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Title	The impact of practice size and ownership on general practice care in Australia

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The impact of practice size and ownership on general practice care in Australia

Recent trends in general practice structure may have an impact on future patient care in Australia

The organisational structure of general practice in Australia has changed considerably since the late 1990s.[1] Prompted by health care system changes, practice cost increases and incentives, originally small-scaled general practices have merged into larger entities.[1]

At present, 2% of Australian general practitioners (GPs) work in solo private practices, while 20% of full-time GPs and 33% of part-time GPs are employed in large practices with six or more GPs.[1] Practice ownership levels have changed as well. In 2020, 25% of Australian GPs were practice owners, a decline from 35% in 2008.[2] Factors such as management responsibilities, financial burdens and a lack of work–life balance seem to discourage practice ownership.[3] Concurrently, commercial ownership models emerged, ranging from ownership by other health professionals to corporate groups of publicly listed companies, with shareholders having little or no involvement in patient care or practice management.[3] In 2000, there were six corporate groups; by 2020, three remained, which operate over 400 medical centres. Survey data from 2020 indicate that approximately 16% of GPs work in corporate-owned practices.[1] Co-located services increased as well. In 2016, 81% of practices had pathology services on location versus 49% in 2010; for imaging, these figures are 30% versus 15% and for physiotherapy 50% versus 29% respectively.[3,4]

Trends towards increasing general practice size and corporatisation have also been reported in other advanced economies. In the United States, about 16% of primary health physicians are employed in corporate-owned practices.[5] Sweden has encouraged for-profit facilities to increase provider choice and competition, resulting in 40% of general practices being privately owned.[6] Corporatisation of general practice in New Zealand is rising as new generation GPs prefer a lower administrative burden.[7] While national policies in the United Kingdom have encouraged partnerships and the integration of general practices to improve service quality and facilitate access, most practice groups have remained independent businesses (< 5% corporate-owned).[4]

Corporate business models may have clear advantages for GPs, including financial security and a better work–life balance, and they might benefit patients as they offer a range of on-site medical services and extended opening hours.[3] However, concerns have been raised about the consequences of growing practice sizes and corporate-owned general practices, in particular regarding corporate obligation to deliver revenue to their shareholders who do not participate in any aspect of patient care, putting profits before patient care.[8] Moreover, some corporations currently active in Australian general practice operate across international borders and their cultures may be inimical to patient-focused health care. The aim of this narrative is to synthesise the available information about the impact of changes to size and ownership on the delivery of patient care and the health care system. The review is based on articles and reports found through an extensive search of the (grey) literature, the reference lists of key articles and related articles, and via the "cited by" feature in Google Scholar. Only publications in English, published after 2000 and applicable to the developments in Australia were considered for inclusion. After screening, 14 publications were included (Supporting Information, table 1).

Impact of general practice size and ownership model

Independent of size and ownership, general practices should deliver high quality services, with commitments to access, continuity and quality of care and optimal use of health expenditure (Box 1).

Impact on access to care

Initially, most corporate practice models offered bulk-billing; however, the introduction of the Medicare rebate freeze in 2013 resulted in a change to mixed- or private-billing models.[9] The expansion of GP practice consolidation and corporatisation is associated with less closely located competition, which may lead to further reductions in bulk-billing and an increase in service fees and out-of-pocket expenses.[10] While there is no direct evidence that larger practices and corporatisation lead to financial barriers to accessing care, access may be affected when multiple smaller practices conglomerate into larger, more centrally located practices, especially for people residing in regional and remote areas where there are already fewer GPs per person.[1] The reported long waiting times in corporate medical centres and the shortage of viable transport options to more distant general practices may further impede access to medical care when required.[11]

Impact on continuity of care

Continuity of care enhances patient satisfaction and trust, which improves the understanding and management of illnesses, adherence to treatment and may ultimately lower mortality rates.[12] Results from an Australian online survey[13] showed that while most participants (n = 2477) do have a usual GP (80%) or general practice (90%), 28% had sought care from multiple practices in the preceding year. Reasons for multiple practice visits were not provided.[13] In larger practices, the "usual GP" was often replaced by "usual practice", resulting in patients consulting GPs they had never met before.[13]

Similarly, higher levels of continuity of care were experienced in small practices (50%) compared with practices with seven or more GPs (31%), according to a study from the UK.[14] A large UK study[4] (n = 903 357) found that corporatised practices provided significantly worse overall patient experience compared with traditional GP practices and particularly in regards to consulting a preferred GP. In the qualitative aspect of an Australian study,[11] participants visiting corporate practices reported a lack of continuity of care and that doctors were often not aware of their medical history. Furthermore, participants indicated that appointments were short, unsatisfactory and lacked follow-up. Lower follow-up rates were also found in for-profit Swedish primary care centres for patients with chronic diseases compared with centres owned by not-for-profit organisations (71% *v* 75%).[15]

Impact on quality of care

While the efficiency of management processes, co-location of health services and extension of opening hours of corporate-owned general practices undoubtedly accommodate the need of patients, research suggests that the quality of corporatised GP services may be worse compared with care delivered by traditional providers.[11,16,17] In a UK cross-sectional study[16] (n = 971 232), out-of-hours services delivered by corporate organisations scored significantly lower for the timeliness of provided care and for physician and overall patient experience. In 2013, a survey[11] of 617 Australian Capital Territory residents did not find a relationship between practice size and patient satisfaction. However, there was a difference between patient satisfaction and care delivered in non-corporate practices (91%) and corporate practices (79%).[11]

A UK study[17] (n = 8300) found that non-traditional providers performed consistently worse ($P < 0.01$) on 15 out of 17 performance measures related to patient experience, cost and efficiency, access and clinical effectiveness. There are few Australian studies that investigate whether size or ownership affects patient outcomes. One of these,[18] which focused on diabetes care in nearly 150 practices across three states between 2011 and 2014, found that neither practice size nor ownership type related to good glycaemic control and completion of annual cycles of diabetes care.

Impact on health expenditure

In 2018–19, about \$8.0 billion (6%) of the total government health expenditure related to benefit paid for non-referred medical services, which include GP services, an increase of 75% in the past decade (Box 2).[19] The concurrent 48% government expenditure increase per capita on received GP services has been linked to the rise in chronic diseases, resulting in a multitude of services delivered to single patients.[1,19] It has been argued that the observed increase might be associated with the practice of overservicing to meet income targets, or with GPs over-referring to commercially related and co-located services.[22] An analysis of 8 years of general practice activity data, found that practice size was positively associated with pathology ordering: practices with five to ten full-time equivalent (FTE) GPs had a nearly eight times higher rate of ordering than those with fewer than two FTE GPs.[23] An investigation of the impact of pathology co-location with similar data found no direct association between co-location and increased test ordering, although the clinical appropriateness of tests was not investigated.[24] In addition, some corporate GPs reported feeling pressured by their employers to increase services billed and the occasional use of provider numbers for clinically unnecessary services or added consultation items without the physician's consent.[8]

There is also evidence of potential underuse of GP services. Up to 40% of emergency department presentations could have been managed in a general practice setting, and a clear relationship was found with lower levels of continuity of care provided.[4,25] Large and corporate-owned practices seem to be associated with overservicing and lower levels of continuity of care and may therefore negatively affect health costs. A considerable amount of secondary care expenditures might thus be saved each year through effective primary health care delivery.

Conclusion

There is a growing trend of general practice consolidation with co-located pathology, imaging and allied health services. This trend is expected to continue as 50% of current practice owners plan to retire within 10 years and nearly 60% of non-owning GPs are "not at all interested" in becoming practice owners in the future.[1] While there is little Australian evidence that worse clinical care is delivered in privately or corporate-owned general practices, there is also no evidence that care is better. Hence, if general practice in Australia is to navigate the future changes in practice size, ownership and increasingly co-located service organisation, more Australian research and potentially regulation are needed to track and control what this means for patient care in terms not only of patient experience but also for health outcomes in general practice.

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[Insert boxes]

[Box 1; dem_mja20.00988_gr]

1 Key elements of general practice service provision

[Box 2]

2 Government health expenditures and Medicare benefits paid per capita in the financial years 2008–09 and 2018–19[19]

	2008–09	2018–19	Increase (%)
Estimated resident population Australia	21 249 199	24 992 747	17.6%
All government health expenditure ($)[1,3]	78.6*	133.6*	70.0%†
Benefit paid all services ($)	14.3*	24.1*	68.9%†
Benefit paid out-of-hospital non-referred services (GP services)	4.6*	8.0*	74.6%†
Benefit paid per capita for total Medicare	671	963	43.5%
Benefit paid per capita for GP services	218	322	47.7%
Average of GP services per capita	5.3	6.3	18.9%

GP = general practice. * Billion. † The increase in percentage is calculated before rounding the expenditures to one decimal point in billions. Source: Australian Institute of Health and Welfare.[20,21]