General practice corporatisation: the half-time score

Paul D Fitzgerald

The medical profession and health policymakers in Australia need to address the ethical considerations and the power imbalance inherent in GP corporatisation

SINCE 1998, LISTED PUBLIC CORPORATIONS have actively sought to capture a significant proportion of the Australian general practice market. They have paid generously for the "goodwill" of existing practices, entered limited contracts with the doctors in those practices, and relocated some of these doctors to large centres where general practice is linked directly with other diagnostic, imaging and treatment services owned by the corporation.

The benefits of these changes for the corporations include assuring referrals to their diagnostic and imaging services (in a competition for market share for these high-cost services), access to private insurance rebates through licensed day-procedure centres, and possible economies of scale.

General practice corporatisation and the issues involved have been described elsewhere.[1-3] However, the process of general practice corporatisation is maturing, and I would like to discuss some emerging trends and their implications.

Emerging trends

The initial enthusiasm for shares in general practice corporations is waning. Shareholders, institutions and analysts now focus on earnings rather than projections. A collapse in the price of shares in listed general practice corporations in August 2001, followed by a partial recovery, led to a more realistic focus on earnings as a determinant of share price. In addition, the collapse contributed to decisions to terminate practice purchases and to delay public listing by at least one corporation.[4]

General practice corporations have not shown the same earnings performance as other sectors of the health market, such as private hospital operators. Those owning their own pathology, imaging and specialist services are more profitable than those without vertical integration of referrals.

These changes, coupled with recent amendments to the Privacy Act — *Privacy Amendment (Private Sector) Act 2000* (Cwlth) — which now require a patient's consent for the transfer of medical records, have caused most general practice corporations to limit new practice purchases, making their initial targets of 50% of the general practice market overly optimistic. Although corporations have a large share of the Perth market (around 40%), it is unlikely they will achieve more than 20% of other metropolitan markets, such as Sydney or Melbourne.

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Future trends include corporatised practices moving away from bulk-billing of all GPs' services (this has already commenced in some areas of Sydney). Mergers between general practice corporations should further concentrate the market.

Other models of general practice integration are emerging, such as general practice market-based cooperatives, where GPs share ownership of diagnostic and therapeutic services and benefit from the profits of those services; Division-based cooperatives;[5] and serviced-office arrangements, where GPs collocate, but retain ownership of their own practice (for example, Health Connectiv Pty Ltd).

General practice corporatisation and medical ethics

In the past, some Australian doctors have been induced to act as agents of corporations, not of their patients.[6,7] I have previously argued that an informed health consumer relies on the advice and assistance of his or her GP. For the health system to operate as a free market, GPs must act as their patients' agent, not as agents of third parties.[3]

As there is considerable information asymmetry between health consumers and providers, access to an informed agent or broker, who is free to act solely as a patient's agent in the health system, is a consumer protection issue, not just an issue of professional freedom.

This is also the primary principle of medical ethics, which for over 3000 years has required doctors to put their patient's health needs before all other considerations.[8] On the other hand, directors of corporations are required to put the needs of shareholders first.[9]

Meeting the needs of shareholders through customer service is good business practice, but the needs of patients and shareholders will not always coincide. In such a situation, if GPs are not able to put their patient's needs before the needs of the corporation their patients lose.

Governments, health consumer representatives, health professionals and managers of health corporations must clearly understand that GPs have a role as honest brokers for their patients in the healthcare system, and must ensure GPs are free to stand up to third parties such as insurers or corporations in the event of competing interests.

Governments and general practice corporatisation

The New South Wales Government was the first in Australia to respond to the potential for doctors to experience competing interests. After ministerial inquiries into the provision of male impotency services and the cosmetic surgery industry,[6,7] the NSW Government introduced amendments to the

Medical Practice Act 1987 (Medical Practice Amendment Act 2000). The Act can now exclude an employer, manager or director from involvement in any company providing medical services if he or she is found to have incited doctors to unsatisfactory professional conduct, or is party to either payment of pecuniary benefits for unnecessary services or directing referrals.

Although some States are prepared to act to the extent of their powers to ensure corporations do not influence clinical practice, the Commonwealth Government has encouraged corporatisation of medical practice through its own inertia. It is responsible, through the payment of Medicare rebates by the Health Insurance Commission, for most of the expenditure in this market, where listed corporations are making shareholder profits largely from the public purse. As an example, the Commonwealth Government permits vertically integrated corporations to share profits from internal referrals while continuing to enforce regulations that prohibit the sharing of profits from referrals between traditional practices.

The Australian Medical Association and some corporations, with the later involvement of the Royal Australian College of General Practitioners (RACGP) and the federal Minister for Health, developed a Code of Conduct, which was released in October 2001.[10] The code was criticised as ineffective at that time.[11,12] At 3 June 2002, the code had three signatories.

Corporatised practice and health policy

The balance of power

The prime policy problem is imbalance in the relationship between GPs and their contracting corporation, and the subsequent vulnerability of their patients to exploitation by third parties. As a result of the Australian Competition and Consumer Commission's (ACCC) interpretation of the *Trade Practices Act 1974* (Cwlth), the AMA is able to provide professional and legal advice about contract issues to its members, but is prevented from representing individuals or groups of GPs in a contract dispute with a corporation.

Leaving aside the possibility that corporate doctors could be deemed to be employees by the Australian Taxation Office, and so become eligible for group representation through a union, GPs under contract are currently sole agents in their relationship with a corporation. Regardless of the details of the contract or the merits of their position, all remedies involve possible civil action.

It is unlikely that many individual GPs would take action against a corporation able to defend its position with hundreds of millions of dollars. It would also be difficult for a GP to win a contested case in a civil court against a well funded opponent.

An additional inhibiting factor for corporatised GPs is the need to renegotiate a contract with the corporation every four to five years. It is a simple matter for the corporation to refuse to renew a contract, or to make a contract so onerous that a GP would not renew. The doctor is then without a practice or an income source, facing ongoing geographic exclusions from the area of the previous contract, as well as the costs and difficulties of establishing a new practice in another area.

Far more subtle, however, is the use of recontracting by corporations to reward profitable or compliant doctors. As more contracts come up for renewal, this is likely to be the most pervasive form of influence corporations exert on GPs.

There is an overwhelming argument that it is in the public interest to support organised representation for GPs in contracts with general practice corporations. If the Commonwealth Government, the ACCC and the AMA are unable to provide this, GPs' class actions in civil courts could provide some relief and alter the balance between individual GPs and large corporations.

GPs of the future: agents or honest brokers?

A policy initiative within the medical profession's grasp is ensuring that GPs clearly understand their ethical responsibilities to their patients, and remain alert to the ways corporations, governments, drug companies and insurers seek to influence them, and so influence the decisions they make on behalf of their patients.

This is not a simple matter. The medical profession must also recognise that its actions as a group determine the services and resources available at a population level, while at the same time encouraging doctors to deliver the best possible care for each individual patient.

As Australia moves further along the path to "for profit" healthcare, there is a need for greater emphasis on teaching professional ethics in undergraduate, postgraduate and continuing education for general practice.

The economics of medical practice

Economists and governments, under the mistaken belief that primary medical care is not delivered in a competitive market, attempt to apply free-market principles without understanding their effects on the operation of the market and the vulnerability of uninformed consumers in the market.

The response to corporatisation of general practice is only one example of government confusion about the components of competition in healthcare, and their need to ensure public protection.[3] Other examples include advertising of medical services, the application of the Trade Practices Act to rostering arrangements by medical practitioners, and recent attempts by the Commonwealth Government and insurers to influence the way GPs prescribe or refer their patients.

A better-informed economic analysis of the operation of the Australian health system, which includes the opinions of consumers and providers, could assist policymakers to design a health system which follows function, rather than the current design which promotes dysfunction.

Legislation

Finally, legislation to cover competing interests when doctors refer should not be seen as a remedy for this problem.

Attempts in the United States to codify relationships between referring doctors and third parties (the Stark Laws)[13] have, for little benefit, increased the clinical and legal complexity of medical practice.

These laws were passed in response to widespread public and legislative dissatisfaction about the perceived divided loyalties of US doctors, and the consequent effects on patient care, resulting from longstanding interference by insurers, governments and corporations in the relationship of trust between doctors and their patients.

Enforcing the existing prohibition of commercial arrangements between referring doctors, and between doctors and third parties, is preferable to legislating to ensure propriety in arrangements which result from corruption of normal ethical practices.

Australians are still in a position to prevent a similar outcome, but the market is operating and time is short.

Competing interests

I am a principal in a general medical practice. I am also a consultant public health physician. Recent clients include the Australian Health Management Group, the Australian Health Insurance Association and the School of Public Policy of the University of Singapore. I am a non-executive Director of the Australian Medical Cooperative Limited, and a Director of Salvere Pty Ltd, a provider of employee assistance programs.

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LETTER

Medical workforce data: who do we believe?

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TO THE EDITOR: In 1997 an analysis of the medical workforce in North Queensland showed that Townsville's 125 000 people were served by about 180 GPs providing about 120 full-time-equivalent (FTE) GP workloads. A doctor–population ratio (DPR) of about 1:1000 was evidence of some sort that the community was reasonably well served, at least according to benchmarks of the time. As a result, the "area of need" status was removed from many North Queensland centres, a decision reinforced by similar findings from the Australian Medical Workforce Advisory Committee (AMWAC) report released soon after.[1] Further, the AMWAC report was the basis of a decision not to increase the number of GP vocational training places in the region, even though there is spare capacity and the program is one of the more successful in terms of retention of rural GPs.[2]

Despite persistent claims to the present time that there is no shortage of GPs in regional centres, in 2002 the number of FTE GPs in this community appears to have fallen to about 95, despite strong population growth to about 150 000 people, resulting in a DPR of around 1:1500. The city's two extended-hours clinics have closed, very few practices direct bill, new residents have trouble getting an appointment in any general practice, and fewer GPs are providing after-hours care. The recent Access Economics report, commissioned by the AMA, indicates that this trend is evident elsewhere.

Anecdotal evidence suggests that it is not necessarily the total number of GPs that is changing, but rather their work patterns. The increasing proportion of female graduates probably reduces the available FTE workforce, and more male graduates are now opting for a lifestyle that better balances clinical work with family responsibilities and interests outside of medicine.

Medical workforce research is an interesting, yet risky, academic business, beset by many complex issues relating to definitions, data sources and the measurement and interpretation of DPRs.[2] Despite our best endeavours and close proximity, the report conducted by me and my colleagues in 1997 was almost certainly incorrect within a very short time. I am inclined to think that GPs have a better sense of what is happening on the ground than do the sifters of data. The biggest challenge to workforce analyses, and therefore to patient access to GP care, may be the societal changes in work patterns, not in raw numbers, and these issues need to be better understood if we are to make progress in managing workforce issues.

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