



GENERAL PRACTICE CORPORATISATION

AMA SCOPING PAPER

November 2000

The AMA Scoping Paper on General Practice Corporatisation was unanimously endorsed by the AMA Federal Council on 10 November 2000.

Background

Corporatised general practice has been around for up to 20 years but until recently, the marketplace has remained fairly static. During this period corporatisation was characterised by a slowly increasing level of medical centre ownership by corporations, individuals and doctors with and without a clinical practice.

New corporatisation

During the last 12-18 months a sudden upsurge in general practice corporatisation activity has occurred. This reflects a culmination of an evolution of 20 years of government policy enacted through regulation, that has allowed GP rebates to increasingly decline against cost of living rises and which has seen doctors lose ownership and control of their practices.

The AMA's key concerns in relation to corporatisation can be summarised as the:

- potential loss of capacity of GP's ability to maintain clinical independence;
- potential for corporate priorities to influence the ethical standards of doctors;
- potential for corporate interests to influence the volume and direction of referrals; and
- tension between the role of the profession (meeting the needs of patients) and the objectives of the corporation (meeting the needs of shareholders) and the implications for professional control of quality and standards.

There is a great deal of variation in the definition of "general practice corporatisation". The AMA recognises that there are several different models of corporatisation. The term in the context of this paper refers primarily to activities that use alternative ownership and practice structures to improve the profitability of general practice (it often also includes capturing the profits from flow-on services). The AMA recognises that there are models of corporatisation that enhance general practice. Of concern, however, are models characterised as "vertically integrated" where the professional and corporate objectives may be in conflict. These models are hallmarked by the concentration of general medical practices under a corporate umbrella, in association with other services such as pathology, diagnostic imaging and specialist services, to generate profits for third parties who are currently often not directly involved in the provision of medical care services. The profit generated from these co-locations and the resulting inter-referrals are directed to outside shareholders or other third parties.

Specific characteristics of the "newer" models of corporatisation give rise to the profession's considerable concern, including:

- the frenetic pace and aggressiveness of recent acquisitions;
- the payment of significant unsustainable goodwill above previous market values;
- increasing involvement in offering non-GP services within the practice structure; and,
- public listing of some of the organisations involved.

Macquarie and United Health Care are examples of multiple centre groups owned by entrepreneurial doctors with little or no personal involvement in the delivery of care. Primary Health Care, Revesco, Foundation Healthcare, Sonic Healthcare and Health Care of Australia are examples of publicly listed health care operators with exposure to GP businesses.

Corporatisation is moving rapidly. The consolidation of the Australian pathology market has gone largely unnoticed. The substantial funding flows arising from listing of GP Corporations can provide the resources needed to purchase large numbers of practices in a short time frame.

There are important differences between the newer models of corporations and traditional corporatisation models and the environment in which each operate. Features of newer models include:

- corporations are listed companies with access to capital markets;
- the market favors vertically integrated models;
- the rate of acquisition by corporate groups has increased;
- ownership of diagnostic imaging business by the corporations is common;
- increasing integration of specialists in corporate centres;
- goodwill payments have increased considerably; and,
- the potential to harness and direct the significant market referring power of general practitioners.

Factors Influencing Corporatisation

A number of key factors are influencing the pace and nature of corporatisation, including:

- the parlous state of General Practice remuneration;
- the paucity of specific practice management training, in both core College training programs and elsewhere;
- increasing expectations of the public in relation to hours, premises, equipment, etc;
- the length of hours required to earn target incomes;
- GP attitudes:
 - more GPs are working part-time with ownership being shared with, or relinquished, to third parties;
 - interest in other lifestyle activities/quality of life (family friendly working conditions) as a priority has increased; and,
 - many doctors now have less interest in management and ownership.
- GPs feel that the community demands a high quality service at an unrealistically low price;
- the shortage of Locums and lack of holiday relief;
- the absence of new workforce to share practice loads;
- the requirement to provide 24hr cover;
- the increasing cost and complexity of practice management:
 - Practice Accreditation
 - GST red tape including BAS
 - PIP paperwork
 - Enhanced Primary Care MBS Item Number implementation.
- growth in alternative health care providers, e-health and the increasing sophistication and demands of consumers;
- the development of large corporations in pathology and diagnostic imaging markets, driven by economies of scale in these capital intensive areas;
- recognition that large sums paid for goodwill for pathology and radiology could be spent in vain if a competitor gains control of the general practitioners and re directs the referrals to its own facilities;
- it may be cheaper to purchase the general practice goodwill and thereby capture the pathology and radiology goodwill, than to purchase the pathology and radiology goodwill from established specialist practices; and,
- capping of Medicare rebates for pathology and diagnostic imaging services, so corporations are

now fighting for market share rather than their previous strategy of increasing service numbers. Amalgamating GP's together and co-locating diagnostic imaging services may well result in capturing many of the GP referrals.

The GP Market

A number of trends have led to an environment that is conducive to non-medical investors:

- Many practices are under-capitalised and/or have not been able to capitalise on or realise potential efficiencies. This professional and financial crisis is due to poor morale generated by both government and public pressure on general practice to accept unrealistic remuneration arrangements.
- Recent public listings of medical centre chains have resulted in the market determining unsustainable valuations of medical practices purchased by those chains, unless seen in the context of capturing income from all the referrals. Applying normal commercial valuations to previously low value general practices is seen as an easy way of generating value in the market, as investors look to the market value of listed assets.
- Corporations must make a return on investment and there is the risk that demands for greater return will lead to less support services for corporate GPs (both staff and facilities).
- Vertically integrated General Practice companies can capture income flowing from GP referrals to co-located diagnostic imaging services.
- Long term growth is expected due to an ageing population and growth in service utilisation among the general population. Advances in technology and emerging approaches to funding and delivery (eg. integrated and coordinated care) suggest an increasing role for primary care and for GPs as gatekeeper into the future.
- Although the GP market is fragmented and operates predominantly on a small business basis, it forms a substantial part of the Australian economy. The large volume of transactions highlights the potential gains to investors from a substantial market share and improving margins through economies of scale and vertical integration.
- The Australian Bureau of Statistics (ABS 1997 report, 1994/95 survey) estimated 20,825 GPs and 33,831 other personnel (about 9% of whom are nurses in primary medical and non-specialist areas) who were in employment as at 30 June 1995, had:
 - gross income of \$2,817 million (94/95, excluding non practice related income);
 - operating profit before tax of \$778 million (margin of 27.6%);
 - total assets of \$1,671 million and net worth of only \$561 million as at 30 June 1995;
 - return on assets 46.6 percent;
 - average gross fees from medical services of \$124,900 per doctor (including both full-time and part-time doctors).
- These GPs generate around \$0.75 billion of pathology and a similar value of radiology. At current market rates the "goodwill" implied in those referrals would be worth around \$2.5 billion. This is, of course, in addition to the "goodwill" implied in all of the physiotherapy and specialist consultations that these general practices generate.
- The majority of general practices are small but trends towards larger practices are apparent, supported by the Commonwealth Government, because:
 - there are greater complexities and risks in running a small business;
 - costs have increased and revenue has declined in real terms;
 - tax advantages have decreased, and;
 - increasing consumer sophistication has required GPs to place greater emphasis on keeping their medical knowledge up to date, providing better facilities and longer opening hours.

Public Interest Issues

While on the surface there may seem to be public benefit from promoting economies of scale, consumer focus and increased competition in the general practice market, the AMA contends that some major factors of greater importance have been overlooked. There is potential for the standards and performance of general practice to be seriously damaged by corporatised medical centres. In particular the ethical standards, developed and championed for over 2000 years, of the absolute independence of the doctor in making judgements for his/her patients and total dissociation from any of the referrals that he/she makes.

Corporations must make a return on investment and there is the risk that a drive for increased profits will be pursued at the expense of quality of service. Corporations have the power to manipulate consumer perceptions of quality with the potential that such perceptions, developed in the interests of increased profits, will provide the corporation with the power to drive standards and practices, rather than the profession determining quality.

Both inside and outside corporate structures the traditional role of the family general practitioner must be valued and maintained. The AMA is concerned that traditional family general practice, and its inherent philosophies so highly valued by the Australian community, including the provision of appropriate personal trustworthy service, sufficient time and appropriate standards in the delivery of health care, be preserved.

The key issue from the public perspective is trust. Patients are consumers in a relationship of trust with a health care provider. Trust differentiates customers from patients. Patients trust that their doctor is there to work for them, to negotiate the best outcome for them in the complex health care system.

Although there are various models for practitioner involvement in corporations, the public must understand that doctors working in corporations may be placed under pressure to give priority to the interests and work of the corporation over those of the patient. A corporation's need to generate profits for third parties has the potential to distort normal professional patterns, and lead to less than optimal outcomes for the consumer, in terms of cost, convenience and health outcomes.

Through judicious use of funds, advertising and lobbying power corporations can potentially alter government policy in ways that may be inconsistent with the public interest. The growth of large for profit corporations with extensive financial resources and interests in the Australian health market may well distort the role of governments as funders, providers and guardians of the public interest.

As corporations gain market share they will have the ability to achieve price rises and/or maintain prices by lowering the quality of their product. (Concentration of markets inevitably occurs, and corporations will reach a balance point where their ability to work together as an oligopoly enables them to force up the price of a product, or force down quality). In Sydney, over 90% of medical pathology is provided by three companies. There may come a point where it is easier to push up the price of pathology services rather than fight for market share in a fixed market.

Professional interest issues

There is already some evidence of professional dissatisfaction amongst the GP's in some corporate medical centres. GPs in these medical centres have complained of occupational stress due to a lack of control over the work environment, complex interpersonal disputes, covering for the professional deficits of colleagues, pressure to turn patients over rapidly, loss of personal relationships with patients, professional compromises to meet the requirements of owners and financial pressures

caused by universal bulk billing. The AMA is concerned that GPs should be fully informed of all the benefits/risks before accepting a corporate offer.

Doctors are increasingly vulnerable industrially, as their ability to be represented comes under increasing threat from changes to the Trade Practices Legislation. Their final recourse to management pressure is to leave the corporate centre, a process with significant costs and complexity as well as legal repercussions in terms of potential breach of contract. The AMA wants to assist GPs through the development and application of professional ethical standards in the workplaces of contracted GPs and in the area of disputes. The AMA currently represents employed and employer GPs and wishes to provide increasing assistance to contract GPs.

The AMA will fight any general practice model that encourages GP's to compromise their professional standards.

Recently, as government has tried to tighten kickback arrangements in pathology and diagnostic imaging markets, corporations have been encouraged to vertically integrate, so as to legitimately reap the benefits from referrals. In some cases all funding flows and profits arising from the activity of their GPs, including referrals, are retained within the one corporation or group of corporations.

Corporations that continue to support bulk-billing by their GPs to attract pathology and diagnostic imaging referral flows, indirectly pressure other GPs to accept unreasonable bulk billing rebates. GPs in their own practices, who spend considerable time with their patients for unreasonably low consulting fees, and do not receive indirect benefits from their pathology and diagnostic imaging referrals, are often worse off financially than rapid turnover doctors in medical centres who are indirectly subsidised by profits from those referrals.

The AMA is concerned about the professional independence of all doctors. If corporations control referrals from a substantial segment of the GP market they could well eventually control the cashflow through and to radiologists, physicians, surgeons and private hospitals, paving the way for US style managed care.

Federal Government Issues

Australia's Federal Government has an overall responsibility to ensure the public interest is served on this issue. The Government is likely to let the market operate and only intervene if there is a demonstrated public threat, or a threat to the government's welfare.

Similarly, health bureaucrats see some benefits from organisation of the scattered GP market. Pathology, diagnostic imaging and GP rebates are currently capped, and, thus, corporatisation will not blow out the GP segment of the health budget, so they are also taking a "wait and see" approach.

The way forward for general practice

General practice has tended to resist changes toward corporatised models and to seek regulation to protect the status quo but corporatised approaches are not entirely without merit and highlight shortcomings in the "traditional" models. For example, GPs could differentiate their services based on customer demand, seek greater economies of scale, adopt modern business practices and cooperate to gain greater leverage from their purchasing power.

- **The KPMG scoping paper on GP Corporatisation** made three recommendations that are of particular relevance:
 - Rec 34 (p121) proposed the development/implementation of a program to assist general practices to embrace micro-economic reform, including improved practice and workforce efficiencies, amalgamation, and other models of cooperative working.
 - Rec 35 (p121) proposed that, following the implementation of the program (above), a planning framework be developed to address the distribution of general practices and to encourage the establishment of new practices in areas of need.
(Such rationing of GP practices might seem to produce short term gain but will undoubtedly produce long term pain as the corporations will purchase the licenses as was the case in pathology.)
 - Rec (112) recommended that the organisations representing general practice assist owners of medical practices, and doctors who work for them, by developing equitable model agreements.
(This issue may be of particular pertinence to corporatised models in which doctors remit a percentage of their fees to the owner.)
- The AMA has developed a set of principles (Nat Conf 2000) to guide policy.

Strategies

From a professional perspective the gold standard is that doctors should maintain a controlling interest in facilities that are their principal place of medical practice. This not only ensures their professional independence, but also gives GPs the freedom to act as their patient's agent, not as the agents of a third party.

Professional independence is paramount. GPs need to be free to make decisions in the best interests of their patients. They must be free from work quotas and free to refer to whom they choose when they choose.

The strategies needed to ensure appropriate corporatisation, that meets professional and public standards is relatively simple and involve addressing gaps that have appeared over the last 20 years in the way medical practice has evolved (since government regulations which saw doctors lose exclusive ownership of their practices).

The AMA recommends the following strategies:

1. Regulation

Any regulation should prohibit doctors or third parties entering into contractual and/or financial arrangements which distort clinical practice. Any such regulation must only be introduced following widespread consultation with and agreement from the profession. There are already precedents for tying in third parties in the recent amendments to the NSW Medical Practice Act, including penalties and disqualification for directors of companies.

In principle any regulation that applies to doctors should also apply to third parties in contractual or financial arrangement with doctors.

Any regulation should also ensure that no doctor is able to benefit, in either a financial or non financial sense, from a referral or recommendation to another health care provider.

Any regulation should further ensure that doctors disclose to patients all financial and non-financial interests, which may have the capacity to influence the information given to the patient so that they are able to give informed consent to a particular method of treatment, or where the doctor reasonably expects to obtain a benefit through a referral or recommendation to another health service provider.

While there may be enforcement problems with such regulation, directors of corporations which breach the regulation are in a difficult position, and corporate governance concerns in larger listed corporations should see directors ensuring the regulation is heeded.

2. *Industrial representation for all GPs.*

There is a growing need for industrial representation for doctors in the community, in corporations and medical centres. Representation should not only focus on terms and conditions of employment, but should also ensure that working conditions allow doctors to perform to acceptable professional standards.

GPs in and out of corporations are largely self employed or contractors, and the AMA is conscious of the implications that changes to the Trade Practices Legislation will have in terms of its role in representing doctors. The recent introduction of the goods and services tax might force a clarification of contractor status and result in such “contractors’ being properly classified as employees. Not only do contractors have to be mindful of the ACCC but also medical defence complexities, issues of ownership of records and indeed practices, loss of superannuation, overtime penalties etc.

3. *Standards/Conditions of Employment*

An alternative worth pursuing is the development of a set of agreed and enforceable minimum standards for conditions of employment for employee doctors. This option would allow the implementation of corporatisation principles already developed by the AMA. The AMA has a good track record in this area with the development of guidelines on conditions of employment for registrars. The basis for any level of enforceability (if at all) of such standards or guidelines is that the guidelines are agreed by employers and employees and have the support of GP groups. In this context this option is only likely to be workable for smaller corporatised practices.

4. *Practice / Agreed Standards*

The development of standards offers the opportunity to at least establish something that is needed by doctors generally but at the same time standards could also be the platform for an industrial role for the AMA should that strategy be agreed. The AMA recognises the RACGP and ACCRM, representing the profession as the prime arbiters of professional standards.

5. *Facilitate alternatives such as Medical Co-operatives, Group Practice Networks/Shared Management.*

These options appear to provide GPs with access to the benefits of corporate structures (to varying degrees) for both mutual and individual reward but ensure GP control. Not only are these alternatives consistent with the AMA position of preference for GP ownership of general

practice but they also offer greater opportunity for the real implementation of principles and standards on corporatisation principles generally and conditions specifically. New models of the co-operative, offering GPs access to the significant benefits of corporatisation but the capacity to maintain control over their practice, are currently being promoted in Australia. One such model is based on establishment as a company with both co-operative and corporate streams. All models, however, need to be tested in detail against the AMA principles for corporatisation and further investigation of GP “controlled” co-operative models might be undertaken as part of this strategy.

6. *Practice Management Services for Small Practices.*

The significant benefits of recent developments in practice management have not reached smaller practices, and many doctors find it difficult to meet increasingly complex requirements from governments and consumers, while still maintaining a full patient load.

Unfortunately the financial situation of many small practices does not permit employment of a professional practice manager, and the responsibility for this task falls on the doctor or the doctor’s family.

Small practices need access to professional management consultancy services which they can trust, and which have the flexibility to manage discrete tasks such as organising a billing system or to take on the full role of practice managers on a part time basis. There are potential benefits also in the longer term for virtual or physical amalgamation of practices and other cooperative arrangements.

The AMA could promote development of a range of models of practice outreach consultancies for small practices.

7. *Information on the Varying Corporate Models.*

When GPs are deciding to join corporate models of practice the AMA should provide advice on:

- the questions to ask to ensure clinical independence;
- contract issues generally, including:
 - remuneration;
 - termination clause;
 - ownership of patient records;
 - future practice rights on termination or expiry of contract, etc.
- options available from the corporate model proposed;
- clear analysis of contracts offered;
- ethical responsibilities;
- legal liabilities; and,
- implications arising from the contract which may impact on quality of service or professional obligations related to delivery of health services.

Ref: KPMG Scoping Paper on GP Corporatisation 2000