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Will the Dental Profession put the Boot into Health Funds?

Cottage Industry

Dentistry is the last great cottage industry even if its technology is a tad more advanced than that which Patrick Meaney colourfully refers to as “carpentry”. It is a cottage industry because nobody has yet demonstrated successfully how to corporatise dentists on a large scale; a fact demonstrated recently when Boots closed its UK chain of 54 practices.

Connection to Health Funds

You may ask what does this have to do with health funds? In a sense, the Hawke Government corporatised medical practices when it introduced Medicare, which in turn was a rerun of the Whitlam Governments MediBank. However, unlike Boots, the Government didn’t take direct responsibility for running the medical practices, preferring to set a price on the services to the doctors then gradually forcing the real reward of doctors down by a process of attrition over some years. The doctors retained the nasty problem of administering their practices. In the past few years doctors began to rebel against Medicare bulk billing arrangements in significant numbers. Since insufficient doctors had been trained to meet the expanded demand created by bulk billing, there was little that the Government could do except watch the proportion of bulk billing practices decline and cop the political flack, or become more generous by raising its common fee schedules. The raising of the common fee schedules is not regarded by doctors as being generous, but simply a recovery of part of what has been eroded over many years.

The underlying problem was that bulk billing arrangements created excess demand since it sent a signal to the patients that attending the doctor was free. Inevitably, when you make a service free to the user excess demand is created.

Health Fund Fees

Whilst health fund clients pay fees to be members, there is a dislocation between the payment of the fees which are often deducted at source from their payroll, or by a bank direct debit arrangement, and the attendance at a service provider. By making treatment cheaper at the service point, the problem of excess demand is created. Health funds usually address this problem by limiting the number of services of particular types which will be covered in a given period. There are also draconian instances of health funds conducting onerous dental practice audits and of making dentists feel like criminals due to simple administrative errors.

In pure economic terms, both supply and demand are being interfered with.

Who Pays for Dental Treatment?

Currently about 68 percent of dental fees are paid by patients direct with 15 percent funded by health funds and the remaining 17 percent by a mixture of Federal, State and Local Government payments or dental service provisions.

I haven't been able to determine the proportion of the 15 percent paid by health funds which are tied to preferred provider arrangements as opposed to refunds to patients after provision of treatment by a dentist. A proportion of services are also provided by dentists employed directly by health funds. It is clear that this proportion remains small. Lack of dentists available for employment will keep it small for the foreseeable future.

Dentists Pricing Power

The most recent available data indicates that while dental numbers are approximately keeping pace with population growth, the actual availability of dental treatment hours is falling behind. The reason almost certainly lies in the increase in female graduations from the early 1990's onwards. Statistical data indicates that on average, male dentists work longer hours than female dentists. In approximate terms, it takes 5 female graduates to replace 4 retiring male dentists. In the current decade, the availability of dental treatment relative to population is declining significantly. The law of supply and demand is inexorable. As the supply of available dental treatment declines, the pricing power of dentists increases. Dentists can decline the overtures of health funds.

Health Funds Hope that Dentists are Uninformed

The health funds have studied the same numbers. They understand that their ability to influence dentists is declining sharply. They know that they must make a significant push to sign up large numbers of dentists as preferred providers before dentists wake up that the health funds have lost their economic power in the bargaining situation. If health funds can sign up a large number of preferred providers now, then they can rely on other factors coming into play. As a proportion of health fund patients under preferred provider arrangements in a particular dental practice rises, then the owner of that practice loses the ability to push up fees beyond that which the health fund is prepared to concede. The dentist fears that if he resigns from the preferred provider scheme, that there will be a period in which it is necessary to go through an expensive practice rebuilding process to attract new patients. The dentists who have been preferred providers for any length of time find it very difficult to withdraw.

As a result of dental supply factors, health funds in certain areas are again making a significant push towards the preferred provider arrangement. Mainly, this has manifested itself in the private hospital area, but recently Western Australian dentists have been faced with a demand to sign on as preferred providers to the dominant health fund in that state. For many years

this health fund has paid benefits on a non preferred provider basis. The implication is that dentists who don't sign on as preferred providers risk health fund members being directed elsewhere. Fortunately Western Australian dentists were sufficiently alert to realise that the health funds bargaining power is a lot weaker than it first seemed.

Backlash

The last time I wrote an article like this I received correspondence suggesting that dentists who read my articles were "unprofessional" to which I reply "nuts". Socialism failed in the workers paradises of Eastern Europe, Castro's Cubans drive 1950's American cars, and the workers of the communist paradise in North Korea are starving compared to their well fed cousins to the south of the 38th parallel. The Chinese leaders looked at what happened to the communist rulers of Eastern Europe and quickly moved towards "socialism with Chinese features". The Chinese features are of course "capitalism". With dentistry like other goods and services, the best way to maximise the dental care of the maximum proportion of the population is to let the cottage industry of dental carpenters apply their trade freely and competitively.

When a couple of cars collided violently at an intersection without damaging the occupants, it was odds on that the strictly capitalist tow truck operators arrived at the scene well ahead of the Government employed Police! The reason was simple. The tow truck operators had to win work in order to survive. The Police got their pay cheques even if they were slow to get to the scene and fill in their reports. In Victoria, two or more tow truck operators often arrived before the police and fought over the wrecks. The process has now become regulated by state law makers trying to improve on the system. As a result it is now sometimes difficult to get a tow truck to remove a vehicle.

In dentistry, the practice proprietor with heavy practice overheads and loans to pay off is more likely to stretch to completing another procedure around closing time compared with the public employed dentist paid on a fixed wage.

The Chinese economy took off as though it was jet propelled when enlightened rulers quietly locked away the thoughts of Chairman Mao and of Karl Marx. The generation of Chinese entering the labour force had been indoctrinated by their grandparents who minded them while Mum and Dad went out to work. The grandparents had memories of what life was like prior to the communist revolution, and advised the kids to forget communism and open a business the first chance that they got. As soon as restrictions were lifted, they dumped the socialist dogma and business exploded.

So Why Boot Health Funds?

Underneath all the glitzy health fund offers to dentists, it is clear that the health fund industry is intent upon turning dentists into preferred providers and signing up as many health fund clients to dental ancillary schedules as possible. This in turn means that dental fees are controlled by a process

which is presided over by health funds. The health funds also get to determine the item numbers that they will and will not pay for, and put out lots of socialist dogma to members about keeping down prices in the interest of members. What they don't mention is that by moving towards restricting patients to attendance at a dentist on an approved health fund, they are attempting to corporatise the dental profession in a similar manner as to the Government corporatising medical general practices via Medicare. It is a system which cannot be made to work because of the growing shortage of dentists.

At the outset, Medicare was relatively generous to the doctors, but as patient demand was inevitably fuelled by the existence of "free treatment" Government Health bureaucrats set out to reduce the reward to doctors by limiting fee increases to below the increase in doctor's costs. Many doctors in strong demand by their patients also received "please explain" letters from Medicare for alleged over-servicing. Increasingly doctors found that they lost control of the structure of their practice and to a significant degree they lost their ability to determine their own income by working harder. It all ended up in a nice socialist mix of rigged supply and rigged demand. Fortunately for doctors they retained sufficient power in the market to be able to withdraw their services. The ones who had joined Medicare and then later left wished that they had never joined.

The results are not unlike that of the former USSR in which workers were paid by the state and told what to produce. As the workers said "they pretend to pay us and we pretend to work". Queuing for hours to buy loaves of bread and other necessities became a common feature of life in Russia. Eventually, the inefficiencies of that system of supply and distribution imploded. The present day Russia may not yet be a capitalist nirvana, but there aren't too many calls by it or other East European states to return to communism.

What Drives Health Funds?

Students of political science in arts faculties or of organisational behaviour in management schools have long observed the phenomena that no matter what the reason for an organisations establishment, once in existence, its dominant objective becomes its own survival. Those who watched the 1980's series "Yes Minister" may not have realised that aspects of the series were so true that they became student texts in public administration courses. Sir Humphrey conspired with other public servants to outwit the unfortunate minister, and whilst he occasionally allowed the minister a modest victory, Sir Humphrey's ever present goal of preserving the Civil Service intact was almost effortlessly accomplished.

Organisationally the most important objective of management in health funds is to preserve and grow the fund and with it their own careers in health fund administration. Where necessary, they will put up fees or interfere with services by limiting benefit schedules, or alternatively control fee payments to service providers to achieve this. The health funds individually and collectively are continuously pitted against the operators of private hospitals

and an array of medical specialists. In their own way, the health funds set out to emulate the experience of Medicare in controlling GP doctor's fees.

While health funds produce annual sets of financials, they sometimes choose to be unclear as to how ancillaries fit in. Put bluntly they don't wish their members to see first hand which services are paying out a good proportion of their membership cost in benefits and which aren't. This would allow members to cherry pick the services. The truth is that health funds commonly struggle to provide hospital and ambulatory care on a profitable or break even basis, and seek to cross subsidise these services by persuading their members to contribute to ancillary schedules. *Evidence from the PHIAC A website indicates that overall health funds collect substantially more for ancillary insurance than they actually pay out in benefits. In particular cases, health funds are actually propping up loss making hospital insurance operations via their profit on ancillary cover.* This raises the question as to who is being short changed. The answer is that in combination both dental service providers and dental ancillary benefit members have a right to be concerned. Dentists, because as a group they are being underpaid for their services, and dental ancillary benefit contributors because they are simply not receiving value for money. All dentists would be well advised to acquaint themselves with the statistics concerning health fund ancillary benefit insurance costs and payments. Many dentists would do a service to their patients if they pointed out the relative cost and benefit. Many patients would be better off not contributing to dental benefits.

I personally have belonged to a health fund for many years, but have not subscribed to ancillary services on the basis that I remain unconvinced of the benefit of contributing for dental or optical benefits rather than saving the ancillary subscription and paying for these services direct from my own pocket.

Impact on Dental Practice Goodwill

Visualise two hypothetical dental practices for sale in the same street and suburb in 2015. Practice A is not a preferred provider. The owner of the practice and his staff have nurtured the patients for many years, charged good fees but always kept the practice appearance inviting to its patients and have gone out of their way to maintain practice relationships. There is a strong bond between the practice, its proprietor, employed dentists and reception staff and the patients. There are family groups which have frequented the practice on a long term basis. The practice is now for sale and the vendor is prepared to commit to appropriate hand over arrangements.

Practice B has an identical number of staff and treats an identical number of patients, but under preferred provider arrangements of long standing. Its fee schedules are lower than practice A's and its ability to vary those fee schedules is totally dependent upon health funds. Over the years health fund payments have fallen behind costs. As a result, its proprietor has struggled to keep his practice renovated and equipment up to date. The practice, like its proprietor, is looking tired.

There are several potential buyers negotiating with the owner of practice A. Potential buyers look quickly at practice B, and once they determine that the majority of its patients have been serviced under long term preferred provider arrangements which limit their ability to set fees, they lose interest. Practice A, together with its premises sells quickly and at a good price. Practice B is difficult to sell, even at a heavily discounted price.

The Lessons

1. Don't sign on as a preferred provider.

2. The dominant concern of health funds is of their own survival, not of the consumer of dental ancillary services.

3. PHIAC A data indicates that health fund dental ancillaries do not represent good value for the consumer.

4. If you have already signed on as a preferred provider, then seek advice as to what your future business plan should be.

5. Being a preferred provider can wreck your practice goodwill value.

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