AUSTRALIAN SOCIETY OF OPHTHALMOLOGISTS INC

SUBMISSION IN SUPPORT OF THE APPLICATION FOR AUTHORISATION UNDER SECTION 88 (1A) and (1) OF THE COMPETITION AND CONSUMER ACT 2010 (CTH)

Form B

Commonwealth of Australia

Competition and Consumer Act 2010 — subsections 88 (1A) and (1)

AGREEMENTS AFFECTING COMPETITION OR INCORPORATING RELATED CARTEL PROVISIONS: APPLICATION FOR AUTHORISATION

To the Australian Competition and Consumer Commission:
Application is hereby made under subsection(s) 88 (1A)/88 (1) of the *Competition and Consumer Act 2010* for an authorisation:

- to make a contract or arrangement, or arrive at an understanding, a provision of which would be, or might be, a cartel provision within the meaning of Division 1 of Part IV of that Act (other than a provision which would also be, or might also be, an exclusionary provision within the meaning of section 45 of that Act).

- to give effect to a provision of a contract, arrangement or understanding that is, or may be, a cartel provision within the meaning of Division 1 of Part IV of that Act (other than a provision which is also, or may also be, an exclusionary provision within the meaning of section 45 of that Act).

- to make a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would or might have the effect, of substantially lessening competition within the meaning of section 45 of that Act.

- to give effect to a provision of a contract, arrangement or understanding which provision has the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of that Act.

  (Strike out whichever is not applicable)

PLEASE FOLLOW DIRECTIONS ON BACK OF THIS FORM

1. Applicant

(a) Name of Applicant:
(Refer to direction 2)

A91360

Australian Society of Ophthalmologists Incorporated (ASO)

(b) Short description of business carried on by applicant:
(Refer to direction 3)

The ASO is the peak medico-political organisation for ophthalmologists within Australia.

(c) Address in Australia for service of documents on the applicant:

Mr Kerry Gallagher
CEO, ASO
Office 6,
The Green House
183 Wickham Terrace
Brisbane QLD 4000

2. Contract, arrangement or understanding

(a) Description of the contract, arrangement or understanding, whether proposed or actual, for which authorisation is sought:
(Refer to direction 4)

Please refer to Schedule 1

(b) Description of those provisions of the contract, arrangement or understanding described at 2 (a) that are, or would or might be, cartel provisions, or that do, or would or might, have the effect of substantially lessening competition:
(Refer to direction 4)

Please refer to Schedule 1

(c) Description of the goods or services to which the contract, arrangement or understanding (whether proposed or actual) relate:

Ophthalmic services, please refer to Schedule 1 for further details.

(d) The term for which authorisation of the contract, arrangement or understanding (whether proposed or actual) is being sought and grounds supporting this period of authorisation:

The authorisation is being sought for a period of 5 years.

3. Parties to the proposed arrangement

(a) Names, addresses and descriptions of business carried on by other parties or proposed parties to the contract or proposed contract, arrangement or understanding:

Please refer to Schedule 1

(b) Names, addresses and descriptions of business carried on by parties and other persons on whose behalf this application is made:
(Refer to direction 5)

Please refer to Schedule 1

4. Public benefit claims

(a) Arguments in support of authorisation:
(Refer to direction 6)

Please refer to Schedule 1

(b) Facts and evidence relied upon in support of these claims:

Please refer to Schedule 1

5. Market definition

Provide a description of the market(s) in which the goods or services described at 2 (c) are supplied or acquired and other affected markets including: significant suppliers and acquirers; substitutes available for the relevant goods or services; any restriction on the supply or acquisition of the relevant goods or services (for example geographic or legal restrictions):
(Refer to direction 7)

The market is defined by regional and metropolitan markets for the supply of ophthalmology services to patients in Australia.

6. Public detriments

(a) Detriments to the public resulting or likely to result from the authorisation, in particular the likely effect of the contract, arrangement or understanding, on the prices of the goods or services described at 2 (c) and the prices of goods or services in other affected markets:
(Refer to direction 8)

Please refer to Schedule 1

(b) Facts and evidence relevant to these detriments:

Please refer to Schedule 1

7. Contract, arrangements or understandings in similar terms

This application for authorisation may also be expressed to be made in relation to other contracts, arrangements or understandings or proposed contracts, arrangements or understandings, that are or will be in similar terms to the abovementioned contract, arrangement or understanding.

(a) Is this application to be so expressed?

No

(b) If so, the following information is to be furnished:

(i) Description of any variations between the contract, arrangement or understanding for which authorisation is sought and those contracts, arrangements or understandings that are stated to be in similar terms:
(Refer to direction 9)

Not applicable

(ii) Where the parties to the similar term contract(s) are known — names, addresses and descriptions of business carried on by those other parties:

Not applicable

(iii) Where the parties to the similar term contract(s) are not known — description of the class of business carried on by those possible parties:

Not applicable

8. Joint Ventures

(a) Does this application deal with a matter relating to a joint venture (See section 4J of the *Competition and Consumer Act 2010*)?

No

(b) If so, are any other applications being made simultaneously with this application in relation to that joint venture?

Not applicable

(c) If so, by whom or on whose behalf are those other applications being made?

Not applicable

9. Further information

(a) Name and address of person authorised by the applicant to provide additional information in relation to this application:

Mr Kerry Gallagher
CEO, ASO
Office 6,
The Green House
183 Wickham Terrace
Brisbane QLD 4000
Telephone: (07) 3831 3004
Email: kerry@vgcs.com.au

Dated **26 February 2013**

Signed by/on behalf of the applicant

(Signature)

Mr Kerry George Gallagher
(Full Name)

Chief Executive Officer ASO
(Position in Organisation)

DIRECTIONS

1. Use Form A if the contract, arrangement or understanding includes a provision which is, or might be, a cartel provision and which is also, or might also be, an exclusionary provision. Use Form B if the contract, arrangement or understanding includes a provision which is, or might be, a cartel provision or a provision which would have the purpose, or would or might have the effect, of substantially lessening competition. It may be necessary to use both forms for the same contract, arrangement or understanding.

   In lodging this form, applicants must include all information, including supporting evidence, that they wish the Commission to take into account in assessing the application for authorisation.

   Where there is insufficient space on this form to furnish the required information, the information is to be shown on separate sheets, numbered consecutively and signed by or on behalf of the applicant.

2. Where the application is made by or on behalf of a corporation, the name of the corporation is to be inserted in item 1 (a), not the name of the person signing the application and the application is to be signed by a person authorised by the corporation to do so.

3. Describe that part of the applicant's business relating to the subject matter of the contract, arrangement or understanding in respect of which the application is made.

4. Provide details of the contract, arrangement or understanding (whether proposed or actual) in respect of which the authorisation is sought. Provide details of those provisions of the contract, arrangement or understanding that are, or would or might be, cartel provisions. Provide details of those provisions of the contract, arrangement or understanding that do, or would or might, substantially lessen competition.

   In providing these details:

   (a) to the extent that any of the details have been reduced to writing, provide a true copy of the writing; and

   (b) to the extent that any of the details have not been reduced to writing, provide a full and correct description of the particulars that have not been reduced to writing.

5. Where authorisation is sought on behalf of other parties provide details of each of those parties including names, addresses, descriptions of the business activities engaged in relating to the subject matter of the authorisation, and evidence of the party's consent to authorisation being sought on their behalf.

6. Provide details of those public benefits claimed to result or to be likely to result from the proposed contract, arrangement or understanding including quantification of those benefits where possible.

7. Provide details of the market(s) likely to be affected by the contract, arrangement or understanding, in particular having regard to goods or services that may be substitutes for the good or service that is the subject matter of the authorisation.

8. Provide details of the detriments to the public which may result from the proposed contract, arrangement or understanding including quantification of those detriments where possible.

9. Where the application is made also in respect of other contracts, arrangements or understandings, which are or will be in similar terms to the contract, arrangement or understanding referred to in item 2, furnish with the application details of the manner in which those contracts, arrangements or understandings vary in their terms from the contract, arrangements or understanding referred to in item 2.

Introduction

1. The Australian Society of Ophthalmologists Incorporated (**ASO**) is the peak medico-political organisation representing ophthalmologists.

2. The ASO is a national organisation representing members in all States and Territories. Membership is voluntary and over 60% of ophthalmologists in Australia are members. Membership figures in all states include:

State	Ordinary Member	Senior Member	Trainee Member	Retired Member	Total
ACT	5	0	0	1	
NSW	178	2	8	6	
QLD	94	1	7	1	
SA	38	1	1	1	
VIC	99	3	7	1	
TAS	7	0	0	0	
WA	46	0	0	0	
TOTAL	467	7	23	10	**507**

3. The objects for which the ASO is established are:

   3.1 to promote, represent, and secure the interests in relation to medico-political and medico-industrial issues of all ASO members within Australia;

   3.2 to represent members' patients in relation to public and private care, and Medicare issues that may arise due to Federal or State government policy, legislation and/or regulation;

   3.3 to provide advice and information to individual members on industrial issues, and identify appropriate representation if necessary or required; and

   3.4 to provide business development and business improvement advice to members.

Background

4. Approximately 10.5 million Australians have at least one vision problem. Persons aged 55 years and over made up 43.5% of all persons with eye diseases and disorders (AIHW 2009).

5. The Eye health labour force in Australia consists of health professionals including ophthalmologists, ophthalmic nurses, optometrists, and orthoptists and tradespersons (AIHW 2009).

6. General Practitioners and optometrists also play a crucial role in the delivery of eye health care in Australia, particularly in the referral pathway to ophthalmologists for specialist eye care.

7. Ophthalmologists are specialist medical practitioners who specialise in eye-related disease, injuries and deficiencies. Ophthalmologists are also known as eye specialists or eye surgeons (AIHW 2009).

8. Those Ophthalmologists who hold Fellowship of the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) and are registered with the Australian Health Practitioners Regulatory Authority (AHPRA) are eligible to practice ophthalmology within public and private settings.

9. Ophthalmologists may undertake further sub-speciality training in areas of uveitis, medical retina, surgical retina, glaucoma, paediatrics/strabismus, neuro ophthalmology, ocular plastics/orbit and ocular oncology. Complex cases requiring diagnosis and or treatment in these subcategories are often referred to sub-specialists in these areas.

10. In 2006 the average age of ophthalmologists was 52 years.

The Application

11. This application for authorisation is made by the ASO on behalf of current and future ASO members who are registered ophthalmologists who practice in a "shared practice".

12. Shared practices generally consist of the following:

    12.1 Two or more ophthalmologists;

    12.2 Shared staff including receptionists, orthoptists, nurses, assistants and ophthalmology trainees;

    12.3 Shared treatment of patients;

    12.4 Shared patient records;

    12.5 Shared practice name trade mark and logo;

    12.6 Shared premise;

    12.7 Shared equipment and supplies; and

12.8 Joint advertising.

13. Other shared practices may also have:

13.1 Common patient administrative systems and procedures and fee collection, and other financial functions;

13.2 Common policies and procedures for workplace relations and staff management; or

13.3 Common service entity.

14. Results from a recent ASO survey of members revealed that 65 % of ophthalmologists were operating within a shared practice. Shared practices are quite common and are becoming increasingly popular in both regional and capital cities (ASO, 2012). There are various reasons for this, including:

14.1 Shared practice arrangements help to ease the cost burden on practitioners. It provides a mechanism which allows ophthalmologists to start practicing with a reduced capital outlay and to exit practicing in a more controlled fashion than if the practitioner were working as a sole practitioner, for example.

14.2 Whilst trading through a partnership is an alternative to trading in shared practice, partnership models are often considered undesirable for various reasons, including joint medico legal liability and business costs/profit attribution difficulties.

15. Shared practices generally comprise of approximately three ophthalmologists as per a recent survey of members' practices (ASO, 2012).

16. Shared practices do not generally grow to involve more than six to eight practitioners. Practices with more than this amount of practitioners tend to put a strain on the shared practice model, as a result of the higher number of patients that are drawn in.

17. The authorisation relates to the discussion of and, if relevant, the making of or giving effect to contracts, arrangements or understandings between two or more ophthalmologists who are members of the ASO and practice in a shared practice as to the fees to be charged for ophthalmology services provided in the practice (**Proposed Conduct**).

18. The Proposed Conduct will be voluntary.

19. The ASO seeks authorisation of the Proposed Conduct for a period of five years.

The Market

20. The relevant markets for the provision of specialist ophthalmology services falls within localised geographic regions.

Supply of Ophthalmology Services

21. As of 30 June 2012 there were 812 practicing ophthalmologists in Australia — refer to Table 1 below (RANZCO 2012).

22. In 2006 approximately 80% of eye health workers worked in major cities (AIHW 2009). This figure is closely reflected in the results provided by RANZCO figures of practicing ophthalmology specialists in Australia.

23. Approximately 67% of Australians with eye disorders lived in major cities (AIHW 2009).

24. There is significantly shorter supply of ophthalmology services in regional areas, especially in remote and indigenous areas of Australia.

25. The numbers of practicing ophthalmologists in each State and Territory in 2012 are outlined in Table 1.

Table 1

Practicing Ophthalmologists in Australia per State/Territory (RANZCO, 2012)

	STATE								**TOTAL**
AREA	NSW	ACT	NT	VIC	QLD	SA	WA	TAS	
Metro*	246 *(76%)*	12 *(100%)*	3 *(75%)*	168 *(87%)*	73 *(54%)*	52 *(84%)*	52 *(75%)*	8 *(57%)*	614 (76%)
Non-Metro**	76 *(24%)*	0 (0%)	1 *(25%)*	26 *(13%)*	62 *(46%)*	10 *(16%)*	17 *(25%)*	6 *(43%)*	198 (24%)
TOTAL	322	12	4	194	135	62	69	14	**812**

*Metro= practicing within a 10km radius of a major capital city

**Non-Metro= practicing outside a 10km radius of a major capital city

26. Demand for the health workforce is increasing due to population growth, an ageing population and cultural and linguistic diversity. Reports predict the percentage of Australia's population over the age of 70 will account or 21.1 % by the year 2021, compared to just 8.3 % in 1996. The growth of those aged 85 years and over is projected to be even more significant growing by more than 60% between 2006 and 2016 (KPMG 2009).

27. Burden of disease has multiple and interrelated impacts on demand for health services, including increasing prevalence of chronic conditions such as diabetes (KPMG 2009).

28. Diabetes is a risk factor for a variety of eye diseases and disorders, especially diabetic retinopathy, cataracts and glaucoma. The prevalence of those diagnosed with diabetes has more than doubled in the last decade. In particular, 37.4% of Indigenous adults are reported to have diabetes and 13% of those with diabetes have vision impairment (Taylor 2009).

29. Overall low vision in Indigenous adults is 2.8 times the rate of the general population and the rate of blindness in Indigenous adults is 6.2 times higher than the general population (Kelaher, M., Ferdinand, A., Ngo, S., Tambuwla, N. and Taylor, H, R. 2010).

30. The ageing population and the increase in prevalence of chronic disease such as diabetes are likely to lead to an increase in demand for eye health professionals, including ophthalmology services, in the foreseeable future (AIHW 2009).

31. Surgical advancements have also led to greater demand for effectiveness of care, in particular surgical interventions and reduction in average length of stays in hospitals. Public demand for best available care and demand by medical practitioners for the best technologies to assist patients have both increased. Surgical advancement and the growing use of medical technology depend on having access to appropriately trained medical professionals, such as surgeons, theatre nurses and technicians. Having a developmental culture and work environment in which advancement and best practice is encouraged as part of day to day practice with support from qualified and experienced practitioners and trainers is also fundamental to providing the best available care. The increase of the number of specialists has facilitated growth of new procedures and treatments. The main link between surgical and technological advancements and requisite benefit to the community is the accessibility and proportion of well-trained specialists available to perform those procedures.

32. The resulting implication for changing technologies is a greater demand for sub-specialisation. However, it is noted that a degree of flexibility will always be required in developing workforce supply solutions with ongoing technology and procedural advancements (KPMG 2009).

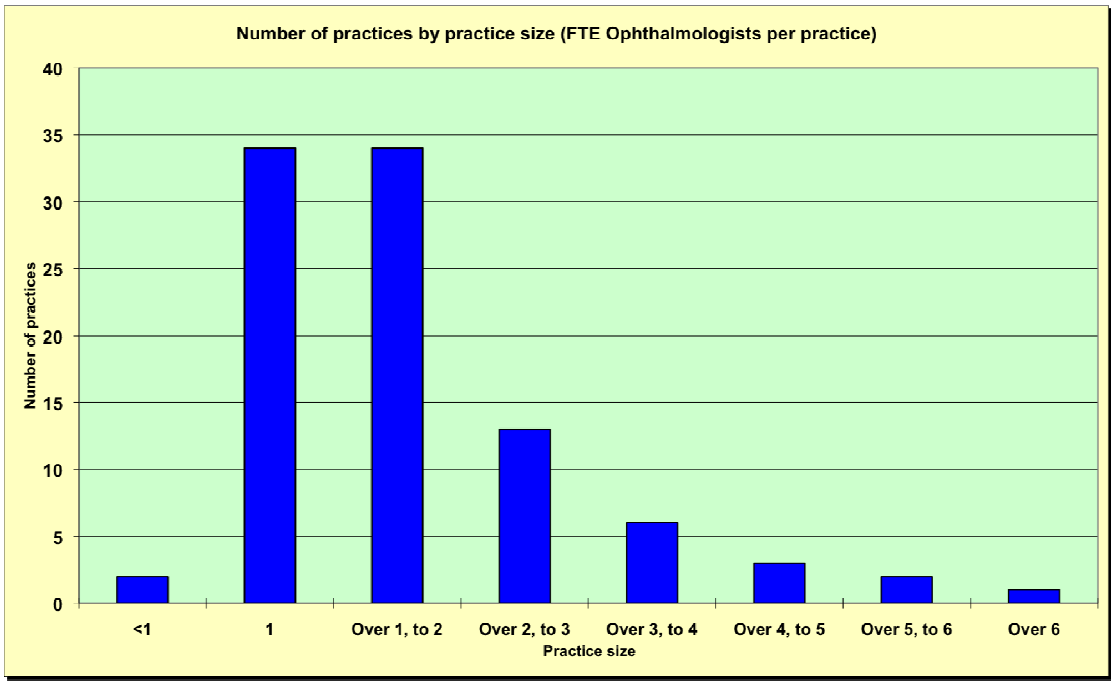
33. Ophthalmologists in metropolitan areas have fairly significant competition between practices and pricing is varied between specialists depending on their level of experience or degree of sub-specialisation.

Practice Characteristics

34. The ASO approximates 95% of ophthalmologists perform work within private practice.

35. As per the ASO/Access Economics Practice Costs Study data, as at 2010 the average number of FTE* ophthalmology specialists per private practice was two — refer to Chart 1 (ASO 2010).

Chart 1 ASO number of practices by practice size (FTE Ophthalmologists per practice)



**FTE- Full Time Equivalent*

36. There are a variety of practicing styles with the recent ASO survey of member's practices — 45 % were operating as sole traders, 20 % as an individual trading through a proprietary limited company, and 9 % as one of two or more individuals trading through a proprietary limited company, 8.5 % as a trust, 4 % as an incorporated partnership or associate, and only 3 % as employee or contractor (i.e. no beneficial equity interest). Types of practice include:

36.1 Sole practitioner;

36.2 Two or more in partnership;

36.3 Over two or more via a proprietary limited company; and

36.4 Shared practices:

36.4.1 Partnerships of two or more practitioners where expenses are shared and profits and losses allocated in agreed proportions; and

36.4.2 Specialists practising in conjunction with one or more other ophthalmologists, charging separately in accordance with agreed fee schedule and undertaking other activities described in sections 12 and 13.

Public Benefits

37. The authorisation sought by the ASO will allow ophthalmologists in a shared practice to agree to fees to be charged to patients by the practice. The authorisation will outweigh any detriment to the public, i.e. patients, as a result of common fee setting within a practice.

38. Public benefits are outlined as:

    38.1 Improved quality of ophthalmology services;

    38.2 Continuity and availability of patient services;

    38.3 Certainty and predictability in price of ophthalmic care;

    38.4 Range of ophthalmology services to meet demand;

    38.5 Efficiency in providing ophthalmology services; and

    38.6 Improved quality of ophthalmology services.

39. Patients will benefit from improved quality of ophthalmology services as common fee setting will promote a culture of teamwork and collaboration between specialists within the shared practice. Ophthalmologists within a shared practice may gain advantage from the ability to discuss patient cases in detail to determine best practice options available for treatment. Such discussions will be further advantaged if open discussions regarding fee structure can take place between professionals to ensure the most accurate and effective ophthalmic service is offered to the patient.

40. An example is the common fees for cataract surgery. In a particular practice the proposed conduct will enable all staff to be transparent regarding costs. A patient with a very difficult cataract surgery can safely be quoted a specified price regardless of complications or additional post-operative care needed in the standard post-operative period.

41. Authorisation for common fee setting also has the potential to facilitate cross referral of patients between sub-specialties as decisions would be based on skill and experience of specialist services rather than on cost. If fees are commonly set the ability to discuss the fees of other specialists will allow treating specialists to hold frank discussions with their patients about cross referrals and costs involved.

Teamwork

42. Quality of ophthalmology services may also be improved through teamwork benefits if common fee setting is in place.

43. A report by the Victorian Quality Council 2010 showed communication and teamwork skills are essential to providing quality healthcare and preventing medical errors and harm to patients. The report also showed improved teamwork

can result in enhanced effectiveness, fewer and shorter patient delays, improved staff morale and job satisfaction, increased efficiency and reduced levels of stress among staff.

44. The report also revealed that breakdowns in communication in health care are reported to occur due to distractions and interruptions, and by organisational cultures that discourage open communication. Recommendations included creating an atmosphere where team members feel safe to speak up about issues relating to patient care (Victorian Quality Council 2010).

45. Therefore allowing ophthalmologists within the shared practice to discuss models of care without restrictions as to fees structures will assist in an atmosphere of open communication and teamwork, leading to improved patient outcomes.

Continuity and Availability of Ophthalmic Care

46. Authorisation for common fee setting improves the ability of a shared practice to function in a cohesive manner and prevent disruption from efficient daily practice such as interruptions and patient concerns regarding equity of care.

47. Patients will benefit from continuity and increased availability of ophthalmology care if the authorisation is given for common fee setting. It may often be the case that patient preference for certain price structures affects the likelihood of accepting an alternative specialist treatment.

48. Ophthalmologists within a shared practice, if common fee setting is in place, will be able to offer commonality of fees throughout the practice ensuring the patient is satisfied in accessing the services of an alternative specialist if their initial treating specialist is unavailable, particularly in:

    48.1 an emergency situation;

    48.2 a situation where a patient requires treatment at fixed time intervals. For instance, patients with neovascular ("wet") age-related macular degeneration (a condition which results in a loss of vision in the center of the visual field because of damage to the retina) require injections at fixed time intervals (which can be as frequently as every four weeks). This commonly results in a situation in shared practices in which the patient needs to receive an injection at a time when his or her treating doctor is unavailable. Such situations give rise to a reasonable patient expectation that their treatment will be consistent in every respect, including as to cost.

49. This will also improve competition based on quality of service rather than on price.

50. Ability for common fee setting among practice specialists may also increase the occurrence of intra practice sub-specialty referrals ensuring patients access highly specialised care. Patients will be less likely to make decisions based on cost and more likely to make them based on the experience and skill of a specialist.

Certainty and Predictability of Price of Ophthalmic Care

51. Inconsistencies between fees for ophthalmologists in the same practice often causes confusion from patients as to why there is a differentiation of fees and results in administration staff frequently spending additional service time explaining why such differences occur. Continuously answering patient queries on pricing structures is inefficient for all staff within the practice including specialists themselves. From the patient's perspective, uncertainty regarding fees can cause anxiety, as well as confusion.

52. Allowing common fee setting within a shared practice will remove these inefficiencies and improve certainty and predictability of price for patients ensuring comfort and prior awareness of the likelihood of expenditure required when receiving specialist services. It will allow the practitioners and their patients to focus on the important issues associated with treatment and avoid the distractions of fee-related issues.

53. The ASO notes that the ACCC has recognised the public interest benefits associated with such consistency, noting in its determination of Vision Group Holdings Ltd's (now the 'Vision Eye Institute Limited') Application for Authorisation (**Vision Group Authorisation**): [1]

> *The ACCC has previously accepted that there is likely to be public benefit from consistent, predictable pricing among health practitioners operating in a shared practice where they work as a team, share patient records, common facilities, a common trading name and common policies and procedures.*[2]

Efficiency in Providing Ophthalmology Services

54. Allowing common fee setting will benefit patients by improving the efficiency of administrative functions within shared practices. The ability to have set price structures will save time for administration staff in billing procedures and continuously communicating to patients why differences in fees occur between practice specialists. The ASO notes that the ACCC acknowledged the likelihood of such efficiency savings arising from general practitioners operating in certain ("group"/shared) business structures in the authorisation granted to the Royal Australian College of General Practitioners, determined on 23 May 2007 (**GP Authorisation**).[3]

55. The ASO further notes the draft determination recently issued by the ACCC (Authorisation – A91334, 12 December 2012) authorising general practitioners to engage in intra-practice price setting, where the ACCC acknowledged the likelihood of administration efficiencies if the proposed conduct was permitted.

56. In saving time patients may also be attended to quicker and patient throughput time can increase allowing improved patient access. Reports from the Victorian Quality Council revealed that breakdowns in communication in health care are reported to occur due to distractions and interruptions. Common fee setting will lead to reductions in interruptions regarding patient concerns for price

[1] A91217.
[2] See also the determinations in A91024 [6.54]-[6.55] and A91094-91095.
[3] [6.62].

differentiation and therefore improve teamwork and its associated benefits outlined in section 39 (Victorian Quality Council 2010).

No Public Detriment

57. The ASO submits that there will be no material public detriment arising from the Proposed Conduct.

58. The Proposed Conduct will only occur within shared practices and not externally between practices. Hence, it will not adversely affect competition forces between ophthalmology practices that maintain the competitiveness of the industry. Patients will continue to have choice over their preferred ophthalmology provider.

59. Competition among different shared practices will continue to be strong as the ophthalmic services market is already competitive and therefore the proposed authorisation is unlikely to result in the increase of fees or to have any anti-competitive detriments.

60. Demand for ophthalmology services within non-metropolitan areas will continue to be higher than supply as ophthalmology services are less concentrated. In Australia in 2007, the rate of specialists in major cities was 2, 3 and 4 times as high as inner regional, outer regional and remote and very remote areas, respectively (Wilson, Cooper, de Vries et al, 2009). This maldistribution applies to all health professional groups. In these instances ophthalmologists are likely already working at capacity irrespective of this authorisation of common fee setting and therefore the authorisation will not lessen competition or result in increases to fees.

61. The majority of public hospitals in Australia offer ophthalmic services. Visiting Medical Officers also provide public services to a range of regional and rural hospitals. Outreach services to regional and rural areas are also provided across Australia by private specialists with partial funding received from Federal and State Governments. Public hospitals are likely to remain a key service provider of eye health services with current government health reform initiatives including the introduction of Local Hospital Networks, Medicare Locals and improved funding models to increase the capacity for public services to cater for the projected demand for eye health services and therefore remain a competitive force within the industry (Victorian Department of Human Services, 2008).

62. Ophthalmologists also compete with optometrists and other eye health care providers outlined in section 5. As optometrists have recently been awarded prescribing rights for Pharmaceutical Benefits Schedule (PBS) eye medicines previously could only be prescribed by general practitioners and ophthalmologists. This has the potential to further increase competition in non-surgical eye care.

63. The authorisation will encourage the formation of shared practices as opposed to solo practices and benefits in broader treatment options and efficiencies they bring for patients.

64. The Proposed Conduct will be voluntary. No individual ophthalmologist or group of ophthalmologists would be bound by the authorisation sought under this application to take part in the Proposed Conduct.

65. In the ACCC determination A91217 for Vision Group Holdings Limited given on September 2010 the ACCC found the following:

For the reasons outlined in Chapter 4 of this determination, the ACCC considers that in all the circumstances the conduct for which authorisation is sought is likely to result in a public benefit that would outweigh the detriment to the public constituted by any lessening of competition arising from the conduct. The ACCC is therefore satisfied that the tests in sections 90(6)/90(7) and 90(5A)/90(5B) are met.

66. The ASO also notes that the ACCC granted authorisation for similar intra-practice fee agreements to:

66.1 the Australian Dental Association Inc, as determined on 10 December 2008 (**Dental Authorisation**); and

66.2 the GP Authorisation.

67. The ASO submits that the Proposed Conduct ought to be recognised as resulting in public benefit which outweighs any potential public detriment.

68. The ASO submits that, consistent with its decisions in respect of the Vision Group, Dental and GP Authorisations, the ACCC should grant the authorisation sought for the Proposed Conduct.

Counterfactual

69. It is anticipated that the number of shared practices will continue to increase, regardless of whether the Proposed Conduct is authorised. This is mainly because the shared practice model is generally viewed as providing the possibility of overhead efficiencies. As the costs associated with ophthalmology practice continue to rise and as practitioners continue to seek flexibility in their working arrangements, it is likely that the shared practice model will continue to become more and more popular. Conversely, none of the expected public benefits as described in this application will be realised if the Proposed Conduct is not authorised.

70. Without authorisation for the Proposed Conduct, the most likely situation would be that ASO members trading in shared practice would continue to price their services individually, without the ability to agree on a common fee structure for the services they provide.

71. The Proposed Conduct facilitates competition for services based on quality of service rather than price. Hence, the extent of competition based on quality of service will be more limited if authorisation is not granted.

72. If the Proposed Conduct is not authorised, patient confusion around differentiation of fees is likely to continue (see section 51) leading to unnecessary time wasted on explaining the fee differences and increasing levels of stress and

uncertainty experienced by all of the practices' stakeholders (doctors, patients and staff) and decreasing the overall efficiency of the profession.

Conclusion

73. The ASO submits that the authorisation for fee setting within a shared practice is in the public benefit.

74. Shared practices have a number of public benefits including improving the quality of ophthalmology services, continuity and availability of patient services, certainly and predictability in price of ophthalmic care, range of ophthalmology services to meet demand and efficiency in providing ophthalmology services.

75. Any public detriment which may arise will be minimal.

References

Australian Institute of Health and Welfare, 2009. 'Eye health labour force in Australia'. Cat. no. PHE 116. Canberra: *AIHW*.

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Kelaher, M., Ferdinand, A., Ngo, S., Tambuwla, N. and Taylor, H, R., 2010, 'Access to Eye Health Services Among Indigenous Australians; an area level analysis', *Published by the Indigenous Eye Health Unit, Melbourne School of Population Health, the University of Melbourne.*

KPMG, 2009, 'Health Workforce in Australia and Factors for Current Shortages', *National Health Workforce Taskforce.*

Royal Australian and New Zealand College of Ophthalmology, 2012, 'Annual Report 2011'.

Taylor, 2009, 'Minum Barreng (Tracking Eyes)', *Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne in collaboration with the Centre for Eye Research Australia and the Vision CRC.*

Victorian Department of Human Services, 2008, 'Victorian ophthalmology service planning framework 2005, & Commonwealth Department of Health and Ageing, Eye Health Progress Report'

Victorian Quality Health Council, 2010, 'Promoting effective communications among healthcare professionals to improve patient safety and quality of care', *The Hospital and Health Service Performance Division, Victorian Government Department of Health, Melbourne, Victoria.*

Wilson NW, Cooper ID, de Vries E et al, 2009, 'A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas', *Rural and Remote Health* 9, 1060 (Online)

Ophthalmology practice costs study, 2008-09

February 2011

Report by Access Economics Pty Limited for

Australian Society of Ophthalmologists Incorporated.

Commercial-in-Confidence

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1 The task

Access Economics was commissioned by the Australian Society of Ophthalmologists (ASO) to conduct a study of the costs incurred by Ophthalmology Practices. The objective was to achieve a robust measure of practice costs. To inform the study, a survey of ophthalmology practices was undertaken in June 2010.

2 Structure of this report

The structure of this report is as follows:

- Part 3 addresses survey design;
- Part 4 addresses the response rate;
- Part 5 explains the methodologies used; and
- Part 6 reports on the results obtained from the survey.

3 Survey design

The survey was designed to measure practice costs incurred by ophthalmology practices in the 2008-09 financial year, so as to enable estimates of:

- The per patient overhead (PPO) as defined in Section 5; and
- The cost per full time equivalent (FTE) ophthalmologist.

Practices were asked to report consolidated data for:

- the practice itself;
- any related entities (service companies, trusts, etc); and
- professional costs met by individual ophthalmologists from their remuneration (typically medical indemnity insurance premia, association memberships and subscriptions).

Practices were asked to report costs in four broad categories:

- Staff costs;
- Premises costs;
- Equipment costs; and
- All other costs not elsewhere included.

Practices were asked also to report:

- the number of FTE ophthalmologists working in the practice;
- leased and owned premises;
- leased and owned equipment; and
- activity levels for 26 MBS items which account for the vast bulk of MBS billings by ophthalmologists.

4 Survey responses

There were useable responses from 83 ophthalmology practices representing 164 FTE ophthalmologists.

The population of ophthalmologists in private practice in Australia is estimated at 750. The response rate ensured a statistically significant estimate. At the 95% confidence level, the confidence interval is 6.6%.

A series of internal consistency and cross checks were undertaken to verify that the data from the survey was robust.

5 Methodology

The estimates are strongly founded in the financial data provided by the practices. To ensure robust estimates:

- Some survey results were trimmed (by excluding the first and tenth deciles);
- Practice costs were measured on an "economic" basis, in particular to take account properly of sunk costs (the cost of capital) when premises and equipment are owned (rather than leased); and
- All costs were measured on an "arm's length" basis.

The "economic" measure of practice costs aims to measure costs consistently in every circumstance without regard to the method of financing (purchase or lease).

The Per Patient Overhead (PPO) is an ASO-developed method for relating practice costs to the volume of 'patient encounters'. Each of the following counts as one 'patient encounter':

- a consultation (eg, MBS item 104, 105 or 109);
- a consultation combined with any in-rooms diagnostic or therapeutic procedure conducted in the same visit;
- any single operating theatre case (which would typically involve a single procedure such as MBS item 42702 but, in some situations, may involve two or more MBS items).

It follows that the number of patient encounters is not the same as the number of MBS items (consultations and procedures) that are billed.

A reliable short-hand method for estimating the number of 'patient encounters' is the total of the number of consultations (MBS items 104, 105 and 109) plus the number of episodes of MBS item 42702 times 1.4.

6 Survey results

In 2008-09, ophthalmology practice costs are estimated at:

- $115 per patient overhead (PPO); and
- $506,000 per FTE ophthalmologist.

It can also be inferred from the survey responses that:

- There is a significant role for high-technology equipment in modern ophthalmology practices;
- Super-specialisation within ophthalmology is giving rise to considerable diversity in models and styles of practice with implications for the amount of specialized equipment used in each practice;
- Larger practices can have millions of dollars invested in specialised opththalmology equipment;
- The replacement value of equipment (owned and/or leased) averaged $840,000 per practice and $430,000 per FTE.

The cost mix is as follows:

Staff costs	40.7%
Premises costs	12.7%
Equipment costs	20.0%
All other costs	26.6%
Total	100.0%