Draft Determination and interim authorisation

Application for revocation of A91340 and A91341 and the substitution of authorisation AA1000638
lodged by
Australian Dental Association Inc
in respect of
agreements as to the fees to be charged for dental services provided within shared practices
Authorisation number: AA1000638

12 April 2023

Commissioners: Keogh
Lowe
Brakey

Summary

The ACCC proposes to grant authorisation to enable the Australian Dental Association Inc 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 ADA. A shared practice is one where the dentists and/or dental specialists are independent businesses, but they operate under a common trading name, share premises, equipment and staff, and share dental records and the treatment of patients across the practice.

The ACCC previously granted authorisation to the ADA in 2008 and 2013 for the same conduct. The current authorisation is due to expire on 18 April 2023.

The ADA is seeking a 12-month extension to enable it to continue with the currently authorised conduct while it completes a review to understand the implications of a change to the definition of 'shared practice' following recent payroll tax developments.

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 proposes to grant authorisation for 12 months.

The ACCC has also granted interim authorisation to enable the arrangements to continue while the ACCC is considering the substantive application.

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 9 March 2023, the Australian Dental Association Inc (the **ADA**), on behalf of itself and members, lodged an application to revoke authorisations A91340 and A91341 and substitute authorisation AA1000638 for the ones revoked (referred to as re-authorisation) with the Australian Competition and Consumer Commission (the **ACCC**). The ADA is seeking re-authorisation for 12 months to enable its members to agree on the fees to be charged for dental services provided in a practice, where the dentists and/or dental specialists operate in a 'shared practice' and at least one party is a member of ADA.

1.2. This application for re-authorisation was made under subsection 91C(1) of the *Competition and Consumer Act 2010 (*Cth*)* (the **Act**). If granted, an authorisation, provides businesses with protection from legal action under the competition provisions in Part IV of the Act. 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 in benefit to the public that would outweigh any likely public detriment (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 Conduct while the ACCC is considering the substantive application for re-authorisation. Granting interim authorisation prior to the expiry of the current authorisation will have the effect of suspending its operation and substituting it with the interim authorisation

such that the ACCC can consider the application for revocation and substitution. The request for interim authorisation is discussed further in section 6.

The Australian Dental Association Inc

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.

The Conduct

1.6. The ADA is seeking re-authorisation for the making of and giving effect to contracts, arrangements and understandings between 2 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.

(the **Conduct**)

2. Background

Previous authorisations

2.1. Since 2008, the ACCC has granted authorisation for similar conduct on 2 occasions.[1] The most recent authorisation was granted on 27 March 2013 until 18 April 2023.

2.2. 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

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

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

The dental industry

2.3. 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.

2.4. 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 Australia, where 27% worked in solo private practice and 56% worked in group private practice.[2]

Developments in payroll tax

2.5. The ADA submits that recent developments relating to the application of payroll tax in shared practice settings has 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.[3]

2.6. The ADA submits it is 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. The ADA expects this review to take 12 months at which time it intends to seek authorisation for 10 years.

3. Consultation

3.1. Given that the application for re-authorisation is to enable the continuation of the status quo for a further 12 months while the ADA is undertaking a review to understand recent changes to the definition of shared practice, the ACCC proceeded to issue this draft determination without inviting initial submissions from potentially interested parties.

3.2. The ACCC now invites submissions in response to this draft determination by 28 April 2023.

4. ACCC assessment

4.1. The ADA is seeking authorisation for Conduct that would or might constitute a cartel provision within the meaning of Division 1 of Part IV of the Act and may substantially

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[2] Australian Institute of Health and Welfare, *Oral health and dental care in Australia*, Commonwealth of Australia, 17 March 2023, accessed 22 March 2023. 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 2.2 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.

[3] See *Thomas and Naaz Pty Ltd (ACN 101 491 703) v Chief Commissioner of State Revenue (2022)* NSWCATAP 220 and *Public Ruling PTAQ000.6.1 Relevant contracts—medical centres*.

lessen competition within the meaning of section 45 of the Act. Consistent with subsections 90(7) and 90(8) of the Act,[4] the ACCC must not grant 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 the benefit would outweigh the detriment to the public that would be likely to result.

Relevant areas of Competition

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

4.3. 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. This is consistent with the relevant areas identified by the ACCC in the previous authorisations.

Future with and without the Conduct

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

4.5. As acknowledged in the previous authorisations, dental practitioners can set the fees they charge patients where they operate under business structures such as partnerships and incorporated entities but not where they are independent practitioners operating in shared practices.

4.6. The likely future should re-authorisation not be granted would be that dental practitioners operating in shared practices would set fees individually which would potentially result in patients charged different fees within the practice or would require practitioners to incorporate or enter into 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 society including as one of its principal elements … the achievement of the economic goals of efficiency and progress.*[5]

4.8. The ACCC has considered the following public benefits:

- patient certainty of price and access to practitioners
- 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.

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4 See subsection 91C(7).

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

Patient certainty of price and access to practitioners

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 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. 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.

4.11. 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. 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. 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.

4.12. 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 between dental practitioners within a practice and may limit access to other dental practitioners within the dental practice. As such, the ACCC considers that public benefit in the form of patient certainty of price and access to practitioners is likely.

Practitioner co-operation improving quality of dental services

4.13. 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.

4.14. 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.

4.15. 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

4.16. 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.

4.17. 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 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

4.18. 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. Dentists may seek part time work for a number of reasons, including for example to allow them to manage work and family commitment or are at a pre-retirement age.

4.19. The ADA also submits that 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.

4.20. The ACCC considers that public benefit in the form of supporting flexible working arrangements for dental practitioners is likely. The ACCC 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

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

- patient certainty of price and access to practitioners 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 due to the ability to facilitate economies of scale and share the costs of 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

4.22. 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.*[6]

4.23. The ACCC has considered the public detriment of the potential for reduced competition.

Potential for reduced competition

4.24. 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.

4.25. 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 plenty of other practices in such localised geographic regions. 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.

4.26. The ACCC considers that the detriment from dentists and specialists agreeing on the fees they will charge within a shared practice is likely to be limited. 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). Dentists 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.

4.27. 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.

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

Balance of public benefit and detriment

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

Length of authorisation

4.29. The Act allows the ACCC to grant authorisation for a limited period of time.[7] 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.

4.30. In this instance, the ADA seeks authorisation for 12 months. The ADA submits that it is seeking to preserve the public benefits recognised in the previous authorisations for the shared practices that fall within the existing definition of 'shared practice' for a 12-month period while it 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 submits that a more detailed analysis of public benefit beyond the next 12 months will be provided in the application for a further 10-year authorisation, which it anticipates being in a position to make in around October 2023.

4.31. The ACCC proposes to grant re-authorisation for 12 months.

5. Draft determination

The application

5.1. On 9 March 2023 the ADA lodged an application to revoke authorisations A91340 and A9134 and substitute authorisation AA1000638 for the ones revoked (referred to as re-authorisation). This application for re-authorisation AA1000638 was made under subsection 91C(1) of the Act.

5.2. The ADA seeks authorisation for Conduct defined at paragraph 1.6.

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 grant authorisation unless it is satisfied in all the circumstances that the Conduct is likely to result in a benefit to the public and the benefit would outweigh the detriment to the public that would be likely to result from the Conduct.

5.5. For the reasons outlined in this draft determination, the ACCC is satisfied, in all the circumstances, that the 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 Conduct, including any lessening of competition.

5.6. Accordingly, the ACCC proposes to grant authorisation.

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7 Subsection 91(1)

Conduct which the ACCC proposes to authorise

5.7. The ACCC proposes to revoke authorisations A91340 and A91341 and grant authorisation AA1000638 in substitution to enable the ADA to make and give effect to contracts, arrangements and understandings as to the fees to be charged for dental services provided within shared practices as described in paragraph 1.6 and defined as the Conduct.

5.8. The Conduct may involve a cartel provision within the meaning of Division 1 of Part IV of the Act or may have the purpose or effect of substantially lessening competition within the meaning of section 45 of the Act.

5.9. The ACCC proposes to grant authorisation AA1000638 for 12 months.

5.10. This draft determination is made on 12 April 2023.

6. Interim authorisation

6.1. The ACCC has decided to suspend the operation of authorisations A91340 and A91341 and grant interim authorisation in substitution.

6.2. The ADA is seeking interim authorisation to preserve the status quo for existing shared practices relying on the current authorisations, which are due to expire on 18 April 2023, while it 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.

6.3. The ACCC has decided to suspend the operation of authorisations A91340 and A91341 and grant interim authorisation in its place for the following reasons:

- There is a need for the continuation of the arrangements after the expiry of the current authorisations on 18 April 2023 while the ADA completes its review of the definition of 'shared practice' following recent developments relating to the application of payroll tax in shared practice settings.
- The relevant areas of competition are unlikely to be altered if interim authorisation is granted due to the Conduct being in place and authorised since 2008.
- Based on the ACCC's assessment to date, the Conduct is likely to result in public benefits and is unlikely to result in significant public detriments.

6.4. Interim authorisation commences immediately and remains in place until it is revoked or the date the ACCC's final determination comes into effect or when the application for re-authorisation is withdrawn.

7. Next steps

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