

Doctor owned investigation and treatment facilities: a conflict of interest or a pragmatic way forward?

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The New Zealand health system is implementing a significant reform agenda amidst continued pressure related to the COVID-19 pandemic. A feature of the response, as the system continues to work through the reform agenda, has been the use of capacity and capability across both public and private components of the sector.

Within this context, the recent (September 2022) Medical Council of New Zealand consultation document on doctors and health related commercial organisations¹ has again highlighted the potential conflict between optimum patient care and the potential for this care to be influenced by financial factors. In relation to referral to a facility in which the doctor has a financial interest, the consultation document includes the statement that: *"You should only do so if you have explored other options with your patient, and there is no suitable alternative that meets your patient's needs."* This statement is a new addition to the existing guidelines (July 2012),² and has the potential to dramatically, and negatively, disrupt provision of healthcare across New Zealand.

Healthcare, globally, is characterised by a number of different funding models. Examples include fee for service models, tax-funded models, and insurance-based schemes.³ In my view, New Zealand is fortunate to have a mixture of both fee for service and tax-funded (e.g., capitation) models, which operate alongside our world-class, no-fault universal accident compensation system. Our structures do, to a large degree, optimise healthcare delivery, in a world where many acknowledge that the tension between value, quality and timeliness is an insoluble problem for most jurisdictions.

In terms of elective intervention rates, tax-funded systems trend to lower levels of intervention, and fee for service systems trend to higher intervention levels—with the obvious inference that any financial interest, or the lack of it, contributes to both trends. As an example, for common orthopaedic interventions, we in New Zealand are in the "middle of the pack".⁴ Whilst there will

always be differing viewpoints it seems clear that prior to COVID-19, New Zealand healthcare serves its population, relative to GDP spent, at levels at or above most other countries. Of course, there is always room for improvement, and this is rightly the focus of the current health reforms.

Outside New Zealand's public hospitals, much of the care at primary and secondary levels is provided in doctor owned facilities, including primary care, radiology and pathology facilities, specialised procedural units, private specialist practices, and private day stay units and hospitals. The amount of work this component of the sector does is significant, again ranging from primary and urgent care to secondary care across multiple specialties.⁵ Many of these specialist units have been developed by doctors in response to demand, and are characterised by innovation, and by the introduction of novel investigations and interventions. Reinvestment is a key for continuous improvement.

I believe that it is rare that such facilities have been detrimental to healthcare delivery. More commonly, these doctor-owned and -lead facilities advance healthcare, and lead developments that are adopted—over time—into the public sector. The introduction of magnetic resonance imaging (MRI) scanning to New Zealand is an excellent example of technology introduction through the private component of system. Three decades ago, this new technology was introduced by a private radiology facility in Auckland. Soon after, this the technology was adopted by several other doctor-owned private facilities and, with its obvious diagnostic advantages, was able to provide contracted services to the public hospitals. Several years later, public institutions acquired MRI scanners—although there is still considerable reliance on private contracting for public patients.

Whilst the private component of the sector does not hold a monopoly on innovation, it is often positioned to adapt faster. These investments in private health facilities are arguably more cost effective, and more efficient and innovative than

the public sector can achieve. Endoscopy, cardiac and interventional radiology facilities in the private sector provide excellent examples. Whilst an exhaustive exploration of innovative practices and facilities is beyond the scope of this editorial, there are many examples where such private facilities lead developments in patient centric care—these include primary care, rehabilitation medicine and cancer care.

Limiting referral to facilities in which a doctor has a financial interest has the potential to impair patient care. In practice, that care would be directed away from units subject to referring doctors' involvement. It would lead to referral away from facilities characterised by doctor-lead innovation and development. Limiting referral to doctor-owned facilities would also likely dramatically reduce technological advancement and innovation across healthcare—a process that has evolved over generations in this country, and that is responsible for many of the models of quality care that currently exist.

It is difficult to imagine the degree of disruption of continuity of care, and system breakdown, that would occur at primary care level if the requirement for referral away from a doctor-owned practice for subsequent investigations and treatment were implemented. The resultant impact on patients is likely to be detrimental, and from a system perspective this approach is likely to add cost, cause delays and exacerbate capacity challenges.

Conflicts of interest must be acknowledged, and patients must be informed. In this regard, the Medical Council of New Zealand's 2012 guidance is sound, with a strong emphasis on disclosure and communication.² Where relevant, this discussion will, for most patients, acknowledge a greater overall under-

standing of the doctor's involvement with aspects of the patients care beyond the consultation role.

I have found that many patients express considerable satisfaction when they understand the role of the consulting doctor in further investigation and treatment. Much has been made of the patient's right to choose. This includes choice of provider and, when fully informed, the choice to consent to investigation and treatment. Within the New Zealand context, this approach has always been underpinned by a relationship based on trust and respect between the doctor and the patient.

At all times the medical profession must have patient care as its primary focus—as clearly enunciated in the discussion document—and at the heart of our profession. The Medical Council of New Zealand discussion document provides excellent guidelines relating to dealings with outside commercial organisations including drug, technology and implant companies. The drivers for these companies are often quite different from doctor-owned investigation and treatment facilities. These drug, technology and implant companies report primarily to shareholders and investors.

At the heart of this discussion, there is huge opportunity for ongoing benefit in patient care—when the risks of over-investigation and over-treatment are fully acknowledged. Careful monitoring, understanding of trends and changes in practice, observation of registry data, and outcome studies for procedural interventions, will ensure that quality care remains the priority. Disruption of the process of innovation, continuous improvement, and to continuity in patient care will be to the detriment of the profession—but most importantly, this will be to the detriment of our patients.

COMPETING INTERESTS

Peter Robertson is Past President New Zealand Orthopaedic Association and President Elect International Society for the Study of the Lumbar Spine. Peter Robertson has financial interests in: TBI Health and MSK Radiology.

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