GP SUPER CLINICS—HAS THE MARKET FAILED?

There is no economic rationale for providing additional health care subsidises for GP Super Clinics, says **Jim Butler**

The GP Super Clinics component of the Rudd government's health policy has been attracting considerable attention recently. The concept of GP Super Clinics was first articulated by the Australian Labor Party (ALP) in its health policy paper in August 2007 when it was in Opposition.[1] Upon winning the federal election in November 2007, the newly elected government set about implementing the GP Super Clinics program by allocating $242.1 million to establish 31 clinics over four years in the 2008–09 budget.[2] The number of clinics to be funded under the program was subsequently expanded in the latter half of 2009 to 36 with a total funding commitment of $275.2 million.[3] The 2010–11 Budget expands the program even further with a commitment of $355.2 million to fund another 23 new GP Super Clinics and provide infrastructure subsidies for 425 existing primary care clinics to enable them to provide 'GP Super Clinic style services.'[4]

The 2008–09 Budget papers provide an insight into the government's economic rationale for the GP Super Clinics program:

> The Australian Government is committed to ensuring that Australians have access to high quality, cost-effective and appropriate primary health care services, which are predominantly funded through the payment of Medicare benefits … However, other funding models and infrastructure development are required to support the provision of certain types of care, *particularly in cases of market failure*. Examples of such initiatives include GP Super Clinics ...[5]

The rationale for establishing GP Super Clinics is that the market is failing to deliver medical services through a particular form of business organisation, which is why we need to subsidise that specific form of business organisation—GP Super Clinics. This argument has little merit. It is not based on the notion that there is general market failure in the provision of medical services as the Medicare subsidies for medical services already address this. Rather, the argument is that the market has failed to deliver a particular type of medical clinic and additional subsidies are needed to correct this. Close scrutiny of the two broad characteristics of GP Super Clinics—the range of professional services offered and the philosophy of service provision—suggests that the market in fact

Jim Butler is Professor of Health Economics at the Australian National University and Director of the Australian Centre for Economic Research on Health (ACERH), an independent research centre that operates as a partnership between the Australian National University, the University of Queensland, and the University of Western Australia.

has not failed in this regard, and that additional subsidises to stimulate the development of GP Super Clinics have no economic merit.

What are GP Super Clinics?

According to the National Program Guide, the health care services provided through GP Super Clinics could include, but need not be limited to, the following:[6]

- General Practice (with privately practising GPs a key element of each GP Super Clinic);
- After-hours care;
- Facilities for regular services provided by other allied health professionals;
- Psychology services and relevant mental health support programs including drug and alcohol counselling;
- Consulting rooms for visiting medical specialists and access to physicians and paediatricians;
- Facilities for practice nurses to provide comprehensive primary health care (as part of a multi-disciplinary team);
- Facilities for running regular chronic disease management programs and community education;
- Dental services;
- Linkages with key components of the local health system such as hospitals, community health services, other allied and primary health care services, health interpreting services, telephone triage services and other established telephone help lines;
- Community health services funded by State and Territory governments;
- Co-located diagnostic services, provided that these are consistent with relevant pathology and diagnostic imaging legislation; and
- Pharmacy services.

In addition to providing a broader range of services from the one clinic, the vision for GP Super Clinics embraces a greater emphasis on preventative services and coordinated/integrated care. This is a key characteristic of Super Clinics emphasised in the work of Jennifer Doggett, a leading advocate of their establishment, and in the final report of the National Health and Hospitals Reform Commission where such clinics are referred to as Comprehensive Primary Health Care Centres and Services.[7] The main premise is that enhancing access to preventative services and improved care coordination for people with chronic diseases (e.g. diabetes) will improve health and reduce demand for hospital services in the longer term.

Program funding

The main stream of government funding for the program is infrastructure capital to subsidise the construction of facilities designed for multidisciplinary care, including allied health services. These capital funds can also be used 'to provide teaching rooms and facilities to make the GP Super Clinics attractive to new graduates, trainees and GP registrars.'[8] Most capital grants will be in the range of $1 million to $10 million with a few grants in excess of this.[9]

Two other streams of funding are also available. A relatively small amount of recurrent funding may be provided to assist with the cost of administrative support. The maximum amount of support under this stream is 12.5% of total Commonwealth funding for the Super Clinics over four years. A third stream of funding provides one-off relocation incentives—a maximum of $15,000 for GPs; $7,500 for allied health professionals; $6,000 for nurses, mental health workers, and ATSI health workers; and $7,500 and for pharmacy/pharmacists (one pharmacy grant per site).

There are three alternative processes for distributing funds: an invitation to apply process (tenders); a joint government process (Commonwealth/state joint funding); and direct engagement (a recipient is already identified). At the time of writing, funding agreements have

been executed for 28 clinics. Of the 37 funding agreements executed or to be executed, 23 have resulted, or will result, from a tender process; 10 from direct engagement; and four from joint government agreements. The average maximum Commonwealth grant per clinic is $4.78 million, and the funds will be made available to clinic owners, including public organisations such as universities.[10] There is no indication that GP Super Clinics will be owned or operated by the Commonwealth.

Financing and choice

Once established, GP Super Clinics will be financed in the same way as other out-of-hospital medical services in Australia. Patients are not required to enrol with a GP Super Clinic; they can choose clinics in the same way they do now. Patients are not required to 'sign on' with a GP Super Clinic for a defined period of time and forgo attendance at other clinics in the process—they retain full choice of doctor and clinic. GP Super Clinics will not therefore become fund-holders for MBS/PBS services with government making lump sum payments to cover the expected costs of consultations, test, investigations and drugs for a defined time period. In other words, GP Super Clinics will not operate as Health Maintenance Organisations (HMOs) or Managed Care Organisations (MCOs).

Nor are GP Super Clinics about salaried medicine. GPs will be free to negotiate the terms of their engagement with a GP Super Clinic as they would with any other clinic, and services provided by the clinic will be billed under the usual fee-for-service arrangements. The only specification with respect to financing is that preference may be given to tenders that propose to bulk-bill for services. The clinics are not therefore a variant of Community Health Centres (CHCs) that first appeared in Australia in the 1970s under the Community Health Program introduced by the Whitlam Labor government. CHCs that engaged GPs did so mostly on a salaried basis, although in other respects the vision for CHCs shares some similarities with that for GP Super Clinics, especially an increased emphasis on prevention and provision of a broader range of services, including counselling and rehabilitation.[11]

Horizontal and vertical integration

GP Super Clinics can be seen as an attempt to increase the extent of both horizontal and vertical integration in the health care market. Horizontal integration refers to the merger of firms at the same stage of production. Vertical integration refers to the merger of firms at different stages of production. In the context of the GP market, horizontal integration refers to the merging of general practices from solo practices into group practices, or from small group practices into larger group practices. In the context of the medical services market, vertical integration would occur if GPs and specialist practitioners such as physicians, pathologists and radiologists merged into one practice.[12]

GP Super Clinics can be seen as an attempt to increase the extent of both horizontal and vertical integration in the health care market.

The 2007 ALP policy document suggests that a GP Super Clinic could have at least five GPs.[13] The question is whether the medical services market has failed to deliver this level of horizontal integration, assuming greater horizontal integration is optimal. Trends in practice size in Australia indicate that practice amalgamations have been occurring in recent times, and these trends are actually highlighted in the 2007 ALP policy document. A study of changes in the characteristics of active GPs in Australia between 1991 and 2003 reports that during this time, the proportion of GPs working in solo practice fell from 25.5% to 13.7% while the proportion working in group practices of four or more partners increased from 34.3% to 59.8%.[14] This trend, prior to and in the absence of additional subsidies to encourage horizontal integration, suggests the health care market is working, not failing.

A 2007 study of the financial performance of vertically integrated medical clinics in Australia indicated that medical businesses that included the provision of pathology and imaging services along with GP services performed better than

businesses that relied on GP services alone.[15] This trend appears to be driven by the ability of a firm to capture higher returns from referrals when vertically integrated.

To the extent that these results are robust, one would expect vertical integration to be occurring in the health care market without any additional subsidies—capital or recurrent—being necessary. Vertical integration does appear to be taking place, with clinics pursuing vertical (and horizontal) integration outside the GP Super Clinics program. Stephen Pincock cites the following example: 'Run by Allied Medical Group, a company with links to Dr Geoffrey Edelsten, the Casey Superclinic was opened in 2005 and currently has consulting rooms and two "emergency room styled treatment rooms," with an on-site pharmacy, Gribbles Pathology collection rooms, and rooms for physiotherapy, optometry and dental services, according to its web site. Open 24/7 and bulk-billing all patients with a Medicare card, the clinic is situated across the road from a local hospital.'[16] The Allied Medical Group now operates seven other Super Clinics in Victoria and several in Queensland.[17]

Not only does the GP Super Clinics program fail to correct a market failure but there is a possibility that it will end up underwriting business failures.

The argument is that market failure in the development of particular forms of business organisation in health care does not withstand scrutiny. Horizontal and vertical integration in clinics has been occurring and continues to occur. GP-Super-Clinic-style organisations emerged before, and independently of, the advent of the GP Super Clinics program.

Preventive care and coordinated/integrated care

Outside the capital grants, a modest recurrent subsidy for administrative costs and the relocation incentives will be provided to GP Super Clinics. Otherwise, each will operate under the same rules and regulations in the Medicare Benefits Schedule (MBS) as other medical clinics in Australia. Specifically, they will have access to the same range of MBS items and the same rebates as other clinics. There are no MBS items restricted to GP Super Clinics so that they could provide additional incentives for preventative care services, nor are there any additional items to encourage greater coordinated/integrated care for chronic disease patients (or any other patients).

It is possible, of course, that GP Super Clinics will provide non-economic incentives to bolster the provision of this type of care. It may be that the constellation of different types of health workers in the one clinic, the association with GP education and training, and the general culture of medical practice in the clinics will lead to a greater emphasis on prevention and coordinated care. However, given that the economic incentives at work are the same as in 'conventional' clinics, there is a distinct risk that the practice style will mirror that found in conventional clinics. As a result, to the extent that market failure can be said to characterise the provision of preventive services and inhibit coordinated/integrated care, there is no economic incentive beyond that provided for establishing a GP Super Clinic for it to operate differently from other health clinics.

Correcting market failure or underwriting business failure?

Not only does the GP Super Clinics program fail to correct a market failure but there is a possibility that it will end up underwriting business failures.

The core of the program is based upon one-off capital grants that do not appear to be contingent upon any financial performance targets being met once the clinic is in operation.[18] The question is how long a GP Super Clinic is required to operate to satisfy the terms and conditions of the grant. DoHA's National Program Guide states: 'Commonwealth funding agreements are likely to require the funding recipient to use the GP Super Clinic consistently with the Program Objectives for a 20-year period.'[19]

If a clinic must remain in operation for 20 years, the question is who will finance the clinic if it experiences operating losses? A GP Super Clinic

is a risky private sector business venture. The clinic may not break even because, for example, the catchment population is not attracted to this style of clinic or a competitor clinic proves more popular.

The repercussions of a Super Clinic going out of business within 20 years were assessed in an addendum to FAQs on the DOHA website.[20] It was pointed out that the Commonwealth has a range of rights under the funding agreement by which a failing GP Super Clinic may be required to repay the Commonwealth a proportion of the funding provided to establish it. Of course, this has not yet been tested so it remains to be seen what remedies the Commonwealth will seek (if any) in the event of business failure, whether it will be successful in recovering any funds, or whether the federal government will step in and provide further recurrent subsidies to keep a failed Super Clinic going.

Unfair competition

Super Clinics are a business organisation involving horizontal and vertical integration of existing types of health care clinics and have already emerged in the private sector independently of the GP Super Clinics program.

The GP Super Clinics program involves substantial capital grants to successful applicants to assist with the establishment of this type of organisation. As the subsidies are available to only a limited number of such organisations, existing clinics that face increased competition from the new Super Clinics are placed at a financial disadvantage because this new competition will not be taking place on a level playing field.

This argument was put by GPs many years ago in response to the introduction of CHCs under the Whitlam government's Community Health Program mentioned earlier in this article.[21] It was raised again recently by a GP in Townsville who expects to face serious competition from a new GP Super Clinic when it opens nearby.[22] These problems will be compounded if the 'infant' fails to mature and the teat of further government subsidises is sought out to remain in business.

Conclusions

Medical service markets have been moving in the direction of greater horizontal and vertical integration where it is economically warranted without procuring any additional subsidies. As there is no market failure for GP Super Clinics to correct, no economic rationale exists for providing subsidies over and above the general subsidies already available for medical services through the MBS. Super Clinics will have no greater economic incentive to provide preventative services or more integrated/coordinated care for chronic disease patients than other clinics because they will have access to the same MBS items and the same MBS rebates for those items as all other eligible providers.

Although there have not been any business failures involving GP Super Clinics so far, government policy could certainly have unintended but predictable consequences. There is a real risk the federal government will end up underwriting business failure by either failing to recoup any of the capital subsidy in the event of a GP Super Clinic folding or by providing additional recurrent subsidies to enable unprofitable clinics to continue operating. Such subsidies may well expose existing clinics to further unfair competition as they tilt the playing field in favour of the new clinics.

None of these arguments undermines the concept of the GP Super Clinic per se. A number of such clinics have emerged in the private sector without any additional subsidies from government, and they may well herald a new style of medical practice. But this is an outcome that itself is best left to a market test.

Endnotes

1. Kevin Rudd and Nicola Roxon, *New Directions for Australia's Health: Delivering GP Super Clinics to Local Communities*, Australian Labor Party (unpublished, August 2007).
2. *Portfolio Budget Statements 2008–09: Budget Related Paper No. 1.10, Health and Ageing Portfolio*, Commonwealth of Australia (Canberra: 2008), 26.
3. Department of Health and Ageing, GP Super Clinics website. The DoHA website lists 37 GP Super Clinics to be funded under the program—the Hobart Eastern Shores Clinic has two sites with their own funding arrangements.

4. *Budget Overview 2010–11* (Canberra: Commonwealth of Australia, 2010), 1–14; *Portfolio Budget Statements 2010–11: Budget Related Paper No. 1.11, Health and Ageing Portfolio* (Canberra: Commonwealth of Australia, 2010), 214.
5. *Portfolio Budget Statements 2008–09*, as above, 110 (emphasis added).
6. Department of Health and Ageing, *GP Super Clinics: National Program Guide* (Canberra: unpublished, DoHA), 7.
7. See following:

- Jennifer Doggett, 'A new approach to primary care for Australia,' Occasional Paper No. 1, Centre for Policy Development (June 2007);
- National Health and Hospitals Reform Commission, *A Healthier Future For All Australians,* Final Report (Canberra: DoHA, June 2009).
- A critical appraisal of the ability of GP Super Clinics to achieve these objectives is provided by Jeremy Sammut, *The False Promise of GP Super Clinics Part 1: Preventive Care* and *The False Promise of GP Super Clinics Part 2: Coordinated Care*, Papers in Health and Ageing (3 and 4), CIS Policy Monographs Nos. 84 and 85 (Sydney: The Centre for Independent Studies, 2008).

8. Nicola Roxon, 'Taking leadership—tackling Australia's health challenges. The health policy of the Labor Party,' *Medical Journal of Australia* 187:9 (5 November 2007), 494.
9. Department of Health and Ageing, *GP Super Clinics: National Program Guide*, as above, Attachment A.
10. Department of Health and Ageing, GP Super Clinics website.
11. The original vision for CHCs was put forward by the National Hospitals and Health Services Commission in *A Community Health Program for Australia* (Canberra: Australian Government Publishing Service, 1973). An overview of the program and CHCs can be found in Fran Baum, Community Health Services in Australia in John Germov (ed.), *Second Opinion: An Introduction to Health Sociology* (fourth edition) (Oxford University Press, 2009), chapter 24. On the role of GPs in CHCs, see Michael Montalto and David Dunt, The evaluation of general practice in community health centres: a critical review, Working Paper No. 25 (Centre for Health Program Evaluation, Monash University, and the University of Melbourne, October 1992).
12. A discussion of horizontal and vertical integration with reference to primary care is provided by Steven Simoens and Anthony Scott, 'Integrated primary care organizations: to what extent is integration occurring and why?' *Health Services Management Research* 18:1 (February 2005), 25–40.
13. Kevin Rudd and Nicola Roxon, *New Directions for Australia's Health*, as above, 19. The 2007 ALP policy statement suggests that a GP Super Clinic 'could include ... a group of five or more privately practising GPs.' However, this specific quantitative 'target' is not mentioned in DoHA's *National Program Guide.*
14. Janice Charles, Helena Britt, and Lisa Valenti, 'The evolution of the general practice workforce in Australia, 1991–2003,' *Medical Journal of Australia* 181:2 (19 July 2004), 85–90.
15. Jane Jones, 'Integration and diversification in healthcare: financial performance and implications for Medicare,' *Health Sociology Review* 16:1 (April 2007), 27–42.
16. Stephen Pincock, 'Coming, ready or not,' *Australian Doctor* (25 June 2008), 23–26.
17. For further information on the Casey Superclinic and other Superclinics operated by the Allied Medical Group, see http://www.alliedmedicalgroup.com.au/casey-superclinic.asp.
18. The actual terms and conditions of the grants are contained in the executed financial agreements with the owners of the clinics. The author attempted to obtain copies of these agreements but was unsuccessful as they are classified commercial-in-confidence. Consequently, the terms and conditions attaching to the grant for any particular clinic are not known.
19. Department of Health and Ageing, *GP Super Clinics: National Program Guide*, as above, 14.
20. Department of Health and Ageing, *Addendum to the Frequently Asked Questions*.
21. Paul Laris and associates, *Community Health Centres in South Australia: A Brief History and Literature Review*, report commissioned by the Generational Health Review, South Australia (unpublished, November 2002). On unfair competition, Laris and associates state on p 14: 'Publicly funded CHCs offering medical care plus a wide range of other health care services and facilities at no cost to patients at the point of delivery were seen by some GPs as unfair competition, especially for small practices.'
22. Andrew Bracey, 'I could be crushed: GP fears super clinic fallout,' *Medical Observer* (23 February 2010).