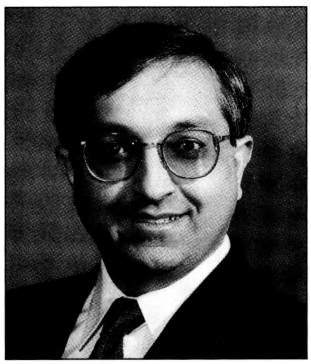
Competition laws, advertising restrictions, misleading conduct and the health sector



Some recent speeches by Commissioner Sitesh Bhojani are part of a major educational effort by the Commission on how the Trade Practices Act applies to medical professionals and the private health sector. The Commission's aim is to help medical and health sector professionals and their associations understand two interrelated issues — rights and obligations imposed by competition laws, and the protection afforded by Commonwealth and state legislation to consumers of medical and health services.

The following article is based on three presentations:

Consumer protection and the supply of medical services — the ACCC view (ACCC and NSW Health Care Complaints Commission joint conference, 'Advertising medical services — in whose interests?', 14 October 1999);

Competition laws: the ACCC role and public interest issues (Royal Australasian College of Surgeons Conference, Victorian State Committee Country Scientific Meeting, 17 October 1999); and

Private hospitals — victors or victims of the Trade Practices Act? (Australian Private Hospitals Association 19th National Congress, 26 October 1999).

Introduction

Since 1974 the restrictive trade practices provisions (sometimes also known as 'the competitive conduct rules') in Part IV of the Trade Practices Act have applied to those professions practising by means of a corporate business structure in Australia. In particular, 'services' has always been defined in the Act to expressly include 'work of a professional nature'.[1]

Commonwealth constitutional limitations exclude from the reach of Part IV, professionals practising in partnerships of natural persons or on other unincorporated bases. Exceptions are professionals whose conduct is in, or in relation to, trade or commerce between Australia and other countries; or across Australian state or territory boundaries or within Australian Territories; or the supply of services to the Commonwealth or its authorities and instrumentalities.

A variety of Australian state and territory legislation or regulations, by specifically approving or authorising certain conduct, had also exempted such conduct by some professions from reach of the Act. For example, *advertising restrictions and fee-setting regulations* (see endnote).

For others in the health sector such as private hospitals and private health insurance funds that carry on their businesses through incorporated business structures, the Act has of course, applied since 1974.

Adjudication

The Commission's role in the professional and health sectors has been primarily as a law enforcement agency administering and enforcing the Act. This includes its adjudication role under Part VII of the Act, which provides mechanisms (technically known as 'authorisation' or 'notification') for parties to gain immunity from legal proceedings for conduct that may otherwise breach the provisions in Part IV (except for s. 46 — misuse of market power — which cannot be given immunity under any circumstances).

1 See s. 4 *Trade Practices Act 1974.*

Restrictive advertising

The Commission also places considerable importance on the application of Part V, that is consumer protection, to the health sector. Of particular concern is whether professionals, professional associations and advisers comply with the law in advertising and other promotional activities. The second part of this paper sets out to challenge some misconceptions held by some in the medical and health sectors.

Changes to the Act

Major changes to the Act were introduced from 1996 to 1998 when the Government responded to various reports, particularly the Reid Committee Report and the Hilmer Report. These changes have markedly influenced the Commission's role in applying the Act to the health sector. Therefore the information in this paper is broadly divided into two sections, before and after 1996.

Pre-1996

Examples of applications for authorisation

From as early as 1974 the Trade Practices Commission (which in November 1995 was merged with the Prices Surveillance Authority to create the Australian Competition and Consumer Commission) had also considered applications for authorisation under the Act by various professions.

Australian Medical Association (Boycott Arrangement)[2]

This was an application for authorisation of a contract, arrangement or undertaking that could have been in restraint of trade. The parties were most of the medical practitioners in private practice in the Australian Capital Territory. The nature of the agreement appeared from a declaration, made by the parties after a meeting on 2 July 1974, which opened with these words:

> We, the private medical practitioners of Canberra, are united in our determination to halt encroachment on private medical practice in the ACT, whether caused by the appointment of full-time salaried specialist staffs to the Canberra hospitals, or by the establishment of health centres staffed by salaried general practitioners in areas adequately served by existing practices.
>
> In order to demonstrate our determination, we will, from the date of commencement of duty of the first full-time salaried specialist appointed in response to advertisements for staffing the proposed Canberra Hospital Service Scheme:
>
> - disassociate ourselves entirely from the salaried system of specialist medical care in the Canberra hospitals by ceasing to give the system any clinical support. We are not prepared to support a scheme which is designed eventually to destroy our chosen mode of practice.
> - make arrangements to ensure that the private medical service which has served Canberra citizens so well for so many years, continues to operate to the satisfaction of our patients despite the difficulties created by the Government.
>
> Thus, patients will have a choice of opting for medical care through an untried, wholly salaried system, or of accepting wholly private medical care of the type they have been used to, supported through membership of health insurance funds. The two systems will become separate and exclusive.

The declaration proceeds in some detail and it includes, for example, the statement that:

> There will be no professional association between private practitioners and newly appointed salaried specialists.

The essence of the AMA's contentions were that the then existing hospital scheme was in the best interests of the public of the ACT and that it was in danger of being eroded to the detriment of the public.

In its decision the Commission noted that for it to grant authorisation, it would first have to be satisfied that the arrangement or understanding results, or is likely to result, in a substantial benefit to the public, that is to say that the preservation of the status quo was a substantial benefit as against the introduction of the changes being resisted. This would mean

2 (1974-75) ATPR (Com) 13-840 at p.8, 866.

deciding between competing views at the professional, political and even emotional level.

The Commission would have to be satisfied further that the substantial benefit to the public, if it existed, would not otherwise be available, that is, that the preservation of the status quo could not be achieved otherwise than by what would amount to a boycott arrangement. The Commission was not so satisfied. There had been a good deal of discussion between the applicants and the administration. The issues were the subject of public debate and political disputation at a time when politics were more than ordinarily volatile.

The final point, on which the Commission was also not satisfied, was that the public benefit, if it existed and was not otherwise available must in all the circumstances, justify the authorisation. This involved balancing the benefit against detrimental effect of the arrangement, such as the dominance it accorded to the parties and the clog it set on further development, which might have to be at a rate and in a direction approved by the applicants collectively. The Commission did not authorise the conduct.

David Ashby on behalf of members of the Pharmacy Guild of Australia[3]

This was an application made on behalf of the Pharmacy Guild of Australia for authorisation of a contract arrangement or understanding referred to in the application as 'recommended pricing services for guild members'. In its decision of 24 November 1977 the Commission concluded that in the circumstances there was no causal link between the operation of the Guild Economic Information Service (GEIS) and the adequate provision of pharmaceutical services to the community as had effectively been claimed by the guild. The Commission did not grant the authorisation but extended the duration of its interim authorisation to enable the guild to make proposed changes to the GEIS.

Sterling Pharmaceuticals Pty Ltd[4]

('Chemist only' arrangements of Winthrop Laboratories and Nyal Company Divisions)

These were three applications for authorisation of a traditional method of working and course of dealings whereby the applicants (Winthrop and Nyal) supplied their products only to pharmacies or hospitals or to wholesalers who supplied only to pharmacies and hospitals.

> The Commission concludes that Sterling's 'C.O.' arrangements limit competition between pharmacy and non-pharmacy retail outlets. The results, in the Commission's view, are that the goods affected have higher prices than would otherwise be the case. This is the direct result. The indirect result is that the higher prices inhibit non-viable pharmacies from leaving the industry. The guild has acknowledged that there are too many pharmacies. The Commission considers that the public would benefit if market forces were allowed to operate unfettered by the restrictions on competition resulting from the 'C.O.' arrangements; prices are then likely to be lower and more non-viable pharmacies would leave the industry.

And

> It is not suggested that the applicant's 'chemist only' policy is purely unilateral and independent of any understanding with other parties, and the Commission is not discussing that hypothetical situation. In the absence of authorisation, the applicant will have to decide whether to discontinue its 'chemist only' policy or whether to continue it, wholly or partly, as a matter of purely unilateral decision that it is prepared, if necessary, to defend as not being in contravention of either s. 45 or s. 47 of the Act.[5]

Deputising Medical Services Pty Ltd[6] *and Radio Doctor Service Pty Ltd*[7]

The Commission dealt with these applications for authorisation which were lodged by solicitors for each applicant on 6 January 1975. On 21 December 1979 the Commission made the following comments in respect of each application and denied authorisation.

> The applicant is apparently a company providing out of hours medical care to patients of subscribing medical practitioners and providing ancillary communications services to such medical practitioners. The conduct the

3 (1977) ATPR (Com) 35-340 at p.16, 910.
4 (1977) ATPR (Com) 35-220 at p.16, 748.
5 ibid at p. 16, 757
6 (1979) ATPR (Com) 35-200 at p.16, 414.
7 (1979) ATPR (Com) 35-200 at p.16, 415.

subject of the application is the requirement that subscribing medical practitioners do not employ any *locum tenens* during the applicant's normal hours of operation and the requirement that the subscribing medical practitioners do not engage the services of companies providing similar services.

At the time of making the application no further details of the services provided or the conduct were submitted and no submission was made as to the public benefit arising from the conduct or the effect of the conduct on competition. The applicant's solicitors did at the time request 'the Commission's indulgence of the requisite time to provide additional material that would enable due consideration to be given to the application. We have asked our client to let us have the necessary further instructions as a matter of urgency'. No material was submitted.

The applicant's solicitor was contacted on two occasions, 30 October 1978 and 11 September 1979, with a request that any submissions which the applicant wished to make be provided to the Commission. The applicant's solicitors have stated that they are unsure whether the conduct was continuing and in any event they have not been able to obtain any instructions from their clients.

In the absence of any public benefit submissions being received the Commission has not been satisfied that the requirements of s. 90(6) of the Act have been met and proposes, subject to any pre-decision conference that may be requested pursuant to s. 90A of the Act, to deny authorisation.

Private hospitals have also utilised the authorisation procedure in the Act as shown in the following examples.

Calvary Hospital A.C.T Incorporated (common form contract)[8]

In May 1979 and March 1982 the Commission granted authorisation to Calvary Hospital in respect of the:

Proposed medical staffing structure for the hospital with accompanying common forms of contract between private medical practitioners and Calvary Hospital A.C.T Incorporated for appointment to the hospital —

(a) for the treatment of hospital patients and for the provision of remuneration for that treatment; and

(b) for the treatment of private patients admitted to the hospital under private medical practitioners.

From the facts placed before it, the Commission concludes that it is being asked to decide not only on the standard form of contract proposed by the applicant but also in respect of the method to be adopted in the appointment of visiting medical officers.

The Private Hospitals Association of NSW Inc[9]

The Commission's decision was made on 27 April 1990.

This decision covers two applications for authorisation by the Private Hospitals Association of NSW Inc (the Association). The first relates to the Association's proposed statement of objects and rules. One of the rules relates to a condition of membership of the Association which is compliance with a code of ethics and business practice. The second requires members of the Association (private hospitals and freestanding day care centres) to be accredited by the Australian Council on Healthcare Standards (ACHS); or be an applicant for accreditation, or satisfy such other assurance requirement approved by a general meeting of members.

ACHS is an independent, non-profit and financially self-sufficient organisation which amongst other things, establishes optimal standards for administration, quality of care, essential services and plant safety for hospitals and health care facilities.

The Commission believes that the accreditation requirement for membership of the Association will raise standards in the industry. On the balance of public benefit and anti-competitive effect the Commission proposes to authorise the application in respect of the accreditation requirement for membership.

In general terms the Commission must be satisfied that this self-regulatory scheme delivers public benefits outweighing any detriment flowing from the arrangements.

In the Commission's draft determination the Commission said it was not satisfied that this

8 (1979) ATPR (Com) 35-100 at p. 15, 581 (1982) ATRPR (Com) 50-032 at p. 55, 362

9 (1990) ATPR (Com) 50-097 at p. 54, 223

test was met and had particular reservations about the adequacy of such key aspects of the code of ethics and business practice as its complaint-handling and reporting procedures and provision for external participation. It said it would be prepared to grant authorisation if these aspects were addressed.

The Commission had a number of reservations concerning the objects and rules which it said would need to be met prior to it granting authorisation. As a result of amendments by the Association to its objects and rules and the statutory requirements of the NSW *Private Hospitals and Day Procedure Centres Act, 1988* the Commission is now satisfied that an adequate complaints handling mechanism will be put in place.

The Commission is of the opinion that the amended objects and rules will result in a level of public benefit which will outweigh any anti-competitive concerns.

The Commission proposes to authorise the application in respect of the objects and rules. It is satisfied that the amendments to the objects and rules meet the concerns which were set out in the Commission's draft determination.

Early Commission enforcement action — against health insurance funds

Even under its former identity the Commission had been concerned about competition issues in the private health sector and to respect the freedom of private hospitals to set their fees for hospital services — unencumbered by pressure of collusive arrangements between competing health funds. In *TPC v St Luke's Medical and Hospital Benefits Association & Ors,* four Tasmanian health funds and their relevant senior managers gave undertakings in the Federal Court on 25 August 1993 not to enter any arrangement that could prevent or hinder Tasmania's private hospitals from setting their own fees for the supply of services to the Department of Veterans' Affairs.[10] The funds also undertook to inform the hospitals that they would not seek to unlawfully influence the hospitals' fee scales.

The funds were: St Luke's Medical and Hospital Benefits Association Ltd, APPM Council Health Benefits Ltd, Queenstown Medical Union Health Benefits Fund and Montagu Medical Union. The fifth fund, The Medical Benefits Fund of Australia Ltd, had provided a similar undertaking to the Federal Court in Sydney on 29 July 1993.

The undertaking followed the institution of proceedings by the Commission on 13 October 1992 against the five funds. The Commission's action stemmed from a decision by the Commonwealth Department of Veterans' Affairs to seek tenders in 1989 and 1990 from private hospitals in Tasmania for the provision of hospital services for repatriation patients.

The Commission alleged that the funds and five senior managers had arrived at an arrangement or understanding that they would attempt to prevent the State's private hospitals from discounting their fees to the Commonwealth for hospital services to Commonwealth repatriation patients.

Post-1974

Regulation of professional markets in Australia

In 1988–89 the TPC announced that it would conduct a research study of the impact on competition of professional regulation in Australia. It produced in December 1990 a discussion paper on *Regulation of professional markets in Australia: issues for review.* The discussion paper contained the following observation:

> In Australia the professions are subject to a diversity of government and self-regulation arrangements which vary considerably between individual professions. In many cases, the regulatory arrangements for particular professions vary between the individual States and Territories.
>
> The traditional justification for regulation of the professions has been the protection of consumers through measures to maintain the quality of services and the competence and integrity of their providers. It is being recognised increasingly, however, that such regulation is not

10 Federal Court of Australia, Tasmania, No TG13 of 1992

without cost to consumers and the community. To the extent that it restricts competition, the service choices available to consumers may be limited, the incentive to innovate and contain costs may be reduced and prices may be inflated as a result.

From the community's perspective, as well as that of the professions themselves, it is therefore important to be able to identify both the benefits and the costs of existing regulatory measures and to assess, as far as possible, for individual professions whether those regulations provide net benefits for consumers after taking account of any costs resulting from restrictions on competition.[11]

Subsequently, the TPC conducted studies and issued final reports on the accountancy profession in July 1992, architects in September 1992 and the legal profession in March 1994.

Adoption of a national competition policy for Australia

The Hilmer Committee's August 1993 Report to the Council of Australian Governments (COAG) on a national competition policy — after citing from a 1990 Trade Practices Commission discussion paper to the effect that data for 1987–88 suggests that five occupational groups alone (lawyers, accountants, engineers, architects and real estate agents) accounted for nearly 2 per cent of Australia's GDP — observed that:

> The professions clearly comprise an important sector of the economy, and their services are a significant cost to many businesses which compete internationally.[12]

The Hilmer report also observed that:

> Whatever significance is attributed to the professions generally, it is important to emphasise that their partial exclusion from the Act is primarily due to a constitutional limitation which is unrelated to the status of professions. The scope of the exception depends largely on the legal form of the business, which varies widely across professions. The overall result is patchy and difficult to justify on public policy grounds.

In Australia, since 21 July 1996, the term 'competition law' can be said to comprise the provisions in Part IV of the Act and the competition codes of each of the Australian States and Territories. In conjunction with private rights of action, enforcing Australia's competition laws is one of the principal functions of the Commission.

Legislative review of professional regulation

Apart from the universal application of the competitive conduct rules to the professions since 21 July 1996, the adoption and implementation of a national competition policy by COAG also means that during the period 1996–2000 the medical professions and others in the health sector in Australia are actively involved in making submissions and other activities as part of the legislative review program of each Australian State and Territory. This is in the context that the program deals with a review of legislation that restrictively regulates the structure or conduct of each of the medical and health sector professions in that jurisdiction.

The National Competition Council (NCC) in April 1997 published a 'legislation review compendium' which collated the list and timetables issued by each State and Territory Government of the legislation to be reviewed by that government for the purposes of its obligations under national competition policy. The NCC is the COAG advisory body on implementation of national competition policy.

The responsibility for oversighting this aspect of implementing Australia's national competition policy rests with the NCC, not the Commission. The Commission's role in this respect has been to assist particular governments seeking submissions from the Commission on the competition issues generally and specifically in respect of various professions.

As a general approach the Commission takes the view, in respect of the future regulation of professional markets, that regulation on professional services needs to be proportional to the potential harm. It should aim to provide

11 *Regulation of professional markets in Australia: issues for review — a discussion paper*, Trade Practices Commission, December 1990 at p. 6.

12 *National Competition Policy Report* by the Independent Committee of Inquiry, August 1993, Australian Government Publishing Service, at p. 135.

a guaranteed level of service quality to consumers to reduce the risks associated with purchasing and using professional services. At the same time, regulation must allow maximum flexibility and competitiveness in service provision.

The Commission suggests some general principles that should be considered when developing an appropriate regulatory regime for a profession. These include:

Demonstrated need for a regulatory solution. Clear identification of the objective of the proposed regulation is needed.

Assessment of the merits of a regulation from an economy-wide perspective. This includes an assessment of the interests of those who the regulation is intended to benefit and those who are regulated, as well as an assessment of compliance costs.

Minimum feasible regulation that is well targeted, minimising restrictions on competition. The effects of various options (including non-regulatory options) should be analysed to determine the net costs and benefits. Where possible, regulatory standards should be consistent with international standards to minimise barriers to international competition.

Competition law or some other controls should apply to 'self-regulatory' activities of professional organisations. This is to ensure that self-regulation does not bring about unjustified restrictions on competition.

The composition of regulatory bodies should balance competing needs. The need to have regulations set and administered by members with sufficient technical expertise and the need to ensure that representatives of an occupation do not have inappropriate control over entry and conduct in a profession.

Regulations should be subject to an ongoing review process. Continual review ensures that the rationale for rule making remains relevant, and includes an assessment of whether regulation remains the best way of addressing problems that arise. Regulatory systems need to be able to adapt and reflect changes in the professional sector.

Additionally, the Commission considers that the following questions will be useful in assessing whether a particular regulatory model for professional practitioners will best meet the community's needs and expectations.

- Does the model facilitate effective competition between players in the sector?
- Does the model allow for the entry of new players, and alternative or para-professionals where appropriate?
- Does the model protect consumer welfare?
- Does the model place consumers in a position to make informed choices about the type of services they require, and the person best placed to provide them?
- Is the model likely to generate consumer confidence in the services provided by a particular profession?
- Will the model maintain and support the integrity and viability of the professions?

How do professional sector regulations limit competition?

In the Commission's view the following seven forms of regulation of professional markets inhibit competition in two broad ways: through their effects on the structure of the relevant professional market and on the market conduct of professional practitioners.

Structural regulations of professional markets include those that:

- regulate entry into the market (including the imposition of educational and competency standards, licensing and certification requirements, and restrictions on entry by foreign professionals and para-professionals);
- define the field of activity reserved for licensed or certified professional practitioners;
- separate the market functionally into discrete professional activities (including those performed by accredited specialists such as insolvency practitioners, barristers and medical specialists); and
- impose restrictions on the ownership and organisation of professional practices.

Conduct regulations include those that:

- limit the fees that professionals may charge or require the application of fee scales for particular professional services;
- prohibit certain kinds of advertising, promotion or solicitation of business by professional practitioners; and
- specify professional and ethical standards to be observed by, and disciplinary procedure to apply to, professional practitioners.

The key is to ensure that such regulation is appropriate and consistent with the general principles outlined above. In this respect, it is suggested the Commission's view is consistent with the views set out in the *OECD Report on Regulatory Reform 1997.*[13]

Applying the competition laws to the medical profession and health sector since the 1996 reforms

Educational role of the Commission

A major educational effort to assist medical and health sector professionals and their associations understand their rights and obligations under the competition laws, has been undertaken by the Commission over the past four years.

I have given more than 50 presentations at various conferences, seminars and formal meetings of professional associations. The Commission's Chairman and other staff have also given numerous presentations.

Each of the medical colleges was written to at the time of the changes in the law with an offer of assistance from the Commission. The aim was to assist those colleges with possible changes that may have been necessary to the constitution, rules or by-laws of such college **if** they contained anti-competitive restrictions. The response was mixed. The Commission's offer was taken up enthusiastically by some colleges, whereas others adopted a 'we are a voluntary private association and you do not have any role over our activities' approach. The Commission is not concerned whether or not its offer to assist was taken up (especially as it does not give legal advice — it simply highlights areas of potential concern from a competition law perspective); rather, it is concerned to ensure that to the extent the law applies, the colleges are complying with the law. That could readily be achieved by the colleges obtaining private sector legal advice as a number of colleges have also done.

As well as a number of general guidelines on competition law matters and the workings of the Act, the Commission has also issued or published the following specific publications to assist the health sector understand the application of the Act.

- *A guide to the Trade Practices Act for the Health Sector,* November 1995.
- *Can the professions survive under a National Competition Policy?,* May 1997. Papers from a joint conference between the Commission, University of Western Australia, Murdoch University and University of Notre Dame.
- *Guide to the Trade Practices Act for the promotion of private health insurance,* April 1998. Joint publication with the Private Health Insurance Complaints Commissioner (now known as the Private Health Insurance Ombudsman).
- *Fair Treatment?* A consultative draft guide to the Trade Practices Act, for the promotion of medical and health services — issued 14 October 1999 seeking community comment until 17 December 1999 before finalisation as a joint publication with the New South Wales Health Care Complaints Commission.

Are professionals' fiduciary relationships or duties incompatible with competition laws?

A constant criticism heard by the Commission in recent times has been that competition laws

13 *The OECD Report on Regulatory Reform Volume 1: Sectorial Studies, 1997* — Chapter 3. 'Regulatory Reform and professional business services' pp. 119–154.

should not apply to the professions because professionals have a fiduciary relationship with their clients and fiduciary duties to fulfil which distinguish them from other businesses. The unstated assumption is that such relationships or duties to clients are incompatible with any obligation to abide by the competition laws.

Is the relationship between a professional and client a fiduciary one?

In Australia there are certain relationships that the law recognises as fiduciary relationships. These are relationships of trustee and beneficiary, agent and principal, solicitor and client, employee and employer, director and company, and partners.[14] However, it cannot properly be said that a relationship between any professional and his or her client is a 'fiduciary relationship'. As was pointed out by Dawson and Toohey JJ in the recent High Court of Australia case of Breen v Williams:

> ... The law has not, as yet been able to formulate any precise or comprehensive definition of the circumstances in which a person is constituted a fiduciary in his or her relations with another.[15]

The High Court has decided that in Australia the relationship between a doctor and patient is not a fiduciary relationship, but essentially a contractual relationship whereby the doctor undertakes to treat and advise the patient and to use reasonable skill and care in so doing.[16] Importantly, the High Court noted that it is of significance that a fiduciary acts in a representative character in exercising his or her responsibility.[17]

As to fiduciary duties or obligations the High Court recognised that notwithstanding the fact that a doctor–patient relationship is not a fiduciary one, fiduciary duties may be superimposed or concurrent with contractual obligations.[18] Fiduciary duties or obligations arise from either of two possible sources: agency or a relationship of ascendancy or influence by one party over another; or dependence or trust on the part of that other.[19]

Even where there is a fiduciary relationship between a professional and a client (for example, as between a solicitor and his or her client) it is important to acknowledge and bear in mind that the fiduciary obligations do not extend over the entire relationship. As Chief Justice Brennan (as he then was) pointed out in *Breen v Williams:*

> It is erroneous to regard the duty owed by a fiduciary to his beneficiary as attaching to every aspect of the fiduciary's conduct, however irrelevant that conduct may be to the agency or relationship that is the source of fiduciary duty.[20]

To similar effect is the statement of Dawson and Toohey JJ:

> Whilst duties of a fiduciary nature may be imposed upon a doctor, they are confined and do not cover the entire doctor–patient relationship.[21]

Fiduciary obligations — incompatible with competition laws?

Even where there are fiduciary relationships the questions that arise are to the following effect.

What is it about the fiduciary relationship between a professional and his or her patient or client that requires the professional to engage in price fixing with his or her competitors? Or to engage in a misuse of market power? Or to engage in exclusive dealing, resale price maintenance or other conduct prohibited by competition laws?

The Commission response to those questions is 'probably nothing'. But in the Australian context there is also a further response if there is something that is anti-competitive and it really is for the patient's benefit or client's benefit. That is, for the public's benefit (as distinct from being a private benefit for the doctors/lawyers etc.). The Parliament has set up a mechanism whereby that conduct can continue with immunity from court action, namely, through authorisation. That is, if professionals can demonstrate that the public

14 *See Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41 at 96; *Breen v Williams* (1996) 186 CLR 71 at 92 and 107.
15 (1996) 186 CLR 71 at 92.
16 See (1996) 186 CLR 71 at 78 per Brennan CJ; 89–90 per Dawson and Toohey JJ; 102 per Gaudron and McHugh JJ.
17 ibid at pp. 92–93, 101 and 113.
18 ibid at pp. 83, 89, 93–94, 107, 132–133.
19 ibid at pp. 82, 134.
20 ibid at p. 82.
21 ibid at p. 92.

benefit of that conduct outweighs its anti-competitive detriment they can obtain immunity from court action for that conduct.

Finally on this issue, it is also worth noting that the relationship between a company director and the company is also a recognised fiduciary relationship. However, there is no suggestion of providing company directors with an exemption or immunity from the competition laws where their conduct can readily be described as imposing a direct liability on the company and an accessorial liability on themselves for exactly the same conduct.[22]

Enforcement

The Commission has also been active in its enforcement and adjudicative roles vis-à-vis the medical professions and the health sector. On 17 December 1998 the Commission settled injunction proceedings it had instituted in the Federal Court of Australia against the Australian Society of Anaesthetists (ASA) and four individual anaesthetists from New South Wales. In its proceedings instituted in October 1997 the Commission had alleged that unlawful agreements were reached by anaesthetists at three private hospitals to charge $25 per hour for 'on-call' services which ensured an anaesthetist, although not on site, was available for emergency and after hours anaesthetic services at the hospitals.

The Commission had also alleged that on 3 April 1996 certain anaesthetists reached an unlawful agreement to tell the administrators at one of the private hospitals that unless the hospital agreed to pay for the supply of on-call services from 1 May 1996 those anaesthetists would not supply such services (a boycott agreement).

The Commission alleged that in late 1994, the ASA (NSW section) formed a sub-committee to formulate guidelines for the provision of on-call services in private hospitals. A sub-committee report was circulated to members in 1995. It said the ASA should 'recommend and set an appropriate on-call fee to be paid by private hospitals to on-call anaesthetists' and that this fee should be $25 per hour.

It was alleged that the sub-committee's recommendations were endorsed by the ASA (NSW) Committee of Management in September 1995 and further endorsed at the annual general meeting of the NSW ASA in March 1996.

It was alleged that the anaesthetists, through their medical practice companies, arrived at agreements with other anaesthetists to charge a $25 per hour on-call services fee. The Commission also alleged that the ASA and its NSW Chairman induced, or attempted to induce, and were knowingly concerned in, or a party to, one or more of the agreements.

The anaesthetists and the ASA gave undertakings to the Federal Court that they would not engage in fixing, controlling or maintaining prices offered or charged by them for the supply of on-call services, and that they would not enter into agreements having the purpose, effect or likely effect of substantially preventing, hindering or lessening competition in the market for the supply of on-call services.

The ASA also undertook to the Federal Court to develop and implement, at its own expense, a program of compliance with the Act. The program will be based on Australian Standard AS 3806. The Federal Court ordered that the respondents pay $60 000 toward the Commission's costs.

In this case the Commission did not seek penalties as it was the first enforcement action against medical professionals since the competition policy reforms. However, a breach of the undertakings to the court would put the specialists or their association at risk of contempt of court.

The Commission is also investigating whether the arrangements and conduct of a specialist medical college, which determine the number of specialists being trained and may impinge recognition of international qualifications or experience, may be a breach of the competition laws.

Also under investigation for a possible breach of the competition laws is the conduct of

22 See *Hamilton v Whitehead* (1988) 166 CLR 121; *Wheeler, Grace & Pierucci Pty Ltd v Wright & Anor* (1989) ATPR 40-940; *and State of Western Australia v Bond Corporation Holdings Ltd & Ors* (1991) ATPR 41-095 at 52, 535.

various medical professionals and their association in their dealings with a hospital owner. The provisions of concern are price fixing, arrangements that lessen competition and primary boycotts.

The Commission has also received inquiries on the introduction of preferred purchaser schemes by a health insurer. Specifically, concern was expressed that as members who use 'preferred providers' would receive higher rebates than those members who do not, s. 47 of the Act which concerns exclusive dealing may be infringed. The Commission accordingly examined the scheme and sought legal advice with particular reference to s. 47 (6) and (7) of the Act. That advice concluded that the preferred purchaser scheme is unlikely to infringe against those sub-sections. It is important to note that the contract between a health insurer and the insured patient is entered into irrespective of (and without the knowledge of) whether or not the particular insured patient will use the services of a 'preferred provider'. It is also noteworthy that there is no 'discount, allowance, rebate or credit' in respect of the consideration paid or payable for the relevant services to be supplied by the fund. That is, in respect of the premium paid to the health insurance fund for the insurance contract. Given that there are a number of forms of third line forcing conduct the Commission has issued a guideline on authorisation and notification of such conduct. The differing forms of third line forcing conduct and the Commission's concerns and priorities are explained on pages 7 to 18 of the *Guide to the Trade Practices Act for the Health Sector.*

Adjudication

AMA

In its adjudicative role the Commission on 31 July 1998 granted authorisation until 30 June 1999 to the South Australian and Federal Australian Medical Associations. The associations had applied to the Commission for authorisation for the AMA and its members to collectively negotiate and give effect to a fee-for-service agreement for the remuneration of visiting medical officers treating public patients in South Australian rural public hospitals.

South Australia has 65 rural hospitals ranging from some with only one doctor to others with between 25 and 50. There are very few resident specialists in rural South Australia and hospitals arrange periodic visits by specialists to cover their needs. Emergency support for complicated matters is arranged by flying 'recovery' teams from Adelaide or by airlifting patients to Adelaide. A major issue in the South Australian rural medical system is trying to attract doctors. Current estimates indicate that the system is short by between 30 and 40 doctors.

In a draft written determination dated 3 April 1998 the Commission indicated it considered that the fee-for-service agreement had anti-competitive effects because it acted as a price floor for all hospitals in South Australia. Hospitals in regions that have little trouble attracting doctors have to pay the same rate for medical services as those in regions that have difficulty. Sometimes negotiations are conducted to provide doctors with a package over and above that provided by the fee-for-service agreement, but negotiations never result in a discount to the hospitals.

While the Commission agreed that the provision of medical services provides many public benefits, it was not convinced that the fee-for-service agreement was the only method that would produce them. The Commission did, however, recognise that the South Australian Health Commission and the AMA and its members have established collective negotiation techniques. In light of the fact that doctors carrying on their professional businesses in South Australia without incorporating were not subject to the Act until July 1996, the Commission indicated that it recognises some public benefit in allowing the parties to phase in a less regulated system.

MBF — notification

In November 1998 the Commission decided not to take any action to remove the immunity provided to the Medical Benefits Fund (MBF) by the lodgment of a notification of exclusive dealing arrangement (No. N30803) requiring private hospitals to obtain quality accreditation before it would enter into a hospital purchase provider agreement.

The Commission received 31 submissions on the notification and met with interested parties. As a result of the concerns expressed in submissions and discussions with the Commission, MBF amended its notification. Rather than limit quality accreditation to ACHS EQuIP only, MBF proposed the following five criteria which any accreditation scheme should meet.

1. It is health care specific, or able to be adequately modified, and that standards are externally set, covering the continuum of care, leadership and management, human resource management, information management, safe practice and evaluation, and are regularly updated.
2. It involves peer review by an independent external auditor who is clinically trained and accredited as a health care auditor by a national or internationally recognised authorising body.
3. It concentrates on best practice clinical standards, patients and outcomes.
4. It provides mechanisms for internal and external continuous quality improvement and ongoing review of organisational accreditation status.
5. It conducts a nationally coordinated clinical evaluation program for benchmarking, performance evaluation and quality improvement using scientifically tested indicators.

The Commission assessed the notification in light of the amendments made by MBF and decided it was unlikely the public detriment would outweigh the likely public benefit. Accordingly, the amended notification was allowed to stand.

However, the Commission may review this decision if it receives any information leading it to believe that the conduct is not likely to result in a net benefit to the public. The Act specifies that a decision by the Commission to allow a notification to stand may be reviewed at any time.

Five Queensland private hospitals

On 1 September 1999 the Commission granted an application for authorisation by five private hospitals in Queensland to exchange non fee-related information; to exchange fee-related information; and to establish a common agent to facilitate the exchange of aggregated data and to assist in the negotiation of a hospital purchaser provider agreement (HPPA), with private health insurance funds.

The application was lodged by:

- Bundaberg Associated Friendly Societies' Medical Institute trading as the Friendly Society Private Hospital;
- St Andrew's Toowoomba Hospital;
- St Andrew's War Memorial Hospital Brisbane; and
- the Uniting Church in Australia Property Trust (Queensland) trading as St Stephen's Private Hospital in Maryborough and the Wesley Hospital in Brisbane.

On the issue of public benefits claimed by the applicants, the Commission considered there are likely to be some efficiency gains arising from operation of the agreement. These efficiency gains may make the applicants more competitive in the market and even enhance overall competition. The Commission accepted that the applicants will enhance their negotiating position by implementing the inter-hospital agreement (IHA) and that in relation to MBF and Medibank Private this also represents a public benefit. The Commission was of the view that there may be some efficiency gains in using a common agent to negotiate HPPAs, but that these efficiencies could be achieved and are likely to be able to be achieved without entering into the IHA.

The Commission concluded that in all the circumstances the proposed conduct would be likely to result in a public benefit that would outweigh the detriment constituted by any lessening of competition.

The Commission was concerned, however, that certain elements of the proposed agreement were relatively open-ended and was not prepared to authorise the IHA in its current form. The current agreement provided for actions such as adding network members and changing the common agents functions which the Commission believes, if authorised, would give rise to the possibility of the public benefits being negated. It believed that a number of

conditions should be placed on the authorisation to ensure the overall balance of public benefit and detriment is not changed.

Unconscionable conduct between big and small businesses — legal boundaries redrawn by Parliament

Reid Committee Report

In June 1996 the House of Representatives Standing Committee on Industry, Science and Technology (chaired by The Hon. Bruce Reid MP) was asked to investigate and report on major business conduct issues arising out of commercial dealings between firms and the economic and social implications of the major business conduct issues. In his tabling speech the Chairman said:

> The report on the Fair Trading inquiry, *Finding a balance: towards fair trading in Australia* ... may come as a shock to many people who have not been following the inquiry closely over the past year. The Committee has felt compelled to make **strong recommendations** to set some ground rules for what constitutes acceptable commercial conduct in Australia.
>
> One witness suggested to us that, 'It's war out there' between small business and big business. On the balance of evidence to the Fair Trading inquiry, the Committee has concluded that small businesses are regularly being confronted with combative and unfair commercial conduct in their dealings with powerful companies.[23] (original emphasis)

The Reid Committee reported in May 1997. In the report the Chairman stated:

> After a detailed investigation the Committee has concluded that concerns about unfair business conduct towards small business are justified, and should be addressed urgently. In an endeavour to find a balance towards fair trading in Australia, the Committee has recommended a number of specific measures, including legislation, **to induce behavioural change** on the part of big business towards smaller business, and to provide unfairly treated small business with a fair deal.[24] (emphasis added)

23 The Hon. Bruce Reid MP, Chair, House of Representatives Standing Committee on Industry, Science and Technology, tabling speech of report, *Finding a balance: towards fair trading in Australia*, May 1997.

24 *Finding a balance: towards fair trading in Australia* report by the House of Representatives Standing Committee on Industry, Science and Technology, May 1997 at p. vii.

Legislative amendments — 2nd reading speech

The Commonwealth's changes to the Act came in through the *Trade Practices Amendment (Fair Trading) Act 1998* which was assented to on 22 April 1998. The new amendments (including unconscionable conduct in business transactions — s. 51AC and Industry Codes — Part IVB) took effect from 1 July 1998. In the Second Reading speech for the amendment Act the Minister said:

> This government is strengthening the *Trade Practices Act 1974* to better protect the legal rights of small businesses, to ensure that small business can confidently deal with large firms in the knowledge that the rules under which they are operating are fair, and that there will be proper redress available when those rules are broken. By adopting these measure the government will achieve the desired outcomes without unduly impacting on the operation of the open market, compromising the basic principles of contractual relations or creating undue commercial risk, concepts which remain at the core of our free enterprise economy.[25]

And

> ... the government would expect that the vast majority of commercial transactions would not be challenged under the new provisions. The fundamental objective of the government in enacting this provision is, in the [Reid] committee's words, to **'induce behavioural change'** where improved standards of commercial conduct are required and not a mere desire to create a more litigious commercial environment.[26] (emphasis added)

Applying the new unconscionable conduct law (s. 51AC) to the private health sector

The Commission has made it known publicly that this is a priority. It is currently working on three cases (not in the health sector) for which it has alleged a breach of s. 51AC. The Commission has discussed with the Australian Private Hospitals Association and others the possible application of the new law to the private hospital sector. The following is an example of the type of issue that may arise in

25 House of Representatives Hansard 30.9.97 at 8880.

26 House of Representatives Hansard 30.9.97 at 8881.

the private health sector and be investigated by the Commission.

In the course of negotiations between a small private country hospital and a large health insurer, the parties agreed to a range of prices that the hospital could charge for various medical procedures. The contract contained an additional clause that stated that these negotiated prices were subject to any other lower price negotiated with any other user of the hospital facilities. The effect of this clause was that the lowest price the hospital charged became the price available to the health fund. In this case the hospital had no real choice but to accept this additional clause as otherwise its patients would not be covered by the particular health fund if the fund withdrew.

In assessing whether or not the above conduct may be a breach of s. 51AC the following factors may be considered relevant:

- the inequality of bargaining strength of the parties;
- the use of pressure by the stronger party, i.e. the 'take it or leave it' approach to including the lowest charge clause;
- the extent to which the stronger party was willing to negotiate with the weaker party; and
- whether the terms used were reasonably necessary to protect the commercial interests of the stronger party.

The Commission is surprised at the level of acrimony that seems to exist between a private hospital on the one hand and a health insurance fund on the other. One would have thought that the long term survival of private hospitals and health funds would require them to acknowledge their inter-dependence and find strategies that accommodate their mutual interests. Whilst there is truth in the observation that private hospitals are dependent on contracts with health funds for survival – so too health funds are dependant on the existence of private hospital services across a broad geographic area to be able to offer the public (their contributors) a worthwhile health insurance product. It is to be hoped that recognition of these mutual interests will prevail and the sharp practices or acrimonious relationships abate.

Advertising medical services — in whose interests?

There appears to be a belief in some quarters of the medical and health sectors that deregulation of advertising restrictions in specific health legislation brought about at the state and territory level by national competition policy means that 'anything goes' or that it is a regulatory 'free for all'. That simply is not true. The belief suggests a misunderstanding of the legislative review element of national competition policy. It also suggests a misunderstanding or a lack of knowledge of the consumer protection provisions in the Act and its equivalent Fair Trading Acts of the States and Territories.

Conversely, other health professionals are reluctant to employ or see others employ advertising that can only serve to provide consumers with useful information about particular health services and practices.

Medical practitioners, other health care professionals, professional associations and professional advisers need to be aware of consumer protection provisions in the Act and relevant state legislation applicable to the promotion or supply of medical and health services. Unless they are aware of these provisions and relevant case law they risk acting in a way that could lead to litigation. This could be civil or criminal litigation by the Commission or civil litigation by private parties.

Consumer protection provisions of the Act and state/territory equivalents

Provisions in the Act aim to protect consumers in the promotion or supply of medical or health services and ensure that professionals who promote and supply their services lawfully are not unfairly disadvantaged.

Part IVA: Unconscionable conduct

Section 51AB: Unconscionable conduct

51AB (1) A corporation shall not, in trade or commerce, in connection with the supply or possible supply of goods or services to a person, engage in conduct that is, in all the circumstances, unconscionable.

51AB (2) Without in any way limiting the matters to which the Court may have regard for the purpose of determining whether a corporation has contravened sub-section (1) in connection with the supply or possible supply of goods or services to a person (in this sub-section referred to as the 'consumer'), the Court may have regard to:

(a) the relative strengths of the bargaining positions of the corporation and the consumer;

(b) whether, as a result of conduct engaged in by the corporation, the consumer was required to comply with conditions that were not reasonably necessary for the protection of the legitimate interests of the corporation;

(c) whether the consumer was able to understand any documents relating to the supply or possible supply of the goods or services;

(d) whether any undue influence or pressure was exerted on, or any unfair tactics were used against, the consumer or a person acting on behalf of the consumer by the corporation or a person acting on behalf of the corporation in relation to the supply or possible supply of the goods or services; and

(e) the amount for which, and the circumstances under which, the consumer could have acquired identical or equivalent goods or services from a person other than the corporation.

51AB (5) A reference in this section to goods or services is a reference to goods or services of a kind ordinarily acquired for personal, domestic or household use or consumption.

Part V Fair trading, Division 1: Unfair practices

Section 51A: Misleading representation about the future supply and use of goods and services

51A (1) For the purposes of this division, where a corporation makes a representation with respect to any future matter (including the doing of, or the refusing to do, any act) and the corporation does not have reasonable grounds for making the representation, the representation shall be taken to be misleading.

51A (2) For the purposes of the application of sub-section (1) in relation to a proceeding concerning a representation made by a corporation with respect to any future matter, the corporation shall, unless it adduces evidence to the contrary, be deemed not to have had reasonable grounds for making the representation.

Section 52: Misleading or deceptive conduct

52 (1) A corporation shall not, in trade or commerce, engage in conduct that is misleading or deceptive or is likely to mislead or deceive.

Section 53: False or misleading representations

53 A corporation shall not, in trade or commerce, in connection with the supply or possible supply of goods or services or in connection with the promotion by any means of the supply or use of goods or services:

(aa) falsely represent that services are of a particular standard, quality, value or grade;

(bb) falsely represent that a particular person has agreed to acquire goods or services;

(c) represent that goods or services have sponsorship, approval, performance characteristics, accessories, uses or benefits they do not have;

(d) represent that the corporation has a sponsorship, approval or affiliation it does not have;

(e) make a false or misleading representation concerning the need for any goods or services; or

(f) make a false or misleading representation concerning the existence, exclusion or effect of any condition, warranty, guarantee, right or remedy.

Section 55A: Certain misleading conduct in relation to services

55A A corporation shall not, in trade or commerce, engage in conduct that is liable to mislead the public as to the nature, the characteristics, the suitability for their purpose or the quantity of any services.

Part V, Division 2: Conditions and warranties in consumer transactions

Section 74: Warranties in relation to the supply of services

> 74 (1) In every contract for the supply by a corporation in the course of a business of services to a consumer there is an implied warranty that the services will be rendered with due care and skill and that any materials supplied in connection with those services will be reasonably fit for the purpose for which they are supplied.
>
> (2) Where a corporation supplies services other than services of a professional nature provided by a qualified architect or engineer to a consumer in the course of a business and the consumer, expressly or by implication, makes known to the corporation any particular purpose for which the services are required or the result that he or she desires the services to achieve, there is an implied warranty that the services supplied under the contract for the supply of the services and any materials supplied in connection with those services will be reasonably fit for that purpose or are of such a nature and quality that they might reasonably be expected to achieve that result, except where the circumstances show that the consumer does not rely, or that it is unreasonable for him or her to rely, on the corporation's skill or judgment.

Equivalent provisions to those set out above exist in the state and territory Fair Trading Acts. However, in those state and territory provisions the relevant reference is to 'a person' rather than 'a corporation' given that they are not subject to the same Constitutional limitations as the Commonwealth.

Commission's involvement in consumer protection issues in the health sector

Enforcement actions

Over the past few years the Commission has acted in various matters to help protect consumers of health sector services and products.

1. On 8 November 1995 the Commission accepted a court enforceable undertaking from the Medical Benefits Fund of Australia Ltd (MBF) about representations made by MBF in correspondence sent to some of its contributors in September 1995.[27] In particular:

- In correspondence to certain Queensland contributors of MBF (Queensland letter) the following statement was included:

  > You may decide to keep your existing level of hospital cover, however new legislative requirements mean that all members must transfer to our 100% hospital service by July 1997.

- In correspondence to certain South Australian contributors of MBF (South Australian letter) the following statement was included:

  > From 1 July 1997, under new government legislation introduced this year, all health funds will only be able to make available 100% hospital cover. As a result, your current level of hospital cover must be phased out by that date.

- In correspondence to certain New South Wales contributors of MBF (New South Wales letter) the following statement was included:

  > MBF offers Basic Hospital Cover as a legal requirement at present, but by legislation this level of cover will cease as of July 1997. You will therefore be required to transfer to an alternative level of cover by that date.

The Commission reached the view that MBF contravened ss 52 and 53(f) of the Act in that representations in the Queensland letter implied it was a legislative requirement that MBF contributors transfer (or subscribe) to MBF's 100 per cent hospital cover product when, in fact, there was no such legislative requirement.

In October 1995 MBF brought to the Commission's attention:

- the South Australian letter which in the Commission's view contravened ss 52 and 53(f) of the Act by stating that under new legislation health funds will only be able to make available 100 per cent hospital cover; and
- the New South Wales letter which in the Commission's view contravened ss 52 and

27 Undertaking given pursuant to s. 87B of the Act, November 1995.

53(f) of the Act by implying that, as a consequence of legislation, MBF contributors would have to transfer to a hospital cover of a different level from the cover which was then known as 'Basic Hospital Cover'.

MBF admitted its conduct contravened the Act and gave formal undertakings for the purposes of s. 87B of the Act: not to repeat any such conduct; to send corrective notices to affected contributors; to place corrective advertisements in specified newspapers; and to implement a trade practices compliance program.

2. In August 1996 in *ACCC v On–Clinic Australia Pty Ltd & Others* the Commission acted against misleading and deceptive newspaper advertising of impotency treatment services.[28] It obtained declarations that the advertising breached the Act and injunctions to prevent further such representations. It also obtained orders for corrective advertising and orders for On-Clinic to provide refunds to consumers. The issues in the case are discussed in more detail below.

3. In December 1996 in the matter of Proctology Centre of Australia (PCA) the Commission accepted court enforceable undertakings to correct representations made in advertisements and to patients by PCA regarding PCA's treatment of haemorrhoids.[29] The representations included: that the treatment was 100 per cent effective; had minimum discomfort; gave instant relief; and needed only one visit. The Commission had received complaints from patients and PCA acknowledged that: in some cases the treatment may be unsuccessful; some pain and discomfort may be experienced; sometimes more than one treatment was necessary; and that the procedure is new and has not yet been scientifically validated by long-term study. In addition to placing corrective advertisements PCA was also required to stop making the representations to patients and to introduce written instructions to staff to ensure accurate information is given to consumers.

4. In July 1997 in *ACCC v Buyers Network International (BNI) Pty Ltd & Ors* the Commission obtained Federal Court declarations and injunctions against BNI trading as Nu-Life Publications and also against its director Mr Donald James Scott Finlay regarding false and misleading claims in national advertising promoting the following publications: *Foods that make you lose weight* and *Honey, Vinegar & Garlic — Nature's Miracle Trio.*[30]

The orders and declarations were made by Justice Beaumont who granted injunctions to prevent BNI and Mr Finlay from making certain misleading claims about the health and weight loss benefits of honey, garlic and vinegar. These included claims that, by using the products as specified in the books, persons can dramatically increase the rate at which they burn calories and achieve substantial weight loss benefits (doubling their rate of weight loss overnight).

The injunctions granted also restrain the making of representations that particular foods contain 'negative calories', and that the consumption of such foods can produce weight loss by burning up the excess calories in other fattening foods.

Justice Beaumont also ordered BNI to publish corrective advertisements. The widespread nature of the original advertisements meant that the representations had been extensively and regularly advertised in publications, including widely circulated national and state newspapers.

The advertisements were required to offer refunds to any dissatisfied customers who purchased the publications as a result of the advertisements. Refunds would include the initial publication cost, the initial postage and handling charges together with any costs of returning the publications. The court ordered that if BNI did not pay the refunds, they would have to be paid by Mr Finlay.

BNI was also ordered to implement a trade practices compliance program, a component of which was to adopt a complaints handling

28 (1996) ATPR 41-517.

29 Undertaking given pursuant to s. 87B of the Act, December 1996.

30 Federal Court of Australia, NSW No. NG 467 of 1997.

system that complies with Australian Standard AS 4269-1995 (complaints handling).

Mr Finlay was also restrained from participating in the exercise of control of any company solely or jointly where that company has not implemented such a trade practices compliance program.

BNI and Mr Finlay were also ordered to pay the Commission's costs of $10 000 in the proceedings.

5. In November 1997 and December 1997 in *ACCC v Jayco Pty Ltd & Others* the Commission obtained declarations and injunctions for breaches of various consumer protection provisions of the Act.[31] The company was restrained from making claims about:

- *Medex Diet Patch* (a bandaid-like patch impregnated with iodine);
- *Thermoslim* (a wafer said to contain thermogenetic [calorie burning] properties);
- *E-Z Trim* (tablets said to possess thermogenetic properties);
- *Acu-Stop 500* (an earpiece inserted inside the ear operating through acupressure);
- *Chitoslim 5000* (a powder said to bind fat before absorption by the body); and
- a publication on *Negative Calories* (a book claiming that 'negative calories can offset the weight-increasing effect of positive-calorie foods).

Mr David Francis, a promoter, consented to orders restraining him from making unsubstantiated representations about a series of weight-loss products and any other products promoted as methods or aids to slimming in the future.

The Commission worked closely and cooperatively with the Victorian Office of Fair Trading and Business Affairs in its investigation of this matter.

The Commission's case was that the representations made were untrue and that people could not lose the weight claimed in the promotional material by using the products. Further, that the representations about the products are not based on, or supported by, appropriate scientific or other recognised and accepted research or studies.

6. In April and June 1998 in *ACCC v Swiss Slimming and Health Institute Pty Ltd & Others* the Commission obtained declarations, injunctions and refund orders in a representative proceeding on behalf of more than 500 former clients of Swiss Slim.[32] They had been enticed to join the program through 'hard-sell' tactics by Institute staff which often played on individuals' insecurities about their weight.

Orders made by Justice Wilcox on 19 June 1998 required Swiss Slim and its director Mr Gerhard Hassler to pay $1 327 657 by way of compensation and $142 667.66 by way of interest.

The Commission received assistance and cooperation from the New South Wales Department of Fair Trading in investigating the matter.

7. On 26 August 1999 in *ACCC v Giraffe World Australia Pty Ltd & Others*[33] the Commission received judgment from Justice Lindgren of the Federal Court of Australia in respect of promotion by Giraffe World Australia of an 'ion mat'. The Commission had alleged there had been 38 representations about the health benefits of using the mat which were misleading or deceptive and in breach of the Act.

A sample from the 38 representations include:

1) Ion mats discharge negative ions which reduce stress and assist in reducing cancer-causing cells.

2) Negative ions promote health and reduce fatigue and stress thereby helping to prevent cancer-causing cells.

3) The ion mat has received approval from the Ministry of Health in Japan and was a proven therapeutic device.

31 Federal Court of Australia, Victoria No. VG 567 of 1997.

32 Federal Court of Australia, NSW No. NG 482 of 1997.

33 (1999) FCA 1161.

4) The ion mat can cure skin problems.

5) Persons using the ion mat will be stronger and healthier within 3 weeks of using it.

6) The ion mat will cure back problems.

7) The ion mat will reduce the nicotine level in cigarettes.

8) The ion mat when used by elderly people will enable them to arch their back and touch the floor with their hands when they were previously unable to do so.

9) The ion mat acts as a blood purification system.

10) The ion mat assists in the treatment of heart murmur.

11) The ion mat alleviates the symptoms of heart trouble.

12) The ion mat will slow down the progress of AIDS and/or cure AIDS.

13) The ion mat improves people who have had a stroke.

14) The ion mat improves a persons [sic] sex life.

15) The ion mat has a health certificate in Japan and Taiwan.

16) The ion mat had been tested and used in Japanese hospitals for 15 years.

17) The ion mat is being used in nearly all Japanese hospitals.

18) The ion mat can cure asthma.

19) The ion mat emits negative ions.[34]

After a contested hearing Justice Lindgren was satisfied that the representations were made by Giraffe World Australia. The Commission also adduced a considerable body of expert evidence including evidence directed to establishing that there is no credible body of research supporting the proposition that the mat would cure or relieve any particular ailment or health condition or promote good health.

Justice Lindgren concluded as follows:

> GW represented that the Mat emitted negative ions or generated them within the body of a person lying on the Mat. It does not. GW should be restrained from making representations to that effect.
>
> GW represented that there was scientific support for the proposition that the Mat, by means of negative ions, produced and would produce benefits for human health. There is not. GW should be restrained from making such representations.
>
> GW represented that various official bodies supported its claims that the Mat offered the health benefits claimed for it. They do not. GW should be restrained from making representations to that effect.[35]

The Commission is still pursuing this matter in an endeavour to obtain compensation/refunds for former clients. Some 800 clients have been identified. The ion mat was sold for about $3000–$3250 each and it is believed some 8000–9000 people were affected by this conduct. Obviously the adverse financial impact as well as personal disappointment and embarrassment, particularly for any vulnerable client, was enormous. It should be remembered that the promotional conduct in this case was not in newspaper, radio or television advertising — it was essentially by word of mouth.

8. In legal proceedings instituted in July 1999 in *ACCC v Vital Earth Company Pty Ltd & Others* the Commission has alleged that Vital Earth has breached s. 52 and s. 53(c) of the Act through advertisements of complimentary health products known as the Vital Silver 2000 Automatic and Vital Silver 2000.[36] In essence the Commission's allegations deal with representations as to the medical or health benefits of the products advertised. The legal proceedings are currently continuing and defended. The Commission has also joined a director of the company to the proceedings.

9. In legal proceedings instituted in July 1999 in *ACCC v Raylight Pty Ltd & Anor* the Commission alleged a breach of ss 52 and 53(c) of the Act through advertisements of complimentary health products known as the Parasite Zapper and the Colloidal Silver

34 id at para 48.

35 id at paras 171, 172 and 173.

36 Federal Court of Australia, NSW No. N711 of 1999.

Generator.[37] Again the Commission's allegations deal with representations as to the medical or health benefits of the products advertised. The advertisements claimed the Parasite Zapper, by passing an electric current through a person's blood, was able to neutralise HIV and other parasites and could effectively treat various serious medical conditions including HIV, hepatitis and herpes. The Colloidal Silver Generator was stated to be effective in killing intestinal bacteria and viruses, to help AIDS sufferers when used with the Parasite Zapper and to prevent opportunistic infections originating from the stomach and intestines.

In November 1999 Raylight gave undertakings to the Federal Court of Australia not to make further such representations and to provide refunds to persons who may have been misled into purchasing the products. Raylight's director also gave undertakings not to make further such representations.

10. In September 1999 in the matter of a cosmetic services provider the Commission accepted from Beautician's Laser Clinic Pty Ltd (BLC) court enforceable undertakings to correct representations made in newspaper advertisements and to clients that BLC's laser hair removal service:[38]

- was guaranteed progressively permanent;
- resulted in permanent laser hair removal;
- was efficient, cost-effective and resulted in genuine, permanent hair removal;
- was US Food and Drug Administration (FDA) certified for permanent laser hair removal;
- was scientifically shown to be progressively permanent; and
- was a LightSheer EP Permanent Laser Hair Removal System.

The Commission considered the claims to be false and misleading as the laser did not permanently remove hair in all cases and the FDA had certified the laser for permanent hair **reduction** rather than removal.

As well as publishing corrective advertising BLC offered refunds to consumers and undertook to implement a trade practices compliance program.

Role of advertising

Information needs

The health sector in general is characterised by marked differences between the amount of information available to consumers (low information) and service providers (high information). The consequences of this information asymmetry may include the temptation to oversupply services, incentives to decrease overall quality where consumers are not able to judge quality differences well, and the potential for choices by consumers that risk their financial and physical welfare. The reduction in this information asymmetry is central to improving the protection afforded to consumers.

To make an informed decision on whether to purchase health services, particularly elective services such as laser eye surgery or cosmetic surgery, and on choosing a medical practitioner, consumers need information about the service or procedure, including:

- risks, side effects and permanency of outcome, and other aspects of the nature and quality of treatment;
- post-treatment care and complications;
- alternative treatment; and
- charges (including charges of ancillary and add-on services).

In addition to information about the procedure or service, consumers would benefit from more information about medical practitioners, particularly their qualifications and experience. Consumers also need information about alternative procedures so that they are aware of all treatment options available and can make an effective choice.

A recent report on health services notes that the ability of consumers to make informed choices about treatment options and providers is one of the most effective ways of enhancing

37 Federal Court of Australia, NSW No. N712 of 1999.
38 Undertaking given pursuant to s. 87B of the Act, September 1999.

competition in the health care market.[39] The report recommends the publication and dissemination of information about individual medical practitioners (i.e. qualifications, specialty, achievements and any disciplinary proceedings).

Advertising as a source of information

Advertising is one way to provide information on medical services although not necessarily the only way or the most effective. In discussions about advertising one could very easily make an unwarranted assumption that advertising is **always** directed to 'inducing people to buy a product or service'. It is useful to bear in mind the definition of advertising:

> to give information to the public concerning; making public announcement of, by publication in periodicals, by printed posters, by broadcasting over the radio, television, etc.; to praise the good qualities of, in order to induce the public to buy or invest in. *The Macquarie Concise Dictionary* Third Edition

Advertising also enables medical practitioners to take the initiative to make themselves known to prospective patients and provide them with the information they require. Advertising can increase consumers' general awareness of the services that can be provided by medical practitioners, particularly in specialised fields such as cosmetic surgery.

Advertising can be a useful tool for members of professional medical bodies to differentiate themselves in the health sector from other groups of practitioners. Indeed, professional bodies can use advertising to explain to the community the services their members provide and the benefits to be gained from choosing one of their members. Unfortunately to date, most professional bodies or associations in the health sector have not chosen to assist the community to understand through honest, accurate and informative advertising the services their members provide or the benefits of obtaining such services from their members.

The Commission's view is that advertising of cosmetic surgery helps inform the community, therefore enabling consumers to make an informed choice. However, inaccurate, misleading or deceptive advertising does not. While the Commission is keen to see factual information provided to consumers, it is imperative that the information provided is honest and accurate. And it must comply with the relevant provisions of the consumer protection laws.

Problems with restricting advertising

The Commission is aware that some participants in the cosmetic surgery sector are keen to see advertising restrictions re-introduced. The Commission has some concerns about any restrictions on advertising that extend beyond those in the Act and the state Fair Trading Acts.

Restrictions on advertising in the past have often required the application of subjective criteria. In practice these criteria may be used to inhibit, or may have the effect of inhibiting, information promotion by health practitioners and thus become an anti-competitive tool. For example, the NSW Medical Practice Regulations 1993 provided that advertising of medical services should not, among other things:

a) be vulgar or sensational; or

b) claim or imply that any particular medical practitioner is superior to another or other medical practitioners; or

c) be unprofessional or likely to bring the profession into disrepute.

Three interpretation problems are common with such restrictions. First, there may not be an accepted community understanding of what amounts to a contravention of these restrictions. Second, there is no guarantee that the profession's interpretation of such requirements is the same as the community interpretation. Third, there is no guarantee that there will be a consistent understanding among the members of a profession about what the restrictions mean.

The vagueness of subjective advertising restrictions also makes consistent and fair enforcement difficult. Such restrictions and their application need to be interpreted according to particular examples. Often, it will

39 *Health Services Policy Review*, discussion paper prepared by Phillips Fox and Casemix Consulting, March 1999, p. 120.

be the relevant industry association that will assess compliance and it may be heavily influenced by established health professionals. These may not welcome the introduction of practitioners with a different approach to promoting or marketing their services. Thus the criteria may be interpreted in a way that results in their acting as a barrier to competition.

In addition, restrictions on advertising have often included highly prescriptive criteria for presentation. In some States, medical rules have required advertisements to be of a defined size, typeface and content. The Commission's view is that such restrictions are costly to enforce and do not provide benefits to consumers proportionate to those costs.

Restrictions have also applied to the medium by which advertisements for medical services could be made. For example, the NSW Medical Practice Regulation 1993 prohibited medical practitioners from advertising their services by television or radio.

Restrictions on the form and content of advertising material beyond the prohibitions in the Act may prevent consumers from receiving useful information about particular health services and practices. Such restrictions also make an unnecessary paternalistic assumption that everyone in the community effectively receives and understands information from the same form or medium of advertising.

Misleading or deceptive conduct can be far broader than just advertising. Even if advertising for cosmetic surgery is stopped, problems would remain with misleading or deceptive oral representations (for example, during a consultation in a surgery or clinic). Consumers may still not be given adequate information about the nature or the price of the service, and whether a particular practitioner is adequately qualified.

Restricting advertising will not prevent misleading or deceptive conduct by unethical practitioners. It will, however, prevent ethical practitioners informing consumers about their services and others from informing consumers about purchasing health services generally, particularly elective medical/health services.

Health services are now widely advertised over the Internet. Even if restrictions on advertising for medical services were imposed in one State, this would not prevent consumers from viewing Internet advertising, from practitioners based in another State. Authorities in the first State will have little control over this advertising.

Finally, complaints about treatment can constitute the major category of complaints about particular medical services. Restricting advertising will not address this problem of inadequate practice and treatment.

Case law on some key issues

Applying the Act to medical advertising and other promotional activity raises issues such as:

- the meaning and significance of words like 'only', 'ever' and 'guaranteed';
- whether silence can constitute misleading or deceptive conduct;
- the importance of the duty of disclosure so that a patient's consent to treatment is based on relevant information and advice; and
- the extent to which a professional promotional activity can be characterised as being 'in trade or commerce'.

The most effective way to understand contemporary interpretation of these questions is to consider some recent case studies.

Some key words and phrases

In *ACCC v On-Clinic Australia Pty Ltd & Others* the court held that the Commission had made out its case that five groups of representations made by On-Clinic were misleading and deceptive on a fair and reasonable reading.[40] The representations were made in newspaper advertisements and related to the efficiency, costs, comparative advantages of treatment and advice preferred by the respondents' clinics for men suffering from impotence. The representations were as follows:

a) 'The ONLY Impotence Treatment **Ever** Proven to Work!'; or 'improve your SEX LIFE with the ONLY impotency treatment EVER proven to work';

40 (1996) ATPR 41-517.

b) 'Bulk Billing. (No charge to you only Medicare)'; or 'All visits 100% Bulk Billed. Medicare (No cost to you)';

c) '4 treatment programmes with GUARANTEED RESULTS, in just 2 visits ...'; or '... can be diagnosed and treated by medical doctors in only 2 consultations';

d) '4 treatment programmes with GUARANTEED RESULTS ...'; or 'PROVEN AND GUARANTEED to work'; and[41]

e) 'Diagnosis using unique medical equipment'.

In reaching the conclusion that the respondents' conduct was misleading and deceptive Justice Tamberlin made the following comments which are instructive:

> The words 'only' and 'ever' are quite unequivocal and admit no exceptions.[42]

As to costs for the patient and to the efficiency or speed of outcome:

> In relation to the representation concerning bulk billing, it was said that if the representation was read as relating to the cost of consultations only, then it was correct, but if it was read to include the costs of the course of treatment, in addition to consultations, then it was false.
>
> In my view, a reasonable and indeed the more likely construction of the words 'without any charge to the patient' or 'at no cost' would be that the total treatment is at no costs to the patient. There is no suggestion that the clinics' services are **partly** 'at no costs'. The words 'no costs' like the word 'free' have a certain allure and will almost always attract a strong favourable attention to a product or service. It is said the same observations apply in relation to the claims that impotence is capable of effective treatment in just four programs; with guaranteed results after only two visits; and the further claims that it could be **successfully** treated by medical doctors in only two consultations.[43] (emphasis in original)

As to the 'guaranteed' claim:

> The reference to 'guaranteed' strongly connotes the certainty of a positive result and the assertion that successful treatment can be effected in **'only'** two consultations reinforces this message. While there is a large component of truth in these assertions, they are nevertheless capable of being read in such a way as to be misleading and deceptive.
>
> The evidence indicates that in a high percentage of cases, the treatment is successful. Nevertheless, the reference to the treatment being 'guaranteed' travels beyond the truth and is therefore false and likely to deceive or mislead.[44] (emphasis in original)

As to the use of the expression **'unique** medical equipment':

> The final representation relates to the use by the first respondent of the expression **'unique** medical equipment'. It is pointed out that if this is read to mean unique medical equipment in an unqualified sense, then it is false because the equipment known as the 'duplex doppler' is to be found in most radiology practices or vascular diagnostic laboratories to which patients may be referred for testing. However, if it is construed to mean 'unique' to impotency clinics, then it is said that the representation is true.
>
> The word **'unique'** on its ordinary meaning denotes exclusivity and, in my view, it is therefore likely to deceive or mislead if read in a fair and reasonable manner. Although the statement appears in an advertisement concerning impotency clinics, nevertheless it asserts that these clinics have some equipment which is not otherwise available. There is no qualification nor is there anything in the language used to vary the literal meaning. It would have been a simple matter to qualify the advertisement but, no doubt, this would detract from its efficiency in attracting attention.
>
> Accordingly, the applicant has made out its case that each of the misrepresentations is misleading and deceptive on a fair and reasonable reading.[45] (emphasis in original)

In defending the case the respondents had argued to the court that the representations set out at (b)–(e) above were ambiguous and that if they were 'read one way they were true, but if read in another way, although they had a "core of truth", they had "a misleading aspect to them".' As to the defence argument of ambiguity Justice Tamberlin said as follows:

41 id at pp. 42, 456.
42 id at pp. 42, 457.
43 id at pp. 42, 457-458.
44 id at pp. 42, 457-458.
45 id at pp. 42, 458.

> Language which can reasonably suggest either a true proposition or a false one can come within the ambit of misleading conduct. It has been held, for example, that a statement that a product will relieve pain will be misleading if it relieves only one type of pain but not another: see *Grove Laboratories v Federal Trade Commissioner* (1969) 418 F2d 489.

See also the remarks of Hill J in Tobacco *Institute of Australia Ltd v Australian Federation of Consumer Organisations* (1993) ATPR ¶41-199 at 40, 793; (1992) 38 FCR 1 at 50, where his Honour said:

> Where, as in the present case, the advertisement is capable of more than one meaning, the question of whether the conduct of placing the advertisement in a newspaper is misleading or deceptive conduct, must be tested against each meaning which is reasonably open. This is perhaps but another way of saying that the advertisement will be misleading or likely to mislead or deceive if any reasonable interpretation of it would lead a member of the class, who can be expected to read it, into error: *Keehn v Medical Benefits Fund of Australia Ltd* (1977) ATPR ¶40-047 at 17, 523; ...[46]

Justice Tamberlin also made a general statement which is well worth bearing in mind:

> If it is sought to attract public attention and custom by the use of **unqualified** assertions of fact, then such assertions should be true as a matter of fact, if they are not to mislead and contravene the norms of conduct prescribed by the Act.[47] (emphasis in original)

Silence as misleading or deceptive conduct

It should be appreciated that silence can also amount to misleading or deceptive conduct for the purposes of the Act. A useful summary of the instances in which silence can amount to misleading or deceptive conduct is set out as follows in a recent judgment of Justice Merkel:

> Silence, without more, would not normally constitute conduct. However, putting to one side the vexed question of a duty to disclose, silence has been recognised as justifying a claim of misleading and deceptive conduct in two situations. The first situation is where it is an element, in all the circumstances of a case, which renders the conduct in question misleading or deceptive: see *Commonwealth Bank of Australia v Mehta* (1991) ATPR ¶41-103 at p. 52, 601; (1991) 23 NSWLR 84 at 88 per Samuels JA and *Demagogue Pty Ltd v Ramensky* (1993) ATPR ¶41-203 at p. 40, 844; (1992) 39 FCR 31 at 32 per Black CJ and at 40–41 per Gummow J. For example, where the relevant conduct involves the supply of goods or services in circumstances where there is an omission to impart information relating to a particular quality or aspect of the goods or services, silence may be the element which renders the conduct in question misleading or deceptive. Such an omission might occur where a product is supplied to a consumer who, to the knowledge of the supplier, dedicates its manufacturing process to that supply on the basis of its continuity, and the supplier fails to inform the consumer that it cannot provide continuity of supply. The conduct in question in that example is not silence alone; it is supply of the product in circumstances in which the failure to inform might render the supplier's conduct misleading and deceptive. The example given is of conduct, involving silence, which is capable of, and therefore may be properly pleaded as, constituting misleading and deceptive conduct.
>
> The second situation is where silence alone constitutes misleading and deceptive conduct. That situation arises by reason of the extended definition of 'conduct' in s. 4(2) of the Act which provides that, for the purposes of the Act, 'conduct' includes a refusal to do any act and refraining from doing that act otherwise than where the refraining was inadvertent. However, in this situation there must be an element of intent in the refusal to do, or the refraining from doing, the act in question: see *Costa Vraca Pty Ltd v Berrigan Weed & Pest Control Pty Ltd* (1998) 155 ALR 714 at 722 per Finkelstein J and the authorities there cited. In substance, the authorities referred to by his Honour require that the silence be intentional or deliberate.[48]

Medical practitioner's duty of disclosure

In relation to the provision of medical services the 'vexed question of a duty to disclose' referred to by Justice Merkel does arise of course. In Australia, the High Court's 1992 decision in *Rogers v Whitaker* makes clear that except in the case of an emergency or where disclosure would prove damaging to the patient, a medical practitioner has a duty to

46 id at pp. 42, 457.
47 id at pp. 42, 458.
48 *Johnson Tiles Pty Ltd & Ors v Esso Australia Ltd & Anor* (1999) ATPR 41-696 at pp. 42, 888.

warn the patient of a material risk inherent in proposed treatment.[49] A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. Whilst the case was one dealing with the liability of a medical practitioner for negligence, the following comments in the joint judgment of Chief Justice Mason and Justices Brennan, Dawson, Toohey and McHugh are very instructive.

> The duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment is a single comprehensive duty. However, the factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors. Examination of the nature of a doctor–patient relationship compels this conclusion. There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession. *Whether* a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; *whether* the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment. Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information.[50] (citations omitted)

Professional's promotional or other activities — 'in trade or commerce?'

The issue which then arises is whether promotional activity by a professional or other professional activity can be characterised as being conduct 'in trade or commerce' for the purposes of the Act and the state and territory Fair Trading Acts. A reference to a couple of cases readily identifies the relevant issues and outcomes.

In *Bond Corporation Pty Ltd v Thiess Contractors Pty Ltd & Others* Justice French made the following comments.[51]

> The express inclusion of 'work of a professional nature' in the definition of services and the use of that term in s. 53 to qualify the area of 'trade or commerce' to which the section applies, suggests very strongly that the words 'trade or commerce' as used in the Act are intended to apply to the provision of professional services.
>
> This view is reinforced by the observations of the Trade Practices Review Committee in its 1976 report on the operation and effect of the Act (the Swanson Report).
>
> The submission had been put to the committee that professionals should not be regarded for trade practices purposes as a part of the

49 (1992) 175 CLR 479.

50 id at 489-490.

51 (1987) ATPR 40-771.

business community. The committee reported on that proposition at para. 10.31 and 10.35:

10.31 The Committee has already expressed its view that the Act should apply in a general fashion to those in the community engaged in trade or commerce. We regard as unrealistic the proposition that members of the professions are not part of the business community.

... Division 1 of Pt V sets certain minimum standards of business conduct. Most, if not all, professions impose equal, if not stricter, standards upon their members. We see no reason why these provisions should not apply to the professions nor would we expect its application to cause the professions any concern.[52]

His Honour then considered the concept of a profession in the following terms.

The scope of 'trade or commerce' can be considered against the concept of 'profession' to determine whether there is anything about the latter that excludes it from the former.

The word 'profession' is descriptive of a class of occupations. The membership of that class is not rigid or static but shifts with general community perceptions — *Bradfield v F.C. of T.* (1942) 34 CLR 1 at p. 7 per Isaccs J.

Whether a person carries on a profession in a given case is a question of degree and always of fact — *Robbins Herbal Institute v F. C. of T.* (1923) 32. CLR 457 at p. 461 per Starke J.

It has been said that the word involves the idea of an occupation requiring either purely intellectual skill or else manual skill controlled, as is painting and sculpture or surgery, by the intellectual skill of the operator as distinct from an occupation which is substantially the production or sale or arrangement for the production or sale of commodities — *I.R. Commrs v Maxse* (1919) IKB at p. 651.

The concept has created difficulties for social scientists. Theoretical definitions by reference to the crucial characteristics of professions are said to have resulted in ' ...a confusion so profound that there is even disagreement about the existence of the confusion' — *Professions and Power* — T J Johnson, Macmillan, 1972 at p. 22.

One suggestion for definitive criteria includes the existence of a requirement for formal technical training accompanied by some institutionalised mode of validating both the adequacy of the training and the competence of the trained individual. The training, it is said, must lead to some order of mastery of a generalised cultural tradition in a manner giving primacy to an intellectual component. Skills in some form of the use of the tradition must be developed and there must be some institutional means of ensuring that the skills will be put to socially responsible uses — Parsons, *Professions* (1968) 3 International Encyclopaedia of Social Sciences cited in Partlett, *Professional Negligence* at p. 3.

A recent paper in the *Modern Law Review* speaks of 'a specific historical formation in which the members of an occupation exercise a substantial degree of control over the market for their services, usually through an occupational association' — Abel, R L, *The Decline of Professionalism* (1986) 49 MLRI.

The literature on the subject is evidently substantial and reflects conflicts on proper approaches to definition.

That question may never be satisfactorily resolved for all purposes.[53]

In conclusion Justice French said:

However, where the conduct of a profession involves the provision of services for reward, then in my opinion, even allowing for widely differing approaches to definition, there is no conceivable attribute of that aspect of professional activity which will take it outside the class of conduct falling within the description 'trade or commerce'.

This conclusion flows from both the judicial exposition and the particular statutory context of that term.

It follows that the provisions of s. 52 are applicable to the giving of professional advice by a consulting engineer and nothing flowing from the characterisation of that occupation as a profession prevents their application.[54]

In *Prestia v Aknar* Justice Santow of the Equity Division of the Supreme Court of NSW discussed at some length the extent to which professions and professional activity is subject

52 id at 48, 384-48, 385.

53 id at 48, 385-48, 386.
54 id at 48, 386.

to the provisions of s. 42 of the Fair Trading Act of NSW (which is identical to s. 52 of the Trade Practices Act).[55] For present purposes the following comments by Justice Santow are useful:

> In so embracing professions and professional activity in s. 42 of the Act, at least to the extent of not precluding their inclusion merely by reason of their professional character, I am satisfied that references to profession and professional activity at the least include the traditional categories of medicine, dentistry and the law.[56]

In summing up Justice Santow set out a number of conclusions. The following three should be borne in mind:

> ... The Act is to govern dealings in the course of those activities or transactions, *including* professional activities, but only those which, of their nature, bear a trading or commercial character.
>
> ... Whether a particular occupation or activity is that of a 'profession' or 'professional activity' is a question of fact and degree. Professional activity refers at least to the particular activity which a member of a profession would characteristically carry out and which is in fact so carried out by that member as such a professional. It may thus not refer to that activity carried on by someone pretending to be in that profession but who is not; however, I do not need to decide that question and refrain from doing so. Activities thus excluded from the professional may still, depending on the facts, be business activity.
>
> ... The narrower interpretation in 2 above may embrace the distinction between the actual exercise of intellectual skills, typically represented by pure advice on the one hand, and on the other, a representation about either the product of that intellectual skill or the practice which generates it. The former would fall outside s. 42, there being no relevant representation with pure advice, at least in the typical case. The latter would be capable of inclusion in trade or commerce, if it inherently bears the necessary trading or commercial character. But even 'pure' advice may carry with it an express or perhaps implied representation about the basis for the opinion, such as that it was given 'after due enquiry', which may, in appropriate circumstances and depending on the terms and subject matter of the advice, bring it within the second category if otherwise satisfying the tests for being in trade or commerce.[57]

The issue of whether or not services rendered by a professional are in trade or commerce was also considered by Professor Bernard McCabe in an article entitled 'Revisiting Concrete Constructions'[58] which discussed the 1990 High Court decision of *Concrete Constructions (NSW) Pty Ltd v Nelson* which sought to rein in the operation of s. 52 of the Act.[59] In a helpful discussion and analysis of the issue in relation to professionals, Professor McCabe's following comments are instructive.

> If one examines the conduct of a professional carefully, it is possible to discern two different species of act. There is first the exercise of the intellectual skill, which is typically expressed in the form of advice to the client. Then there are the representations about the advice and the adviser that are essentially made to promote the business of providing the intellectual skill. It follows that one may distinguish between the commercial activity of providing the advice (and the representations made in relation to it) and the actual content of the advice.
>
> While the professional relationship clearly bears a trading or commercial character in that a service is provided for reward, the content of the service falls outside the central conception of trade and commerce. In other words, the advice is the product: misrepresentations that are made in relation to it in order to induce the client to enter into the professional relationship will clearly be conduct in trade or commerce. The content of the advice, however, will relate to some other matter distinct from the professional relationship. Where a doctor gives a diagnosis, for example, her or his advice relates to the illness in question and does not bear at all upon the terms of the commercial relationship between doctor and patient (although where the doctor recommends a course of treatment that would require the patient to extend the commercial relationship to include the additional service, the advice does go directly to matters of trade or commerce). So, too, with lawyers: where the lawyer advises a client on an appropriate structure for their business, the

55 (1996) *ATPR Digest* 46-157.
56 id at 53, 338.
57 id at 53, 344.
58 (1995) 3 *Trade Practices Law Journal* 161.
59 (1990) 169 CLR 594.

> lawyer is rendering advice that relates to matters of trade, but which do not directly relate to the terms of the commercial relationship between lawyers and client.[60]

Finally, it should be borne in mind that a new sub-section 6(4) was added to the Act in 1986 which applied ss 52, 53 and 55A (as well as the other provisions in Division 1 of Part V) of the Act, in the Territories, to the promotional activities of individuals engaged in a professional activity. The concern seemed to be that the then established interpretation of 'trade or commerce' excluded certain professional business activity.

The Commission welcomes and supports the legislative changes that have lifted the restrictions on the freedom of medical and other professionals to communicate directly with consumers through advertising. The changes provide a genuine opportunity for medical and health sector professionals to take a major role in informing and educating the public about the services they provide and how members of the public should select the appropriate medical or health care practitioner. The Commission encourages medical and health care professionals to provide members of the public with honest, accurate and complete information to enable them to make informed decisions about choosing the right professional and/or consenting to the treatment or service to be provided.

There are significant information imbalances between consumers and medical or health services providers. It is likely also that advertisements or other promotional activity may be seen by people who are in a vulnerable state (for example, because they are suffering from an ailment or condition) as well as by people who are not. Therefore, it is imperative that advertising or other promotional activity complies with the law, especially the consumer protection laws. This is particularly so given the potential adverse consequences of some forms of medical treatment or services.

To minimise the risk of legal action it is essential that medical and health care professionals properly understand the legal obligations of their advertising or other promotional activities. There are risks of being taken to court by private parties. Where there is evidence to establish a serious breach of the consumer protection provisions of the Act (or state and territory equivalents), medical and health sector professionals are also at risk of facing any one or more of the following non-exhaustive consequences through legal proceedings by the Commission (or other relevant agency):

- court orders restraining the medical or health service provider from engaging in specified conduct;
- court orders requiring the medical or health service providers to do specified things, for example, place corrective advertisements or notices;
- court orders declaring that specified conduct is in breach of the Act;
- court orders recording findings of fact for use as prima facie evidence in subsequent litigation (for example for compensation by private parties);
- court orders requiring the advertising, offering or payment of refunds and/or compensation;
- court orders recording a criminal conviction against the medical or health service provider for breach of some of the consumer protection provisions of the Act;
- court orders requiring the medical or health service provider to pay a fine (a maximum of $200 000 for a body corporate or $40 000 for an individual); or
- court orders requiring the medical or health service provider to pay the Commission's costs.

In addition there would be the time, stress, embarrassment and the medical or health service provider's own legal expense associated with the legal proceedings.

Some future issues

Turning to the future, apart from the various investigations and applications for authorisations, what are some of the key issues

60 (1995) 3 *Trade Practices Law Journal* 161 at 174.

for the private health sector from the Commission's perspective?

I think there are three matters worth noting. The first is the Government's announcement to introduce legislation for no gaps and known gaps insurance. The details of proposed legislation allowing for no gaps and known gaps insurance are yet to be finalised. Whether the legislation should or should not be introduced and the reasons proffered for those viewpoints, and whether the legislation will result in pro-competitive gains, are matters of policy. That is, a matter for the Government. The Commission's aim is to achieve compliance with the requirements of the Act. This will be the thrust of our attention to the proposed legislation.

Second, there has been a variety of dialogue between health insurance funds, private hospitals, the Health Minister's office, the Commonwealth Department of Health and Aged Care, the Consumer Affairs Division of Treasury and the Commission on the nature of the negotiations for the HPPAs between the health funds and individual private hospitals. The possibility of a voluntary or mandatory code of conduct governing the manner in which HPPAs are negotiated is being considered. The outcome of that process may well be significant for the future of the private health sector.

Third, as part of the legislative amendments introducing the Government's recent 30 per cent rebate for health insurance the Australian Senate passed an order moved by Senator Harradine:

> That there be laid on the table as soon as possible after the end of each period of 6 months, commencing with the 6 months ending on 31 December 1999, a report by the Australian Competition and Consumer Commission containing an assessment of any anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses.

Conclusion

The debate in Australia about applying competition laws and competition policy to the health sector continues to rage. For example, the following extract from a submission is indicative.

> The Australian Doctors' Fund has been an outspoken critic of the application of National Competition Policy primarily, but not solely on the delivery of health care.[61]

By way of contrast one could consider the following.

> ... providers would have to please patients rather than governments or insurance companies. A market-driven system would develop in which providers competed for patients in the ways providers have always competed: higher quality and lower costs. There are two possible scenarios for the future of health care in Australia. We can continue more of what we are doing now: increasing controls, decreasing choice, limiting access, lengthening waiting lists and increasing costs. Or, we can organise a system in which health services are provided for profit and purchased by consumers. We have tried government controls and they have failed. It is time to make the market save the health system.[62]

Medical professionals and others in the health sector enjoy the fruits of competition in other sectors of the economy. The Australian community can legitimately expect the professional and health sectors of the economy, in respect of the 'business activities' dimension of a professional's practice of a profession or health care services delivery:

- to be subject to the same laws and procedures for obtaining immunity for anti-competitive conduct as all other businesses; and
- to contribute to the Australian economy the fruits of competition that other sectors of the business community (including government businesses) are expected to provide.

The Commission has already taken action for anti-competitive conduct and for misleading or deceptive conduct or other breaches of the consumer protection laws in the medical and

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61 Australian Doctors' Fund submission to the Productivity Commission Inquiry into the Impact of Competition Policy Reforms on Rural and Regional Australia – P.C. Submission No. 105 – 20 November 1998.

62 Professor Steven Schwartz, vice-Chancellor, Murdoch University, Perth, Western Australia, 'Cough up for a better quality of mercy – Want a cure for the health system? Try the market', *The Australian*, Thursday, 14 January 1999 at p. 9.

health sector. In doing so the Commission is seeking to fulfil Parliament's overall objective underpinning the Act namely, to enhance the welfare of Australians through the promotion of competition and fair trading and provision for consumer protection. Health issues are currently a priority in the Commission's work. In view of the possible unfamiliarity with advertising and the fact that the consumer protection laws apply to the advertising and other promotional activities of professionals, including medical or health sector professionals, the Commission urges professionals, professional associations and advisers to take action to ensure compliance with both the competition and consumer protection laws.

NOTES

For example, Rule 34 **Medical Rules** 1987 under the *Medical Act 1894 (Western Australia)* provides s. 34 (1) Subject to subrule (2), a medical practitioner shall not cause or permit an advertisement to be published in connection with his practice as a medical practitioner except in accordance with Schedule 2. (2) Where the Board is of the opinion that by reason of the isolation of an area, the unavailability of newspapers or postal services or both the Board may approve of advertising by means other than those referred to in clauses 1 and 2 of Schedule 2. Schedule 2 provides in part as follows: (1) An advertisement shall not occupy more than a 5 centimetre wide column or equivalent space. (2) The printing of the advertisement shall be: 'run on' without spacing or display of uniform type for the name and other particulars in the typeface used for non-display advertisements (3) The content of the advertisement shall state only: (a) with respect to medical practitioners — (i) the name of the medical practitioner and if the practice is carried on in association with other medical practitioners the names of the other medical practitioners; (ii) the address of his practice or, if more than one, then each of those addresses; (iii) the telephone number of each practice and the telephone numbers to be called after hours; (iv) the title 'doctor' or such other title indicating that the person is a medical practitioner that is approved by the Board; (v) the languages spoken by the medical practitioner; (vi) the hours of attendance provided by the medical practitioner. (b) the commencement of a practice — the extension of a practice to a new area — the resumption of practice — the closure of a practice for any period exceeding 30 days — the resumption of a practice after any period exceeding 30 days — the change of address of a practice — the sale of a practice, as the occasion or circumstances requires.

(4) An advertisement shall not appear in more than 2 newspapers circulating in the area of the practice. (5) An advertisement shall not appear in more than five consecutive daily issues of a newspaper. Also see Chiropractors Registration Board Rules 1966 made under the *Chiropractors Act 1964 (Western Australia)* which includes: s. 10C(2) A chiropractor shall not: tout or canvas for patients pay, or offer to pay, commission for the introduction of new patients practice, or offer to practice, for donations in lieu of fees depart from his scale of fees and charges except bona fide necessitous cases.