distinguishing beneficial *intra-practice* price from price setting between practices).

This is creating considerable confusion about where the line is between a setting where independent practitioners are providing services to patients as a *shared* practice and a setting where there is a *single* practice providing services to patients.

In early February the Queensland Government announced a grace period on the application of this ruling until 30 June 2025 to allow certain medical practices time to work though the implications and change their business structure. The statement on this is accessible here: https://www.business.qld.gov.au/running-business/employing/payroll-tax/taxable-wages/contractors/amnesty

The statement indicated that full details would be provided shortly. However, the ADA's understanding of this statement is that the amnesty is not open to dental practitioners.