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Summary

Over the past two decades the Australian healthcare sector has been fundamentally restructured by two developments – a redirection of government policy toward privatisation of publicly funded institutions, and a new interest in strategic investment from the corporate sector. Together these developments have dramatically reshaped the healthcare sector. This new healthcare sector is no longer dominated by large public institutions surrounded by a constellation of small, independent, practitioner owned and operated service facilities. In its place stand large corporations tied to government through contract agreements. As a consequence the incomes of these healthcare corporations depend almost entirely on the public purse. The changes to the sector can best be summarised as a transition from a 'cottage industry' of owner-operated facilities into a vertically and horizontally integrated 'medical-industrial complex' combining general practices, hospitals, insurance companies, research and teaching institutions, and services such as radiology and pathology.

The full implications of this new system for the healthcare system are enormous. Privatisation – here defined more broadly than usual to go beyond asset sales and contracts to include greater corporate control, various marketisation and commercialisation policies and the rationalisation and 'reform' of public services – has been propounded as the means to harness competition and, through this, increase patient choice, deliver more effective services, increase the quality of services and provide better healthcare.

However the evidence does not support these claims. Instead, we see the following trends:

- Corporate medicine is fundamentally self-interested medicine. The interests of the patients and doctors no longer converge as doctors are increasingly becoming part of a corporate enterprise. In so doing they lose their capacity to make independent decisions about what is in the best interests of their patients. To maintain their incomes, they are pressured to see more patients, to see patients for only one problem per visit, to prescribe minimum quantities of drugs to ensure return visits, to increase the number of diagnostic tests and the use of high technology medicine, and to refer patients to services owned by the corporation itself. With corporate medicine, the restraints on ethical behaviour – already lightly felt – are released altogether. After all, the maximising of profit is neither illegal nor unethical indeed, it is a duty to the shareholders.

- Corporate medicine is expensive medicine. The private sector does not, and cannot, offer more cost-efficient services when these are funded from the public purse, nor is there more effective service provision when under the control of the private sector. Despite widespread presumptions to the contrary, privately owned or run hospitals are not more efficient; nor do they reduce the budget burden on government. A system that increases the power of the private sector relative to the public sector results in more costly healthcare services, largely because this new system is based on the principle of continual growth and expansion. There is no evidence, either in Australia or overseas, that a healthcare system that is

organised primarily around private delivery of services can be run at a lower cost than a publicly owned and operated system. The evidence shows that any cost-reductions in the private sector come through the elimination of skilled staff, services and standards. Investors do not respond to competition or other changes in the market by decreasing their level of profit. Financing this new health system means having to divert increasing amounts of precious public funds to ensure the profit margins of the new investors.

- Corporate medicine threatens the 'gold standard' of healthcare services that had been established by the previous system, that is, the teaching and research institutions. The privatisation of teaching and research institutions demonstrates that the corporations have moved out of the margins of the healthcare system right into its heart. Through control of the research and teaching institutions the corporations are better able to direct research toward profit-making technologies and to control professional recruitment and training.

- Corporate medicine means the end of universal healthcare. The Australian healthcare system is being rapidly transformed into a two-tier system, with a chronically under-funded public sector struggling to offer basic services for the majority of the population, and a private system providing services that are also funded largely out of the 'public purse' but available only to the wealthier members of society.

- Corporate medicine means less patient choice. As the corporations increase their range of activities and send tentacles throughout the system, patient 'choice' becomes increasingly limited by the offerings of one of the big corporations. For instance, patients are already finding themselves referred to a hospital by a Mayne Nickless corporate medical centre, staying in a Mayne Nickless hospital, visiting a Mayne Nickless radiology or pathology clinic, and consuming Mayne Nickless drugs.

- Corporate medicine means less accountability within the system. Along with deregulation and self-regulation, increasing corporate control leaves the system wide open to rorts and fraud. The sharing of information and medical discoveries become limited, accountability decreases, and existing inequities of access to necessary services are further entrenched.

- Corporate medicine means policy making becomes less effective and government control over health policy is diminished. Governments may, for example, develop legislation aimed at limiting over-servicing and outlawing certain practices including contractual relationships between services such as laboratories with medical clinics, fee-splitting and 'kickbacks'. However national legislation is made irrelevant and impotent once responsibility for services is handed over to the private sector. Policy making is reduced to what can be put in a contractual agreement and the courts become the decision-makers and arbitrators in disputes over quality or costs of services.

Despite the evidence showing the negative impact of privatisation and increasing corporate control over the health system the Federal Government continues to follow a

market-based ideology. It has assisted in promoting private health service facilities by providing a private health insurance rebate, creating public panic about the capacity of the public hospital system to provide services, restricting funds for public services and encouraging the entry of large corporations into the healthcare industry.

As a consequence, all Australians will be witnesses to an ever-increasing escalation of costs for healthcare, a system in which inequality will be further entrenched and in which standards and quality will deteriorate.

The perilous road ahead has already been sketched out, but there is still a window of opportunity for it to be re-drawn. The existing healthcare system requires an effective response from both government and the professions. The principles on which such a response should be based are clear. The need for profit must be made subservient to the needs of the patient, and the need for effective policy making must be placed above the investment strategies of corporations.

1. Introduction

Over the past two decades the healthcare services sector in Australia has been marked by two massive shifts – a change in the nature of the healthcare market and a shift in the direction of government policy. In regard to the former, large investors have, since the late 1970s, increasingly identified the healthcare sector as a growth area for expansion and profit. As a consequence, independent hospitals and services have been selected and purchased, and 'chains' of related businesses forged together under a few large, corporate structures. This inflow of investment capital and its impact on the nature of the market can best be summarised as a transition from a 'cottage industry' of owner-operated facilities into a vertically and horizontally integrated 'medical-industrial complex', to use a phrase made famous by Relman (1980) when he described the same process in the United States twenty years ago.

While healthcare corporations have been busy consolidating their position, the government has been focused on its own policy agenda. Since the 1980s, Australian governments have increasingly and persistently pursued marketisation policies such as privatisation and contracting out. Initially concentrating on marginal areas of government activity such as shopping malls, abattoirs and catering services, privatisation policy eventually shifted to 'core' areas of concern such as transport, communication, defence, education and healthcare services (Collyer et al 2001). As a consequence of this shift, by the end of the twentieth century, the previously sheltered position of the healthcare services sector had been transformed. The two developments – one within industry, one within government – would independently bring changes to any healthcare system. Together they offer an extremely potent mixture.

In Australia, while the private sector has always provided many health services, state and federal governments pay the majority of the costs. In 1999 the Federal Government budgeted $22 billion for health. Of this the Medicare benefits schedule is worth $6.8 billion, $5.5 billion goes to states and territories through the Australian Healthcare Agreements, and $3.5 billion goes to the Pharmaceutical Benefits Scheme.

The system of government-provided revenue, drawn from the tax base, and its transfer to the private sector in the form of subsidies and the provision of infrastructure, has long been a characteristic of the health system in Australia. Despite this, healthcare services in Australia have traditionally been sheltered from market forces, and the majority of funding has been spent on the provision and delivery of services, rather than on the creation and support of for-profit activities. However, the entry of the corporate sector into a market arena which has always relied upon government funding, coupled with the eagerness of governments to retreat from direct service provision (while unable to release themselves from financial responsibility), has offered investors a unique opportunity.

Elsewhere, including the USA, health corporations draw financially from personal insurance contributions for private health cover (often provided in an employment package). In Australia, however, healthcare corporations have tapped into a much more lucrative source of funding for their expansion – Medicare, our universal health insurance system. Thus in fostering a process of corporate control of the healthcare

sector, and pursuing policies toward the divestment of responsibility for the delivery of healthcare, Australian governments have facilitated the creation of a new market, with increasing opportunities for large corporations in the private sector to draw upon public funds.

This paper argues in favour of a broad definition of 'privatisation'. Definitions of privatisation tend to be somewhat narrow in focus, limiting it to an economic or financial transaction between the private and the public sectors. The paper also rejects the view that the privatisation of government services or assets is simply a rational, coherent solution to financial and administrative problems of the state (eg. Domberger and Piggott 1986). On the contrary, having examined the evidence, it is clear that privatisation is fundamentally political, rather than fiscal (eg. Henig et al. 1998:463), and that to narrow the focus is to be unwittingly captured by current doctrine or ideology. In contrast, a broader definition understands privatisation as part of a wider policy trend that extends beyond asset sales and contracts, and includes various marketisation and commercialisation policies, the rationalisation and 'reform' of public services, and even government budget cuts (Samson 1994).

While the reformulation of the concept is based on firm evidence about the actual experience of privatisation, a further challenge can be raised to the privatisation orthodoxy. Although it is common to focus on privatisation as an action of government, this focus unnecessarily divorces government activity from other processes occurring within the marketplace. While privatisation *is* often an explicit government policy, there are changes occurring in the market sector which may be responses to international circumstances, or precipitated by government actions that were not intentionally directed in this manner. These changes in the market sector may also be fruitfully described as privatisation, because they too involve exchanges of resources between the private and public sectors, or reshape the roles, responsibilities or functions of the state, and so transform the capacity of the state to make and implement policy. Hence we argue that privatisation is most accurately defined as any activity which reduces, or threatens to reduce, the size or capacity of the public sector relative to the private sector.

This new and broader definition of privatisation, therefore, includes the process of corporatisation within the public sector (where government departments are restructured as business entities), and corporatisation within the private sector (where large private sector corporations buy up many small, independent enterprises, often integrating these within massive and powerful conglomerates). Both these activities imply an increase in the relative size and power of the private sector. As a consequence of the unprecedented developments in the corporate sector, outlined in the paragraphs above, privatisation can no longer be regarded as simply an increasingly common government policy but a unique phenomenon of the late twentieth and early twenty-first centuries (Collyer et al 2001).

This paper documents the development of the vertical and horizontal integration of the healthcare services sector, focusing particularly on new corporate organisational forms in the ownership of hospitals, general practice, pathology and radiology laboratories. The paper argues that in the Australian context, the private (including the corporate) provision and ownership of health service facilities is more costly than public provision.

Evidence for this view will be provided to show that the corporate sector does not, and cannot, offer more cost-efficient services than the same services funded from the public purse; nor is there more effective service provision when under the control of the private sector. Furthermore, the paper will demonstrate that deregulation and self-regulation leaves the system wide open to rorts and fraud; that, contrary to popular belief, competition does not necessarily benefit the consumer or patient; and that privatisation decreases accountability within the system and further entrenches inequities of access to necessary services. The paper concludes with an analysis of the implications of these twin developments – government privatisation policy and the increased corporate control within the private sector – for the healthcare services industry.

2. Australian healthcare: case studies in corporate control

This section outlines some case studies that illustrate the process of privatisation within the hospital sector, and the increasing corporate control of general practice, radiology and pathology. A series of vignettes are also provided giving specific examples of what is happening in each of these sectors.

2.1 Australian hospitals: Case study 1

Over the past decade, the Australian hospital sector has undergone a massive economic and administrative reorganisation (Collyer 1998). In many ways, this reorganisation has merely echoed developments in the hospital system of the USA, but it has been a precursor for the dramatic changes about to occur in the National Health Service in the UK where the recent re-election of Prime Minister Tony Blair promised an extensive privatisation program based on the alleged 'success' of the Australian case. In the United States, the establishment of Medicare and Medicaid in 1965 helped to support the growth of for-profit hospitals. Corporate investors entered the US hospital market, and during the ten years following the introduction of Medicare, the for-profit hospital sector grew by 55 per cent in comparison to 28 per cent for the non-profit sector (Sax 1990).

Australia developed its own, more comprehensive, government-funded insurance scheme in 1975 (Medibank). Following quickly on the heels of its introduction, small investors bought private and practitioner-owned hospitals, constructed new private hospitals, and purchased a few public hospitals (Panoptes 1981). By the mid 1980s there were many investors in the Australian hospital market, including American Medical International, Hospitals Corporation America (known as Hospital Corporation Australia), Markalinga Trust, Ramsay Healthcare, Health and Life Care, Australian Hospital Care, Moran Healthcare, and Medical Benefits Fund. Some of the investors were corporations not previously involved in the healthcare services sector, such as James Hardie Industries, Dalgety Farmers and Mayne Nickless. Some corporate investors exploited the possibility of diversification, combining hospital services with other business opportunities. For example the John Flynn hospital on the Gold Coast was designed to attract wealthy South East Asian clients for heart, hip and cosmetic surgery in a popular resort area. The hospital complex was planned to include a luxury hospital, a hotel (including conference facilities), shops, homes for hospital staff and a golf course.

By the end of the 1980s, competition and rationalisation in the hospital industry reduced the number of corporate investors and brought about the birth of a number of financial giants. The 1987 share market crash was a factor in this reorganisation. Mayne Nickless, the largest of the new conglomerates, was one of the few corporate players to benefit from the share market crash. Others such as Alpha Pacific and Ramsay Healthcare had large debt burdens, and Healthcare Corporation, half-owned by James Hardie Industries, was unable to develop further due to a lack of capital.

The 1990s, however, brought about a new and gold-lined pathway for investment when state governments introduced privatisation into the healthcare services sector. In 1989, the New South Wales Liberal Government (first under Premier Nick Greiner, then John Fahey) announced its plans to sell off $500m worth of healthcare sector assets (including most of the state psychiatric hospitals), to close hundreds of public hospital beds, and to open many more private ones (Hicks 1989). The Victorian Liberal government (under Premier Jeff Kennett) soon followed this lead, rationalising services, closing and amalgamating public hospitals, supporting the creation of new 'private' facilities, introducing competitive tendering of services, and publicly stating its commitment to using market mechanisms to 'reform' public services (McGuire 1994:75). The most significant development however, occurred in NSW, where the government offered the private sector a contract to run a public hospital (for a profit). While the non-profit, charity sector had long been a partner with government for the delivery of (Medicare) hospital services, until the 1990s this form of co-operation had been denied to others. The 1992 contract with the Mayne Nickless group, Healthcare of Australia (HCoA), to build, own and operate a 'public' hospital at Port Macquarie in NSW was the first, and perhaps most controversial, of these partnerships (Collyer 1997).

The following decade witnessed a range of similar developments in the hospital sector, with governments in Victoria, South Australia, Western Australia, The Australian Capital Territory, and Tasmania following the lead of New South Wales by offering contracts to the private sector to supply hospital services. Some contracts involve only the management of the hospital, as the building and its facilities remain under public ownership (eg. the Modbury hospital in SA under contract to Healthscope); while others are more complex (such as the Port Augusta and Mount Gambier Hospitals in SA), where the private sector builds and retains ownership of the buildings, but leases these to the health department, which then manages and delivers hospital services. Related to these new forms of partnership between the private sector and the state, are developments involving the co-location of private hospitals on the grounds of, or adjacent to public hospitals, and the consequent sharing of facilities and staff under a plethora of complex financial arrangements (eg. at Flinders Medical Centre in SA, and Canberra Hospital in the ACT).

In short, in the hospital sector we have seen a major restructuring, with private capital investors entering into contracts with the states to provide hospital services. This has replaced the historical shape of the sector where the governments of the Australian states provided services through links with not-for-profit hospitals. The situation means direct transfers of public money to private-for-profit corporations, whose bottom line is their return to investors rather than the delivery of hospital services to the sick.

Vignette: Mayne Nickless

In 1986 Mayne Nickless, the transport company, bought into the hospital sector with the purchase of a 20 per cent stake in a Newcastle-based chain of five hospitals (Thomas 1994:75). Two years later Mayne Nickless had a 51 per cent holding in the Hospitals of Australia Trust which it split into a property trust and a hospital management centre. By 1991 Mayne Nickless had entered the 'big league'. It made an offer for Hospitals of Australia and in 1991 purchased the US company, Hospital Corporation of Australia. HCA had 8 hospitals and about 910 beds. This made Mayne Nickless the largest operator of private hospital beds in Australia, with about 2,000 beds in 16 hospitals in NSW, 3 in Queensland and 4 in Victoria. It negotiated a management contract to operate St Vincent's Hospital in Lismore (which had previously been a publicly run hospital) and a 15-year lease on the Mosman Community Hospital. By 1994 the Mayne Nickless group (now called Healthcare of Australia or HCoA) had 22 east coast hospitals, two others under construction, a total of 2,500 hospital beds, turnover of $260m a year, and earnings of $45m before interest and tax (Thomas 1994:74). By 1996, HCoA was clearly Australia's largest provider of private healthcare services and was operating hospitals overseas in India and Indonesia. In 2001 HCoA manages 4,900 acute hospital beds, that is, 21 per cent of the private for profit beds in Australia, and treats 360,000 patients per year.[1]

HCoA offers an example of the horizontal and vertical integration of the health sector. It controls almost 30 per cent of the hospitals market, 20 per cent of the pathology market, and 10 per cent of the radiology sector. It bought into hospitals in 1986, pathology laboratories in 1995, radiology in 1997, and is currently adding medical centres to its growing health services portfolio. It is the largest hospital and private pathology provider in Australia. Radiology and pathology generate one quarter of the company's healthcare income. As the company's web page puts it, with the purchase of medical centres around Australia it 'enables patients to obtain a comprehensive range of health services … [with] specialist centres located alongside many HCoA hospitals'.[2] The Mayne Nickless group offers other services in the healthcare sector that make it an extremely well integrated enterprise. In 1994 HCoA received $15m from the federal government to manage programs for the clients of the Department of Veterans Affairs. More recently, its parent organisation, Mayne Nickless, has been involved in a take-over of FH Faulding and Co. (an Australian owned, international pharmaceutical firm), an acquisition that will give Mayne Nickless access to an established healthcare logistics system, R&D enterprises in Australia, entry into wholesaling and manufacturing, and a network of 600 retail pharmacies across several Australian states.

1 www.maynick.com.au/ business/ health_carehtml

2 ibid

2.2 General practice: Case study 2

General medical practices in Australia have traditionally been small, independent, practitioner-owned enterprises. Corporate take-overs of these practices emerged slowly during the past two decades, but have become increasingly evident within the last couple of years. In fact, in the last two years there has been a trebling of the number of general practices that are controlled by large corporations (Kerin et al 2001). It has been predicted that 60 per cent of general practices will be owned by corporate structures by 2002 (van Senten 2000). Even if overestimated, this will rapidly transform self-employed, small-scale, general practitioner based enterprises into members of vertically integrated chains of practices linked to pathology and radiology testing and merging under the same corporate organisation as a variety of other services, such as health insurance, hospital ownership/management, and even pharmaceutical and research facilities.

Under the terms of corporatisation, general practitioners give up the ownership of the general practice and its patients in exchange for corporately provided services such as administrative staffing, accounting, and equipment. The new practice may also rent space to allied businesses such as pharmacy or medical specialists (Price 2001).

The corporate general practice market is said to be worth $2.7b. There are five major players in Australia – Mayne Nickless, Foundation Healthcare, Primary Healthcare, Medical Care Services and Endeavour Healthcare. Together these five companies have contracts with 3,000 of Australia's 20,000 general practitioners (Kerin et al 2001).

Mayne Nickless has only recently bought into the general practice market, offering medical practitioners a computerised administrative system. Foundation Healthcare is the largest general practice management company, with 6 per cent of doctors signed up. In its first six months it was managing over 450 doctors, and currently has 1,000 doctors and 135 medical centres (Price 2001). Foundation Healthcare envisages managing 4000 general practitioners, or about one in every five in Australia (Ryle 2000).

Medical Care Services (previously Revesco) has about 150 doctors under contract and 12 medical centres in Perth. In addition, this company owns half of Gribbles Pathology. Primary Healthcare has been part of the corporatisation of medical centres for 15 years. It now has 320 doctors under contract and several clinics across NSW. It offers a whole range of related services for its GPs to refer its patients to, including psychiatry, dentistry, plastic surgery, and dermatology. Endeavour Healthcare has 25 per cent of the Perth general practice market and also has pathology, radiology and occupational health assets (Price 2001). Investors in Endeavour Healthcare include Kerry Packer, Australia's media mogul, and Richard Pratt, a significant player in the packaging industry.

The increasing success of corporations in obtaining control of general practice is a critical factor in the consolidation and extension of corporate control over the health system as a whole. The significance of these developments is outlined in greater detail in Section 3.

Vignette: Medical Care Services Limited (previously Revesco)

Kiwi Gold was incorporated in 1987, and listed on the New Zealand stock exchange, to acquire, explore and develop gold and other mineral deposits. In 1997 under the leadership of Ian Trahar, the company name changed to Revesco, and in 1999 it changed its business direction to the medical services industry, purchasing a 49.9 per cent holding in the Gribbles Pathology Group. Revesco announced the purchase of the Perth based General Pathology Laboratories Group in November 1999. In the same month it purchased the Perth Surgicentre from Alpha Healthcare, while in December 1999 it moved from New Zealand to Australia. As of 27 February 2001, Revesco had market capitalisation of $256.39m. On March 26, 2001 it announced that it had acquired the balance of Gribbles Pathology. The corporate strategy of Revesco is displayed on its web page: 'Medical Care Services Limited is a pro-active company whose corporate goal is to develop and grow services to medical practitioners and to develop and expand medical diagnostic services to medical practitioners'. The purchase of general practices is the first step in this process:

> The acquisition of the Perth Surgicentre further complements the Company's move toward offering a total service to general practitioners and specialists, who provide services to patients through the company's network of medical centres. The company looks forward to working closely with the existing users of the facility and envisages no material changes to the existing operations.[3]

The half yearly report to 31 December 2000 states that the company 'is committed to continue its medical centre strategy throughout metropolitan Perth and regional locations and believes that the continuous consolidation and rationalisation of its operations will result in positive benefits in the near future'. Medical Care Services provides services to fifteen medical centres, having 'rationalised' six others. As the report states in the next sentence, the strategy for achieving this is 'attracting more medical practitioners to provide their services at company operated medical services [and] to ensure that they are operating at full capacity'.

[3] www.revesco.com.au/ 19/1/2000

2.3 Radiology and pathology: Case study 3

The Australian radiology market is currently worth $2b and the pathology market is not far behind (Price 2001). Like general practice, pathology in Australia started as a cottage industry, with many doctors in private practice employing their own technicians. However from the mid 1970s in Australia (Taylor 1979) and also the United States, pathology laboratories grew in scale as businesses and were consolidated into a few large companies (Conn 1978). The privatisation of the public hospital system has also contributed to this process. While most public hospitals initially employed their own pathologists, there has been an increasing reliance on contracts with private pathology companies. Some hospitals, such as those in Sale in Victoria, have entered into agreements that contract with a pathology company to provide services to the hospital, but also allow use of their laboratory facilities to offer private services to specialists and general practitioners in the surrounding area.

Radiology has followed a similar pattern, with hospital radiology services initially being provided by either salaried radiologists or by visiting radiologists paid on a fee-for-service basis by the hospital. Privatisation of radiology began in the early 1990s with the establishment of contractual arrangements with groups of radiologists. An early example is Sydney Hospital, where the case load of the hospital was thought to be too small to necessitate the employment of full-time radiologists, even though this was a cheaper option than the paying of fees to visiting radiologists on a payment per examination basis. One of the first contracts was offered in 1991 to a group of three radiologists who were interested in providing services for a total group fee or lump sum (Domberger and Hall 1995). Privatisation of radiology has increasingly occurred in other parts of Australia, although more recently it has been organized as a contract with a corporate body rather than a group of practitioners.

In radiology we have seen the repeat of trends concerning the introduction and use of technology that have occurred elsewhere in the health sector. While innovative medical technologies were once a characteristic of the large public teaching hospitals, it is increasingly the case that private hospitals and clinics have purchased the latest technology. For example, the majority of magnetic resonance imaging scanners are now found in the private sector (HIC 1993) and there has been a dramatic increase in private services for complex technologies (AIH 1990:130-133). As a consequence, public patients are finding it more difficult to gain access to the latest technology, while those with private means, or private insurance, have access to the latest technology in private hospitals, where costs are underwritten by Medicare.

The process of obtaining control of pathology and radiology practices, by the same companies involved in the corporatisation of general practices and hospitals, is the most recent part of the vertical and horizontal integration of healthcare in Australia. The profitability of radiology is suggested by Mayne Nickless' experience, with radiology and pathology generating 25 per cent of its healthcare income. It is also demonstrated by Sonic's profit levels in this area. Following its merger with the SGS Medical Group,

Sonic reported (in March 2001) a first half net profit after tax of $11.5 m, 63.6 per cent higher than for the previous period.[4]

Vignette: Sonic Healthcare

Sonic Healthcare is a medical diagnostics company which claims to be the market leader in pathology and radiology services in Australia and New Zealand. It is also an aggressive leader on the take-over market. Sonic is the majority owner of the biotechnology company SciGen, which is developing human growth hormones and is attempting to gain monopoly rights on Hepatitis B vaccines in the Australasian region. In April 2000 Sonic acquired Hitech Pathology, and announced mergers with Melbourne Pathology and Diagnostic Medlab in Auckland to become one of the largest pathology laboratories in Australasia. As the Managing Directors Report for 2000 makes clear, Sonic intends to pursue the same monopolistic strategies in the radiology area and aims to take over the radiology business of Pacific Medical Imaging, Australia's third largest radiology group with an annual revenue of $85m: 'In line with its leadership role in the rationalisation of the pathology market, the company is now ideally placed to provide leadership in the corporatisation of radiology'. The *Financial Review* reported on 1 June, 2000 that pathology giant Sonic Healthcare has 'entered into a strategic alliance' with the general practice corporation Foundation Healthcare 'in a deal that entrenches the take-over of local GPs'. Sonic is capitalised at $1.1b and will invest $21.9m in Foundation Healthcare, giving them a 10 per cent share holding. The head of Sonic Healthcare, Dr Colin Goldschmidt has suggested that the clinical and the diagnostic sides of the two companies would be kept separate:

> Dr Goldschmidt said his pathology labs would have first option to provide pathology services at Foundation medical centres and his company would benefit from being introduced to the doctors in those centres. He stressed, however, that all doctors in the alliance would have unfettered clinical independence (Moynihan and Clegg 2000:1).

In the Managing Directors Report of 2000, Sonic notes the development of corporatisation and consolidation in the general practice market. It points out, 'control of vertically interrelated healthcare entities by single corporate players has foreshadowed the 'integration' of the sector'. On the one hand Sonic claims that it will maintain its different companies at arm's length: 'This decision is a strong statement that we wish to remain an independent diagnostic company, free of any possibility of competition with our own referring practitioners'. On the other hand, however, it also acknowledges that its 10 per cent holding in Foundation Healthcare 'is a strategic step to address the company's positioning for the future'. Sonic goes on to note:

> Our investment in Foundation has established a strategic alliance between the two companies, whereby each company will leverage off the other's specialised expertise and specific market presence. We are optimistic that the alliance will provide Sonic with competitive advantage and that the relationship will be mutually beneficial well into the future.

In ongoing developments Foundation Healthcare intends to use the capital raised by the issue of 28.5m shares to institutional investors for the acquisition of United Healthcare in Victoria.

[4] www.aho.com.au/home

3. Consolidating and extending corporate control: key developments

The trend towards the introduction of the corporate sector into mainstream health service delivery has seen a number of developments that have both consolidated and extended corporate control. This section outlines these key developments.

3.1 Capturing the referral system

The corporate sector has focused much of its energy on consolidating a range of healthcare services, including diagnostic laboratories, day surgery and therapeutic services, into multi-purpose, co-located healthcare facilities. Commonly referred to as 'vertical integration', this process is often justified on the grounds that such facilities are more convenient for patients. However, when implemented by companies that have significant financial interests in the services provided, there are substantial incentives to keep referrals 'in house', to encourage and increase private health service usage and to make it increasingly difficult for patients to avoid using privately owned facilities.

Initial efforts to co-opt doctors into plans for vertical integration were not particularly successful. The first attempt occurred during the 1980s when entrepreneur Geoffrey Edelsten established a network of 24-hour medical centres. By 1985, Edelsten (financially backed by Abignano Ltd), and competitors such as Viscount Holdings Ltd, had introduced clinics into Victoria, NSW, Queensland and South Australia. The second attempt followed the introduction of legislation by the Keating Labor Government, to allow third party companies to sign contracts with individual doctors or hospitals so that health services would be supplied for fixed fees. This legislation, little remarked upon at the time, allows health insurance companies (or other corporations such as unions or employer groups) to offer direct contracts with hospitals (which then sign up appropriate specialists) for services supplied to their members. Although a number of these schemes are in place, such as those with The Australian Services Union and Medicare Private (Collyer and White 1997), they have not been popular with doctors.

Throughout the 1990s, these developments were fiercely condemned by the Australian Medical Association and the Doctors Reform Society. Doctors' resistance to contracts was based on a number of concerns. They claimed that their income would be reduced, that the corporation would intervene in the patient-doctor relationship, and that patients would increasingly be able to attend only the hospital with which their doctor or health insurance scheme has a contract, a problem widespread in the USA with its system of HMOs. There was also the fear that such contracts would undermine professional autonomy and lead to a 'sausage-factory' approach to treatment. When the health insurance funds in New South Wales attempted to make doctors obtain prior approval for the prescription of certain drugs, the AMA rejected this development as being a shift towards American style 'managed care' where clinical decisions are subject to the directions of the corporate health insurer. The then President of the AMA, Dr Keith Woollard, described the attempt to introduce control over prescribing 'as an outrageous attempt at bureaucratic intrusion' in the doctor patient relationship (AMA 1996c). Attempts by the National Mutual group (HBA in Victoria and Mutual Community in

South Australia) to introduce a contract health plan with specialists also met with AMA condemnation. As the AMA stated:

> The real problem with managed care contracts lies with what is motivating the funds. That motivation is their desire to reduce costs incurred by funds when sick members utilise hospital and medical services. The only player in the equation who can do this is the doctor. That's why funds - inevitably - will use their contractual power over doctors to minimise costs … [D]octors on managed care contracts are provided with financial incentives and penalties which make them cut costs to the financial benefit of the health fund and the detriment of patient care' (AMA 1996a).

Indeed the AMA and the health insurers have increasingly been at logger-heads, with the AMA claiming that 'the Australian Health Insurance Association has antagonised almost every doctor in Australia over their managed care proposals, and is now lobbying for even greater restrictions, where health funds will be the only winners' (AMA 1996b).

In this setting, the targeting of general practices rather than individual practitioners has been a much more successful strategy to circumvent the issue of professional autonomy. Co-opting the group most resistant to the intervention of corporate medicine by offering freedom from financial and organisational administration has been a 'master stroke'. It has been a major step toward achieving integration, and it has increased the corporate control of general medical practices in Australia. In exchange for their practice, GPs are provided with an office, car, staff and accounting services. Under these arrangements the doctors are not salaried employees. Thus they can claim they are still 'professionals' with their clinical freedom intact. The new corporate managers have apparently convinced many GPs they will not curtail their autonomy by, for example, forcing the doctors to use the corporation's own pathology and radiology services. One such promise was given by Ken Jones, one of the founders of Foundation Healthcare: 'Those decisions [about referrals to radiology and pathology] will be left to individual doctors ... We will have to demonstrate that we can provide the best service. This whole process is very much patient driven' (Treadgold 2000).

This claim that corporations are not interested in controlling the referral systems within the practices would have some weight only if the systematic corporatisation of general practice is a profitable strategy because of the individual throughput of the practice itself, rather than as a means to establish control over the referral system. At first glance it does appear that the practice itself might offer an attractive financial return. After all, the new owner will receive about 45 per cent of the doctor's fees, generated largely out of Medicare (White 2001). The AMA's paper *Scoping Corporatisation* supports this view that the cash flows through a general practice are one of the reasons for corporate interest:

> … long term growth is expected due to an ageing population and growth in service utilisation among the general population. Advances in technology and emerging approaches to funding and delivery (eg. integrated and co-ordinated care) suggest an increasing role for primary care and for GPs as gatekeepers into the future. Although

> the GP market is fragmented and operates predominantly on a small business basis, it forms a substantial part of the Australian economy. The large volume of transactions highlights the potential gains to investors from a substantial market share and improving margins through economies of scale and vertical integration (AMA 2000:3).

Business analysts, however, are sceptical that the investment in general practices will result in a sufficient return to the investors. The KPMG report, *Corporatisation of General Practice,* states flatly that no matter how well run, the revenue generated by a general practitioner would be unlikely to give both an income to a practitioner and a return to an investor (KPMG Consulting 2000). As a business journalist has shown, the arithmetic is simple:

> General practice, on its own, is not where big money is made in medicine. The average Medicare payment to radiologists in 1999-2000 was $650,000 and the average to pathologists was more than $600,000, however the average to general practitioners (including those working part-time and full-time) was about $110,000. A bulk-billing general practitioner wanting to generate an after-expenses but pre-tax income of $130,000 (assuming the cost of running the business is taking 35 per cent of revenue) needs to conduct 37 standard consultations a day, five days a week, 48 weeks a year. In other words, one patient every 11 minutes, seven hours a day, with public holidays and a couple of weeks off over Christmas (Quinlivan 2000).

The conclusion we must reach then, is that despite their protestations to the contrary, investors are interested in general practices *because* they will capture the general practitioners' ability to refer up the system to the more lucrative pathology and radiology sectors. This conclusion is borne out by the KPMG report which stated that 'the returns for the investor must come from [the medical] centre's tenants, from negotiated arrangements with other service suppliers and/or cross subsidies from other businesses (for example, pathology and radiology) owned partially or wholly by the investor' (KPMG Consulting 2000). Targeting of general practice as a means to controlling the referral system is also a clearly stated strategy of Mayne Nickless:

> Mr [Peter] Smedley [CEO, Mayne Nickless] said he would focus on vertical integration of the healthcare business, including possible alliances with groups of general practitioners, to help channel customers to Mayne's radiology, pathology and hospital businesses (Price 2000).

The financial impact of the corporatisation of GPs and the integration of services such as radiology and pathology under the same corporate umbrella, is likely to be enormous. It is well known that where health services are delivered by the private sector, there is a subsequent and significant increase in the use of expensive allied services and medical technologies (AIH 1990:130-33; Pollock et al 2001; Robertson et al 1999). These services are all capital intensive, requiring an accumulation of large amounts of capital. Such capital is available only to governments or to large corporations. As capital intensive industries, their fixed costs are high, while their variable costs are low. That means there is an incentive for increasing throughput, as this will bring large returns. It is not surprising then, that the Health Insurance Commission is 'investigating whether

the rapid rise of vertically integrated health companies is responsible for an increase in the pathology referrals recorded in Western Australia in recent months'. The head of professional services at HIC Mr Ralph Watslaff said 'we are looking to whether or not there is any heightened inappropriate practice or excessive servicing' (Moynihan and Clegg 2000:1).

The *1999-2000 Professional Services Review* found that the corporatisation of general practice has led to many doctors seeing inappropriately large numbers of patients, neglecting patient care and claiming inordinate sums of money from Medicare. The AMA and the Royal Australian College of General Practitioners have called for an inquiry into the corporate takeover of family general practices. The response of government has been to reject the need for such an inquiry and to state that it is using a 'wait and see approach' (Kerin 2000).

3.2 Co-ordinated care: Another gift to the corporation

That the key to controlling the health system lies in the control of general practices was well recognised within the federal health bureaucracy when it developed the 'Co-ordinated Care Program'. This policy initiative, first touted in 1995, was well received by general practitioners as it offered financial incentives to strengthen their role as the 'hub' of the healthcare system. Essentially it involves GPs devising personal care plans for patients, and managing and coordinating the referring of patients through the maze of the healthcare system by acting as their agent to purchase essential services (eg. community services for family planning, sexual assault, or homeless youth, as well as hospital services or in-home care). It is financially attractive to doctors, as for the first time it makes a single healthcare provider responsible for the patient from their first consultation through to the end of their illness, giving the practice a significant cash flow from which it can negotiate the price of services purchased for its patients. In its initial stages, the program involved about 1,600 doctors and 16,000 patients in 13 areas across Australia with the practices being given block grants to co-ordinate care for a given population rather than providing it solely on a fee-for-service basis.

The program is continuing despite an extensive national evaluation showing that in comparison to traditional approaches, there has not been an improvement in services nor a reduction in costs. The program is of great interest to the business sector, and several health corporations such as Kaiser Permanente (the largest US managed care organisation and a world leader in managed care) have become involved (Cresswell 1996; Kerin 1999). This is not surprising given that the Co-ordinated Care Program increases the cash flow and profitability of the practice, strengthens the role of the practice in the referral system, reduces the risk of losing patients to other practices (and health corporations) when they refer them to other services (by keeping all referrals 'in house'), and provides corporate medical practices with additional Medicare funding for being part of the program.

The paradox at the heart of the co-ordinated care programme is that it was introduced to improve services to patients, by providing general practitioners with financial incentives. With the restructuring of general practice under corporate ownership, however, this money now flows directly to the corporate employer, thereby distorting

the original intention of providing incentives for individual practitioners to improve healthcare services.

3.3 Medical training and research: The greatest gift of all?

Corporate control over the health system via control of general practice is increasing through the use of a variety of strategies, not just the Co-ordinated Care Program. Another strategy has been to invest in GP training through outsourcing arrangements with government (Ferguson 2000), and even more significantly, the privatisation of public teaching hospitals such as the Austin Repatriation Teaching Hospital in Heidelberg, Melbourne. The buying of teaching hospitals is a strategy for ensuring market dominance. The corporations seek to gain a good market share, but they don't need to own all hospitals in an area to do this, they simply need to own or have management contracts with 'key' hospitals in order to control the market (Lindorff 1992:263). 'Key' hospitals may be the tertiary hospital in the region (the one to which all the smaller hospitals must transfer their patients for specialised treatment - like the Port Macquarie Base Hospital in NSW), those which contain the high technology machinery or equipment, or those that are significant centres of research, training and education. The privatisation of teaching and research institutions demonstrates that the corporations have moved out of the margins of the health system right into its heart, just as they have done in the USA. It has allowed them to integrate their operations further, as well as enhance their reputations as companies with the capacity and desire to deliver quality healthcare (Lindorff 1992:185). Through control of the research and teaching institutions the corporations are better able to direct research toward profit making technologies, to control professional recruitment and training – ensuring that corporations will have future employees trained to their own specifications – and enable the corporate sector to become involved in the setting of prices, standards, and practices in all hospitals. Essentially it allows the corporations to control the environment within which they operate.

In addition to the extension of corporate influence into the medical training sector, there have been some important developments in the research and development (R&D) arena, in particular, the take-over of FH Faulding and Co. by Mayne Nickless. By purchasing Faulding, Mayne Nickless increases its vertical integration by linking its hospitals business with an established logistical arm in the healthcare sector. Faulding had an established health logistics system, sourcing and supplying a variety of products to a wide market. Mayne has a natural synergy with its own transport and (non-health related) logistics expertise. The take-over enables Mayne to strategically integrate its hospital and logistics arms. It also gains access to the system of drug distribution in which wholesalers and manufacturers supply the hospitals and retail pharmacies, enabling Mayne to 'close the loop' by extending its influence in the health sector to the purchasing selections of the pharmacists, and thus the products recommended and given to customers.

As a result of the merger, Australia loses an independent foothold in the global pharmaceutical market. As a small Australian company, started in 1845 and dwarfed by multinationals, Faulding found that the only way to achieve international status and sell its products to the USA was to purchase an American drug firm which already had an

American market. It did this and now operates in over 70 countries. The merger with Mayne Nickless however, is likely to involve the sale of Faulding's US based oral pharmaceutical and injectables businesses to overseas corporations, and perhaps the closure or sale of the Australian based research facilities in Melbourne and Adelaide. This will be a significant loss to Australia in terms of its research system and its linkages into the worldwide R&D system. Mayne Nickless will however, be in a position to increase its capitalisation, allowing the newly expanded company to fund new ventures overseas, particularly in the hospitals market throughout Asia.

What role has the Australian government played in bringing this situation about? A number of policy decisions precipitated this situation. In particular, in 1998, complying with world trade rules, the government introduced intellectual property legislation outlawing generic drug development in Australia while these were under patent in this country. Faulding is a leader in generic (unbranded) drugs which it sells on the global market after the patents expire. As Australia's largest drug R&D institution and a manufacturer of generic drugs, Faulding was disadvantaged by government policy. Australia's patents expired later than overseas markets, but other manufacturers had set up in Australia because it protected their trade, and they threatened to move offshore if the government changed the Australian patent laws to expire at the same time as those overseas. Faulding stated that as a result, it would be forced to take its research offshore, and asked unsuccessfully for a similar world trade exemption to the one allowed to Canada (Brooks 1999; Gottliebsen 2000). This policy position increased Faulding's vulnerability in the market place to take-over.

The three case studies outlined in section 2, together with the key developments that have consolidated and extended the process of corporate control in the health system illustrate the extent and nature of the recent reorganisation of the healthcare sector. In the past, the sector was dominated by publicly owned and managed hospitals, research institutions, laboratories, and completed by an array of small, independent private hospitals and medical centres. In this system, services were delivered by a mix of salaried or fee-for-service practitioners. It is now characterised by a shrinking number of public institutions overshadowed by a few large private corporations that own or manage a significant percentage of these facilities. The following sections examine the implications of this systematic change toward a heavily privatised health system.

4. Paying for corporate healthcare: the real costs

Historically, Australian health policy makers have shown little insight into the real impact of the market on the healthcare system. An example of this can be taken from the Commonwealth Department of Health's submission to the Senate Inquiry of 1987 into the private hospital system. At a time when the corporate sector was first showing its interest in the hospital market, the authors of the report dismissed public concerns over the aggressive marketing techniques of foreign investors into the private hospital market and the threat of over-servicing in the healthcare sector (Senate Select Committee 1987:259). The Senate Report argued, on the contrary, that foreign investors would introduce and maintain high standards of services and management efficiency. Furthermore, it contended that the new corporate hospitals would offer a new 'yardstick' for the industry, bringing in professional and corporate knowledge and techniques into the hospital sector (Senate Select Committee 1987).

Similar views were expressed four years later in *The National Health Strategy*, a major research and policy initiative of the then Federal Labor government. Once again public concerns were dismissed, with the authors of the report arguing that private hospitals have a greater incentive to implement efficiencies, and that allowing a small number of corporate operators to control the hospital market will lead to more effective use and better management of hospitals (Macklin 1991:117).

The experiences of the past decade, however, appear to have begun to shake such naive perceptions of privatisation in the hospital sector. A more recent, bipartisan Senate inquiry into the hospital system recommended that:

> No further privatisation of hospitals should occur until a thorough national investigation is conducted and that some advantage for patients can be demonstrated for this mode of delivery of services (SCARC 2000).

In addition to this, several plans for hospital privatisations have been abandoned in the Northern Territory, NSW and Victoria. How has this 'sea change' in attitude toward the privatisation of hospital services since the 1987 report come about? A major explanation is the fact that the empirical evidence does not support claims the private sector can increase patient choice, deliver more effective services, increase the quality of services and provide 'better health care across the board' as claimed by individuals such as Michael Wooldridge (cf: Wooldridge 1999). The following sections elaborate on this point.

4.1 The efficiency of corporate medicine

The first evidence to show that the private sector might be a less than ideal partner came from the USA where there has been comparatively little public involvement in health service provision and where large health corporations have been well-established for several decades. Health Management Organisations (HMOs) have integrated insurance, hospital ownership and management with related services such as radiology. Studies in the USA suggest that these large hospital conglomerates have driven up healthcare costs

as a result of over-servicing, increased use of diagnostic tests, the expansion of services and the introduction of new technologies. Despite the fact that HMOs generally own several hospitals and related businesses, potential 'economies of scale' are not passed on to the patient, as investor-owned hospital chains have higher patient charges per admission and higher operating costs (Relman 1980:371).

These higher costs have been well documented. For example, Lewin, Derzon and Margulies (1981) compared 53 non-profit, non-chain community hospitals with 53 corporate-owned chain hospitals, in the states of California, Florida and Texas. They found that charges per admission were 17 per cent higher in corporate-owned hospitals. They also found that operating costs per admissions were slightly higher in the investor hospitals. Furthermore the investor-owned hospitals generated higher revenues from ancillary services, such as radiology, supplies and drugs. The general service costs were 13 per cent higher in the corporate chains, mainly because of higher administration and general costs. Higher costs were also due to the imposition of corporate charges on individual hospitals by the home office (Lewin et al 1981). This study suggests that centralised planning in the 'free market' does not appear to work - if reducing costs is the aim. As Pattison and Katz conclude, 'the data do not support the claim that investor-owned chains enjoy overall operating efficiencies or economies of scale in administrative or fiscal services' (1983:353).

Other US studies have compared for-profit with publicly managed hospitals, and it is evident that for-profit hospitals spend 23 per cent more on administration than do comparable private not-for-profit ones, and 34 per cent more than public hospitals. In addition to higher administrative costs, for-profit hospitals also have higher total costs per in-patient day and per discharge (Woolhandler and Himmelstein 1997, cited in Pollock et al 2000). Wohl, summarising early US findings stated: 'the chaining of hospitals under corporate umbrellas has actually led to the escalation of health costs rather than the cutting down' (Wohl 1984:90). Indeed the private provision of services has been shown as far less cost efficient than the public provision of services in the USA.

Research in Australia confirms the American findings. Duckett and Jackson's (2000) comparison of the public and private sectors concluded that the provision of hospital services by the public sector is significantly more cost efficient. The evidence for this is based on a comparison of the estimated costs per patient separation according to Diagnostic Related Group (DRG) cost weights. Similar findings have been reported elsewhere in Australia showing the high administration costs in the private hospital sector. For instance, in the Queensland government's submission to the Senate inquiry, evidence was presented to show that administrative costs for private hospitals are 31 per cent higher than comparable public hospitals (SCARC 2001, submission 41). The NSW experience does not differ from this, with the privately owned and run Port Macquarie Base Hospital costing the state government 30 per cent more than its other (publicly owned and run) public hospitals - which works out at about $6m extra per year in recurrent funding (Collyer 1997; Queensland Nurse 1996).

Evidence is also available from many of our Auditors-General, who have independently examined the contractual costs to government of building and running public hospitals

where a private company is involved. For example, the SA Auditor General found that the private sector lease arrangements for the Port Augusta Hospital and Mount Gambier Hospital had cost the taxpayer an extra $2.5m and $4m respectively (South Australia Auditor-General 1997). The NSW Auditor-General, Tony Harris, was scathing of the contractual arrangements for Port Macquarie Base Hospital, concluding that the state has paid for the capital cost of constructing the hospital 'twice over': it will pay $143.6m for a private hospital instead of $50m for a public hospital, and it will not even own the building at the end of the twenty year contract (NSW Auditor-General 1996). The WA Auditor-General, Des Pearson, found that the $21m savings that were predicted for the Joondalup Hospital would not eventuate from this privatisation and could result in a lowering of quality of service (Bower and Pryer 1998). As a consequence it is not difficult to conclude that despite widespread presumptions to the contrary, privately owned or run hospitals are not more efficient nor do they reduce the budget burden of government.

4.2 The effectiveness of corporate medicine

Although it is fashionable to argue that it doesn't matter whether healthcare is provided by the private or the public sector, world-wide comparisons show that publicly provided healthcare systems have the lowest infant mortality rates, even lower than those with national health insurance schemes.

A study by Elola, Daponte and Navarro (1995) contrasted healthcare systems organised around a national health system (that is public) and those financed through national health insurance systems (that is private). They found that overall the countries did not differ in infant mortality, potential years of life lost, or life expectancy. After controlling for the effect of gross national product and healthcare expenditure, however, infant mortality was found to be lower in countries with national health systems. This is because publicly run systems are more likely to result in an even regional spread of services and access to these services is the most important factor in infant mortality rates (Shi 1994). Similarly, countries that place an emphasis on providing strong infrastructure for primary care services achieve better health levels for a variety of health indicators across the age span (Starfield 1995:1350).

Access to primary services, mortality, and morbidity, are clearly linked to measures of equity in society. The more equitable the distribution of wealth, the healthier the population (Wilkinson 1990). Equality, equity and access to primary care make for a healthier population.

4.3 Corporate medicine and the facilitation of choice?

More than one-third of patients are now treated in private hospitals, largely due to the increase in private institutions, from 391 to 502 over the past ten years (ABS 2001). This rise has been brought about by the twin actions of government and business. The federal government has contributed to the increase of private health services through its campaign to increase the membership of private health insurance programs. The multi-billion dollar subsidisation of the health insurance industry – estimated at between $2.5 and $3b per year – brought the industry three million new customers and a record

surplus this year of between $850 and $950m (Kerin 2001; Carter and Chapman 2001). The government achieved this rise in membership largely by instilling fear in the population about a 'crisis' in Medicare and the public hospital system, and by allowing the industry to impose severe financial penalties on those who fail to take out insurance. This legislative change is highly discriminatory, with older Australians facing higher premiums if they now join a private health fund. Moreover, the policy is clearly inefficient, as it provides a subsidy largely to those who already had private insurance (cf: Duckett and Jackson 2000).

The anxiety induced in the public by the government's own media campaign has been compounded by a continuous media interest in reporting negatively on the state of the public healthcare system and allegations that there is a crisis in the Medicare system. Many individuals appear to have been convinced by the rhetoric that the private health insurance rebate will 'take the pressure off the public system' and 'provide much needed funds into public hospitals'. These claims are groundless however, because even when Australians use private hospitals or private health services, the state still pays for a substantial proportion of their medical services through the Medicare system (cf: Davoren 2001:21), and the private health insurance rebate has been shown to be an ineffective means to fund health services, as it is more efficient to put the resources directly into Medicare rather than giving it to individuals (Smith 2000; Duckett and Jackson 2000; Robertson et al 1999; Deeble 2000; Gray 1999-2000:6). In fact, by providing subsidies to the private sector, the private sector is given the funds to attract resources *away from* the public system, thereby adding to pressure on the public system. Thus the federal government has assisted in increasing the use of private health service facilities by providing a health insurance rebate, creating public panic about the capacity of the public hospital system to provide services, and continuing to restrict and cut funds for public services.

4.4 Capacity of government

Corporate investment in the healthcare sector can undermine the capacity of governments to make and deliver effective policy. Governments may, for example, construct legislation aimed at limiting over-servicing, outlawing certain practices and contractual relationships between services such as laboratories with medical clinics, fee-splitting and 'kickbacks'. However national legislation is made irrelevant and impotent by the provision of a complete 'package' of services by a single corporation or by the provision of services in one building or in close proximity. At the same time, this situation ensures the maximisation of returns to the corporation (Davis and George 1988:204). Paradoxically, in terms of recent calls for a smaller state, privatisation increases the need for state bureaucracy to enhance monitoring and surveillance, as government is required to ensure that contractors and private firms fulfil the terms of their contracts. Overseas experience supports the view that privatisation has increased the regulatory burden for governments (Haque 1996:201).

It is also very difficult for governments to successfully intervene in private investment decisions once healthcare services are owned and delivered by the private sector. Foreign investors can easily circumvent legislative requirements once they have entry to the market, even though these actions may be contrary to the national interest and fail to

ensure net economic benefits to the public sector (Senate Select Committee 1987:267). Current trends toward privatisation and corporate control make it more difficult for the state to politically 'steer' the society and the economy (Ernst 1993:37), as well as to control rising healthcare costs. Yet the need for strong state regulation is borne out by overseas experience. In the USA during the period between 1982 and 1986, studies show that it was the direct regulation of healthcare prices rather than market competition that led to a slowing of the rate of growth of hospital costs (Biles et al 1980; Robinson and Luft 1988).

A further example can also be provided to demonstrate the erosion of governmental capacity in the face of increased power of the private sector in health services delivery. This is that once market principles are introduced, the basis of decision making about the location of hospitals changes. No longer are needs identified by a process of government assessment of the requirements of the population and determined according to evidence of inequity or changes in patient demand. Rather, it is the return to investors that drives the decision making process and the final arbitrator of decisions becomes the legal system rather than the bureaucracy or political arm of government. Disputes over the building and location of new hospitals are taken to the courts, where decisions are made according to the property rights of entrepreneurs, not the user rights of consumers nor the service responsibilities of government (Duckett 1989). Consequently, the Health Commission in Victoria, for example, has been unable to prevent the private sector from building hospitals in localities that will maximise private revenue from the public sector – competing with nearby public hospitals for patients – rather than providing new beds in under-supplied areas. Given that all hospitals, both public and private, are subsidised by government, this situation 'wastes' scarce public resources and produces no net gain in health services for the community.

Despite the growing evidence that corporatised and privatised healthcare delivery is not the panacea it is purported to be, and despite some apparent changes in official attitudes towards the privatisation of hospitals outlined at the start of this section, governments still pursue an increased role for private interests in the health sector vigorously. As the following section will show, this has some serious implications for patient care.

5. Whither patient care? Ethics and professional autonomy

The twin developments of the privatisation of public health care and the corporatisation of other health care services have had a profound influence on professional autonomy, professional ethics and the priority given to patient care. The changes have heralded a significant shift in the ethical basis of health care delivery and the capacity of the medical profession to ensure the integrity of the system.

5.1 Do doctors care?

It is neither new nor radical to argue that encouraging the private sector into the healthcare system may threaten the autonomy of the medical profession and undermine the quality of care patients' receive. Such claims have been made by numerous scholars and the debate stretches back into the dark of history. For instance the French academic Emile Durkheim, often hailed as the 'father' of sociology, pronounced that the medical profession functions as a 'moral authority' in society, providing a buffer and intermediary between the patient and the less ethical demands of the market (1933:26). Durkheim also suggested that the professions 'lubricate the wheels of capitalism', suggesting that these elite occupations are essential to the smooth functioning of the capitalist market, but they do this while simultaneously providing a service to those in need. Several decades later an American sociologist Talcott Parsons (1970) revitalised and extended this view. He argued that the normative framework of the profession is not only essential to the therapeutic regime, but brings about a professional-client relationship which is the exact opposite of the contractual business relationship and which 'reintegrates' sick people into the social system. As such, the professions are essential to restoring the normative order of capitalist society. In other words, the medical profession helps to ensure that life is not overly harsh, brutish, or short.

This normative perspective has often provoked a very heated response from those who reject the view that socialisation into the 'norms' of the profession and its ethics act to ensure restraint on self-interest and over-servicing. Instead it is suggested that the 'norms' of the profession have never been sufficient in practice to prevent fraud, negligence, inappropriate behaviour and over-servicing for personal gain. Rather than accepting the profession's own view of themselves, critics suggest that the professions enjoy unrivalled autonomy, prestige and financial reward. Unlike other occupational groups, the medical profession controls its own work, the healthcare services, patient-doctor interactions, and the medical labour force (eg. Willis 1983). Some scholars even took the position that the ethical orientation of the professions was a ruse or sham, pointing out that professional ethics, built around codes of behaviour, standards of practice, and a responsibility to the community, not only sustain professional solidarity but reinforces the dominant position of the professions in the occupational hierarchy (Freidson 1970). For the feminists, professional closure and medical dominance also means that doctors have an inappropriate level of control over women's lives (eg. Rose and Hanmer 1976).

Although no satisfactory compromise on this position has ever been reached, it is clear that there are fundamental connections between the level of occupational autonomy

doctor's enjoy, their self-interest and their interest in patient welfare. Indeed it is crucial for the professions to, at the very least, *appear* to be concerned with the interests of the public, rather than just their own interests. This is because it is their *claim* to be concerned for the patient which prevents the profession from being subject to external scrutiny and control (Johnson 1972:56). In other words, it is the profession's apparent restraint in self-interest which is the key to economic, cultural and institutional power (Hafferty and Light 1995), and simultaneously, it is the profession's autonomy and control which enables doctors to focus (perhaps coincidently) on the needs of their patients.

5.2 Deprofessionalisation and patient care

During the 1980s, the degree of autonomy held by the medical profession was thought to be under threat from an incursion by the nation state (White 2000). It was suggested that the state was exploiting its capacity to intervene in the doctor-patient relationship, and that its tendency toward bureaucratisation was undermining the dominance of the profession and bringing about de-professionalisation (eg. Haug 1988). By the end of the century, after corporate investment in healthcare has built to unprecedented heights across the globe, it has become clear to many within the field that the threat to medical sovereignty and the healthcare system is not coming from the nation state, but from the market (eg. Hafferty and Light 1995; Navarro 1986; White and Collyer 1998). Once again the autonomy of the profession has become a central issue.

Medicine that is delivered by large-scale corporations is a fundamentally self-interested form of medicine in which the interests of patients and doctors no longer converge. Doctors become part of a corporate enterprise and lose their capacity to direct their own behaviour toward the need of the patient and their capacity to act in the interests of the profession itself. Where healthcare is provided as a public 'good', the medical profession is answerable to demands by the public for good healthcare – which is one of the primary reasons for the profession being targeted by both the state and healthcare corporations. Johnson (1972) recognised this mutual dependence when he argued that the power of the professions and the state are not inversely related. The professions, by dint of their expertise and association with an altruistic service ethic, are co-opted to provide legitimacy to both the state and the healthcare corporations, in order for these to act as financiers and managers of healthcare services. As a consequence, the future may bring a new and uncomfortable alliance between consumers and the medical profession, as increasing demands are placed on the profession by corporate managers to discard the public interest for the institutional goals of efficiency and profit.

With the recent entry of pro-market policies into the NHS in Britain, and systematic corporate investment into Australia, the deprofessionalisation and 'proletarianisation' theses begin to take on new importance. In Britain, the shift to market-based delivery of health services was implemented explicitly to limit the power of the medical profession.[5] This move appears to have also undermined the existence of, and effectiveness of, a service ethic in the healthcare services sector. Although it should not be suggested that the service ethic has been the *raison d'être* of the profession –

[5] See Light 1993:284

evidence points clearly to the contrary – it is nevertheless the case that in the past there has been some alignment of interests between the profession and the patient, and that it has been in doctors' interests to take into account the health of patients, irrespective of costs to the public or private sector.

Therefore, in a healthcare system composed of an integrated corporate network of health services, the restraints on ethical behaviour, already lightly felt, may well be released altogether. After all, the maximising of profit is neither illegal nor unethical – it is a duty to shareholders. A recent US case is notable: a patient lost a case against her doctor and his Health Maintenance Organisation when the court ruled that the doctor's duty was to maximise profits and that this outweighed his responsibility to the patient (Costa 2000). In Australia in the late 1980s it was conservatively estimated that there was $100m dollars a year of Medifraud, a figure that the federal executive of the AMA formally accepted. In 1992 it was estimated that Medifraud was about $500m (Auditor General 1992), and in 1999-2000, fifty doctors were reported for Medifraud. Reporting on the lack of prosecutions for Medifraud in an article titled 'Doctors accept BMW bribes in kickback culture of creative fraud' the *Sydney Morning Herald* stated, 'It's just too easy to side-step the penalties, or too onerous to prove the level of proof required to put someone in jail'. Commenting, the AMA claimed that rising Medifraud was a consequence of corporatisation, with junior doctors being forced to treat too many patients too quickly (Kerin 2000).

These illustrations suggest that the ethical and normative behaviour of physicians and other health providers is shaped by the institutional environment, not just by the profession or occupation to which they belong. They also suggest that employees of corporations will have different goals and aspirations to those working for themselves or for the public sector. The difference is most marked in a comparison of private and public sector providers, where the former have moral obligations to investors, and these take priority over their social obligations to patients or customers (Pollock et al 2001).

5.3 Quality of services

Systematic corporate investment in the healthcare sector also has the capacity to significantly lower the quality of services. The Doctors Reform Society (DRS) has reported Health Insurance Commission figures showing that doctors employed by corporations have to put through more patients to maintain their income, having to see eight patients an hour to ensure the same income as seeing six in their own practice. The DRS goes on to suggest that this is having a major impact on the behaviour of the GP, seeing patients for only one problem per visit, prescribing minimum quantities of drugs to ensure return visits, and a worsening of the turnstile approach to medical practice (Costa 2000).

Theories of competition assume the operation of a free market, but the healthcare sector in Australia and in most democratic, industrialised countries, does not have any features of the free market. Given that all health companies in Australia are heavily reliant on government for a substantial portion of their income, it fails to make sense to assume that competition could operate in this sector. Instead the price and quality of services are negotiated with government and laid out in the terms and conditions of the service

agreements. Furthermore, the range of services and the quality of services are maintained only where these are fully stipulated by contract and where the government is prepared to pay a high premium. Where a high premium is not forthcoming, and where Australian governments have attempted to 'drive a hard bargain' in its contracts with the private sector, corporate actors have in many cases resorted to effective blackmail or retired from the contract. The evidence is that firms will provide high quality services where they are explicitly paid to do so, or when the expense can be subsidised by high profits elsewhere and this can be justified as a good public relations exercise. However delivering quality care rarely results from competition itself, as companies are more likely to respond to competition by cutting staff or swapping highly trained staff for lesser trained staff. This is known as reducing hospital costs by seeking 'labour mix improvements'.[6]

6 cf: www.maynick.com.au/news/nr/00112-austin.html

6. Conclusion

The full implications of recent changes to the Australian healthcare system described in this paper are almost incalculable. Where this system was once dominated by a network of public hospitals, research institutions, laboratories, and medical centres, with care delivered by a mix of salaried or fee-for-service practitioners, we have now a system characterised by a few very large corporations that own and/or manage large and small hospitals, medical centres, insurance companies, community programs and allied services, and with increasing linkages to medical education, training and research.

What are the implications of this change? The first is the impact on the cost of providing healthcare services. We have shown that a system that increases the power of the private sector relative to the public sector results in more costly healthcare services, largely because this new system is based on the principle of continual growth and expansion. There is no evidence, either in Australia or overseas, that a healthcare system organised primarily around private delivery of services can be run at a lower cost than a publicly owned and operated system. Corporations are more concerned with increasing revenue than with cost reduction, and any cost-reductions come largely through the elimination of skilled staff, services and standards.

Financing this new health system also means diverting increasing amounts of public funds to ensure the profit margins of the new investors. Attempts to tighten controls over the amounts demanded by the operators have been futile to date. Demands for higher reimbursement from Medicare have been accompanied by threats of legal action and in some cases the right to sue has been enshrined in the contract. Given the greater power of corporations, and the sensitivity of the electorate to any withdrawal of healthcare services, governments are not in a position to ignore investors' demands, and governments have been extremely reluctant to cancel contracts when conditions have not been met. As a consequence, the majority of health related contracts, which may have appeared to offer at least short term savings to government, have resulted in the escalation of service fees and charges over the life of the contract.

A second implication of corporate domination of the health system is the potentially negative effect on health outcomes. In the Australian case, Medicare was introduced as a mechanism to rationalise inputs in a system with both private and public providers, and as a means to ensure universal coverage. It was not designed as a system to control outputs (eg. the effectiveness or quality of care). The only controls on output have been through professional, peer control mechanisms, and these are largely 'normative' (ie., based on encouraging conformity to a set of values and ethical standards), and largely divorced from the financing of care (there is no direct financial incentive to provide care based on medical need). There is no evidence to suggest that contracts with private companies would offer a second mechanism to ensure quality of outputs. Although some of the contractual arrangements specify outcomes (eg. PMBH is obliged to maintain current standards of infection control within the hospital), governments rarely have the capacity or political will to enforce contracts (eg. the extreme reluctance of the previous Victorian government to rescind the ambulance service contract with Intergraph, and the SA government's inability to deal effectively with Healthscope

when it did not comply with its contract to operate Modbury Hospital). In the past, health service standards were largely determined by the institutional practices of public organisations and the professionals working within them. The few private institutions were exhorted to adopt the same standards. The revolution within the sector has relegated the public institutions to play a minor role. Health standards are increasingly being determined according to the business needs of the large corporations, rather than by 'normative' professional practices.

A third implication is the undermining of the principle of universality in the healthcare system. As Stephen Leeder reminds us, it is too easy to forget that there was a time of great inequity in healthcare, when those without means were faced with either charity or no care at all, while the needs of the rich were always attended to (1999-2000:9). The Australian healthcare system is being rapidly transformed into a two-tier system, with a chronically under-funded public sector struggling to offer basic services for the majority of the population, and a private system providing services that are also funded largely out of the 'public purse' but available only to the wealthier members of society. It is clear that the healthcare system has been transformed from a 'public good' to a welfare service: a transformation begun under the Hawke/Keating Labor Government, but accelerated under the Howard Government.

A fourth implication is the effect on the capacity of the nation state, and through this the citizens, to maintain any level of control over our healthcare system. As the corporations increase their range of activities and send tentacles throughout the system, patient 'choice' becomes more restricted. As Boreham (2001) argues, patients are already finding themselves referred to a hospital by a Mayne Nickless corporate medical centre, staying in a Mayne Nickless hospital, visiting a Mayne Nickless pathology clinic, and consuming Mayne Nickless drugs.

The diverse strategies of many corporate actors, acting independently or in concert with others (and in many previously unrelated areas of the healthcare sector), has combined with policy directions of federal and state governments to create a profound impact on the Australian healthcare system. This impact is no less significant, nor less far-reaching, than the introduction of HMOs in the USA. Despite repeated assurances from policy makers that we will not adopt an American style healthcare system, the only difference here has been the route through which the corporate sector has entered to achieve its objectives. These objectives of control, monopolisation, and high, sustained profits, could not have been reached without the full co-operation of the federal and state governments. Government policy has not only produced the conditions for the flourishing of large, private healthcare businesses, but has actively and expensively subsidised the creation and development of the market and continues to ensure that companies may derive their income from the 'public purse'. The impact of third-party control over the financing of services has been well documented in the USA, and as we have argued, the differences between that system and ours are now few and minor. What we have in Australia is the rise of HMOs under a different name. Although initial actors may have pursued corporate capital in partnership with government as a pragmatic solution to a severely under-resourced sector, the early trickle of interest has turned into a flood of corporate actors eager to provide services, and in the process, the structure of the system has been irrevocably altered.

This new market, highly dependent on the government, can effectively dictate the terms of the healthcare system through financial interest in hospitals, general practices, allied services, research and education. The consequences of this include: undermining the governability of society, damaging the capacity of governments to manage, plan and co-ordinate the healthcare services sector for the benefit of its citizens, and taking from the medical profession what little ability it had to act in the interests of its patients. As a result, all Australians will be witnesses to an ever increasing escalation of costs for healthcare, to a system in which inequality will be further entrenched, and to an acceleration of crises with an increasingly noticeable deterioration in standards and quality.

Addressing the problems that we have raised in this paper requires a decisive policy response from both the professions and government. The professions must recognise and acknowledge that their own self-interest has served them well in the past, enabling them to establish a credibility and authority which co-incidentally assisted the patient. However this self-interest was once tempered by an ethos of disinterested delivery of services, enabling the professional to establish a relationship of trust that the service would be in the patient's own interest. In this new environment, ethical motivations have been clearly usurped by the corporations' need to improve the profitability of delivery, and traditional relationships between doctor and patient, once premised on trust, are now determined by contracts, quotas and profit levels. The peak medical professional groups must realise that their professional autonomy is under threat, and an independent future will depend on an alliance with patients, not the corporations.

For government, there is a need to revisit past debates about the uniqueness of the healthcare services sector and the reason it was, for so long, protected from the free market. The basis of these concerns has not been diminished with time. There remains a pressing need to exercise control over investment and development in the healthcare sector. The great tragedy of recent policies in supporting the entry of the market is that the ability to control the siting and development of health resources has been lost to policy makers and handed over to the market. It will take an act of great political will to try and take back from this sector the power it has attained. Nevertheless it is time to demonstrate some political fortitude by retrieving the policy-making capacity of government. It is time also to reassess the outflows of public money to the private sector which is threatening to become an unstoppable flood. One suggestion would be to replenish the public system, enabling it to regain its role in setting high standards of care for all citizens. Another is to draw a rigid distinction between the private-for-profit sector, and the not-for-profit and public sector, cutting Medicare rebates for services to those in the private-for-profit sector, and making those who invest in it true participants in a market economy, rather than subsidizing them from the public purse.

References

ABS (Australian Bureau of Statistics) 2001, *Australian Social Trends 2001* Australian Bureau of Statistics, Canberra.

AIH (Australian Institute of Health) 1990, *Australia's Health* Canberra, Australian Institute of Health.

AMA (Australian Medical Association) 1996a, 'National Mutual Contract Push Will Fail' Press Release, March 29.

—. 1996b, 'AMA Slams Health Insurers' Plans' Press Release, 14 May.

—. 1996c, 'Doctors to Become Health Fund Lackeys?' Press Release, 14 July.

—. 2000, *AMA Scoping Paper – November 2000 General Practice Corporatisation* http://domino.ama.com.au

Auditor General 1992, *Medifraud and Excessive Servicing* Audit Report No 17, Health Insurance Commission.

Biles, B; Schramm, C. and Atkinson, J. 1980, 'Hospital Cost Inflation Under Rate Setting Programs' *New England Journal of Medicine* 303: 664-8.

Boreham, T. 2001, 'Hospital Giant Plans $1.8bn Drug Deal' *The Australian* 1 June.

Bower, A. and Pryer, W. 1998, 'Family Warn of Extra Costs at Hospital' *West Australian* 12/3/98.

Brooks, P. 1999, 'Privatisation of Teaching Hospitals' *Medical Journal of Australia* 170:321-322.

Carter, S. and Chapman, S. 2001, 'John's $12 Tonic: Press Coverage of the Government's Selling of a Private Health Insurance Rebate' *Australian and New Zealand Journal of Public Health* 25 (3):265-71.

Collyer, F.M. 1997, 'The Port Macquarie Base Hospital: Privatisation and the Public Purse' *Just Policy* 10: 27-39.

—. 1998, 'Privatisation and Australian Hospitals' *Health Issues* Health Issues Centre, Melbourne. September, 56:12-14.

Collyer, F.M., McMaster, J. and Wettenhall, RW. 2001, 'Privatization and Public Enterprise Reform in Australia' in Farazmand, A. (ed) *Privatization or Public Enterprise Reform?: International Case Studies With Implications For Public Management* Greenwood Press, Westport, Connecticut.

Collyer, F.M. and White, K.N. 1997, 'Enter the Market: Competition, Regulation and Hospital Funding in Australia' *Australian and New Zealand Journal of Sociology* 33(3): 344-63.

Conn, R. 1978, 'Clinical Laboratories: Profit Centre, Production Industry, or Patient Care Resource?' *New England Journal of Medicine* 298:422-442.

Costa, C. 2000, 'Corporatisation of General Practice: A Professional Viewpoint' *New Doctor* 74: 1-4.

Cresswell, A. 1996, 'Managed Care Group Moves in On SA Trial' *New Doctor*, 1 November.

Davoren, P. 2001, 'Why Private Health Insurance Initiatives Don't Help Public Hospitals' *New Doctor*, Winter 75:21-22.

Davis, A. and George, J. 1988, *States of Health* Sydney, Harper and Row.

Deeble, J. 2000, Private Communication and paper to Health Policy Group, Sydney University.

Domberger, S. and Hall, C. 1995, *The Contracting Case Book: Competitive Tendering in Action* AGPS, Canberra.

Domberger, S. and Piggott, J. 1986, 'Privatization Policies and Public Enterprise: A Survey' *Economic Record* 62 (177):145-62.

Duckett, S. 1989, 'Regulating the Construction of Hospitals or Vice Versa' *Community Health Studies* 13(4): 431-440.

Duckett, S. and Jackson, T. 2000, 'The New Health Insurance Rebate: An Inefficient Way of Assisting Public Hospitals' *Medical Journal of Australia* 172:439-42.

Durkheim, E. 1933, *The Division of Labor in Society* Macmillan, New York.

Elola, J; Daponte, A; and Navarro, V. 1995, 'Health Indicators and the Organisation of Healthcare Systems in Western Europe' *American Journal of Public Health* 85:1397-1401.

Ernst, J. 1993, 'Steering the Healthy Course: The Case for Government Involvement in Health Issues' *Health Issues* 37:15-18.

Ferguson, H. 2000, 'Corporation Bid for GP Training' *Australian Doctor* Sydney, 21 July:1-2.

Freidson, E. 1970, *Profession of Medicine* New York, Dodd Mead.

Gottliebsen, R. 2000, 'R&D: Research and Destroy' *The Australian* 21 November.

Gray, G. 1999-2000, 'Maintaining Medicare: Rhetoric or Reality?' *New Doctor* Summer 72:5-7.

Hafferty, F. and Light, D. 1995, 'Professional Dynamics And The Changing Nature Of Medical Work' *Journal of Health and Social Behaviour* (extra issue):132-53.

Haque, M. 1996, 'Public Service Under Challenge in the Age of Privatisation' *Governance* 9 (2): 186-216.

Haug, M. 1988, 'A Re-examination of the Hypothesis of Physician Deprofessionalisation' *Milbank Quarterly* 66:48-56.

Henig, J; Hamnett, C. and Feigenbaum, HB. 1998, 'The Politics Of Privatization: A Comparative Perspective' *Governance* 1 (4) pp. 442-68.

Health Insurance Commission (HIC) 1993, *Proliferation of new Technology in Private Sector* Melbourne, Health Issues Centre.

Hicks, R. 1989, 'Hundreds More Hospital Beds To Close: Prime Sites Will Go In State's $500m Health Sell-Off' *Sunday Telegraph*, 16 April.

Johnson, T. 1972, *Professions and Power* Macmillan, London.

Kerin, J. 1999, '"Failed" Health Plan Expanded' *The Australian* 26th August.

—. 2000, 'Turnstile Doctors in Medifraud' *The Australian* 18 October.

—. 2001, 'Health Insurer Defends Big Profit' *The Australian* 18 July.

Kerin, J; Price, G. and Stock, S. 2001, 'The Great GP Takeover' *The Australian* 16-17 June.

KPMG Consulting 2000, 'Corporatisation of General Practice' *Scoping Paper Prepared for Commonwealth Department of Health and Aged Care'* Canberra, May.

Leeder, S. 1999-2000, 'How You Can Help Maintain the Health of Medicare' *New Doctor* Summer, 72:7-11.

Lewin, L; Derzon, R. and Margulies, R. 1981, 'Investor-Owned and Non-Profits Differ in Economic Performance' *Hospitals* 1 July: 52-58.

Light, D. 1993, 'Escaping The Traps Of Postwar Western Medicine' *European Journal of Public Health* 3 (4): 281-89.

Lindorff, D. 1992, *Marketplace Medicine* Bantam Books, Sydney.

Macklin, J. 1991, 'Hospital Services in Australia: Access and Financing' Issues Paper No 2. Canberra, *National Health Strategy*: Department of Health Housing and Community Studies.

McGuire, L. 1994, 'Service Delivery Agreements' in Alford, J. and O'Neill, D. (eds) *The Contract State* Centre For Applied Social Research, Deakin University, Victoria.

Managing Directors Report 2000, SonicHealthcare Limited: http://www.sonichealthcare.com.au/ar00/mdreport.htm [12 April 2001]

Moynihan, R. and C. Clegg 2000, 'Corporate Medicine: Coming to the Local GP' *Australian Financial Review* 11 July, Sydney.

Navarro, V. 1986, *Crisis, Health, and Medicine* Tavistock, New York and London.

NSW Auditor-General 1996, *NSW Auditor General's Report For 1996* Volume 1, The Audit Office of NSW, NSW Government.

Panoptes, A. 1981, 'Give us Your Sick, Privately Insured' *New Doctor* 19: 23-25.

Parsons, T. 1970, *The Social System* Routledge and Kegan Paul, London.

Pattison, R. and Katz, H. 1983, 'Investor-Owned and Not-For-Profit Hospitals' *New England Journal of Medicine* 309: 347-353.

Pollock, A; Shaoul, J; Rowland, D. and Player, S. 2001, *Why It Matters Whether the Public Sector or the For-Profit Private Sector Delivers Key Public Services* Briefing note 4: Response to the Report of the IPPR Commission on Public Private Partnerships. Health Policy and Health Services Research Unit, School of Public Policy, University College London.

Price, G. 2000, 'Pain in Mayne is Plain' *The Australian* 15 November.

—. 2001, 'Firms Fight For $2.7bn in Doctors' Fees' *The Australian* 16-7 June.

Queensland Nurse 1996, 'Privatisation of Public Health - In the Public Interest?' Sept/October.

Quinlivan, 2000, 'Strategy: Corporate Medicine' *Business Review Weekly* 29 September.

Relman, A. 1980, 'The New Medical-Industrial Complex' *New England Journal of Medicine* 303: 963-70.

Robertson, I; Richardson, J. and Hobbs, M. 1999, 'The Impact of New Technology on the Treatment and Cost of Acute Myocardial Infarction in Australia' CHPE Technical Report 10, Monash University.

Robinson, J. and Luft, H. 1988, 'Competition, Regulation and Hospital Costs, 1982-1986' *Journal of the American Medical Association* 260:2676-81.

Rose, H. and Hanmer, J. 1976, 'Women's Liberation, Reproduction, and the Technological Fix' in Barker, D. and Allen, S. (eds) *Sexual Divisions and Society* Tavistock, London:199-223.

Ryle, G. 2000, 'Profits or Patients' *Sydney Morning Herald* 10 August:31, Sydney.

South Australian Attorney General 1997, *Auditor General's Report on Summary of Contract*, tabled 9/7/97, South Australian Parliament.

Samson, C. 1994, 'The Three Faces Of Privatisation' *Sociology* 28 (1):79-97.

Sax, S. (1990) *Healthcare Choices and the Public Purse* Sydney, Allen and Unwin.

SCARC (Senate Community Affairs Reference Committee) 2000, *Healing Our Hospitals* Australian Parliament. www.aph.gov.au/senate/committee/clac_ctte/pubhosp/CONTENTS.HTM

Senate Select Committee 1987, *Private Hospitals in Australia*, Report by the Senate Select Committee on Private Hospitals and Nursing Homes, April, Commonwealth of Australia, Canberra, AGPS.

Shi, L. 1994, 'Primary Care, Speciality Care and Life Chances' *International Journal of Health Services* 24:431-458.

Smith, J. 2000, *Tax Expenditures and Public Health Financing in Australia* Discussion Paper No. 33, September, Australia Institute, Canberra.

Starfield, B. 1995, 'Health Systems Effects on Health Status - Financing VS the Organisation of Services' *American Journal of Public Health* 85(10):1350-51.

Taylor, R. 1979, *Medicine Out of Control* Melbourne, Sun Books.

Thomas, T. 1994, 'Mayne Limbers Up For A Privatised Hospital System' *Business Review Weekly* 16 (23) June 20:74-8.

Treadgold 2000, 'Health: Organising GPs into Efficient Business Units' *Business Review Weekly* 24 March.

van Senten, J. 2000, 'Battle Over GP Data Warms Up' *Medical Observer* 21 January:24-25.

White, K.N. 2000, 'The State, the Market, and General Practice in Australia' *International Journal of Health Services* 30: 285-302.

White, K. 2001, 'What's Happening in General Practice? Capitalist Monopolisation and State Administrative Control: A Profession Bailing Out?' *Annual Review of Health Social Sciences* 10:5-18.

White, K. and Collyer, F. 1998, 'Healthcare Markets in Australia: Ownership of the Private Hospital Sector' *International Journal of Health Services* 28: 487-510.

Wilkinson, R. 1990, 'Income Distribution and Mortality: A 'Natural' Experiment' *Sociology of Health And Illness* 12:391-412.

Willis, E. 1983, *Medical Dominance: The Division of Labor in Australian Healthcare* George Allen and Unwin, Melbourne.

Wooldridge, M. 1999, 'Address to Macquarie Bank by the Minister for Health and Aged Care' www.health.gov.au/medicare/yr

Woolhandler, S. and Himmelstein, D. 1997, 'Cost of Care and Administration at For Profit and Other Hospitals in the United States' *New England Journal of Medicine* 336 (11) 769-774.

Wohl, S. 1984, *The Medical Industrial Complex* New York, Harmony Books.

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