Proposed dental scheme

By Graham Middleton, BA, MBA, AFAIM

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Like most bureaucratically-worded reports, the report of the National Advisory Council of Dental Health (Dental Health Report) uses ponderous language, with the result being that it is not immediately clear what its recommendations amount to. Way back in Appendix C (page 93) however, it states that the cost of a scheme for 7.6 million adult patients (as defined) to be $11.4 billion with a further $2.5 billion for a universal dental scheme for 5.4 million children. This amounts to a total of $13.9 billion over the forward estimates for 13 million people. The other nine or ten million Australians will continue to pay their own way!

Oral health and dentist availability much improved

The dental health report indicates that there has been a long-term historical trend of an increasing use of dental services by the adult population and an increasing average number of dental visits made per year (page 37). It also indicates that over the last decades, clinical practice in oral health, home care and fluoridation has led to significant improvements in oral health (page 20).

This suggests that the proponents of national schemes are complaining about a situation which is actually improving, not regressing. I expect that hard-nosed officials at the Department of Finance and Treasury responsible for advising the government on how to balance its budget will pick up on this significant fact. The report notes that there has been a long-term historical trend of an increasing use of dental services by the adult population and an increasing number of dental visits made in a year.

The rate of increase in dental numbers (see below) indicates that the availability of dental appointments is increasing at a faster rate than the population. This also begs the question: why fix something that isn't broken?

Total numbers of hygienists, dental therapists and oral health therapists are expected to increase from 2404 in 2010 to 4017 in 2020.

Cargo cult mentality

In some people's eyes, every perceived problem should be addressed by establishing an expensive, bureaucratically-controlled government scheme. Welfare groups have been calling for a universal Medicare-type scheme to 'dampen the breakout of dental fees' in the words of Tony Nicholson of the Brotherhood of St Laurence. Such a scheme would cost a lot more! It would almost certainly result in a universally mediocre standard of dentistry emerging as has occurred elsewhere. The mantra of such organisations is that dentists earn too much, but they don't have reliable information to back up their beliefs. In a similar vein, Jeff Richards of Monash University supported a universal scheme on behalf of another welfare organisation. He referred to the shortage of dentists based on OECD figures. Those types of international comparisons are notoriously unreliable but the figures are quoted as though they

are a mantra. Our own Australian Bureau of Statistics can't even work out what dentists earn or regularly publish up to date figures. Who is to say that an OECD average, even if the figure is correct, is the right ratio of dentists to population for Australia to aim at?

What the Tony Nicholsons of this world don't understand is the wide variety of dental practices and fee structures. No two dentists are exactly alike, with each having subtle mixtures of dental work that they prefer to do coupled with variations in fees. It's a bit like judging restaurant prices on the most expensive whereas there is a vast difference from dearest to cheapest.

Alleged shortage of dentists

The dental health report implies a shortage of dentists, but is somewhat equivocal. It indicates that there were 10,404 practising dentists in 2006 and that in the 2010/2011 there were 13,830 dentists registered. Of these, 94% were active, meaning 13,000 practising dentists. This implies a compound annual growth rate of numbers of practising dentists of 4.556% per annum. In other words, the increase in the number of dentists is much larger than the percentage growth in the Australian population. While the population growth in recent years has varied from year to year, taken overall the dental numbers are increasing at about three times the rate of increase of the population. However, three dental schools have not yet graduated their first dental classes, which will start to occur in 2013, and from that point on assuming no changes to current immigration patterns, the rate of increase of dentists will accelerate significantly.

The problem with all of these statistics is that it ignores what is happening on the ground. While health bureaucrats have convinced themselves that there is a shortage of dentists or, alternatively, have argued that there is a shortage of dentists to achieve certain outcomes, many areas have seen a rapid increase in the numbers of dental practices and of dentists seeking full-time employment. Nor do statistics measure the proportion of dentists who are underemployed and who are available to work additional sessions.

Certainly in some remote areas, such as far north Queensland, there is a shortage of dentists, but this isn't an indication of an overall shortage. Remote areas also experience shortages of a range of other employment categories. That's the reason why the mining industry pays high wages to work in remote locations. While special measures are necessary to provide services in remote locations, this in no way indicates a need for a national dental scheme. A simpler way of dealing with the issue is to heavily bias dental course vacancies, particularly in the regionally based dental schools, towards postcode groupings in the reasonable expectation that many graduates will take up an opportunity to practice in or near their original home town, friends and family.

On page 38, the report noted that:

- The number of domestic graduates has increased faster than expected (through increases in graduate numbers in the long-standing dental schools);
- The full extent of international students remaining in Australia to practice may not be captured in the migration assumptions in existing models; and
- The number of successful ADC candidates is larger than expected.

The explosion in dental numbers is beginning to be undeniable, but the bureaucracy which determines how many dental schools and dental school places should be funded and establishes immigration targets appears to be in denial, as a letter from a Health Department official to the Australian Financial Review of 6 March 2012 indicates. The report's authors could not tell us clearly how many dentists there were in Australia at the end of 2010. Their quotation of Australian Institute of Health and Welfare projected shortfall of 800-900 dentists by 2020 is at variance with the situation in dental practices today and is clearly wrong.

Health Department bureaucrats are failing

The above points to a serious failing in the bureaucracy. Centrally located bureaucrats can easily access numbers of dental graduates and dental registrations, as well as numbers in the yet-to-graduate final year of dentistry, and the numbers likely to graduate in the first year of each of the three new dental schools. For a health department official acting with the authority of the department, getting all that information is easy. As for retirement of dentists, the recent deregistrations of older dentists would be an accurate indication of the likely retirements over the next year or two. All of this should take a couple of bureaucrats armed with a computer or calculator and a few days to arrive at a reasonably accurate projection over the next couple of years when so much information is already known. The fact that the committee was surprised by the changes in dental workforce figures, but were unable to put down the numbers of graduates and ADC qualified dentists for 2010 and 2011, suggests perhaps that the committee was reluctant to find the truth.

As the report indicates, the numbers of dental auxiliaries are also increasing rapidly.

Counting Teeth

I'm reminded of the story of a group of monks who, in the Middle Ages, had a debate about how many teeth there were in the jawbone of an ass. When one of their number suggested that they visit the stables and look into the mouth of an ass, some recoiled in horror. Apparently they were at risk of committing the mortal sin of heresy if the number of teeth were not in accordance with accepted religious doctrine.

Dental academics

The report indicates that 42% of dental academics were aged 50 or older in 2006, which could potentially lead to higher retirement rates in coming years.

The entire Australian workforce is working longer, retirement ages of all manner of occupations have been extended, the pensionable age is rising and the population is living longer. Under these circumstances, we expect the average age of academics to rise with these overall trends. This may not be as big a problem as the report implies.

Workforce demographics

The report also says 'the dental workforce is also ageing, which may lead to more dental practitioners retiring, reducing the hours they work in coming years'.

As the availability of dental appointments is increasing faster than the population growth and the attendance rate of the population at dental surgeries is rising, the ageing workforce is clearly not a problem, particularly with the substantially increasing supply of dentists. The report indicates that the average age of dentists is 45, which we note is roughly the mid point of dentists' most productive years. With the significant increase in the number of new graduates entering the dental workforce, the average age will fall. Indeed, it has probably already done so since the report only mentions dental

graduation figures up to 2009. However, as there is a general tendency for the entire workforce to work longer, we would expect the average age of dentists to settle at around 42 or 43 years long-term.

Public sector issues

The report indicates that there is a significant difference in expected salaries for the public and private workforce and that there is also a lack of a defined career path in the public sector compared to the private sector.

This writer has worked in both public and private sector employment, spending quite a few years in each. The private sector overwhelmingly demands more effort and minimises its own bureaucratic procedures. The public sector wallows in red tape and managerial and administrative structures. The best graduates who are likely to become the best dentists will inevitably be drawn into the best private sector dental practices. Those who have difficulty in gaining positions in private sector employment will then seek employment in the public sector.

It would be interesting to know the ratio of work value to salary of the public sector compared to the private sector. If public sector dentists are doing less procedures per session than private sector dentists, the difference in work value per dollar of salary is likely to be a great deal less than supposed. It would also be interesting to know the cost of administering and supporting each public sector dentist compared to the cost in efficient private practices.

Who misses out?

The dental health report looks at some categories of deserving poor. It also acknowledges that there are some self-funded retirees (some well off) who are eligible for pensioner concession cards, but it omits to deal with whether or not this category should be provided with free public dental services or not, nor does it compare their relative ability to fund dental services with that of the working poor.

As an aside, it is noted that welfare lobbyists appear to be vehemently opposed to tight means testing which would provide services to those genuinely unable to afford good dental treatment as opposed to those who can afford to pay for it but who simply choose not to prioritise it, or to avoid going to the dentist for other reasons. Their arguments suggesting a need for a universal dental scheme and arguments against tight means testing are unconvincing.

There is an implicit assumption that economic factors are the main reason that lots of people don't attend a dentist regularly. While economic factors are undoubtedly a reason why some people sit on public sector dental waiting lists for long periods of time, there are also many middle class, non indigenous Australians living in urban environments with good access to dentists who have unfavourable visiting patterns and their reasons for non attendance are clearly not based on affordability.

A council discussion on universal dental care

The report indicates that the committee was divided between those wanting a universal scheme and those who did not (probably including the ADA member). Although they don't give a breakdown of numbers, it is obvious that the proponents were in the majority, who sought: 'a progressive tax arrangement to increase and redistribute dental expenditure more equitably through the system...'

In other words, the proponents want a centralised bureaucratically conducted public-funded dental scheme paid for by increasing marginal tax rates on higher income earners.

This writer has been accused of presenting anecdotal rather than real evidence. I simply point out that I've been advising dentists on business matters for 25 years and that scarcely a workday passes when I'm not in contact with dentists across Australia. I observe a multitude of dentists' financial results. I talk with dentists, consult to dentists, value dental practices, advise dentists buying and selling practices and benchmark dental practice performance. The consistent message that I have been getting from dentists for several years was of a situation of an emerging surplus of dentists which is growing rapidly. Physical evidence of this is that:

- Very large numbers of dentists routinely apply for advertised dental job vacancies in major cities. Several years ago it was often difficult to attract a reply because there was a shortage of dentists. The response to advertised vacancies indicates a change from a shortage to an oversupply.
- About two and a half years ago the chronic situation of there being dental locum vacancies across country Victoria changed. Whereas once I always had some dental clients in country Victoria who at any one time were desperate to fill a dental vacancy, that situation has changed. Vacancies now fill readily and locums are easier to obtain. It's a similar situation in areas within reasonable distances of Australia's other capital cities.
- On a regular basis I hear stories of dentists who are working limited days or sessions per week who would like to do more but cannot get full employment, or of dentists who work a day each in several practices in order to fill in a week. These are not satisfactory work situations. Again, they are an indicator of an oversupply of dentists relative to patient demand for dental services.
- Dentists who I speak to daily about practice valuations and who provide me with details of numbers of surgeries and number of days worked by employed dentists and dental auxiliaries indicate to me that there is a substantial proportion of practices which have spare capacity in that they have one or more surgeries together with a dentist or a dental auxiliary who is under-utilised. They would like to attract more patient bookings but they are not available. Invariably, the reason for non-availability is the number of new practices which have sprung up in major population centres.
- It has been pointed out to me by dentists in Geelong that the number of practices in that area has approximately doubled in recent years. It's also been pointed out by dentists in Darwin that a number of new practices have sprung up there in the last couple of years and it's a similar story in the Hills district of Sydney, etc. These aren't anecdotes, they're facts.

Professionally, I'd be interested to meet a bureaucrat dealing with dentistry in the Department of Health in Canberra who has spoken to as many dentists practising in private practice throughout Australia as I have.

Remember the Henderson Enquiry

I am reminded of the Henderson Enquiry into Poverty, which was set up by the Whitlam government in about 1973. The real concern of welfare organisations at that time was that poverty, as it was understood in Australia prior to that time, had been diminishing. The welfare organisations needed the government to find

some more poverty because they needed more 'clients' so that they could maintain their relevance. Henderson came up with a new definition of poverty for them.

Pre-judgement

Government bureaucracies don't set up committees at random. They advise ministers to establish committees after they have predetermined the result that they want. Having done that, they then hand-pick a committee with a majority of carefully chosen appointments guaranteed to deliver their predetermined outcome. In this case, reading between the lines suggests that the evidence does not support a universal scheme but that a universal scheme is what the committee wanted. In the discussion of the dental workforce, the committee avoided the obvious conclusion that if we are not already at a point where there is a significant oversupply of dentists, then such a situation is inevitable in the very near future. The committee wouldn't have wished to explicitly contradict the Minister for Health who is on record talking about the shortage in the dental workforce.

The changing budget outlook

A conflicting factor is that between the time of the committee's formation and the finalisation of the report, albeit that the period was only about five months, the government's budgetary situation worsened and it became increasingly locked in to producing a budget surplus in the 2012/2013 financial year, with longer term reduction of Federal government debt having become a political necessity.

Masking the report

An interesting fact is that the report was released to the general public on Monday, 27 February 2012, masked by intensive media coverage of the Kevin Rudd vs Julia Gillard leadership ballot. When governments want the general public to note a report, they pick a clear news day and release the report with fanfare. However, when governments wish to mask the release of information, they pick a time when the public and media are heavily focussed on something else: the day before the Melbourne Cup, he day before a grand final or at a time when the public is distracted by some other major event.

The obvious conclusion is that between the time at which the minister agreed to setting up the committee and giving its terms of reference and when the report was delivered to the government, it had become apparent within the halls of Treasury, Finance and Health Departments that a universal national dental health scheme could not be fitted into the budget.

Oversights

What all of the proponents of universal dental health schemes, together with Health Department bureaucrats, have neglected to do is to recognise that increasing the dental workforce beyond that necessary to fill the demand for appointments; including appointments for those who would qualify under a rigid means test will inevitably do is to tempt some dentists to over-service in order to gain sufficient fees and work to earn a reasonable income after establishing a practice and paying ongoing overheads. The undeniable fact is that health professionals have been able to increase demand for their services and that is why, in some universities, health economics is studied as a separate discipline to the normal micro economics and macro economics courses.

The majority of dentists are ethical

The Chronic Disease Dental Scheme (CDDS) is now a subject of considerable concern in the dental fraternity. While many dentists treated a moderate number of patients under this scheme and were appropriate in its use, albeit that some have gotten into trouble for not complying with some aspect of administrative detail, there was clearly an outright abuse of the scheme by a small minority. Particular dentists clearly over-serviced; just as a minority of dentists either extend their services where services are provided by health funds, or tick an additional item number. As a layperson, I trust my dentist but I have little inkling as to what he is doing when he is working in the back of my mouth. As with other professions, the overwhelming majority of dentists I know have strong ethical attitudes to such matters, but there will always be a minority who will exploit an opportunity. In the situation where too many dentists are produced and hence some practitioners are far from busy enough, the temptation, virtually the necessity, of over-servicing will present itself. That will lead to an increase in overall dental expenditure, not a decrease.

The normal micro economic mantra that increase in the supply of dentists will simply reduce the cost is in conflict with health economics, which teaches us that health professionals have a unique capacity to widen demand for their own services. However, Department of Health bureaucrats and welfare agency advocates are arguing the standard micro economic approach rather than the health economics approach and hence are wrong.

The restaurant analogy

Just because the poor cannot afford to patronise the most expensive restaurants doesn't mean that they cannot access quality food at fair prices. For those who can't, there are social services and welfare agencies who deal with the poorest in our community. However, no Australian politician or bureaucrat has suggested that we have a national scheme 'to increase and redistribute restaurant expenditure more equitably through the system'. That system was tried in Soviet Russia and its satellites and it ended in mass shortages, starvation and political upheaval. Now that the food distribution and marketing system is privatised, quality food is readily available. Isn't it funny how private enterprise delivers the product or service!

While bureaucrats claim that the government will pay for root canal therapy where warranted, as opposed to an extraction, how will that decision be made? Will it be made professionally by the dentists and their patient on a one-to-one basis, or will there be special approvals for items beyond a certain dollar amount? It is almost inevitable in the health system that any part of the health system which starts to cost the federal budget substantial sums of money finds itself being rationed or wound back. For example, reduction of pathology or radiology rebates. Inevitably systems designed to catch a small proportion of health professionals who set out to game the system end up creating dead weight administrative losses throughout the system. The frustrations and costs of these dead weight losses are the underlying reason why the best and brightest of dental graduates seek to work in privately run dental practices. They are also the reason why the best and brightest of dentists choose to run their practices without the interference of third parties such as government schemes or health funds. Health funds classically and unavoidably take a significant amount of contributions to pay for their overhead (administrative) costs which are over and above the administrative costs of the dentists who do the treatment.

What politicians and bureaucrats don't get

Dental practices can be likened to a range of businesses and professional services. Successful and consistently profitable dentists achieve this by satisfying their patients' needs. This in turn generates personal referrals of family and friends. Successful dentists tend to be both highly efficient clinicians and match this with good practice appearance and organisation. Across the dental spectrum there is a wide variety of skillsets depending upon an individual dentist's experience, post-graduate training and areas of special dental interest. There is also a wide variety of profitability and fee scales. However, many people are prepared to pay good fees to attend a dentist of their choice.

Conclusion - tightly means tested scheme is the answer

Read closely and extrapolated, the information produced in the report indicates that there is no justification for a universal national dental health scheme. Whilst there are always advocates for a scheme such as this to fix an alleged problem, the reality is that a tightly means tested scheme can be introduced easily. Centrelink already collects and regularly updates data on pensioner assets and incomes and adjusts pensions accordingly. With the data available to Centrelink, it is easy to draw a tight line which would need to be much tighter than the existing concession cardholder test and issue a similar card for dental benefits. Such a system can ensure that the genuinely poor can access dental treatment, but close the gates on middle class welfare. Contrary to claims by some welfare organisations that it would be difficult to put such a scheme together, the infrastructure and data already exists and government can put such a scheme in place with limited administrative cost. Naturally, Health Department bureaucrats who may have hoped to set up another substantial organisation headed by appropriately ranked public servants to administer a universal dental scheme may not be in favour of such a tightly means tested outcome. The Canberra based federal bureaucracy is ever ready to trot out new schemes on which to expend taxpayers' funds because it enhances their empires. The majority of the rest of Australia who pay the taxes that have to finance such largesse have a right to be critical.

Other contemporary matters

Bizarre practice valuation techniques

At the risk of being accused of criticising the opposition, I draw attention to a bizarre dental practice valuation technique being used by an organisation valuing practices for a particular bank. This technique projects fee growth forward over a number of years without indicating how the numbers are arrived at. The growth rate forecast is way beyond the dental norm. It then applies discounted cash flow techniques of net present value (NPV) and internal rate of return (IRR) to the extrapolated profit but doesn't show the actual working of its calculations. The resulting value looks impressive but when looked at closely, has no mathematical foundation. Basically it's faked.

If the staff of the major bank concerned are silly enough to lend to dentists on this basis, so be it. However, if some of the bank's customers have borrowed unseemly amounts of money based upon false valuation techniques and get into financial trouble, senior compliance managers will have to explain to senior management how such valuations were accepted. The other problem is that the resulting value has no basis in the reality of the marketplace. Practice owners get a quite unrealistic view of the apparent worth of their practice, while naïve buyers may think that the approach is accurate. Practice owners who go to sell their practice on this basis are likely to find that harder-headed advisers will quickly pick holes in the value. Ultimately, such techniques may encourage particular bank lending staff to overlend and bank loans officers want to lend because their salaries will be a reflection of the value of their loan portfolio. However, there is usually tension between the loans officers and the credit controllers who want to see proper process. Periodically, banks have to eradicate outbreaks of fraudulent lending based upon particular valuers (sometimes real estate valuers and sometimes business valuers) arriving at numbers to suit the deal rather than representing an honest appraisal of the value of the business or property concerned. The particular valuing organisation has a history of valuing certain other types of business, but not of dentists and has little knowledge of dental practice.

The importance of hard data to dental valuation

There is no shortage of persons, some with impressive qualifications, who bob up and claim to be able to value dental practices. However, the real underlying basis of the valuation must be access to a deep pool of actual dental financial information, including benchmarking data, a large pool of satisfactorily completed valuations and a large pool of actual contracts of purchase and sale. A valuer can look at photos of practice premises, operatories, waiting areas, etc, and save the cost of expensive travel to all parts of Australia. Providing we have comprehensive dental data, as well as good financial and related data from the practice concerned, we can produce accurate practice valuations. However, a valuer who has visited a practice but doesn't have a deep pool of reliable data, particularly of actual practice sales but also of benchmark performance data, will be unable to value accurately. The important issue is to check the actual valuation experience of the organisation concerned.

About the author

Graham Middleton personally has been advising dentists on strategic, practice management, valuation and conflict resolution processes for 25 years, the last 18 as a partner and director of Synstrat Management Pty Ltd and Synstrat Accounting Pty Ltd. He was once a regular army officer, and later Director Human Resources Manager, Attorney General's Department of Victoria. He is considered an expert on dental practice valuation and practice performance benchmarking. He has spent many years advising dentists in respect of their business and financial strategy and measuring their practice and financial performance. He is the author of the Synstrat Guide to Practice Management, 50 Rules of Success as a Dentist and Buying & Selling General & Specialist Dental Practices. He is a long-term contributor to the Australasian Dental Practice magazine. The Synstrat Group is an independent data-based organisation providing management, benchmarking, valuation, financial and accounting services to the dental profession. Synstrat Management Pty Ltd is a Licensed Dealer owned by its directors who work within the Synstrat Group. Tel: (03) 9843-7777 Fax: (03) 9843-7799 Internet: www.synstrat.com.au Email: dental@synstrat.com.au