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Dr Richard Chadwick
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Dear Dr Chadwick

RE: AUSTRALIAN DENTAL ASSOCIATION INCORPORATED APPLICATION FOR AUTHORISATION A91094 & A91095 – INTERESTED PARTY CONSULTATION

Thank you for your letter to the South Australian Dental Service (SADS) dated 25 July 2008 regarding an application by the Australian Dental Association Incorporated (ADA) seeking authorisation from the Australian Competition and Consumer Commission (ACCC) for possible price fixing conduct and exclusionary provisions with respect to shared practices in the dental profession.

You have invited a submission on the likely public benefits, the effect on competition or any other public detriment from the proposed arrangements.

Effect on competition or any other public detriment

In 2005, there were around 850 dentists in South Australia (SA), with around 650 of these working in the private sector. Due to significant demand for public dental services and insufficient public sector dentists to meet this demand, SADS purchases around $5 million worth of dental services annually from the private sector, which is significant. Services purchased consist of emergency general restorative and denture services. SADS is concerned that any significant reduction in the genuine competition available within the private sector may impact negatively on the future cost of purchasing those services.

Most private dentists set their own fees against a standard suite of items contained in the *Australian Schedule of Dental Services,* which is published by the ADA. SADS sets its own prices that it will pay to purchase dentistry from the private sector. These are based on the *Department of Veterans' Affairs Local Dentist Officer Fee Schedule.* Although these prices are typically lower than fees set by private dentists, in metropolitan areas, SADS is currently able to meet its required needs from the private sector. This is not always the case in rural and remote areas, where there is a recognised national dental workforce shortage.

On 1 July 2008, two Australian Government dental initiatives came into operation, both of which are likely to increase demand in both the public and private dental sector.

Under the first of these initiatives, the Teen Dental Plan, the Australian Government will issue vouchers to parents of teenagers aged 12-17 years in families in receipt of the Family Tax Benefit A or in receipt of ABSTUDY. The voucher allows for check-ups and preventative care with either private dentists or public dental services. Under this eligibility criterion, vouchers will be issued for around 87% of teenagers in this age bracket. Medicare will pay public dental providers (who must bulk bill) and those private dentists who chose to bulk bill up to $150 for a single item which covers a range of examination and preventative services. For services provided by private dentists who do not bulk bill, eligible teenagers or parents of eligible teenagers can claim a rebate of $150 from Medicare.

The second of these initiatives, the Commonwealth Dental Health Program will provide State and Territory public dental services with additional funding over three years to cover a range of public dental services and help clear the backlog of people waiting for public dental treatment. Of this funding, in 2008-09, SADS anticipates that it will spend around $5 million towards providing additional general restorative and denture services to public clients. SADS plans to purchase a significant proportion of these additional services from the private sector.

The Teen Dental Plan may reduce the capacity of private dentists to treat public dental clients, including under the Commonwealth Dental Health Program. There are a number of reasons for this. Work required by dentists under the Teen Dental Plan is likely to be less complex than the restorative and denture services required for adult public clients. It is anticipated that around 50% of teenagers who are provided dental services under this plan will require no further dental work past their check-up, making this a quick, straightforward and lucrative service item for private dentists.

SADS anticipates that the extra demand for private dental services as a result of both the Teen Dental Plan and the additional funding provided to SADS under the Commonwealth Dental Health Program will result in reduced capacity of private dentists to treat public dental clients. It is anticipated that this reduced capacity will occur in some areas of metropolitan SA and to a much larger extent in rural and remote SA, where SADS already experiences difficulty in purchasing private dental work.

Any significant reduction in competition in the private dental sector that may result from price fixing conduct coupled with this increased demand for dental services in the private sector could impact negatively on the future costs to SADS of purchasing services from the private sector. This would in turn affect the ability of SADS to meet its public dental needs from the private sector, particularly in rural and remote areas.

Likely public benefits

The ADA's submission to support its application for authorisation makes a number of assertions around the public benefits of allowing dentists and dental specialists in shared practices to agree fees to be charged to patients of their practices.

It is asserted at clause 4.1 of the submission that "[a] shared practice cannot exist without the ability to agree on fees to be charged by the practice". SADS questions this assertion, given that there exists and has existed for a number of years, shared practices that have not agreed on common fees. The ADA's submission also contradicts its own assertion, stating at clause 3.10(e) that shared practices are already one of various business structures used in private practice. It also states in clause 3.14 that in the ADA's Dental Practice Survey undertaken in 2005, 20% of private practices who responded indicated that they had some form of "associate relationship" (i.e. shared practice). These shared practices clearly did not have common fee agreements in place.

It is noted, that clauses 4.2 – 4.9 mostly list the benefits of shared practices rather than the benefits of allowing common fees to be agreed in these practices. Benefits listed include improved availability of dental services for patients, continuity of patient care, quality of dental services available as a result of teamwork and shared care, increased range of services available to patients in the one location and increased productivity and efficiency in the provision of dental services resulting from shared practice costs.

While SADS agrees that shared practice arrangements benefit clients and the shared practices in these ways, SADS notes that these arrangements are already widespread, without common fee agreements in place. It is questionable whether shared practice arrangements that allow these benefits to occur also require a common fee to be charged.

As an example, at clause 4.7, the ADA's submission mentions an Australian Institute of Health and Welfare report which considered that increases in productivity are more likely to be achieved in larger dental practices where there are favourable circumstances for expansion, and economies of scale. While this is acknowledged, SADS believes that the charging of a common fee is irrelevant. An increase in the productivity of a dental practice gained through economies of scale does not rely on a common fee agreement.

Thank you for the opportunity to comment on the ADA's application.

Yours sincerely

DR TONY SHERBON
Chief Executive

18 / 8 / 08

Att. Ms Ilona Balint, Adjudication Branch, Australian Competition and Consumer Commission