Sustaining quality general practice in a flawed market

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BACKGROUND Recent years have seen an increasing corporatisation of general practice.
OBJECTIVE This paper considers how divisions of general practice should respond to the corporatisation of general practice.
DISCUSSION Corporate models are an economically rational outcome of structural features of Medicare funding for Australian general practice. One limitation of these structures is that they are indifferent to quality. Corporate general practice competes with divisions of general practice at some level because it provides an alternative organisational structure and service values for large numbers of general practitioners. Accepting this, the challenge for divisions becomes one of differentiating themselves from the corporate model through a focus on promoting and encouraging quality practice.

Divisions of general practice represent an attempt by the Commonwealth Government to implement a level of management of the public investment in general practice services provided through Medicare.

'The main aim of the divisions program is to improve health outcomes for patients by encouraging general practitioners to work together and link with other health professionals to upgrade the quality of health service delivery at the local level'.[1] They now claim to be 'an increasingly important component in leading the change in primary health care'.[2]

Australian general practices are being 'corporatised' as 'for profit' businesseses. This model brings together a number of elements that maximise revenue streams from general practice. These elements are:

- There are financial incentives for frequent short consultations. Medicare is the principal source of general practice income.[3] Payments by Medicare are structured in a way that better remunerates time spent by GPs providing many brief patient encounters, rather than fewer longer encounters.[4] Brief encounters may necessitate increased referral by the GP to specialist services.
- Vertical integration of GP and referral services which takes advantage of the higher profit margins in these specialist services. While inducement to a GP to refer to a particular specialist is illegal, referral streams can still be captured by making these services locally available. Proximity facilitates both referral and patient access to specialist services. As noted above, the limited care available in a short consultation can be compensated for by a specialist referral.
- Product placement that encourages use by the most easily managed market segment. Large medical centres, with extended hours, located in suburban shopping centres offering 'one-stop shopping' (general practice, diagnostic, specialist and pharmacy services under one roof) and providing free services, are convenient and may lower the threshold for use. Any capacity to induce demand would mitigate the impact of increased turnover on practice revenue.[5]
- Economies of scale for practice overheads.

While these structural elements are not new, corporate medical centres have undergone recent rapid growth. In the Canterbury area in New South Wales, for example, 30% of GPs practise in corporate medical centres, and more are being approached to join these services. General practitioners from corporate medical centres have been less likely to become division members or to seek representation on the division board.

Where general practice models focus on financial returns they may do so at the expense of health outcomes. This occurs because of the perverse incentives provided by Medicare arising from the agency problem in health whereby consumers have imperfect knowledge about the service they are consuming.[6] Poor health outcomes may arise for a number of reasons.

These include:

- Short encounters are thought to mitigate against high quality care[9]:

- they detract from the doctor-patient relationship, which is thought to be an important contributor to holistic healthcare[7]
- they do not permit preventive activities to be undertaken
- they do not permit the management of complex problems. This may result in unnecessary specialist referrals and loss of skills in general practice.

There is a consensus both from government funders and the medical profession that brief encounters are less efficient than standard consultations. Evidence for this is the financial incentives provided by the government to GPs who comply with professional standards which mandate a longer average consultation time.[8]

- The market positioning and segmentation strategies adopted by corporate medical centres have the potential to result in 'cream skimming' by which patients with complex care needs preferentially attend other models of general practice. These patients require longer consultations and higher levels of skill thereby giving GPs lower returns for their effort. Continuity of care is one of the hallmarks of general practice[9] and is thought to contribute to improved health outcomes, especially for people with chronic disease. This is because:
  - the close relationship which develops between the patient and their GP allows the GP to better detect changes in health status[10]
  - continuity enhances the provision of preventive care[10]
  - patients are more likely to adhere to therapy from a GP whom they know and trust.[11]

Continuity of care may be diminished if GPs are treated as commodities rather than professionals, patients tend not to see the same GP, or time constraints militate against comprehensive record keeping.

The professional values of general practice emphasise quality care in the face of financial incentives to the contrary. The normalising force of professionalism may be eroded by the commoditisation of GPs, or if the practices in which they work are controlled by nonmedical people.

How should divisions respond?

The central problem to be considered here is how divisions of general practice should respond to the issues fuelling the corporate model of general practice.

Porter has observed that a business can differentiate its products on three criteria: price, innovation and quality.[12] Corporate medical centres have adopted a strategy based on differentiation through a low price, low cost, high turnover market position, where price is taken in a broad sense which includes the patient's transaction costs. This strategy is indifferent to quality, as the Medicare funding model is blind to quality. In contrast, the purpose of divisions of general practice is to enhance quality in general practice. It is in this, and innovation to this end, that their core competencies lie.

A pure business model assuming an efficient market would suggest that the response by divisions of general practice to corporatisation should be to develop a market position differentiated by quality. There are two barriers to this. First, the implicit but untested notion that divisions of general practice have an equal responsibility toward all potential GP members and therefore should offer services equally to GPs in corporate medical centres. Second, the market failure arising from the limited capacity of consumers to recognise high quality care. This is reflected in a price inelasticity whereby low income consumers forego necessary healthcare as the price of this care increases.[13] Management of these two problems therefore becomes the key to the response by divisions of general practice to corporatisation.

The issue of equality of access by GPs to services provided by divisions of general practice can be managed by turning the problem around. The problem is not whether the division has an equal responsibility to all its potential members, but rather how it can make the biggest difference to the quality of care provided by those GPs it is able to engage with the limited resources available to it. The implementation problem then becomes a question of how to engage GPs in the pursuit of quality in the absence of the types of managerial control systems available where employer-employee relationships exist.

Two strategies are available to general practice to address the problem of the level of payment made for quality. Consumer willingness to pay can be enhanced through a marketing program that creates a differentiated position for quality general practice. For example, the Standards Australia quality logo is well known, and vendors who seek it presumably feel that it allows them to command a premium for their product. It could be possible to market accredited general practices in the same way. Capacity to pay can also be enhanced through value added services which target those with a capacity to pay, and by strengthening the remuneration system to reward quality. Examples of the former include charging a premium for a guaranteed appointment time or seeing the GP of one's choice. An example of an attempt to remunerate quality is the blended payments system introduced over the past decade by the commonwealth government. Divisions can have a role in developing and promoting initiatives of this type, but this area is not well developed and the examples provided are intended to be illustrative rather than to suggest the best ways forward.

The capacity of divisions of general practice to increase returns for quality general practice is contingent upon their capacity to engage GPs to provide quality care. The approach outlined does not preclude the participation by any GP, but may be less attractive to those with successfully established income generating

strategies, including those working in corporate medical centres.

Conclusion

The proposed strategies may be high risk because of the substantial barriers that exist to the implementation of quality programs in general practice. The most important of these is the tension between quality and revenue that arises from current funding arrangements. However, the stakes for divisions of general practice are high because failure to tackle the issues raised by corporatisation may otherwise render them redundant.

Conflict of interest: none declared.

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