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Original Article

New Private Practice Paradigms in Pakistan

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ABSTRACT

Introduction: *The medical private practice is changing quickly due to many reasons. Most of practitioners need a comfortable environment and working conditions to deliver healthcare services to the patients. Multi-specialty clinics, owned by private entrepreneurs, have been established in the big cities to earn maximum revenue. The small GP clinics are very difficult to be established in big cities. The revenue earned by the small clinics is very low as compared to their expenses such as rent, utility bills & paramedical staff payments. It is the need of the time that complete revised private practices paradigms should be developed.* ***Objective****: to find out (1) future employment structure of the doctors in private sector. (2) To find out whether single specialty clinics are better than multi-specialty clinics in the future scenario* ***Sample Size:*** *A total no of 302 personnel's data was collected through survey. MBBS Doctors, PG Diploma Holders, FCPS, Teaching Medical College Professors from different specialties were enrolled in the survey.* ***Study design & Methodology:*** *The collected data was collected and graded in the excel sheet. The data was analyzed on SPSS version 20 to find the different relationships. The statistical analysis has been recorded and reproduced in the conclusions and results.* ***Sampling Method and Design:*** *Consultant of various disciplines working in private sector having their own clinics or working with different multi-specialty clinics were included in the study. The privately owned GPs were also included in the study for purpose of comparison for compensation in various disciplines.* ***Results:*** *The landscape of medical practice is changing very quickly. Various practice options requires financial and legal knowledge of the various fields. New health commission reforms have provided a platform for healthy competition among the competing physicians and surgeons .****Conclusions:*** *It has been found out that the private practice has taken the shape of industry. All the resources should be used carefully to earn the maximum revenue for meeting the requirement of all stakeholders. The change in the private practices paradigms is very huge which is very difficult for the general practitioners and single specialty clinics to adopt.*

Key words: *private practicing paradigms, employment models for doctors, single specialty practice*

INTRODUCTION

There are many changes in the various disciplines of medical practices in previous years. Economic viability has become an important aspect of practicing doctors. Most of the consultants are deciding to practice alone or with the multi-specialty group. Different doctors have different opinions about the different practicing paradigms.[1] It is important to know the future trends for the private practice for MBBS GPs, PG Diploma holders, consultants, Medical College Teaching professors, non-medical hospital administrators and private hospitals owners. The private practice as GPs is no more rewarding in big cities. Patients are referred to different diagnostics centers by the GPs for different test. These diagnostic units have taken the shape of multispecialty clinics or small scale hospitals. The doctors are losing their relationship with the patients as they previously have. Most of the new FCPS doctors preferred to join the private hospitals as compared to practice alone. So, it is very important how to negotiate with the owner of the private hospital whose priority is only revenue collection only. There are options like hospital employment, engagement with the large multi-specialty group,[2] or to continue with the single specialty for the doctors. There are different employment models available with us.

1. Today's practice and future prospects.
2. The health commission reform has already changing landscape in the hospital physician relationship.

The number of solo and small practices is decreasing in the market. In the recent survey, 64% of the family physicians have shown their interest a multi-specialty as compared to

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single specialty practice. Most of the new FCPS doctors are ready to join a hospital as full time employee.[3] The remaining new FCPS doctors prefer to work as part time employed with private hospitals. It is very clear that new GP's are not added to health care delivery system in the recent years.

There are many reasons that why new FCPS doctors are choosing the private hospitals and multi-specialty clinics[4] rather than to start their own single specialty practice. A shortage of profitable revenue streams like ambulatory surgery, imaging centers; dialysis centers, etc are only possible on hospital level or in a multi-specialty clinic. The induction of patients and prospect of increase revenue is only possible through better coordination between the doctors and the hospital management. For doctors, the certainty of increased reimbursement is most important. From hospital management point of view, they look for least overhead expenses, low reimbursement to the doctors which is the only way to increase for their profitably. The millennial doctor's generation essentially needs a soft landing.

The slogans provided by the Multi-specialty Clinics are as under:

Table 1: The "Slogans" Of Multispecialty Clinics / Hospitals

Multispecialty clinics say	*What they mean is*
For the good of the clinics	Socialize income for the clinics
Economy of scale	Co-mingle expenses
Mitigate risk	Limit upside potential
Optimize administrative and financial resources	Create layers of corporate infrastructure

Table 2:Comparison Of Single Specialty Versus Multispecialty Hospital

	Multispecialty	*Single specialty*
Primary care	Yes	No
Referral network	Built-in	Unlimited by group
Capital	Accessible	Dedicated
Resources	Multiple	Limited
Infrastructure	Cumbersome	Straightforward
Decision-making	Shared, slow	Direct, rapid
Risk	Limited	Increased
Reward	Limited	Unrestricted

HYPOTHESIS QUESTIONS:

1. What considerations new consultant doctors have in establishing their relationship with the private hospitals?
2. What is the role of consultant doctors in taking decisions in the management of hospitals?
3. What are the benefits between single specialties, self-own clinics and multispecialty hospitals owned by the private owner?

RESULTS

The consultant's survey was conducted regarding all these above 3 questions. The data collected is summarized below.

	Qualification	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MBBS	64	21.2	21.2	21.2
	FCPS	120	39.7	39.7	60.9
	PG Diploma Holders	48	15.9	15.9	76.8
	Teaching Hospital Consultants	30	9.9	9.9	86.8
	Non-Medical Hospital Administrators	17	5.6	5.6	92.4
	Private Hospital Owner	23	7.6	7.6	100.0
	Total	302	100.0	100.0	

Data collected about the Q1. Showed that consultant doctors were more concerned about governance, compensation[5] and future benefit plans if they practice with private hospitals.

		Frequency	Percent	Valid Percent	Cumulative Percent
ADMINISTRATION PARTICIPATION					
	private owner	147	48.7	48.7	48.7
	consultants	154	51.0	51.0	99.7
	MBBS Doctors	1	.3	.3	100.0
	Total	302	100.0	100.0	
	Private Clinics				
	one Doctor G.P Clinic	232	76.8	76.8	76.8
	Family Physician Clinic	70	23.2	23.2	100.0
	Total	302	100.0		
	Multi-Specialty Clinic				
	Compensations	193	63.9	63.9	63.9
	administration Issues	43	14.2	14.2	78.1
	Work Environment	66	21.9	21.9	100.0
Valid	Total	302	100.0	100.0	
	Age				
	25-30	64	21.2	21.2	21.2
	31-40	48	15.9	15.9	37.1
	41-50	137	45.4	45.4	82.5
	51-60	53	17.5	17.5	100.0
	Total	302	100.0	100.0	
	Male	202	66.9	66.9	66.9
	Female	100	33.1	33.1	100.0
	Total	302	100.0	100.0	

The doctors who were starting their practice were less concerned about all other things except compensation whereas the old practicing doctors were more concerned about the management of the hospital, governance sharing and future prospects. The private owners of the hospital and

multi-specialty clinics do not want doctors to be shared in governance and financial matters. They want to keep the doctors simply to their compensation.

Qualification * ADMINISTRATION PARTICIPATNT Cross tabulation

Count

		ADMINISTRATION PARTICIPATNT			
		private owner	consultants	Doctors MBBS	Total
Qualification	MBBS	0	64	0	64
	FCPS	120	0	0	120
	PG DIPLOMA HOLDERS	27	21	0	48
	TEACHING HOSPPITAL CONSULTANT	0	29	1	30
	NON MEDICAL HOSPITAL ADMINISTATORS	0	17	0	17
	PRIVATE HOSPITAL OWNER	0	23	0	23
	Total	147	154	1	302

Data collected about the Q2 had shown that consultant doctors were more concerned about governance of the hospitals. They considered that they have better knowledge about the working environment, patient's satisfaction and facilities to be charged from the patients. The private owners[6] do not like this as they consider that it is the responsibility of the hospital management to develop a policy how to run the hospital.

Data collected about the Q3 showed that consultant doctors were more concerned about their independence in their practice. Although, there is no "one-size-fits-all" practice design. It is important for consultants in single specialty to take decisions that will result in their personal and professional upheaval. In the past few decades, it was considered that doctors-patients personal relationship is important for better satisfaction of the patients. Now the patient's satisfaction is changed and new dictum is "BIGGER IS BETTER". It is true that strength, size and financial power of the private hospitals are alluring qualities. Multi-specialty clinics and private hospitals begin to grow from 2010.[7] The changes in the health care delivery system begin to threaten the small practicing doctor's autonomy and income. There was always growing pressure on the local physicians to integrate with local hospitals for having diagnostic facilities. Multi-specialty clinics provided all these diagnosis facilities which boost their business. Most of the multi-specialty clinics have slogans like "Assessable, high Quality, Cost effective Health Care Delivery system".[8]

DISCUSSION

Prevention of GDM becomes the need of the hour.

In the present study the mean age of the GDM patients was 27.2 years and it is almost in par with the studies done by Priyanka Kalra et al[14] and Rajesh Rajput et al[15] and a study done from South India had also showed that age of the mother with more than 25 years are at the risk of developing gestational diabetes and which is true in our patients. In our study majority of the antenatal mothers had education only upto primary school and they were belonging to either lower middle or upper lower type of socio-economic class but most of the Indian based studies had shown that GDM is more common in upper class mothers with high educational level but due to current urbanization and industrialization the situation had changed where even people living with low economic status also are more prone to develop diabetes.

The current study had shown that increasing age and BMI of more than 25 had strong association in the incidence of GDM and the same was also been observed in earlier studies as well.[16,17] Family history of diabetes mellitus has been reported to be associated with higher chances of developing GDM[18,19] and in our study also it had been proven. Interestingly, history of diabetes in mother was more common than the history of diabetes in father (36% vs. 24%). Probably the mothers of GDM women might also have had suffered from GDM in their pregnancies but remained undetected, hence supporting the familial association of GDM. In the present study majority of the mother's with GDM were found to be primi and few of the studies had quoted that GDM was most common in multiparous women but an Indian study done in Haryana did not show any association between the parity and GDM.

As previously described in many studies in our study also it was proven that more than 7 kgs of increase in weight in the first 2 trimester are more prone to develop GDM. In our study the most common maternal complication was vaginal candidiasis followed by premature rupture of membranes and the similar type of results was shown in a study done by Priyanka Kalra etal.[14] In her study she had quoted that hypertension was also more common among the GDM patients but in our study only 4% of the subjects had hypertension. In the present study almost 88% of the deliveries were by LSCS which was much contradicting to the study done by Gajjar et al[20] were only 19% of the deliveries for GDM mothers were LSCS. The most common reason for LSCS was considering it as a high risk pregnancy.

Among the various foetal outcome reported, macrosomia was the most common in our study and similar type of result was also reported by Priyanka Kalra et al[14] and Hong et al[21] but in their studies the overall percentage was less it was only 19% and 9% respectively, but in those studies the incidence of still births, hypoglycaemia and hyperbilirubinemia were high which were very less in the present study.

In the present study it was shown that GDM patients had a significant weight gain after the initiation of insulin therapy and there was also significant positive correlation between the dose of the insulin and the weight gain and this result was almost in par with the study done by Juan For GP practice, socialization is very important in the previous decade. The role of socialization has been taken up by the

media. The multi-specialty clinics have a number of techniques for image building in the society. This has increased the number of patients to the multispecialty clinics and the private hospitals have their built in referral network including GPs, quakes and other health care facilitators.[9] There are also administrative issues in the multi-specialty clinics. Autonomy and decision making among doctors has decreased with the increase in number of specialties under one roof. The larger multispecialty clinics or hospitals become more bureaucratic and policy driven. Clashes begin to immerge between the management and the consultants on the issues of referrals, commercial contacts, performance of procedures, deciding work hours and compensation. It is usually considered that single specialty practice is more financially rewarding in the past. Due to changing scenario, it is very difficult to keep one aloof from the other specialties.

The major question whether a consultant should work alone or in partnership with multispecialty group need to be analyzed on analytical, logical and fiscally sound basis.[10] There are many benefits in working with the multi-specialty clinic/ private hospital; like fiscal security, technical facilities and to have shared administrative and paramedical staff.

CONCLUSION

The consultants have seen the endovascular wave approach. They are able to right the surf rather than to be crashed by the change. The changing medical practicing paradigm have spread all over the country so the consultant doctors have to adopt the change. The various paradigms options have given us insight to the different paradigms. The consultant should adopt the best option available to him based on his specialty, job experience and the area of work. It is further concluded that more researches should be carried out on different variable effecting consultants practicing options.

It is very difficult for the consultant doctors who were practicing independently as single specialty clinic to adopt the change. They do not want to give up their self-reliance and independent practice for employment with private hospitals. It is very difficult for them to answer the administrative staff about the practice in the hospital. Doctors- Private hospitals employers' relationship is always very complex. Our study showed that the 60% of consultant doctors viewed their relationship with hospital management as poor. Only 10% of the consultant doctors viewed their relationship with the hospital management as positive. Surprisingly the management showed positive response about the doctor's behaviour in the hospitals. The reason may be that the hospital management is professional in dealing with HR problems.

Future Recommendations for Private Practice in Pakistan:

The multispecialty clinic and the private hospitals is the need of the time. There is very less place for new GPs to enter into the market place and compete with the giants. There is rising expenses of administration, rent, paramedical staff, utility bills and other, which start from the day one of the month. It is very difficult for the new doctors to get their due share from the day one. So the option is to join a multispecialty clinic or a private hospital as full time or par time, as deems fit. It is important to negotiate carefully when joining a private hospital. Most of the private hospitals have agreements that provide a system to recognize and appropriate reward a consultant for his efforts in developing, managing and improving efficiency and quality in the hospital. The hospital hierarchy aligns its incentive for improved communications skills with management and the patients.

If the consultant succeeds in providing cost effective care to the patients and getting paid reward, he will be more satisfied towards the management.

Another model is the sharing between the consultants and the private owners. The consultant is more autonomous in dealing with patients and gets the rewards of his services. This model is more suitable for the senior consultants having patient loyalty list. Each doctor decides his own reimbursement formula and pays a percentage of the gross revenue to the hospital. Historically this is the most effective practicing paradigm in the market.

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