MinterEllison
LAWYERS

5 September 2008

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Ms Ilona Balint
Australian Competition and Consumer Commission
GPO Box 3131
CANBERRA ACT 2601

Dear Ms Balint

Australian Dental Association applications for authorisation A91094 and A91095

We refer to Dr Chadwick's letter dated 22 August 2008 and thank the Commission for the opportunity to respond to the submissions received from interested parties relating to this application for authorisation.

Please find attached the Association's response to the submissions lodged by SA Health and the Centre for Oral Health Strategy, New South Wales.

We note the Commission's request for further information relating to the provisions of the Act in respect of which authorisation is sought. Authorisation is sought with respect to an exclusionary provision (Form A) to ensure that any agreement with respect to fees within a shared practice could not potentially constitute a provision of a contract, arrangement or understanding between practitioners which is said to have the purpose of restricting or limiting the supply of dental services to patients in particular circumstances or on particular conditions, namely, other than in accordance with the agreed fee schedule.

As the conduct covered by both Form A and Form B is the same, the submissions made by the Association apply to both applications.

If you have any further questions, please do not hesitate to contact Justin Oliver on (07) 3119 6322.

Yours faithfully
MINTER ELLISON

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AUSTRALIAN DENTAL ASSOCIATION INC

SUBMISSION IN RESPONSE TO SUBMISSIONS LODGED BY THIRD PARTIES IN RELATION TO THE APPLICATION FOR AUTHORISATION UNDER SECTION 88(1) OF THE TRADE PRACTICES ACT 1974 (CTH)

1. Introduction

1.1 On 18 July 2008, the Association lodged two applications for authorisation with the Australian Competition and Consumer Commission (**ACCC**) in relation to the making of or giving effect to contracts, arrangements or understandings between two or more dentists and/or dental specialists who practice in a shared practice as to fees to be charged for dental services provided in the practice (**Applications**). It also lodged a submission in support of the Applications (**Submission**).

1.2 The Applications were lodged on behalf of members who are general practice dentists and dental specialists, current and future, who practice in a shared practice.

1.3 On 28 July 2008, the ACCC wrote to interested parties and invited submissions in relation to the Applications by 15 August 2008.

1.4 The ACCC received five submissions from:

(a) Rural Dental Action Group;

(b) Dental Practice Board of Victoria;

(c) Centre for Oral Health Strategy, New South Wales;

(d) South Australia Health; and

(e) Dental Board of Queensland.

1.5 By letter dated 22 August 2008, the ACCC wrote to the Association inviting comments on the submissions lodged by interested third parties. These are the Association's submissions.

2. South Australia Health

Public benefit

2.1 In its submission dated 18 August 2008, South Australian Health (**SA Health**) stated that *'there exists and has existed for a number of years, shared practices that have not agreed on common fees'*. The Association notes that shared practices currently in existence typically take the form of partnerships. The Association is seeking authorisation for its members to set fees for shared practices that may include, *but are not limited to*, a partnership structure.

2.2 A partnership is a particular type of legal relationship in which participants share revenue, costs and (most significantly) liability for the acts and omissions of their fellow partners. This potential liability for a partner's actions is a limitation on the extent to which shared practices are utilised in Australia. A practitioner may be willing to share revenue and costs with another practitioner, but may be unwilling to accept the potential liability for that practitioner's actions, either as a partner or employee. This limitation stands in the way of the use of the shared practice structure.

2.3 The authorisation, if granted in the terms sought, will encourage the further use of the shared practice structure. This will, in turn, result in the expansion of the public benefits associated with shared practice identified in the Association's original

submission. For example, a practitioner who is able to join a shared practice will be able to:

(a) share many of the costs of establishing a practice with the other practitioners in the shared practice. This is of particular relevance in rural and regional areas where:

(i) costs are a potential barrier to establishing a new practice; and

(ii) there is currently a severe shortage of practitioners;

(b) offer a better quality of care to patients as a result of:

(i) being able to take advantage of the knowledge and expertise of fellow practitioners in the shared practice;

(ii) having access to facilities that the practitioner would be unable to acquire if practising alone; and

(c) offer this higher quality of care at a lower cost to patients, since costs will be shared with other practitioners.

2.4 SA Health questioned whether 'a common fee' is required in order to produce the benefits identified in paragraphs 4.2 to 4.9 of the Association's Submission. SA Health suggests that these are the benefits of a shared practice rather than the benefits of allowing common fees to be charged by those practices.

2.5 This ignores the basic proposition that it is unrealistic to expect a shared practice to exist without having a single schedule of fees charged by the practice. The Association, in paragraph 2.3 of its Submission, outlined the typical features of a shared practice. It is of course possible that one or more of these features might exist without agreeing on fees. Individual practitioners could, for example, share premises. However, paragraph 2.3 describes what is, in substance, a single dental practice (especially from the perspective of the patient). It is a contradiction in terms to expect dentists to share the costs and responsibilities for patient care described in paragraph 2.3, and yet to compete with each other on fees with a view to, among other things, winning patients from fellow practitioners in the shared practice.

2.6 As noted above, to the extent that shared practices already exist, with common fees being charged, they are typically structured as partnerships. However, as also noted above, the partnership structure limits the attractiveness of shared practice and the associated public benefits, the existence of which are acknowledged by SA Health.

Detriment to the public

2.7 While it is not clear whether SA Health contends that the authorisation *will* result in a lessening of competition, the Association submits that:

(a) there will be little, if any, lessening of competition as a result of granting the application; and

(b) even if there is some lessening of competition, it would be outweighed by the benefits to the public associated with an increase in shared practice.

2.8 The Association reiterates that the Application relates only to conduct *within* shared practices. It will not adversely affect competition *between* dental practices. A

lessening of competition would only be expected to result if, in the absence of the authorisation, a dentist who wished to establish him or herself in a shared practice instead:

(a) operated in a shared practice, but competed with his or her colleagues on fees; or

(b) established him or herself as a sole practitioner.

2.9 As noted above, the first proposition is a contradiction in terms.

2.10 The second proposition is unlikely to occur in rural and regional areas, where there is currently a severe shortage of dentists. In the absence of the authorisation, the greater likelihood is that a dentist will not establish a practice at all in a rural or regional area.

2.11 Even if a dentist, who is denied the opportunity to practice in shared practice, instead establishes him or herself as a sole practitioner, the dentist will be unable to offer the same range, quality and cost of care that could be offered in a shared practice. This means that even if there is a lessening of competition as a result of the expansion of the shared practice structure, that same expansion will result in an increase in the public benefit associated with the shared practice structure that would outweigh any detriment to the public.

2.12 The conduct that is sought to be authorised will increase the opportunities for practitioners to operate in a shared practice, making it easier for practitioners to offer a greater range and higher quality of services to patients. In the future without the authorisation, it does not follow that dentists will offer the same range or quality of services in competition with each other.

2.13 SA Health also expressed its concern that *'any significant reduction in competition in the private dental sector that may result from price fixing conduct coupled with ... 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'.*

2.14 While SA Health has recognised that there is a shortage of dental services, it has not recognised that the authorisation will help increase the availability and range of dental services, especially in rural and regional areas where the shortage is most acute. The authorisation will increase the availability of dental services to meet the increased demand predicted by SA Health. Any potential for practitioners in a shared practice to increase fees in dealing with government purchasers of dental services (such as SA Health) will be offset by the bargaining power of State and Federal Governments in the acquisition of dental services.

3. Centre for Oral Health Strategy, New South Wales

3.1 In its submission dated 15 August 2008, the Centre for Oral Health Strategy, New South Wales asserted that *'the evidence presented of a beneficial impact for the public in this application is not strong'.* It stated *'in the absence of such evidence, a mechanism be put in place to measure performance in achieving the claimed public benefits'.*

3.2 The Association submits that the public benefits associated with the conduct to be authorised are self evident and that the test for authorisation is satisfied without the need for on-going performance measures. The expiry of the authorisation in 5 years will provide an opportunity to review the public benefits and detriments (if any) associated with the authorisation.