General practice: balancing business and care

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Are general practices in New Zealand hybrid organisations? If they are examples of hybrid organisations, is 'hybridisation tension' increasing?

Early in the 1990s, traditional distinctions between public, private and third sector (the collective grouping of voluntary, non-profit and non-government organisations (NGOs))[1] blurred as increasing levels of state service provision were transferred from public to voluntary and non-profit organisations. This resulted in blended or hybridised organisations, structured and operated as non-profit, but expected to behave as more business-like providers of community and social services.[2] Today, hybrid organisations are found at the convergence of public, private and non-profit sectors. Most of these organisations still retain at least some of the inherent tensions born from this blurred state. For instance, there are tensions between volunteer or employee mission-based values and an organisation that must balance its service provision within its funding, creating what is known as 'hybridisation tension'.[3]

Some NGOs such as Māori providers receive Vote:Health funding to provide clinical services, making them clear examples of hybrid organisations. Hybridisation tension can clearly be seen when a Māori organisation is required to report on its activity, based on mainstream concepts. In addition, hybridisation tension can be seen in the area of chronic condition prevention and management. Health funding contracts have focused on reporting and 'widget' counting. As a result, the role of practice nurses is frequently modelled to fit funding and contractual agreements. Opportunities to use nurses' extensive clinical skills and knowledge to support patients at risk of, or living with, complex chronic disease is consequently missed.

The main business model of New Zealand general practices is that of a private business. This includes the long dominant owner-operator small business, as well as professional partnerships between small numbers of general practitioners (GPs), and the recently emerging large corporate or social enterprise organisation with GPs as employees. Yet despite this private business model, general practices receive substantial public funding. Historically, such funding has allowed GPs to achieve an appropriate balance between community and patient health-care provision and maintain a viable business. However, increasing Ministry and District Health Board (DHB) stakeholder expectations, including requirements to provide and manage a wider array of primary care-based services, is making this balance look increasingly fragile.

Organisational tensions brought about by hybridisation pressures in general practice are not new. The tensions between receiving state funding for patient care and maintaining business viability go back at least to 1941, when the right was enshrined for GPs to charge patient co-payments while also receiving General Medical Services subsidies.[4] However, these pressures appear to be increasing. The last 20 years has seen the introduction of budget-holding and the development of primary care organisations, including the Independent Practitioner Association (IPA) movement.[5] Concern that IPAs lacked accountability when spending publically funded budget holding savings was a driver behind the Primary Health Care Strategy, leading to the establishment of community participation in governance of Primary Health Organisations (PHOs) in the early 2000s.[5,6] The IPA Council was formed in response to these changes, to represent the interests of organised general practice within the PHO environment.[6] Moves towards more care in the community,[7] while applauded by general practice, is accompanied by ongoing concern that

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visible progress towards 'funding following the patient' lags behind the rhetoric.

Other indicators of hybridisation include the adoption of business practices from outside the health sector. Within DHBs, the increasing use of business process improvement approaches such as Systems Thinking, LEAN and statistical process control,[8] have become popular over the last decade. Such approaches required modifications from their industrial origins, but once adapted to the health-care environment, they have delivered improvements in health delivery performance and effectiveness.[9] The development of alliances between DHBs and PHOs over the last 5 years has seen local health systems adopting and adapting an industry-based contracting model, with some promising results.[10,11]

Adopting business practices from other sectors is an indicator of hybridity. This is seen in the increasing use of business process performance measurement, not for external compliance reporting, but for internal quality improvement of key processes within general practices. For instance, focusing on the performance of vital business functions such as patient invoicing and payment, although not clinical, are critical to the sustainability of GP-owner practices. Yet despite the potential for such approaches, smaller owner-GP practices in New Zealand often struggle to free up the time to apply business methods.

Similar to Australia,[12] evidence of corporatisation of New Zealand general practices is increasing, with equity in general practices being acquired by investment-led groups or network structures. Such acquisitions are primarily viewed from a return-on-investment perspective rather than a wish to improve health-care delivery, which is a typical change in business model that creates hybridisation-driven tension.

The network practice acquisition business model also changes the balance of GPs as traditional owner-managers, allowing doctors, nurses, practice managers or administrators to become shareholders as well as employees of group practices. Corporatisation also results in other specialist managerial roles, such as business managers and practice accountants.

In summary, common responses to hybridisation include greater professionalisation of staff,[3] increased adoption of managerialist private sector practices,[13] and the development of performance measurement approaches that allow transition from an altruistic mission to a more business-like footing.[14] Many of these responses are already in place, particularly within larger and more developed general practice organisations. Other forms of managerialist practices, such as Lean Thinking,[8,15] the Balanced Scorecard, and customer-centric business models such as the New Zealand Business Excellence Framework,[16] have not been widely adopted.[17] Perhaps extended adoption of such approaches could provide general practices with further opportunities to respond to the evident and emerging pressures of hybridisation.

Given these developments, we see benefit in exploring the phenomenon of *hybridisation* in general practice. The conflicting pressures facing general practices, such as uncertain funding of an integrated primary care-centred model, expectations to offer and manage a wider suite of health pathways and care activities, and increasing issues of unmet need, convince us that there are important indicators of hybridisation tension emerging.

In the context of a national policy for greater integration within the health system, the development of alliance contracting, and a shift of services from secondary to primary care, we pose the following questions:

- Is New Zealand general practice becoming more hybridised?
- If so, what are the medium and long-term consequences of hybridisation?
- How is general practice responding to increasing hybridisation tension?

Call for special issue papers

We are therefore planning a special issue of the *Journal of Primary Health Care,* focusing on the issues and tensions arising from increasing levels of hybridisation in general practice. We seek papers that comment on, or offer solutions to, the problems and tensions that doctors, nurses and other staff employees face in owning, running and working in New Zealand general practice.

Contributions could be in the form of original research, quality improvement projects, case studies and viewpoint manuscripts.

Papers could include, but are not limited to, the following topics:

- Balancing the demands of hybridised business models in New Zealand general practice.
- Implication of uncertain funding streams in an integrated care model.
- Māori Health provider perspectives.
- The impact of the proposed Social Bonds on general practice funding.
- Opportunities for general practice that are a result of hybridisation.
- Geographic location and responses to hybridisation.
- Impact on rural/urban divide and population groups.
- Impact of hybridisation on general practice staff mix and availability.
- Effect of hybridisation on sole owner general practices.
- Different responses to increasing hybridisation.
- What does increasing hybridisation mean for patients and for integration of health services?
- The role of general practice performance measurement in responding to hybridisation.
- Social implications of a more hybridised general practice sector.

Guest editorial team

The guest editorial team consists of three University of Otago academics, who bring complementary experience and perspectives on health care:

Dr Fiona Doolan-Noble: a senior research fellow in rural health at the Department of General Practice and Rural Health, Dunedin School of Medicine;

Dr Richard Greatbanks: a senior lecturer at the Otago Business School, University of Otago Dunedin; and

Dr Carol Atmore: the current HRC Foxley Fellow, working in the Department of General Practice and Rural Health, Dunedin School of Medicine.

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