GM:NH

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Committee Secretary
Senate Standing Committees on Community Affairs
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Dear Secretary,

I thank the Committee for the opportunity to make a submission to the Senate Inquiry into 'Value and affordability of private health insurance and out-of-pocket medical costs'.

I am the founding partner and director of Synstrat, a business advisory group set up in 1994 to offer strategic and financial guidance to business owners. Synstrat is retained by a large number of dental professionals across Australia – in the hundreds. In this sense the company has a unique and broad perspective in respect of the intersection of the Dental sector and the Private Health Insurance sector which I wish to shape with the Committee.

General Observations

I first make some general observations for the benefit of the Committee:

1. Health fund advertising is almost exclusively aimed at extra's cover where the big health funds make a gross margin of up to 22% because they can ration the benefits to patients.
2. Health funds don't concentrate on advertising hospital insurance because it is hard to control costs as they cannot determine when and how often people get ill or have accidents.
3. Health funds limit the services dentists can offer to patients with extra's cover.
4. Health funds ration benefits they will pay on behalf of patients with extra's cover. For example, a patient may be in need of several crowns but their health fund indicates that they can only have one in a 12 month period.
5. Health funds mislead members as they refer to 'their preferred providers' implying that health fund employed dentists are superior. There is no basis of fact in the label. They are simply a dentist who at some time in the past were persuaded to sign an agreement with a health fund. No qualitative checks on the dentists or their practices were carried out in most cases. Usually the most experienced and gifted dentists have chosen not to be preferred providers because they have loyal patients regardless of health fund activities.
6. Health funds carry out the highly dubious practice of paying differential rebates so that their members who go to their preferred providers cause a higher rebate to be paid to that dentist, than to the patients preferred dentist who is not a preferred provider. This causes a reduction in the quality in dental care.

7. There are between 1,300 and 1,500 surplus (full time equivalent) dentists in Australia. This has come about because of:-
    a. Errors in forecasting dental numbers resulting in a huge dental immigration program – since ceased, but the damage has been done.
    b. Addition of extra dental schools in Australia in recent years taking the number from 5 to 9. Once a Vice Chancellor establishes a dental school it's there forever.
8. Many dentists at the bottom of the profession are working part time and often for low wages. By contrast, 20 years ago virtually all dentists were solidly booked out weeks in advance; these days many dentists have difficulty filling their book on a day to day basis and often have significant gaps in the day.
9. Non busy dentists have high overhead costs as reception still has to be staffed and they require a chairside assistant even when there are gaps in the appointments.
10. Rent, dental supplies and substantial repayments on expensive dental equipment and fitout financing are typical of many practices. A modest 2 person dental practice would typically involve a capital investment of $350,000 to $600,000)
11. Whilst it is true that there are a relatively small number of leading dentists who do well, usually these dentists have drawing power because of their personality and their advanced clinical skills. In truth, no dental practice is identical. For example, some dentists like to do lots of endodontics which requires lots of delicate work and looking through high powered microscopes, others refer out all their endodontics to a dental specialist. Some dentists place their own implants while others refer out the surgical part of the procedure to a specialist – who may be a periodontist or an oral maxillofacial surgeon or a prosthodontist. Some dentists do high class crown and bridge while others refer it out to prosthodontists. Some dentists have hygienists who look after people's oral health while other dentists do not and choose to refer out to specialist periodontists. Some dentists extract wisdom teeth while others refer them out to an oral maxillofacial surgeon etc.
12. Digital x-rays, cerec machines for cutting crowns, high powered optics, modern dental chairs and a variety of instrumentation are found in leading practices but even those with just essential basic equipment have still had to outlay hundreds of thousands of dollars to set up.
13. By comparison a medical GP has negligible equipment and does little more than very basic checks and sends patients off to a pathology, radiology or specialist referral done elsewhere.

<u>Desperation Can Lead To Fraud</u>

Immigrant dentists who have come to Australia and pass, usually after 2 or 3 attempts, the Australian Dental Council exams to be recognised, often have difficulty in getting work because of doubts about dental education standards in some countries. It's not uncommon for them to start up a new practice borrowing heavily for fitout. Except in the circumstances where they have bought into an existing practice, from day one they have a shiny new practice but they have no existing patient referral base and can sit idle other than the odd patient coming to them. By contrast a long established dentist has a large number of patients on their books and those patients can keep coming back to a dentist that they know and trust. They also refer their friends, relatives and neighbours to a dentist that they trust.

Flowing from this, the new dentist (whether overseas or locally trained) has difficulty in financing the ongoing running of their practice and when they get a patient are sorely tempted to over service, or in some cases, abuse their patient relationship. For example, experienced dentists tell stories of a new dentist doing a check up on a patient and advising them "you need eight fillings". The patient, a bit alarmed, goes back to their original dentist with this message who checks their mouth carefully and advises them that they don't need any fillings! What the new dentist is doing is drilling and filling perfectly good teeth in order to bill a health fund for work which afterwards is near impossible to check whether it was needed. And the same could apply, for instance, to more expensive crown work.

As a result of these stories the public are particularly averse to going to new immigrant dentists and continue to use long established dentists. However, over the longer term some of the new dental practices will sustain themselves long enough to gain a foothold in the profession and a gradual build-up of a referring base of patients. However, some practices fall over silently. If they are in a shopping centre they get boarded over while the centre manager arranges for the space that they occupied to be filled by some other tenant.

Knowing what I know there is no way that I would go to a dental practice set up by a recently qualified dentist, nor would I recommend that any family member or friend go to a practice newly set up by a young inexperienced dentist.

The Great Myth

Health funds pretend that they have made access to dentistry better for the public. They fail to say how their actions have led to a serious decline in dentist standards.

Recommendations

If one stands back and observes the intersection between the Dental and Health Insurance Sector, the developing long term trajectory is unhealthy and must be reversed. A abuse of market power scenario is developing, which will benefit neither dental professionals nor the patients they serve. The following recommendations are made:

1. Governments should not promote, through education subsidies or immigrant intakes, a chronic oversupply of dentists in the market. When the number of dentists exceeds demand by a substantial amount, all that is created is an inefficiency in government education funding and the social cost of an oversupply of narrowly and highly trained citizens who are unemployable in areas in which the public and the citizens have invested.
2. The government should re-examine the efficacy and benefit of allowing health insurances to operate in both the insurance and health services market, particularly in relation to:
    a. The use of variable rebate system which in the medium to long term will produce a distorted and dysfunctional market situation
    b. The use of patient data provided for legitimate insurance related reasons being abused to develop and promote the use by customers of insurance company connected health care providers.

3. The Government should recognise the current trajectory will ultimately eliminate patient choice - the opposite effect to that which private health insurance was supposed to foster – and respond accordingly to prevent this situation from taking further hold on the community.

I would be pleased to give further evidence to the Inquiry.

Sincerely,
SYNSTRAT GROUP

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