Dental success and failure in 2017

By Graham Middleton, BA, MBA

"Dentists who are afraid to advise patients to ditch their extras cover slide into preferred provider arrangements, only to find that their fees are reduced, patient treatment options are reduced and they are on a pathway to dental oblivion..."

Having viewed the financials of numerous dental practices on a virtually daily basis over many years, it's apparent that the best practices have the following characteristics:

1. Consistency

The most successful practices have remarkable consistency. This may be attributed to a combination of clinical skill, consistency in the conduct of the practice and high levels of interpersonal skill. Dentists of average clinical skill with above average interpersonal skill will be more successful in practice than dentists with highly developed clinical skills who's interpersonal skill is found wanting.

Predicably, well-performed dentists with good hands and well-developed interpersonal skills shun health fund preferred provider arrangements because they are confident of:

a. Attracting a steady new patient flow; and
b. Holding on to those patients long term. It has become apparent that practices with high percentages of patients not associated with large health funds are far more consistent in their performance and that non-preferred provider patients tend to refer other patients of similar quality.

2. Investing in premises and practice

Well-performed dentists invariably have attractive dental premises (mostly owned). They are conscious of the presentation of the premises and periodically update the appearance, knowing that the patients they already treat will remain loyal to them. If the appearance of premises falls away, those patients will cease recommending their dentist to friends, relatives or workmates for fear that they will not like what they see.

3. Performance

Invariably, the most successful dentists are also the leading fee producers in their particular practices. Usually, they are the leading producer by a significant margin. In such practices, it's normal for 90% of the actual profit to be earned in the proprietors' surgery or in multi-owner practices in the associated owners' surgeries rather than in the surgeries of their employed dentists and hygienists. Assistant dentists, apart from having to be paid to do the work not fitted into the owners' surgery, tend to be slower and use up more chair and assistant cost per dollar of fees.

4. Trust and marketing

It is well-established that:

a. The vast majority of patients are personally referred by existing patients who trust their dentist, who like the practice presentation and the receptionist;
b. Letter box drops are of negligible benefit to dentists. Unless the householder has a toothache when the dentists promotional blurb arrives in the letterbox, it goes straight to the recycle bin and is promptly forgotten;
c. Local newspaper advertisements are of negligible benefit to established dentists and only a slight benefit to new practices;
d. Practice websites have lost much of their potency as most practices now have them. However, they are useful for newly referred patients to verify the practice location and contact details to make appointments;
e. While the younger generation access social media, it remains overwhelmingly the case that flow of new patients are by word of mouth from existing patients referring their friends; and
f. Older patients tend to be better off financially and display more loyalty to their dentist.

5. Health funds

None of the top performing dentists I know are preferred providers to health funds. That's right... none!

Dentists need to be wary of health funds promising to increase their income or of marketing which turns out to be pushing an alliance of health funds.

Abuse of trust

The key issue in a patient-to-dentist relationship is trust in the dentist by the patient. In recent years, a massive oversupply of dentists has led to instances of new practice owners with significant overheads but too few patients, becoming so desperate to cover their expenses that they have abused the trust of new patients. Instances of patients being offered a free check-up, then being told that they need 8 fillings and going back to their original dentists only to be told that they don't need any fillings have become too frequent. Similarly, patients have been advised to have all their teeth extracted and replaced by devices mounted on 4 implants when this is often not the best clinical option.

Reinforcing trust

In this environment, Mr and Mrs Citizen have learnt to be wary and the safest way of finding a dentist when moving to a new area is to rely upon personal recommendations of friends and neighbours. This greatly increases the probability of their being treated by a dentist who is both competent as well as being trustworthy.

Size of practice

While acknowledging the existence of entrepreneurial dentists and corporates, the evidence does strongly point to the fact that as a general principle, big practices are not efficient. Rather, the most consistently successful dentists I have dealt with are dentists with good clinical minds, fast hands, good interpersonal skills and practices of a size being limited to:

- One owner dentist;
- One owner plus one dentist;
- One owner plus one dentist plus one hygienist;
- One owner plus two dentists plus one hygienist;
- Two owner dentists;
- Two owners plus one dentist;
- Two owners plus one dentist plus one hygienist; and
- Two owners plus two dentists plus one hygienist.

In each case, overwhelming the profit is earned in the proprietor's surgery(s) with quite a few leading dentists working two surgeries alternatively. Some additional clinical staff don't really exist to make high profits but rather to do the dentistry and hygiene work that the owner(s) doesn't want to do. However, I've seen lots of evidence of practices owned by one proprietor dentist with three or more employed dentists begin to decline in profitability as the owner is forced to spend too much time fixing up other dentists problems, or in practice administration. Practice administration multiplies where there are a significant number of part-time chairside assistants, receptionists or infection control nurses, as opposed to fewer full timers. Because dentistry is a business where the owner has to spend as much time as possible within the confines of their own operatory, having a large staff quickly leads to diseconomy of scale. At a certain point, the owner dentist loses more income from their own operatory than they gain by having additional clinical staff.

The practice manager myth

Contrary to the belief of many practices, the most profitable practices we know do not have practice managers, albeit some give the receptionist that courtesy title and some have a part-time bookkeeper do some additional practice administrative tasks for a day or two a week. It helps measurably if the receptionist, chairside and infection control positions can be filled with a minimum number of full time bodies rather than many part timers.

Simplicity

The key to avoiding an additional management tier between practice owners and non-professional staff is simplicity, i.e. having the bare minimum number of full time staff to support the dentists in the practice. Everybody is busy and because busy people tend to enjoy their work more than those that are not busy, such practices tend to be happier places in which to work. The exception to the full time mantra is the part-time bookkeeper. The most profitable dentists are the owners of practices where large fees are earned with minimal clinical staff with the biggest output in the proprietors' surgery. We therefore observe that:

- Simplicity builds profit;
- Staff complexity eats up profit; and
- Practice managers are often profit destroyers.

Unable to change!

I recall a dentist in a significant rural town who sought my advice as to why he was making a pathetically small profit out of a practice with $2 million plus of fees. The practice had 5 surgeries, 6 employed dentists in a variety of part time arrangements, with himself working full time. He also had a moving feast of chairside assistants and a receptionist ruled over by a practice manager. The practice manager had a cosy relationship with the practice accountant

around the corner who knew nothing of dental benchmarks. Neither the accountant nor the practice manager wanted to make changes. My advice was along the lines of we can help you to be more profitable but structural change is necessary:

"We'll have to take over providing business advice from your accountant."

The dentist rang me to say that: "His practice manager didn't want to make changes."

My reaction to that was: "I'm not going to spend time advising you if we're going to be stuck following the advice of a practice manager whose main priority is to protect her nest, rather than see the practice become successful and profitable."

Dental Case Studies

Case study 1 - Rick's practice

The practice is located in an established middle-income suburb of a major city. About 10 years ago, the owner separated from an associated owner of a joint practice by mutual agreement. His co-owner tended to be listless and displayed no ambition but impeded progress in the overall practice. After working initially from rented premises, Rick found a suitable site on which to build dental premises to a good, but not lavish standard.

Rick has outstanding interpersonal skills and is a regular participant in a local theatre group. He has built his practice to a $2 million plus turnover. In addition to Rick, who works full time, he has a full time assistant dentist and a part-time dentist. Rick generates over $1 million of fees in his own surgery and his full time assistant nearly as much. The practice is not a preferred provider, but Rick is well-booked as is his practice assistant dentist who, apart from being a good dentist, also benefits from Rick's profile in the local area. Presentation of the practice is excellent and it performs well-above the average benchmark standard. Rick will not entertain the idea of being a preferred provider.

The lesson: You can't afford a partner/associate who holds back a practice. In essence, there are practice builders and practice destroyers. Rick is a practice builder; his former associate was a practice destroyer.

Case study 2 - Huey's practice

For a long time, Huey practiced in partnership and the practice was in a rut. The practice's fees were set too low and they had rented far too much space. However, Huey took the opportunity to buy his partner out. He also acted on advice to adjust his fees. Fortuitously with a rent renewal option due on the premises and vacant space occurring in adjacent suites, Huey was able to negotiate a lower rent per square meter of space and to reduce the total amount of space rented from his landlord. As a result of multiple changes and concentrating as much dental work as possible into his own surgery, the practice is now much more profitable.

The lesson: Sometimes there is a good practice locked inside a mediocre one.

Case study 3 - Ian's practice

Ian sought advice many years ago as he wondered whether he had bought a lemon of a practice. In discussion, it transpired that the premises, a street front, were poorly presented and lacked a bathroom. Ian thought it was a waste of money spending on a Landlord's premises, but was persuaded to treat the necessary improvements as a marketing expense. Ian is a good dentist with a quirky sense of humour and his practice bloomed despite having two other practices nearby. He has never been a preferred provider.

The lesson: Good practice presentation is essential.

Case study 4 – Joe's practice

In reality, no two dental practices are alike and each has at least a subtly different mix of treatments and client list. Joe is long established but long ago specialised towards high quality cosmetic dentistry, giving patients the "Hollywood look". Joe has been successful and has built significant personal assets. He receives lots of personal referrals from patients, both male and female, whose appearance he had significantly improved. While his practice might be too specialised to be readably saleable, he has reaped strong rewards and the quality of his work has endured. An assistant dentist does much of the non-speciality work in the practice.

The lesson: Many dentists have established profitable niche practices with substantial personal referral bases. Doing quality work is essential to maintain those personally referred bases, but the nature of that type dentistry lies beyond the scope of health funds.

Case study 5 - Paul's practice

Paul has been a successful practitioner for many years and in the distant past was a pioneer in general practice, providing implants under sedation. He practiced in associateship with another leading dentist who was accomplished in orthodontics. Eventually, their respective plans required more space and they separated their practices.

Paul has outstanding interpersonal skills. Not only was he an expert in placing the implants under sedation, but finished off with high quality crown and bridge work. He employed an assistant dentist to perform the routine dentistry which was not cost-effective for him to do, given that his regular stream of personal referrals, including many from other dentists, kept his operatory well-booked at a high rate of fees. His fee output equates to that of several dentists of average benchmark performance. Paul has never entertained the idea of being a preferred provider and indeed, only a small element of the work he does would be paid for by health insurance funds.

The lesson: There has always been room in dentistry for niche practitioners who are high quality clinicians, provided that their personal and practice presentation is of the highest standard.

Case study 6 - Matt's practice

Matt is a reserved but popular dentist with great hands. He achieved significant success in motor racing and having purchased a practice off his former employer, sought advice on how to make it more successful. He was asked to engage an experienced marketing consultant who had advised on political campaigns. The consultant dwelled on his motor racing prowess on the basis that it distinguished him from other dentists with surrounding practices. Since that time about 22 years ago, his practice has always been well-booked and he backs up the image with

quality treatment. Along the way, he purchased the dental premises to enhance his control over the practice. He is not a preferred provider and for many years, has been the biggest fee generator in his practice.

Comment: There have been many dentists who distinguish themselves outside of dentistry. Relatively few continue to practice full time in dentistry. Presenting an image of interest to patients and to the local area is positive.

Case study 7 - Matt's country practice

Matt bought a practice from his former employer in a large country town. The practice had a branch in a smaller nearby village. Overall, it employed three full time dentists. Matt is a good dentist, but inevitably found that a fair bit of clinical time was wasted in moving backwards and forwards to the small satellite practice in the outlying village, about 30 minutes' drive away. When the landlord in the village indicated that he would not be renewing the lease because he planned to build something else on the site, Matt sought advice.

He was advised that as the population of the small village regularly shopped in the bigger town, they would attend his practice there. The landlord's action gave Matt the perfect reason to close down the satellite practice and be more efficient working from the one location. Subsequently, patients continue to seek appointments at the main location. His former landlord was blamed for depriving the village of its dental practice! Matt is not a preferred provider and has practiced profitably for many years. He continues to be easily the busiest dentist in his practice.

The lesson: Running a tight practice in a single location with an owner who produces substantial fees in their own surgery is a key to profitability. Indeed if examined closely, 90% of the profit in the practice comes from Matt's own surgery.

Case study 8 - Alexander's associateship

Alexander migrated to Australia from Canada with a view to buying into a dental associateship. He was an experienced dentist with an impressive array of clinical skills. After working in an associated practice for about a year, he was able to purchase equity. Alexander had observed a number of inefficiencies in the practice. He noted that too much work was being referred out to specialists which he himself could do, but he also mentored the younger of his associates to do more. Practice staffing was also tightened up. The practice had been treating a significant number of patients belonging to major health funds. Recognising the danger of becoming overly connected to those funds based on observations of what had occurred in North America, Alexander set out to advise as many patients as possible to either cancel their extras cover or transfer it to one of several small mutual funds. Bit by bit, Alexander won the confidence of his associates who recognised he was leading them to a more profitable, and in the long term safer, business model. As a result, the practice will have significantly greater goodwill value in the future and generate more profits year by year in the interim.

The lesson: Mastering the skills to do as many clinical procedures as possible and eliminating the influence of major health funds in practice, are keys to financial success.

Health funds winners vs losers

The financial results of dental practices clearly indicate that those dentists who:

1. Have the interpersonal skill to successfully advise patients to ditch extras cover;
2. Are able to involve their receptionist in selling the same message;
3. Have made their practices attractive; and
4. Are confident dentists who provide quality treatment...

create practices in which both their patients and themselves are better off.

However, those dentists who are afraid to advise patients to ditch their extras cover slide into preferred provider arrangements, only to find that their fees are reduced, patient treatment options are reduced and they are on a pathway to dental oblivion. Eventually, they risk their practice goodwill being worthless.

Disclaimer

Although the case studies represent actual events, the names and details have been altered to protect privacy. Any resemblance to dentists of the same name is coincidental.

About the author

Graham Middleton personally has been advising dentists on strategic, practice management, valuation and conflict resolution processes for 30 years, the last 23 as a founding 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 Synstrat Dental Stories, the Synstrat Guide to Practice Management, 50 Rules for 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 financial services company. Both Synstrat companies are owned by the same directors who work within the Synstrat Group. For more information, call (03) 9843-7777 Fax: (03) 9843-7799 Email: dental@synstrat.com.au or visit www.synstrat.com.au.

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