MinterEllison
LAWYERS

14 December 2012

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Australian Competition and Consumer Commission
GPO Box 3131
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Attention: Luke Griffin (luke.griffin@accc.gov.au)

Dear Mr Griffin

Australian Dental Association: Authorisation applications A91340 and 491341 – Interested Party Submissions and Request for Further Information

Thank you for your letter of 27 November 2012. We respond as follows on behalf of the ADA.

1. Comments on submissions received by the ACCC

1.1 As noted in your letter, the ACCC has received four submissions on the ADA's application. The ADA provides the following comments on these submissions.

1.2 The ADA notes with interest that the SA Dental Service supports the application, recognising that there may be potential public benefit, and that there is no apparent public detriment, in granting an extension of the existing arrangement. This is noteworthy as the same body, in commenting on the ADA's authorisation application in 2008, expressed concerns that the conduct might impact negatively on the future costs of purchasing services from the private sector, affecting the ability of the SA Dental Service to meet its public dental needs from the private sector, particularly in rural and remote areas. The more recent comments in relation to the current application for authorisation suggest that these fears have not materialised.

1.3 The only other submission the ADA wishes to comment on is the submission received from the Consumers Health Forum of Australia (**CHF**). The ADA notes that the CHF is not opposed, in principle, to the concept of intra-practice price setting by dental practitioners, but has expressed concern in relation to the supporting material presented by the ADA, arguing that it is unclear whether the decline in the rate at which fees are increasing is attributable to shared practices.

1.4 As noted in the ADA's application, the benefits associated with shared practices are largely qualitative in nature, and it is difficult to quantify the benefits of this structure through statistical evidence. Nevertheless, the ADA considers that the data presented to the ACCC is consistent with the propositions that shared practices reduce cost pressures by allowing participating dental practitioners to share fixed and common costs, and make it easier for practitioners to offer a wider range of facilities and services to patients. We have produced below comments from a number of dental practitioners which support this proposition.

1.5 The ADA also notes the CHF's comments in relation to the application of the authorisation to dentists who are not members of the ADA. The ADA comments on this in section 3 below.

2. Request for Further Information

2.1 The ACCC has requested further information on two topics:

(a) In light of concerns that the authorisation would only apply to ADA members, please provide details of annual membership fees and any other factors that are relevant to the accessibility of ADA membership.

(b) In the ACCC's 2008 Final Determination A91094-5, the ACCC requested that, should the ADA request reauthorisation, the ACCC would expect the ADA to provide examples of where the conduct had been implemented and demonstrate the benefits/detriments of the conduct to assist the ACCC in considering:

- the availability and cost of dental services, particularly in rural and regional areas and
- public expenditure on dental care through the purchasing of services from private clinics (paragraphs 6.66 and 6.67).

The ACCC requests with some specific examples or case studies regarding the areas outlined above to demonstrate how the authorisation has resulted in a public benefit.

2.2 The ADA's response to both of these requests is set out below.

3. Details of annual membership fees and any other factors that are relevant to the accessibility of ADA membership

3.1 In relation to the concerns expressed by the CHF, the ADA makes the following comments.

3.2 The application of the authorisation to members of the ADA does not impact upon the balance of the benefits and potential detriments associated with the conduct that is the subject of the application. The ADA is the peak body representing dentists in Australia, representing over 90% of the dentists practising in Australia. In so far as the conduct for which authorisation is sought results from the members of the ADA operating in shared practices, those benefits are widespread.

3.3 The ADA is not opposed to the authorisation extending more widely. However, it is not clear that the ADA has standing to apply for authorisation on behalf of any dentist who is not a member of the ADA. This is the reason why the ADA sought authorisation only on behalf of its members.

3.4 In relation to the ACCC's specific request for information, the ADA responds as follows.

3.5 The ADA is comprised of a national body and a series of State and Territory branches. Applicants for membership make their application to their State or Territory Branch. The Branch then determines if the applicant qualifies for membership. In the vast majority of cases membership is granted, although in some cases an applicant's past experience with the relevant registration authority or a breach of the ADA by-laws or code of conduct might mean an application is unsuccessful.

3.6 Fees vary from branch to branch. For example, the annual fee in NSW/ACT is $1286; in Victoria it is $964; and in Queensland it is $890. Members pay an additional fee of $660 per annum for the national body. Reduced fees are payable by dental students.

4. Information regarding the availability and cost of dental services (particularly in rural and regional areas) public expenditure on dental care through the purchasing of services from private clinics

4.1 The ADA has been provided with comments from a number of dental practitioners in regional areas which support the claims made by the ADA in the application for authorisation. These comments are set out below.

(a) Dr Wayne Ottaway (Launceston, Tasmania)

Dr Ottaway is practices in a shared practice in Launceston.

This practice has five dentists and has been in existence since 1946. It has grown from a sole practice to now having five dentists with nine surgeries. A dental laboratory is also associated with the dental surgery.

Most dentists in Launceston are employed in group practices. Dr Ottaway believes this helps reduce upward pressure on fees.

In this shared practice, dentists can reduce costs to patients and offer a more complete range of services by investing in better and more advanced equipment. This is particularly important in an area such as Launceston, since a wider of range of services alleviates the need for patients to travel to Hobart or Melbourne for treatment or scans. The dentists in Dr Ottaway's practice can take 3D x-rays, place implants and perform major oral surgery, with sedation if required. These services would be prohibitively expensive for a dentist in sole practice, but are less expensive if the necessary equipment is amortised over the whole group.

Each dentist in this practice has his or her own area of interest, be it oral surgery, orthodontics, dentures, cosmetic or children implants. This means dentists can and do refer patients to other practitioners within the within the practice.

The other benefits of operating within a shared practice are summarised by Dr Ottaway as follows:

- Shared premises
- Shared reception
- Team of staff
- One computer record system
- One account and payment
- Never closed if one dentist is away, always someone available
- Shared sterilisation area
- Shared compressor, suction, amalgam separator
- Shared waste collection including sharps and medical waste
- Ability to share cost of 3D dental imaging x-ray machine

- Extensive range of surgical instruments
- ECG and pulse oxymeter monitoring equipment
- Full range of services
- Emergencies covered
- Peer review and support
- Associated dental laboratory

Dr Ottaway considers it is necessary to have a common fee structure within the one practice. For example, patients often travel from remote areas in family groups, as it is more efficient for the children to receive treatment from one dentist (eg orthodontics), while parents are seeing other dentists at the same time. In this context, it is not feasible to suggest that dentists can or would differentiate on fees. Similarly, if one dentist is absent and a patient is seen by another dentist in the same practice, then that patient has a reasonable expectation of the range of fees.

Dr Ottaway's practice also provides visiting dental services to Flinders Island. When one dentist visits Flinders Island, charges are the same as for patients in Launceston. A dentist in a sole practice would be unable to provide such a service without closing his or her regular surgery. Yet because the fixed costs associated with the regular surgery are still incurred, the patients on Flinders Island would have to pay a premium to cover those extra costs.

Dr Ottaway confirmed that, as a group, his practice does not discuss fees with any other dental practice.

(b) Dr John Gibson (Sale, Victoria)

Dr Gibson practices in a shared practice in Sale.

Dr Gibson's practice utilises a service provider which delivers services and operating facilities to practitioners at reduced cost, as the service provider is able to manage staff and purchase consumables at lower cost. Operating in a shared practice also gives Dr Gibson access to facilities that he would not normally have as a sole practitioner. His practice has, for example, a shared OPG machine, as well as access to in-house training programmes and training facilities.

Although Dr Gibson does set some of his fees individually, the shared practice has a largely common fee structure. This allows consistency in the event that one practitioner commences a course of treatment and another has to finish it. The shared practice is also able to offer a wider range of expertise to patients in the community.

(c) Dr Ron Blake (Mareeba, Queensland)

Dr Blake practices in a shared practice in Mareeba.

Dr Blake considers that practicing in a shared practice enables him and his colleagues to reduce costs for staff, as well as compliance costs such as practice accreditation. Other items, such as practice management software, also become more affordable.

Dr Blake's practice has been able to negotiate more favourable deals on materials and other services, such as utilities and banking, because of their increased scale. They have also been to share the large capital cost of major items of equipment, such as an OPG machine and lasers.

The ability to lower their costs relieves upward pressure on fees and enables the practice to offer a wider range of services. This further lowers costs to patients since it lessens the need for patients to travel to receive dental care.

4.2 While this is only a small sample of dentists practising in a shared practice structure, these comments support what the ADA believes to be quite apparent - the shared practice structure increases the ability of dentists to share (and thereby reduce) costs, putting downward pressure on fees and enabling shared practices to offer a wider range of services. In so far as this reduces the cost of providing dental services, it also increases the ease with which public dental services can be acquired from private practitioners.

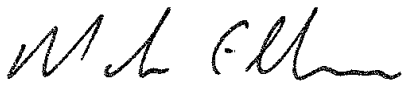
4.3 As set out in the supporting submission, authorising dentists to operate in a shared practice without having to incorporate or enter into partnership increases the extent to which these benefits can flow to patients. As previously stated, from the patient perspective it is not realistic to expect dentists to operate in a shared practice structure without the ability to agree on fees, hence the need for authorisation.

5. Conclusion

5.1 We trust this information is of assistance to the ACCC. The ADA would be happy to provide further information if required. The ADA would also be happy to provide contact details for the practitioners who have provided the above comments should the ACCC wish to make contact with them directly.

If you have any questions please contact Justin Oliver on (07) 31196332.

Yours faithfully
MINTER ELLISON



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