The business of general practice

Doug Baird MBChB Dip Obst FRNZCGP

***Doug Baird** is Chairman of the IPA Council of New Zealand. He has been in general practice in Freemans Bay in Auckland since 1979 and has been a strong advocate of general practice in both the NZMA, and the IPA movement. He was a founding director of ProCare and continues in this role. He is married with three teenage sons and favours writing, motorcycling and fishing as relaxing pastimes.*

First let me declare an interest. As Chairman of IPAC I represent the business of organised general practice (OGP) and work with a management team and an executive of nurses, doctors and managers to promote and strengthen the role of general practice in New Zealand. I believe the future of general practice and of doctors who want to practise family medicine rests with strong, well organised general practice at a local, and national, level.

Traditionally graduates from medical school who had chosen not to spend long years being subjected to a mixture of torture and near slavery in the hospital system, or who had a genuine love of ongoing community-based medical care, did general practice. There was no formalised training and the quality assessment consisted of the local community deciding if you were an OK 'quack' or not. Not infrequently communities lacked choices and had to settle for whom they got.

The almost exclusive model was ownership of the business, which oftentimes was situated in the front of the large residence of the practitioner. GPs mostly practised in solitude, were usually male, and sometimes the only employee was the doctor's wife who acted as receptionist-manager, and even nurse. Ongoing education was visits from drug 'reps' and the odd session organised at the local hospital. Incomes were adequate and equated to around half those of the surrounding private surgical consultants. Professional representation was provided by the pan-professional BMA. This was the case until the mid-1970s.

There has been so much change in the last 30 years that the only thing that remains similar is that most general practices are still owned by general practitioners. Even this model is undergoing changes, albeit less rapid ones. Going into practice now involves business as well as emotive choices. The pitfalls are rapidly catching up with the advantages and the income is generally less than that of a Medical Officer Special Scale (MOSS) working in a small rural hospital. Being a MOSS was traditionally seen as a step in the door for immigrant doctors, or a step toward the door for semi-retired docs.

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There are now more women and part-timers doing general practice and the ownership of practices does not have attraction for these people. The burdens of compliance to the multitude of rules and regulations that govern small business in general and general practice in particular are daunting and, added to the quotidian tasks of caring for a community of patients, make practice arduous and far from risk-free. Rooms can no longer consist of a converted bedroom and sitting room but are mainly purpose-built and shared in governance with others. As well, practice staff work in teams which add knowledge and skills, but increase the demand for guidelines, protocols, meetings and the need to work well with others. Incomes are relatively poor compared with the past relativity of general practice and there is no room for relaxed financial management. There are now three national bodies in Wellington representing the interests of general practice: IPAC, the NZMA and the College.

The only time I find nostalgia acceptable is when I look in a mirror. I do not denigrate or resist much of the change that has occurred in the delivery of general practice care in New Zealand. I strongly believe that the health of the people of this nation depends strongly on quality care provided by teams of doctors nurses and others working in a community-based setting in agreement with policies that recognise that preventative health care delivers the greatest gains.

The future of general practice is exciting and the business of general practice needs to be carefully considered and managed to provide for a willing vibrant and sustainable work-force to provide that future.

For new graduates to choose general practice as a vocation there needs to be clear and attractive pathways for them to follow. They need to see that they are valued and supported in the way that hospital and private consultants are. This means the business of general practice must be clearly defined and strongly supported. The business can have more than one model; in fact a number of models could strengthen the sector.

My experience of general practice is that most business decisions are pre-ordained before they and their effects are even understood. For many doctors their first general practice is also their only one and the structures and consequences of these structures are set in ignorance and naivety. They become irreversible and frustrating. Business studies are undervalued by undergraduates who often see discussions of business as tainting of their pure desires to heal. This is laudable, but dumb, thinking.

Almost all general practice will soon be practised under the umbrella of Primary Health Organisations (PHOs) yet it is unlikely that many PHOs will take any financial risk for the general practices.

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Rule 1: Common sense would suggest that anyone contemplating ownership or governance of a general practice should align themselves with an organisation that protects the interests of their business. This would be a PHO that is allied to a successful IPA where the PHO, in discharging its responsibilities, recognises that the success of its general practices is seminal to its own achievements. Join the IPA and help empower it rather than just hanging onto its coattails via the PHO.

There are going to be a number of models of practice ownership along with the traditional owner-operator genre. Some GPs have become entrepreneurial and have extended their practices to employ other doctors and supporting nursing and reception staff. Some clinics have private non-medical ownership where all staff are employees. In areas of need, community groups or government have provided facilities and staff, and doctors have worked in fee-for-service or salaried positions. Some IPAs and PHOs have looked at models where they own the practices of their associated doctors and the doctors are employees of the organisation.

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Rule 2a: Make a decision based on your desired workload, working life expectancy, income and leave needs and whether you want to be the boss or an employee before committing yourself to a choice of working circumstances.

Rule 2b: If you are going to own and govern your own business you should expect to earn more to compensate for your business risk and the cost of the use of capital in ownership. In other words, there should be clear compensation to you for paying for the set up and running of the business and for the extra work involved in employing and managing other health professionals and support staff.

There were two traditional ways of getting into general practice. The first was doing a locum for a doctor who either never returned from the holiday and left you the practice (read here less than desirable place to practice) or who cleverly arranged for you to fall in love with his town and find his patients really interesting (read here seaside, lake or ski town) and 'reluctantly' sold you the practice (and house and car and ageing but 'indispensable' receptionist). The other way was to find somewhere you really wanted to live and then set up a practice in that same suburb or town because it seemed like the nicest place to be. This has lead to areas like Remuera and Ponsonby being grossly over-doctored whilst leaving a good number of nearby suburbs (within 30 minutes drive) very short on GPs.

Rule 3: Live where you can afford or want to, and do serious demographic and business studies before putting up your shingle.

A good business is established by people who see both its potential and its pitfalls and who make plans to maximise the first and mitigate against the second. We are professionals who rail against patients who do not seek our advice or, if they do, do not take it, yet we seldom seek legal, accounting and business advice before we have established patterns that serve us poorly. Often these patterns are impossible to change and patch-up remedial action is all that can be undertaken.

Rule 4: Get good legal and accounting advice in the planning stages of going into general practice no matter the model you intend to work under. Ignore this rule at the peril of always being in catch-up mode.

Although the catch-cry of the modern general practitioner is that due to increasing compliance demands we no longer have the desired time to spend 'just seeing patients' there is the potential risk of making general family practice your only source of income. Being a generalist, no matter the knowledge and skill required, is never rated as being as valuable as being a specialist, no matter the knowledge and skill required. A good little earner to add

to your broader work base is a must. Sub-specialities within broader areas of skill are the new diversification.

Rule 5: Find an allied health area where you can add value and market yourself in that role. Travel medicine, women's health, men's health, sports medicine, children's health, elder care, minor surgery, sexual health, counselling, manipulotherapy and hospice care spring quickly to mind. You might argue that all these things are what general practices do. However, for 15 years I did almost all the accident repairs and suturing in Freemans Bay until an A&tM Clinic opened 500 metres up the road and from then I have not done an accident suturing job in 10 years. I didn't change and they were no better at it than me, but they were better marketers.

Working in isolation leads to loss of skills and to paranoid delusions about 'them' and 'us'. Make sure your professional career is supported by multiple involvements with your colleagues in medicine and nursing and that you are open and discursive in your interactions. Peer groups for quality and increasing of skills, attending courses on business and accounting learning, representative and political organisations and associations set up specifically to protect your interests should all attract your interest, time and involvement. Become a leader, or a strong follower.

Rule 6: Jesus was a carpenter, you become a joiner.

Rule 7: Never let your spouse or 'significant other' have anything to do with working in or managing your practice. This rule is self-evident and if you require explanation you should ignore all the advice so far given in this column and head for connubial and working bliss in some charitable organisation that is desperate for your skills.

For general practice to remain the centrepiece of current and future primary health care strategies for New Zealand, it needs to have a clear and strong presence in Wellington. It needs to be represented in a way that makes sure that there is no potential for important issues to divide the profession, or for political and government organisations to use divisive strategies amongst our representatives. Graduates making their choice as to their career in medical practice will be spending thirty or more years working in that field. Budding and new GPs need to know that their work future is as good and ensured as possible. The skill bases of organisations and their leaders must be utilised specifically rather than indiscriminately.

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It seems clear to me that GPs who are interested in the quality of medicine practised in general practice get to be leaders in the College; doctors whose concerns are in the area of advocacy, ethical and pan-professional issues get to be leaders in the NZMA, and those who have knowledge and interest in the business, organisation and management of general practice get to be leaders in the IPA movement. When these organisations start proclaiming loudly and inadvisedly in each others' areas of representation and expertise, they threaten the strength and future of general practice. GPs need to be involved in membership of all their professional organisations and leaders in the one that takes their interest.

Rule 8: Get involved in your professional organisations and ensure that they stick to their knitting. This will more than almost anything else ensure the future of general practice and its business.

I have many more bits of advice and plenty of philosophical discursive ideas on the multiple choices and pathways that make up the future of successful general practice in New Zealand, and one of the most important is embracing practice nurses as our partners in the provision of care in our sector. Unfortunately there is only so much space for me, so I will finish with the rule that governs everything we should do:

Rule A: If it ain't fun then it ain't worth doing!

'In September 2004, a federal appeals court upheld a class-action lawsuit on behalf of physicians who charged that their patients' insurance companies had conspired to curb reimbursement for the physicians' services. The judge described the case as "almost all doctors versus almost all major health maintenance organizations". The case has revealed issues that have long lurked beneath the surface of the managed-care revolution. Physicians are accused of driving up costs and exploiting the third-party-payer system by overcharging for their work. Managed-care organizations are accused of systematically obstructing and delaying payment for legitimate services in order to improve their bottom lines. In the end, the court's involvement in controversies about billing practices may help to expedite changes in the health care payment system.'

Kesselheim AS, Brennan TA. Overbilling vs. Downcoding – The Battle between Physicians and Insurers. N Engl J Med 2005;352(9);855–857.