

WHEN the corporatisation of general practice first hit the headlines, the fear that it would compromise GPs' clinical independence loomed large.

Fast forward to today, and even 5-10 years on there still remains no clear answer on the issue.

Earlier this year, Dr Tony Webber, director of the Professional Services Review, pushed this issue back into the spotlight when he was reported in the *Sydney Morning Herald* expressing concerns about signs that doctors in corporatised practices were generating exces-

sive Medicare payments through overservicing.

Federal Health Minister Mr Tony Abbott reacted by telling that newspaper he was "highly unenthusiastic about any further moves to corporatise medicine", and was concerned that public companies couldn't produce a profit and pay doctors without ultimately having "additional and arguably unnecessary services".

But with only a small number of cases overall ending up with the PSR, and with Medicare Australia not keeping data comparing corporate with non-corporate practices, the issue fizzled out and off the front pages.

But suspicions continue to exist even though hard facts don't.

Professor Paul Komisaroff, director of Melbourne's Monash Centre for the Study of Ethics in Medicine and Society, believes that the concerns about compromised clinical autonomy are well founded, and refers to anecdotal feedback he has received that indicates it does occur.

However, a five-year ongoing study he is conducting of the "micro-ethical styles" of 60 GPs in all types of general practices, including corporatised practices, has so far shown no indication of compromised clinical

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autonomy in corporatised general practices compared with traditional family practices.

While GPs in the study have reported feeling limited in the quality of care that they can provide, they attribute this to financial pressures on general practice as a whole.

"It indicates that GPs are under economic constraints, whether they are corporatised or not, and these constraints, such as providing a good consultation in a short time, are the most important factors affecting quality of care," he says.

But he believes the study's results don't mean that such

compromises are not occurring, it may simply mean that they are hidden by more pressing problems.

Professor Helena Britt, director of the Australian Institute of Health and Welfare's general practice statistics and classification centre, has similar suspicions that corporatised general practices might be ordering higher rates of pathology and imaging, despite the fact data from the institute's Bettering the Evaluation and Care of Health (BEACH) program offers only circumstantial evidence of this.

A study of BEACH
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pathology referral data between 1998 and 2001 found that the size of a general practice was significantly related to the rate of tests ordered. In particular, practices with five or more GPs were associated with a 33% higher rate of test ordering per GP.

Another survey of radiology referrals between 1999 and 2000 also found higher rates for larger practices of 11-15 GPs.

But Professor Britt acknowledges that the problem with these data is that large, multi-GP practices aren't necessarily corporatised practices.

"Nevertheless, you would have to wonder why a non-corporatised large practice would order more pathology and imaging [per GP] ... than a solo practice," she says.

"As a result I believe that the data suggest that there may be an increased likelihood of ordering pathology and imaging associated with corporatised general practices."

But despite these concerns, corporate GPs themselves have failed to materialise with stories of undue pressure being applied to over-

service, over-order tests or direct referrals to services owned by these companies.

Dr Beres Wenck, chairwoman of the RACGP national standing committee on GP advocacy and support and former Queensland AMA president, says while 5-10 years ago concerns and warnings about the corporatisation of general practice were continually raised at AMA and RACGP meetings by her and others, they don't appear to have come to fruition.

"We weren't alarmist, we were just concerned about this big change that was afoot and wanted to ensure that any damage was avoided or minimised," says Dr Wenck, who is a Brisbane GP in a non-corporatised practice.

"In my RACGP position I am out and about, meeting with GPs all the time, and I'm not hearing of doctors being really compromised and experiencing clinical interference from their managers in corporatised general practice."

Dr Joe Kosterich, a Perth GP and former medical director of Endeavour Healthcare, now owned by Independent Practitioner Network, attributes the ini-

tial negative reactions to plain old hysteria, as well as "scaremongering" by some doctors who were acting to protect their interests.

"They were scared that a large corporatised practice was going to open up next door and take away their business. They were protecting their own turf by accusing us of unethical behaviour."

Dr Kosterich suggests data such as that from BEACH showing higher rates of test ordering by larger practices can be explained by more benign factors.

"It is possible that [corporatised general] practices that are vertically integrated have more investigations done because patients are more likely to do them when they are located next door," he says.

"These practices are also better managed, such as having good IT systems in place, and are geared up for recalls."

"In addition, the patients may tend to self-select, such as older patients who require more investigations may be more likely to come to corporatised general practices due to the easier accessibility provided by locations near public transport." ●