The state of dentistry 2019

By Graham Middleton, BA, MBA

"There is a wealth of evidence indicating that corporate practices are at high risk of failure..."

Many experienced dentists look back over the past 30 years and say that they have enjoyed the best years of their profession, but among the current privately owned practices, there are still many which are successful, respected practices able to maintain good fee levels by providing quality treatment and holding onto the loyalty of long-standing patients.

Practice builders v practice destroyers

The contrast between dentists who are able to imbue patients with the confidence to have follow-up appointments and over time create their own referrals, i.e. practice builders, and those who lose patients, has never been more critical. With dental registrations growing at about twice the rate of population growth, practice principals cannot afford to retain practice destroyers but must nurture practice builders.

The critical role of personal referral

Whenever I ask a dental audience whether they receive most of their new patients via the personal referrals of their existing patients to their friends, relatives, neighbours and work mates, there is an overwhelmingly positive response.

When I ask whether they receive many new patients from letterbox drops or advertising in the local newspaper, the reply is that the response is low, albeit that a local newspaper advertorial story when a practice has been relocated has a useful limited time value.

Websites tend to be mainly accessed by potential patients who have already been personally referred by existing patients and go to the website to find out how to make an appointment or to confirm the practice location.

Bright new shiny practices won't turn on referrals; that depends on the quality of the personal relationships with patients, but decaying premises overdue for new carpets and paint turns off referrals because existing patients feel that they might be embarrassed if they recommend the practice to their friends.

It's all about relationships... stupid

A group of four principal dentists employ a mix of dentists who fill in the other two chairs in the practice, plus the unused sessions of the four principals. One of the principal dentists wants to sell his part of the practice. The other dentists in the group don't wish to buy it and he offers his part of the practice for sale externally. The practice has some features of a partnership and some of an associateship. The dentist who buys it has done a Graduate Business Management course and is ambitious. The protocols within the practice dictate that patients are first of all allocated to their dentist of choice, normally one of the principals. If that dentist is fully booked, they are then normally booked to an employee dentist and all of the partners/associates share in the income of the employee dentist. Dentists in the group have had a good record of retaining patients, generating repeat appointments and personal referrals.

The new ambitious "partner/associate" involves himself with practice administrative issues. He also handles lots of appointments but after a time, it is noticed that the work done by employee dentists is diminishing. The two practice receptionists who have worked in the practice for a considerable period of time point this out to the older dentists and the older dentists start to take a searching look at the appointments. It becomes apparent that the new part owner is burning off patients who are not having follow up appointments. There have been requests for the dental records of some of his patients from other practices. Worse still, he is demanding that the receptionists fill his book at the expense of the surplus referrals to the other partners which would normally flow to the employed dentists. He has a manner which is offending both the patients and the practice staff.

Eventually, the other partners are forced to act. The newest partner is told bluntly "shape up or else". Reception staff are provided with a protocol devised by the partners that surplus patient referrals related to the partners are to go to the jointly employed clinical staff. The aggressive newcomer has had his wings severely clipped and is forced to modify his chairside manner to retain patients.

Doing a "Smedley"

18 years ago, Peter Smedley, who had risen in the executive ranks at Shell and then had amalgamated a group of financial services companies into the Colonial Group, became CEO of Mayne Health Limited. Smedley, who had achieved the acclaim of Colonial Group shareholders when it was sold to the Commonwealth Bank for a huge price, was riding high. He was recorded as saying that all businesses are alike but his hubris led to a rude awakening.

Mayne Health ran a network of private hospitals and the two keys to its profitability were the bed occupancy rate ratio and the operating theatre usage rate. Smedley went on an inspection tour and discovered that the hospitals were providing surgeons with sandwiches and coffee when they had a short break from surgery to eat lunch. He immediately

ordered that the practice stop, sending out the message that he wasn't in the business of feeding high priced help.

Smedley built on his fundamental error and failed to get control of the doctors' loyalty. Doctors, particularly surgeons, found that they no longer had any input into what was happening in their hospitals. They believed that Smedley's changes were compromising the care given to patients.

The surgeons, who are fiercely independent professionals, then proceeded to leave the hospitals for lunch in nearby eateries and instead of the operating theatre being unused for 15 or so minutes while they ate a sandwich and drank a cup of coffee, an hour's stoppage became normal. Smedley and his executive team didn't get the message and he was too blind to see the danger of regarding surgeons as hired help rather than influential professionals.

In actual fact, it is surgeons who book patients into hospitals to have surgery done. The referral chain works like this. A patient consults a GP doctor who orders necessary x-rays and tests and possibly sends them to a specialist physician for an opinion or sends them direct to a surgeon. The surgeon examines the patient in their rooms and then the surgeon's staff book them for an operation. The patient receives a letter from the surgeon telling them to report to XYZ hospital at a certain time and advises them of their expected stay, who will be the registrar assisting at the operation, the anaesthetist and the after care physician.

Many surgeons had multiple hospital surgery lists including in non-Mayne Health hospitals. When they found themselves being treated poorly in the Mayne Health hospitals, they had their staff book their patients to alternate hospitals operated by non-Mayne Health owners. The first that Peter Smedley knew of this was when he opened the monthly accounts and discovered to his horror that theatre and bed occupancy had plummeted across the Mayne Health group and it was now making losses, requiring notification to the stock exchange.

Smedley set one of his senior executives a task to find out what the problem was with the surgeons. A group of surgeons were invited to a meeting at one of the hospitals and the senior Mayne Health executive stood before a lectern and started to do a presentation. A surgeon in the audience stood up in full view of everybody. The executive stopped his presentation, looked at the surgeon and asked him what he wanted. The surgeon, very politely in front of the whole room, asked him where he thought Mayne Health's patients were coming from. The executive replied that they were coming "from health funds". The surgeons in the room broke up in laughter, stood up and walked out.

Smedley, conscious of his Shell background with its worldwide pecten symbol present in every one of its service stations, had also decided that Mayne Health needed a logo and he introduced the infamous red dot. Unfortunately, back in 2002, lots of patients were World War 2 veterans who remembered the red dot as being the symbol on Japanese war planes. It certainly wasn't the brightest choice of logo! Shortly after the disastrous losses, Mayne Health dispensed with Peter Smedley's services as CEO and the company later changed its name to Health Scope.

Smedley's elementary mistake was to fail to recognise that it was the surgeons who booked their patients into hospitals to have operations, not the health funds which in many cases paid for them. His prime customers were in fact the surgeons who had the power to direct where they operated. They found his management style and methods insulting. His mistake was at a huge cost to the company and cost him his job.

Becoming a "Smedley"

Once long-term dental practice vendor leaves their practice, their large lists of loyal patients who referred other patients to them gradually dissipates. The corporate dental practices gradually lose patients and profitability. Some will be better at patient retention than others but in the long term, they will decline relative to good private practices which are able to retain the loyalty and referral power of patients and build strong patient bases. Across medical, dental and veterinary corporates, a variety of corporate managers have become "Smedleys"!

Size of practice is an illusion

There will be exceptions, but overwhelmingly, the most profitable solo dental practice principals operate single chair, two-chair or three-chair practices. Generally, a fourth chair in a solo owner practice produces too little profit to be worth the investment. This is partially due to the fourth chair having the least experienced dentist operating it, but it is also due to the fact that at a certain level of overall practice staffing, the principal dentist is too often diverted from focus on their own operatory to fix up problems for other dentists or has to deal with too many administrative issues.

Over many years, the most successful sole proprietor practices I have dealt with have been two-dentist practices - a principal who is skilled across a wide spectrum of dental treatments, who produces a high volume of fees, and an assistant dentist who deals with the principal's overflow including treatments of the type which the principal doesn't wish to do. It is not uncommon to find four or five chair practices which are far less profitable than these advanced two-chair practices.

The profit is in the principal's surgery

Marcus, a practice principal, owns a practice and premises with three chairs. He is the most talented dentist in the practice and operates easily the most profitable surgery. He has three other dentists spread across the other two surgeries. He approached Synstrat to discuss the option of expanding the premises, putting in an extra surgery and fitting it out. The overall cost would be about $500,000.

Our approach was to assess the income coming out of each of the existing surgeries operated by assistant dentists. It became immediately obvious that a couple of the dentists in the practice working four clinical days and three clinical days each were slow, happily spread out work and spent a fair amount of time chatting to chairside assistants. The reality is that if their work was booked properly, they would be doing two and a half days and two days each and there would immediately be two and a half spare chair days in the practice. Proper analysis indicated that the marginal profit on each of them was very low. The solution was to block up the dentists' bookings and free up chair time for a faster assistant dentist. Capital expenditure is not required.

Somewhere, there will be an exception to every rule, but overwhelmingly, over many years, the most profitable practices owned by a single dental principal are one-chair, two-chair or three-chair practices.

Rarely does profitability extend to a fourth chair because too much of the principal's time is wasted fixing other dentist's problems, or even worse still, an extra layer of staffing is required in the form of a practice manager. The sad truth is that most practice managers are profit absorbers rather than profit generators. However, we are not referring to efficient receptionists who have a courtesy title of practice manager.

The limitation on principal dentists

Principal dentists, unlike the owners of a multitude of other businesses, have to spend as much of their working day as possible inside their operatory working efficiently on a succession of patients. This permits minimum time to oversee other aspects of the practice and they cannot afford a significant drag on their personal efficiency.

Sometimes, a sole proprietor practice with, say, five chairs and an array of part-time and full-time staff, find themselves running a virtual employment agency but earning less than the principal of well-conducted two-chair practices. Practice size is an illusion. The efficiency of the principal's operatory is far more important than the number of chairs!

Single location is best

Dentists who concentrate their practice in a single location are significantly more efficient than those whose practices are situated in two or more locations. This begs the question as to how corporates can run practices in many locations as well as competent dental practice owners working from single locations. The answer obviously is that they cannot.

Too many associated owners/partners

Practices with more than two associated owners are not as profitable per owner or as efficient per dollar of fees as are the better sole/owner practices. Furthermore, some are poorly structured in ways which create disincentives for performance and encourage over-staffing. They are often difficult to turn around because of fundamental differences of opinion between practice associates/partners, as well as their respective advisors.

Dental start-ups are high risk

The very fact which makes some dental practices successful is also the reason why dental start-ups are high risk. Successful practices are enduring because they have a substantial loyal patient base which also refers substantial new work to them. However, very few people driving along a road or walking down the street see a dental sign and decide to pop in as though they were going for a cup of coffee or buying a loaf of bread. Dentists are in the relationship business and a new dentist, unknown in the area, starting a practice, has zero referral base whereas a long-established practice nearby with a loyal patient base will continue to get the referrals for most new patients in the area. This is the prime reason why existing practices have goodwill value.

A few start-ups are successful but overwhelmingly, most struggle and many fail. If they survive, it's usually after years of personal sacrifice. Many start-ups disappear, quietly becoming an empty building for rent or for sale or an empty space in a shopping mall partitioned over and disguised behind an advertisement. In nearly all cases, rather than starting a practice, the dentist will be better off buying a practice for sale and building on an existing client list. The days of 30 years ago when practices were heavily booked and a new practice could grow quickly because of the length of waiting times for dental appointments are long over.

Relationship practices

These days, a dentist's chairside communication skills are at least as important as their clinical skills and the rapport of a receptionist with patients is also vital to practice success. The kind of advertising strategies which work for supermarkets or pharmaceutical products don't work inside relationship practices or businesses such a dentistry, veterinary practices, medical practices, women's hairdressers and men's barbers to name a few.

Successful principals keep it simple

Long checklists are loved by some dental consultants but the reality of successful practice is to reduce your checklist to around four to five vital factors:

1. Is the receptionist keeping the principal's surgery well-booked with quality patients, with the principal being alert to the opportunity to squeeze in an extra procedure before close of session to generate profit at the margin?
2. Appointments in second and third surgeries should be blocked up such that the chairside assistant's time isn't being wasted on slow practitioners.
3. Do employed clinicians have good retention rates and do dentists generate personal referrals?
4. Are fees right for your local market?

At field kitchens!

There is an old army custom that when soldiers are in the field and meals are served from field kitchens or hot boxes, that the officers eat after their soldiers. Good dental leaders don't brag about how much money they are making in front of their staff. If practice principals feel that they must own a luxury vehicle, it's best left at home. Drive an ordinary vehicle to work. There is a parable that business declines the year after the owner starts driving a Porsche.

Sensible practice principals are at work early as you cannot expect your staff to be on time if you are not. You show concern for your staff. Personal greetings are important but then get on with work. Staff prefer to work in a properly run, busy practice.

Are corporate practices succeeding?

There is a wealth of evidence indicating that corporate practices in the dental, medical and veterinary professions are at high risk of failure, as indeed, were the corporate accounting roll-up failures of 20 years ago. An observation is that the stock brokers and investment bankers that promote corporate IPO's have a very poor understanding of what it takes to sustain success in practice once the vendor dentists have completed their contractual obligations and departed. The investment returns of dental and veterinary corporates in the form of dividends and stock market movements in the year ending 30th June 2019 ranged from dismal to disastrous.

Those dentists who conduct well-regarded practices and who have corporate competitors can rest assured that with corporate ownership, these practices will,

over time, lose their market share to privately-owned practices which concentrate on having good relationships with patients as well as providing quality treatment.

Employed dentists with no owner on site won't be concerned about what happens outside of their own operatory and if they feel like cruising out the door at the end of their session, will, in many cases, happily forgo the opportunity to squeeze in one more filling and risk that the patient might not come back. They are not paying the wages of their chairside assistant and the chairside assistant will be happy that they can clean up and knock off a little early. It's akin to the American expression that "nobody checks the oil in a rental car".

There is actually no way the corporately owned practices can match the performance of well-conducted privately owned practices, no matter how much urging they receive from visiting corporate managers.

The corporate appetite for buying dental practices is drying up. Maven, owned by New Zealand's Abano Group, has stopped buying practices. The disastrous Smiles Inclusive Ltd is struggling for survival; others have reduced appetites and are only prepared to purchase multi-chair practices where at least 60% of the fees are earned by dentists other than owners and who are prepared to sign contracts. Highly profitable practices available to corporates meeting this criteria are relatively few in number.

Value of contractual rights

Employee dentists who are well-known in the local area and who would have the option to establish a local practice or work in a different practice if they found their corporate's management style not to their liking, will be averse to signing contracts which require them to give up their rights to alternate practice. If a new corporate owner demands that they sign a contract which takes away their existing options, they have every right to demand a fee for doing so. The idea that a corporate can purchase a practice and then demand that employed dentists sign contracts has failed on many occasions.

Part sales

Dentists who sold part of their practice to Smiles Inclusive are fearful as a result of that company's losses and diminished share price and impact on its operations. They contemplate the probability of bleak outcomes. Nor has much been heard of the Peter Hughes/Carl Burroughs associated Kikada Lane Dental Scheme of late.

Stockbrokers contemplating backing a corporatised dental roll-up need to stop and contemplate the bleak financial outcomes of dental and veterinary listed corporates in the year to 30th June 2019. Those with longer memories will remember the corporate accounting failures of Stockford Accounting, Harts Australasia and Knights Insolvency. Dentists with good memories will remember the failure of dental laboratory company Pearl Health Care Limited. While the medical profession might ask whatever happened to Vision Group, Foundation Health Care or Orthopaedic Group Limited (OGL). Corporatisation of professional practices has many failures and many difficulties and the idea that a corporate roll-up can be floated onto the stock market at a high price earning ratio needs to be evaluated rationally. If the market price earning ratio of large companies is around 16, which is high by historical standards, the price earning ratio at which dental corporates should be offered to the market should be around 8 or 9 or possibly less because of their much higher risk. Regrettably, stock broking analysts have insufficient knowledge of weaknesses of the business models concerned.

Bank's attitude

Historically, corporates have utilised a combination of bank debt and share scrip to purchase practices. Given the obvious weaknesses of the professional practice corporate model, bankers will now be wary about supporting new roll-ups.

Payments in share scrip

Dentists should be particularly wary of taking share scrip in lieu of cash if approached to sell their practice.

About the author

Graham Middleton personally has been advising dentists on strategic, practice management, financial, valuation and conflict resolution processes for 32 years, the last 25 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 Management of the 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. Call Tel: (03) 9843-7777, Fax: (03) 9843-7799, visit www.synstrat.com.au or email dental@synstrat.com.au..

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