Policy Issues Paper no. 14
September 2000

Corporatisation of general practice

Divisions of general practice across Australia have expressed varying levels of interest in and concern about the possibility of the corporatisation of general practice. Some of the concerns relate to a potentially vastly altered health system, some are related to practice-level business concerns and of course some fit into both these categories. This paper makes no attempt to canvass all of them but to identify some of the issues that are relevant to the publicly funded Divisions of General Practice Program. It summarises some of the greatest concerns about corporatisation, provides a rationale for why some of the broader issues are relevant to divisions, and mentions some of the implications at the local levels that divisions and their representative organisations might need to consider.

The paper concludes with a draft position, on which GPDV invites feedback from divisions.

Context

Many of the issues associated with corporatisation have been outlined in various papers produced this year, including the General Practice Partnerships Advisory Council (GPPAC) discussion paper and Barry Catchlove's (KPMG) scoping report on the corporatisation of general practice, commissioned by the Commonwealth and presented at the AMA conference. Although 'corporatisation' can cover a variety of models it is used in this paper to mean ownership by a company where the owner(s) does not work in the practice, but invests in it for profit. Corporations are often associated with ownership of a range of other services, most notably pathology and radiology. Some of the most frequently expressed concerns about this type of arrangement include:

- structural incentives to refer patients to other tests or services (owned by the same corporation)
- reduction of access to services in some areas, through larger, centralised practices
- possibility of a decline in quality of practice and possible loss of clinical autonomy
- risk of publicly listed companies losing their assets in the event of bankruptcy, leaving no infrastructure for the delivery of general practice services
- lack of regulation of owners who are not practitioners, and therefore not subject (in some states) to the Medical Practitioners' Board
- personal and professional satisfaction of GPs.

Some of the potential benefits of corporatisation include more efficient practice management, carried out by non-GPs with expertise in the area, and made easier through economies of scale in corporatised models. This may benefit:

- GP workload (reduced need to work excessive hours and cover after hours; greater possibility of leave for study and other purposes)
- practice organisation (including introduction and use of IM&T, qualifying for PIP)
- quality of practice (support in adopting accreditation standards, achieving other standards in particular areas)
- GPs experiencing difficulty in selling their practices.

The relevance of corporatisation to the Divisions' Program

> *The main aim of the Divisions Program is to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals to upgrade the quality of health services delivery at the local level.*
> (Commonwealth Department of Health & Aged Care, May 1999 *Implementation Guide*, p.4)

The Divisions' Program represents a partnership between the general practice profession, government and community. Divisions are part of the Commonwealth GP Strategy and work towards whatever changes are necessary to support and improve the delivery of high quality, accessible services to communities. The work of divisions is all about improving co-ordination of services and planning with the rest of the health sector (both primary and acute) and working towards improved quality at the general practice level. Strategies related to improving practice quality might include supporting the accreditation process, implementing particular population health strategies (e.g. immunisation), supporting use of evidence-based medicine, facilitating co-ordination of care, adopting information management and technology (IM&T), etc.

The GP Strategy Review suggested that one of the many ways of working towards these ends was to establish larger practices, which would, it argued, assist business management aspects of practice and this would in turn free GPs' time for clinical work or other activities to enhance their professional and personal lives. This may suggest that the benefits attributed to corporatisation may actually arise from the size of a practice, rather than the ownership structure itself.

Which structure?

The amalgamation funding program, *GP Links* was established as a result of the Review's recommendations. It is important to look at the *GP Links* program, in terms of both its aims and divisions' approaches to it, because many of the benefits that corporatised models claim to offer (listed above) might also be possible through other practice structures. GPs in a reasonably sized practice, with a practice manager, may be able to achieve the potential benefits of corporatised models while retaining ownership of the practice.

Different divisions (and SBOs) took different approaches to the *GP Links* program. Generally Victorian divisions supplied their members with information, but regarded the matter as an individual business one. GPDV had the view that it was an individual business decision and saw its role as one of providing information to divisions to facilitate amalgamation for those who were interested, rather than promoting the amalgamation agenda more directly.

These different approaches arose partly because the primary function of the amalgamation and the ideal size of a resulting practice was not made clear. To what extent was amalgamation a business decision? To what extent was it about addressing workforce issues? To what extent was it about improving quality of care? Each of these ends may have required a different practice structure. The GP Financing Group set the levels of incentives, but they did so without any clear, detailed framework having been provided by government on what the program was trying to achieve, or on the desired size of resulting practice.

There has not been wide debate, let alone agreement, about the ideal size of a practice. While it is widely acknowledged that divisions represent a range of GPs who practise in different settings,

this lack of agreement about the ideal structure of general practice makes it difficult to advocate a particular type of practice in the face of possible corporatisation.

There is a role for state and national divisions' organisations to continue to facilitate discussion about the structure of practice. GPDV will be looking at this as a focus for its Victorian Divisions' Conference in March 2001.

Ownership

There is a similar lack of agreement about whether a GP owner will be (automatically) more ethical than a non-GP owner so that the practice will therefore tend to deliver better quality services; whether GPs will tend to behave more ethically when self-employed than when employed by corporations; and whether non-GP owners are motivated by profit to a greater extent. A range of views on these sorts of issues was aired at the AMA conference in May.
Given the difficulty or perhaps impossibility of achieving consensus on the ideal structure and the ideal owner, there is a tendency to focus on the individual (GP and/or consumer) choice as an overarching concern. Yet providing an environment where corporate structures flourish has an impact on other forms of general practices, as in any free market arrangement, and may ultimately make them less viable by comparison. However desirable "choice" may be – for both GPs and the community – we may effectively reduce or remove choice by ignoring the way competitive markets operate.

Extent of corporatisation

Evidence does not seem to have been systematically collected about the extent of corporatisation and approaches by corporations. The KPMG study was unable to analyse its extent in the three weeks it was given to conduct the consultancy. Some branches of the AMA have surveyed members and some divisions are noting approaches of corporations to practices. The main source of up-to-date information remains newspaper articles. Monitoring that goes beyond the adhoc collection of anecdotal evidence appears to be a task that would be most appropriately undertaken at the national level. The Commonwealth in particular may have an interest in this sort of information, to inform its policy response. The Department of Health & Aged Care's project on corporatisation may address this issue, as it examines the broad issues of corporatisation across the medical sector.

Membership and participation in divisions

If general practice becomes increasingly corporatised, divisions at the local level may need to consider membership and representation issues. Would their membership base be changed or need to change? What might this mean for the way divisions operate? Who is it that divisions will represent in a largely corporatised climate, and whose interests will they advocate? Who do they represent now? To what extent will the issues taken up by divisions in future relate to business matters and to what extent will they be about improved quality of practice?

At the moment there is anecdotal evidence from some divisions that practice owners carry more weight in decision-making than non practice owners. In the future, there may be few GP owners and many employees. Would divisions permit practice owners who are not GPs to be members? Could they remain relevant if they didn't?

Other implications for divisions at the local level

Access

Access to general practice services at the local level is core divisions' business. The possible impact of corporatisation on patients' access to services needs to be carefully considered. This may be a particular issue for divisions in rural and regional areas, where amalgamating or centralising existing practices presents obvious access problems but where economies of scale may also make it less likely that corporations would find it profitable to buy up practices. Given the well-documented current difficulties of access in rural areas, any further reduction would obviously be of concern. If, as the corporations argue, it becomes increasingly attractive to work (as an employee) fewer hours in a well-supported, corporatised practice, and if these practices are mostly in the city, it may well become even harder to attract GPs to rural areas than it is now.

However, it has also been pointed out that in Victoria, moves to buy up practices have occurred in some rural areas.

Corporatisation could also have implications for access to particular types of services, including consultations relating to mental health and drug & alcohol issues. Some GPs choose to conduct long consultations on particular health issues although this is not as economically viable for the practice. If corporations did not encourage long consultations, it could therefore have a negative effect on access, although in the longer term this may force a change to the incentive system or the structure of the MBS.

Quality in practice

As argued above, issues related to the quality of services provided by general practice are also the essential business of divisions. The impact of corporatised models on provision of education, practice support and promotion of guidelines, to name a few, will need to be examined. The intended regionalisation of GP training and the contestability process also present an opportunity for corporations to get involved.

There are already some very large practices (involving 15 GPs or more) that do not use divisional CME but organise their own CME and other quality assurance activities – functioning effectively as a mini-division. Ownership of several large practices might place the corporation in the position of a division – with GP support and development provided by large, well-resourced practices within an accredited system.

Primary health integration

Aside from corporatisation, there is currently a great deal of interest in developing alternative structures to support and to deliver primary health care. The Commonwealth has signalled its interest in the concept of Divisions of Primary Care. A consortium of six divisions is negotiating with the Commonwealth for funding to develop a proposal to investigate alternative primary care structures. In Victoria, the Primary Care Partnerships are working on improved co-ordination between state-funded primary and community care and general practice.

It seems unlikely that the corporations will experience the same imperative as divisions to improve co-ordination with state-funded services. Questions also arise about whether their employee GPs will want to be represented by divisions, whether divisions will represent their interests and how this might occur. The impact of more corporatised service delivery on GPs'

work with other health professionals and divisions' relationships with other agencies, including state-funded ones, will need to be carefully considered.

Information to GPs

There is some interest in divisions presenting information to their members about the potential benefits and disadvantages of various corporatised models, as well as a range of alternative models GPs may wish to consider when deciding which business decision to make if they are approached by a corporation. This is precisely the sort of material and discussion that was facilitated by the AMA at its May conference and has also been produced by the SBO in WA. It may be worth reducing some of the duplication by divisions and various GP organisations in this area, where there is likely to be most demand from GP members of all organisations.

Divisions as co-operatives

Divisions may wish to consider whether they should have a role in actively promoting alternative co-operative structures, to achieve the possible benefits of corporatisation, while retaining GP control, to address GPs' concerns about both clinical autonomy and financial independence.

They may also wish to consider whether they might want to go one step further and provide aspects of practice management and/or become the alternative 'corporation'. The public funding of divisions that is tied to a range of other activities and outcomes may be an impediment to the division acting as a 'corporation', particularly for the smaller, less entrepreneurial divisions. GP concerns about budget holding may also be a factor. However, there is obviously interest in exploring this idea, and the feasibility study which the Commonwealth Minister has agreed to fund may clarify matters or at least provide a solid basis for future discussion.

Implications for individual GPs

There is a range of issues that divisions may choose to address because they are close to the hearts of most practice-owning, working GPs, even though these issues may fit more appropriately with the aims and objectives of the AMA as the professional organisation representing doctors. These include:

- How to get return for the investment represented by ownership of a practice, given the difficulties commonly experienced in selling to members of the more recently trained GP workforce, many of whom have different expectations of their working life and do not want to be practice owners
- The choice between being an owner or part owner (through equity or shareholding) or an employee
- How to maximise income while delivering reasonable quality service – does this mean retaining ownership of the practice or might it mean selling?
- How to ensure that GPs maximise profit in the advent of deciding to sell a practice
- If a GP decides to maintain an existing practice, will it remain viable if corporatisation becomes widespread?

Draft GPDV position

The board of GPDV discussed corporatisation at its meeting in late August and agreed that GPDV:

- acknowledges the importance of concerns about maintaining clinical autonomy and ensuring practice management and ownership models that will lead to high quality, accessible care for communities.
- recognises that, while the core business of divisions is to enhance the quality of health care delivery at the local level, there is not yet a formal consensus among divisions and their members about which specific practice model is most likely to achieve this; nor is there a clear, shared view about the extent to which the type of owner – GP or not; GP working in the practice or elsewhere – may affect the particular clinical and ethical issues that arise in corporate models of general practice.
- believes that corporatisation has the potential to significantly affect how a division operates and is interested in identifying the possible impact of the corporatisation agenda on divisions of general practice in Victoria.
- believes that maintenance of standards in corporate and other structures is most appropriately addressed through the RACGP Standards for General Practices.
- believes that while divisions have a role in assisting and advising their member GPs on the issues surrounding corporatisation, the individual practice-level business issues arising are primarily a matter for the AMA.
- believes that there must be an examination of the issues of legal ownership and regulation of practices which impinge on corporatisation as it affects the delivery of high quality primary health care. GPDV will raise this issue through the Victorian Advisory Committee on General Practice (VACGP).*
- would like to liaise with government and other general practice organisations to discuss the different roles that different players may take in relation to corporatisation. The VACGP provides the opportunity to begin this work in Victoria, as it brings together governments and consumers as well as the different general practice organisations.
- believes that it would be worthwhile to monitor the extent of corporatisation (approaches, responses, acquisitions etc.) to enable analysis and the development of appropriate state and national responses by the profession, divisions, the community and government. This monitoring appears to be a task to be most appropriately undertaken at the national level and GPDV looks forward to completion of the work of the DHAC project team, the GPPAC-GPFG joint corporatisation working group and of ADGP's proposed taskforce on corporatisation.

GPDV would welcome comments on this paper, and in particular on the draft position.

* The issue was discussed at the September meeting of the VACGP and a representative of the Medical Practitioners Board has been invited to the October meeting to discuss it further.

Further information on general practice and corporatisation

Further information resources are available on GPDV's web site at www.gpdv.com.au. Follow the links to *Issues* and *Corporatisation*.

Some of resources included are:

- GPPAC issues paper
- DHAC's KPMG Consulting scoping paper on general practice and corporatisation
- GPDWA paper including questions to ask when approached by a corporation
- Information on applications for Commonwealth funding for a feasability study into alternative models to corporatisation of general practice
- Link to RACGP taskforce paper
- Definitions of corporatisation (memo to GPPAC-GPFG joint working group)

General Practice Divisions – Victoria Ltd
ABN 80 081 371 968 ACN 081 371 968
1st Floor, 458 Swanston Street
Carlton Victoria 3053
Tel: (03) 9341 5200 Fax: (03) 9348 1375
Email: gpdv@gpdv.com.au Website: www.gpdv.com.au