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# Official Committee Hansard

## SENATE

SELECT COMMITTEE ON MEDICARE

**Reference: Medicare**

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**SENATE**  
**SELECT COMMITTEE ON MEDICARE**

**Tuesday, 23 September 2003**

**Members:** Senator McLucas (*Chair*), Senator Barnett (*Deputy Chair*), Senators Allison, Forshaw, Humphries, Knowles, Lees and Stephens

**Senators in attendance:** Senators Allison, Barnett, Forshaw, Humphries, Lees, McLucas and Stephens

**Terms of reference for the inquiry:**

To inquire into and report on:

The access to and affordability of general practice under Medicare, with particular regard to:

- (a) the impact of the current rate of the Medicare Benefits Schedule and Practice Incentive Payments on practitioner incomes and the viability of bulk-billing practices;
- (b) the impact of general practitioner shortages on patients' ability to access appropriate care in a timely manner;
- (c) the likely impact on access, affordability and quality services for individuals, in the short- and longer-term, of the following Government-announced proposals:
  - (i) incentives for free care from general practitioners limited to health care card holders or those beneath an income threshold;
  - (ii) a change to bulk-billing arrangements to allow patient co-payment at point of services co-incident with direct rebate imbursement;
  - (iii) a new safety net for concession cardholders only and its interaction with existing safety nets, and
- (d) alternatives in the Australian context that could improve the Medicare principles of access and affordability, within an economically sustainable system of primary care, in particular:
  - (i) whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system;
  - (ii) the implications of reallocating expenditure from changes to the private health insurance rebate, and;
  - (iii) alternative remuneration models that would satisfy medical practitioners but would not compromise the principle of universality which underlies Medicare.

**WITNESSES**

**DUCKETT, Professor Stephen, Professor of Health Policy, La Trobe University.....1**  
**SWERISSEN, Professor Hal, Director, Australian Institute for Primary Care, La Trobe  
University .....1**

**Committee met at 9.06 a.m.****DUCKETT, Professor Stephen, Professor of Health Policy, La Trobe University****SWERISSEN, Professor Hal, Director, Australian Institute for Primary Care, La Trobe University**

**CHAIR**—I declare open this public meeting of the Senate Select Committee on Medicare and welcome everyone here today. As those of you who have been following the inquiry would know, an issue that quickly emerged from the submissions was whether the government's A Fairer Medicare package contained measures that could have an inflationary effect on the cost of health care. Given the implications of higher costs for access to health care, the majority of the committee decided it was necessary to get some independent analysis of the figures. That analysis would help to settle the issue one way or the other. The committee commissioned the Australian Institute for Primary Care at La Trobe University to conduct this research. The AIPC was asked what, if any, inflationary effects on health care costs for consumers are likely to emerge from both the government's A Fairer Medicare package and the opposition's proposal. The AIPC delivered its report to committee members on Friday and at a private meeting a few moments ago the committee has agreed to publish the report. Copies are available from the secretariat and have been published on the web site of the committee.

Today's meeting has two objectives: firstly, to enable the research team from AIPC to brief the committee on the methodology and outcomes of the project; and, secondly, to give members of the committee the opportunity to discuss aspects of the report with the research team. I propose to allow the presentation to conclude prior to any questions. Senator Barnett will participate by means of teleconferencing. He is in Tasmania and unable to be here in person.

I welcome Associate Professor Hal Swerissen, Director of the Australian Institute for Primary Care, and Professor Stephen Duckett, Dean of the Faculty of Health Sciences and Pro Vice-Chancellor Health Developments at La Trobe University. First of all, can I thank you on the record for changing your arrangements to fit in with the need of the committee to be able to deal with the presentation today.

**Prof. Duckett**—Bulk-billing is a really important issue for Australians, and the government and the opposition have put forward policy proposals to address the decline in bulk-billing. These are very important issues and I think it is very good that the Senate committee has decided to seek advice on precisely what the implications of this might be for Australians. We have presented our report and would like to take this opportunity to briefly run through the report to outline the key assumptions that drive our conclusions. Then we look forward to questions.

**Prof. Swerissen**—I might take you through the documents.

*A PowerPoint presentation was then given—*

**Prof. Swerissen**—I remind the committee that the question we have been asked to look at is what, if any, inflationary effects on health care costs for consumers are likely to emerge from the government's A Fairer Medicare package and the opposition's proposal. The model that we have developed, which is outlined in the report, is to examine that question in relation to changes in

out-of-pocket costs for consumers, since the out-of-pocket costs that consumers bear are essentially the inflationary impact that is there in relation to health care costs for them. Out-of-pocket costs, OOP, plus Commonwealth payments less practice costs equals the principal GP income source. That is the way we have built that up. General practice income aspirations determine bulk-billing rates, so we have needed to develop an estimate of what we think general practice income aspirations are. The income aspirations also determine their out-of-pocket charging levels. GP income aspirations are constrained by supply issues, the number of GPs who are available in particular settings, and administrative regulations which apply to the Medicare scheme. We have built up our model using those assumptions.

Turning firstly to the question of what has happened to GP incomes, we conducted an analysis of the Commonwealth expenditure per full-time equivalent GP and of real practice costs. The expenditure is in fact logged against average weekly ordinary time earnings, and what we have got there is a graph which shows that the gap between average weekly ordinary time earnings and the Commonwealth expenditure on full-time equivalent GPs has grown over the period from 1993 to 2003. When we actually look at that in a little bit more detail, what is obvious is that the GP incomes were 5.2 times average weekly ordinary time earnings in 1993-94 and they have fallen to 4.7 times average weekly ordinary time earnings by 2002-03. An increase of 10.6 per cent is needed to return GP incomes to par with average weekly ordinary time earnings at present values. That is probably a conservative estimate of their aspirations. Last night we were provided with figures by the Health Insurance Commission which we have been after looking at their relative incomes in relation to surgeons. In the past five years their relative incomes in relation to surgeons have fallen by 7.5 per cent. This is a figure of 10.6 per cent over the best part of 10 years but their relative incomes in relation to surgeons, which would be another estimate, have fallen by 7.5 per cent over the last five years. That suggests that GP incomes in terms of their aspirations are probably falling compared to other relevant sources of comparison for them.

The practice costs are the second part of the analysis. We looked at the work done by PricewaterhouseCoopers for the relative value study conducted for the Commonwealth. In December 1999 PricewaterhouseCoopers for a three-doctor practice found that costs were \$113,526 per GP. We adjusted those figures up to give us a comparative figure for 2003 by CPI to give us a number of \$130,676 per GP. That is probably a conservative estimate because we have used CPI to do the adjustment rather than using a wage index and most of the costs for practices are in fact in wages and salaries for the people who work for them. If we had used a wages and salaries investment, that cost would have been higher, so that is again a conservative estimate of costs that are there for the GP practices at the moment.

We looked at bulk-billing trends to see what had happened. That is the graph from 1984. Essentially it goes up to 1995-96, plateaus and then starts to come down fairly significantly from about 1999-2000, which suggests that it parallels the changes that are occurring in GP incomes over that period of time as GP relativities are falling, so what happens is that the GPs drop their bulk-billing rates to seek alternative sources of income by increasing out-of-pocket costs. That is the most likely explanation for those bulk-billing changes occurring.

We did an analysis of out-of-pocket costs, and the blue line is out-of-pocket costs averaged across all patients. What that line shows is that average out-of-pocket costs across all patients from 1984 to 1997-98 fell over time against CPI and then increased from the period 1997-98 to

2002-03. Out-of-pocket costs for those people who are charged out-of-pocket costs, not everybody, so this is not an average across all patients but only for those people who are actually charged out-of-pocket costs, have been gradually increasing over the whole period of the Medicare scheme and have gone up by about 44 per cent over the period of the scheme. So there has been a progressive increase in out-of-pocket costs for those people charged out-of-pocket costs and there has been a recent average increase in out-of-pocket costs across all patients as bulk-billing rates have fallen. So there is a relationship between bulk-billing rates and average out-of-pocket costs across all patients. As bulk-billing rates fall, average out-of-pocket costs across all patients increase.

We looked at the question of supply of GPs and what impact that has on what is known as price elasticity for GP services, in other words the extent to which any increase in price reduces the likelihood that people will come to visit a GP. There are significant variations of GP supply across geographic settings and that is reflected in particularly bulk-billing rates across geographic settings being lower where there are lower levels of GP supply. The price effects on utilisation are generally marginal. What that means is that if there is a small increase in prices for GP services then there is generally a very small impact indeed for the change in the use of GP services. The current Medicare administrative arrangements mean that in order to charge any out-of-pocket costs at all the full cost of the bill must be given to the patient, which we have called the hard threshold. Where there is high supply and a hard threshold, this constrains out-of-pocket costs because that change in price from around zero to around \$33 or \$34 is not a marginal increase, it is a significant increase, and it therefore introduces a significant price signal. There is a possible impact in terms of recent falls in GP supply from government constraints on GP access to providing services through the vocational training scheme, the management of training places in universities, the controls on overseas trained practitioners and so on. These are probably beginning to have an impact on supply and may be contributing to the bulk-billing decline in metropolitan areas, where the supply is tightening up.

This slide shows the estimation of the parameters for 2002-03 which we used in our report. We used an average GP rebate of \$28.57, which was calculated from health insurance figures. We have an average out-of-pocket non-bulk-billed GP services of \$12.91, again calculated from health insurance figures. We have used the PricewaterhouseCoopers adjusted estimate of \$130,676 for the practice costs. We have used the variations in bulk-billing rates across metropolitan city, outer metropolitan, rural and remote settings so that we have allowed for variations in different settings. We have used the Commonwealth Department of Health and Ageing estimate of 7,000 services per year for a full-time equivalent GP to conduct the calculations which I am about to take you through.

The baseline estimates for income in this table here show in the first column metropolitan capital city, metropolitan other, rural and rural remote. The rows reflect those geographic variations. In the first column we have presented the bulk-billing rates for 2002-03. Then we have calculated the bulk-billed services, which are a function of the percentage by the 7,000 services that the average full-time equivalent GP provides. Then we have calculated the non-bulk-billed services. We have estimated the non-bulk-billed income, which is presented there. We have estimated the bulk-billed income and have then calculated a total fee income which, for metropolitan capital cities, is estimated at \$221,676. We have then netted off the practice costs, which leaves you with a figure of \$91,000 for the average net income of a GP for a capital city

after practice costs. They are the average figures that we have calculated and, similarly, for the other three geographic settings, which we have highlighted there in the slide.

We have also had to estimate what the health care card utilisation will be since the government scheme in particular requires bulk-billing for health care card holders, or concessional patients, as they are known. We used the Australia health survey data, which provides a relationship between health care card holders, concessional patients and their use of services. The ratio is in fact higher for concessional patients than it is for the rest of the patient population by a factor of about 1.43. When you calculate out the numbers for the major cities of Australia, for example, 31.7 per cent of the patients in the Australian health survey were concessional patients but they used 45.3 per cent of the GP services because they use more services. If you take those figures through, what is interesting to note is that the current bulk-billing rate in major cities is 72.3 per cent whereas the proportion of GP services which we estimate would be used by health care card holders would be 45.3 per cent. So about 30 per cent of people being bulk-billed do not meet the concessional patient criteria. However, if you go down to the outer regional and remote Australia estimate, what is interesting to note is that about 57 per cent of the services are probably being used by health care card holders and the current bulk-billing rate is about 54 per cent. That suggests that bulk-billing rates for cardholders and the current bulk-billing rates are roughly equivalent as they stand at the moment and there is quite a significant difference between capital cities and rural areas.

Using those data, we then went on to model the government package. We used the Medicare data available through the Health Insurance Commission for 2002-03. We utilised the government average of health card incidence of 50 per cent because the government's model, as far as we were able to tell, assumes a 50 per cent health care card utilisation factor, so health care card holders across the board use about 50 per cent of the services. However, we have calculated slightly different numbers because we have used the Australian health survey data, which give slight variations depending on whether you are in a capital city or a rural setting. We have also included the government's estimates in the tables for comparative purposes. We utilised the average bulk-billing rebate increase by government regional incentive payments, which are in the package, and those figures are highlighted in the report.

We have then created three scenarios: the current out-of-pocket cost, the current bulk-billing rate and the health care card only bulk-billing rate. We did an analysis to find out, if we set the income target at 10.6 per cent increase to restore relativities with average weekly ordinary time earnings and we left bulk-billing rates at health care card levels, what the effect would be on out-of-pocket costs if GPs were to meet their income targets. What would we see happen here? To remind senators, the government's package is an increase in the rebate of \$1 for major capital cities; for other metropolitan areas, \$2.95; for rural areas, \$5.30; and in remote rural areas, \$6.30. There will be access to direct billing for those people who agree to participate in the scheme, which means they will no longer be subject to the hard threshold of the Medicare administrative arrangements. So they can charge a marginal copayment or out-of-pocket charge rather than having to provide a full bill to the patient. There is gap insurance after non-indexed \$1,000 out-of-pocket costs for non-health care card holders and an indexed safety net of \$500 out-of-pocket costs for health care card holders.

The analysis of bulk-billing rates and out-of-pocket rates at current levels is shown in this table, which is similar to the earlier one that I produced. Effectively, when you look through the

analysis, at the end we have the government estimate, using the 50 per cent threshold for health care card holders, and we have our estimate, which is based on the Australian health survey, with a slight variation. But it shows that there is not a whole lot of difference between our estimate and the government's estimate. They come within \$1,000 of each other or thereabouts. When you compare that to our estimated income target that GPs would have if they were to restore average weekly ordinary time earnings, clearly what is happening here is that GPs in rural settings would in fact reach their targets, but they would not reach their targets in metropolitan city and other metropolitan areas. So they would be a good \$10,000 to \$15,000 short in metropolitan areas because there is not sufficient rebate compensation for GPs in metropolitan areas for them to reach their income targets, whereas the government scheme is quite successful in achieving that in rural settings. The scheme would achieve it in rural settings, but it would not achieve it in metropolitan settings.

The implication of that is that, insofar as GPs would then have an income target based on, say, average weekly ordinary time earnings, they would then have to find other ways of achieving that outcome in metropolitan settings. They would most likely drop their bulk-billing rates and achieve their income targets through out-of-pocket costs for consumers. So we then modelled the scenario: what would be the most likely threshold figure for them to set for bulk-billing rates? Because the government scheme is a participating scheme which says that GPs must bulk-bill cardholders in order to participate, this suggests that GPs, if they are acting rationally to optimise their income, would in fact bulk-bill health care card holders, then they would seek to achieve their incomes through out-of-pocket costs for non-health care card holders. Behaviourally, it is unlikely that GPs would have a complicated set of transaction costs beyond differentiating between cardholders and non-cardholders. When we looked at it, it did not seem that it would be easy for them to find other administrative devices to do that which would not increase their transaction costs significantly. We then modelled the effect of current out-of-pocket costs relating to bulk-billing rates for health care card holders only. When we look at the last two columns, again we find there is a slight difference now between the income on the government's estimate and our estimate, which reflects the fact that there are variations in rural areas.

The effect overall is that now GPs will achieve their income targets, or come very close to them, in both the metropolitan areas and the rural areas. The reason there is a slight decrease in the rural areas compared to the previous chart is that the number of health care card holders exceeds the current bulk-billing rate. They would have to increase their bulk-billing rates in order to do that, which would mean a slight decrease in their income levels because they are in fact not achieving as much through the rebate as they are through out-of-pocket costs. There is a slight trade-off between that \$6.30 or the \$5.50 and the out-of-pocket costs. Nevertheless, they get very close to achieving their income targets, so we think that is probably a swings and roundabouts arrangement. The real effect is in the metropolitan areas, where they would achieve their income targets, so it is quite likely that that is a feasible scenario.

We have then modelled it as if they achieved their income targets exactly for metropolitan areas and country areas, and we asked what would happen to bulk-billing rates and out-of-pocket costs. We have a chart that shows the average out-of-pocket costs required to meet the target. It demonstrates the total gross fees they would achieve and their total income target on a gross basis, without netting off the practice costs. The charges would range from \$10.98 to \$13.79 in remote rural areas and to \$15.84 in non-remote rural areas. On that, there would be an increase in average out-of-pocket costs across all patients of 56 per cent from \$3.94 to \$6.16 because of

the decrease in the bulk-billing rates in metropolitan areas of about 20 per cent if GPs are to meet their income targets. I emphasise that. That assumption is important in this analysis. If GPs are happy not to meet their income targets then that analysis is less relevant. But, on the assumption that they are seeking to restore their income targets back to average weekly ordinary time earnings, the effect would most likely be a 20 per cent decrease in bulk-billing rates in metropolitan areas and about a 56 per cent increase in out-of-pocket costs across the board once those bulk-billing rates fell and consumers were paying those charges.

There would be an increase in bulk-billing rates in rural settings because the bulk-billing rates are currently slightly below what we estimate the number of health care card holders to be, so we estimate there would be a three to six per cent increase in bulk-billing rates in rural settings. We also think that, because of the changes the government is proposing in its package, there would be increased convenience for current non-bulk-billed patients because of the administrative changes to Medicare. There would be a slightly reduced gap payment across the board because, although bulk-billing rates fall and the average for all patients goes up, the costs for those people who are not bulk-billed at the moment would actually come down. It would be a swings and roundabouts analysis. For those people who are already paying out-of-pocket costs, we estimate that on average that may well come down. What the real behavioural effects would be in a real environment are difficult to predict. This is an averaged model. It is possible that prices would simply remain where they are, but on our modelling they would reduce.

For the impact of the opposition's package, we used three scenarios: current out-of-pocket charges and current bulk-billing rates; current out-of-pocket costs and health care card bulk-billing rates; and the full uptake of the package. The opposition's package has an increase of bulk-billing rebate to 95 per cent and then subsequently to 100 per cent of MBS, which is a change over a period of time. It provides incentives for reaching bulk-billing targets: \$7,500 to reach 80 per cent in metro areas, \$15,000 to reach 75 per cent in fringe rural areas and \$22,500 to meet 70 per cent in remote rural areas. All payments are automatic to doctors.

The current bulk-billing rates and out-of-pocket cost scenario is essentially modelling what is currently out there and what would happen. Again, looking at whether GPs meet their target incomes, the effect would be that, because the opposition's scheme is slightly more generous than the government's in relation to the rebates because it is an average rebate across the board, GP target incomes as we have modelled them would in fact be met in metropolitan areas but not in rural areas. This is because the current bulk-billing rates are not sufficiently high enough to actually achieve the effect unless they meet those targets. In this scenario, the incentive payments are not reached because we did not do a modelling which assumed a percentage of practices achieving the incentive payments. Because on average the incentive payments are not reached under the current levels, the incentive payments are not factored into this analysis. In effect, this is an analysis which just demonstrates the impact of the increased rebate levels under the opposition's package rather than the effect of both the incentives and the rebates. Under this scenario, they would not make the income targets in rural settings.

We then looked at the effect if doctors dropped their bulk-billing rates to health care card or concession card only but left their out-of-pocket charges at current levels and what the effect would be when you modelled the rebate flow through. What you find is that, at 95 per cent and at 100 per cent, the income targets are achieved for metropolitan areas and, again, they are not achieved at rural areas because the bulk-billing rates in rural areas would be insufficient for the

rebates to achieve the income targets for GPs as we have modelled them unless the targets are lifted. We then factored in the incentive payments for the opposition's package and included those in the analysis. When incentive payments are actually included and GPs achieve them, they can achieve the income targets for both the rural and metropolitan settings. The opposition's package will allow GPs to achieve their income targets on the modelling that we have done, using both the incentives and the rebate levels that the opposition has proposed. It marginally achieves it at 95 per cent level for metropolitan areas and achieves it reasonable comfortably at the 100 per cent rebate level.

Summarising the opposition's package, the impact with incentive payments and rebate levels at current out-of-pocket charges would see an increase in the incidence of bulk-billing to around 77 per cent of services, which is an across-the-board increase. Because of that and because we have modelled it this way, there would be no change in average copayments for non-bulk-billed services and there would be a reduction in average copayments across all services of around 25 per cent. So there is a net reduction because of the effect that the opposition's package has in achieving those income targets using the incentive payments and the rebate levels. In effect, that occurs because the government's package is about a third of the opposition's package in government expenditure terms so there is a trade-off between GPs reaching their income targets, either using government expenditure to do that or through out-of-pocket expenditure. That is a relatively straightforward trade-off which occurs in those two sources of income which they have.

If we look at comparing the impact on bulk-billing rates, this graph shows that the current levels of average bulk-billing rates are in the yellow, the government's predicted fall in bulk-billing rates is in the blue and the opposition's bulk-billing rates show a slight increase in current bulk-billing rates. In the metropolitan areas, that is quite clear; in rural areas, the government's package does increase bulk-billing rates compared to the current levels. So the major impact of the government's package is in metropolitan areas, whereas in rural areas there would be relatively little change, and there would be a protection of health care card holders in rural areas by the government's package, which would see a slight increase in the bulk-billing rates. But across the board, in the modelling that we have done, there would be a fall as a result of the government's package and an increase as a result of the opposition's package.

As regards the impact on out-of-pocket costs for non-bulk-billed patients, again, what happens is that in the opposition's package they remain the same because they are modelled that way. In the government's package, they go up slightly in rural areas because there is an increase in the bulk-billing rate because of the health care card holders and they go down slightly in metropolitan areas. Remember, this is for people who pay out-of-pocket costs; this is not the average across all patients.

The next slide shows you the average across all patients. Here we get a different effect because of the decrease in the bulk-billing rates. What happens is that the government's average out-of-pocket costs across all services go up and the opposition's average across all services goes down. That concludes the presentation of the modelling that we have done. We are happy to answer any questions that you might have of us.

**CHAIR**—Thank you very much, Professor Duckett and Professor Swerissen. I will start with some technical questions. In your document you say you think it is most likely that bulk-billing

rates will go to 50 per cent. In your presentation you have talked about how that will occur. Could you explain a bit further the fact that you get to 50 per cent because of the differential access to bulk-billing that currently exists? Could you explain in a bit more detail how you get to that 50 per cent, please?

**Prof. Duckett**—If you turn to page 20 of the main submission, in table 2 we have the current estimated bulk-billing rates by region. There is another table, on page 22, which is one of critical tables of the submission. You have there our estimates of the current bulk-billing rates, which are consistent with the government's estimates, and our estimates of the current proportion of GP services used by cardholders. Overall, you end up with about 50 per cent of GP services currently being used by cardholders. That is the bottom line, but it varies across the regions. In outer regional or remote Australia about 57 per cent of GP services are used by cardholders and the bulk-billing rates are currently about 54.7 per cent. So almost all cardholder services are bulk-billed, but not all. Our modelling then goes on to suggest that, under the government package, that 54.7 per cent will go up to 57.4 per cent. The 50 per cent is that estimate. Is that what you were asking?

**CHAIR**—Yes.

**Prof. Swerissen**—The other thing worth saying is that the bottom line, which is the total figure, says that 34.8 per cent of people would qualify for a concessional patient status. When you look at the use of services by that 34.8 per cent of people in the Australian health survey, you can see that they in fact use 49.7 per cent of the services. So they use more services than the non health card holder population. In effect, they use 1.43 times more services.

**Prof. Duckett**—In part because a significant proportion of cardholders are older people and they use more facilities.

**CHAIR**—Certainly. I think that is an important analysis on a geographical basis to be understood by the committee as well. You say early in your document that using target income is 'conservative methodology'.

**Prof. Swerissen**—Yes.

**CHAIR**—You have talked today about how you have just recently got information about relativities with costs for surgeons. I dare say, not being a health economist, that there is a whole range of different methodologies you could have undertaken. Can you tell me why you picked the target income methodology and what other methodology you could have used?

**Prof. Duckett**—I suppose the conventional wisdom in economics is that you aim to maximise your income. If one adopted that assumption, then you would expect to see higher rates of out-of-pockets and so on. Essentially, a target income approach is at the low end of what you would expect to see in the behaviour of an ordinary person. It basically says, 'We will increase our income just enough to feel comfortable rather than as much as we possibly can.' So, in this report, we have tried to take a conservative approach. If we had chosen a maximised income model, the question would have been what is a maximum income that a doctor can earn. You would have had to make all sorts of very heroic assumptions, I guess. We have tried to take the most conservative assumption of income aspirations. Then you say, 'What is the target income

and what do you think doctors are aiming to get?' One approach is to say that they look around at their colleagues in the community and see how, on average, Australians have moved in their incomes. So we looked at average weekly ordinary time earnings. We said that a reasonable assumption is that they try to restore their relativity to average weekly ordinary time earnings.

Another assumption you could make is that they look at their colleagues at medical school and see how their income has gone, which is to say that they look at how specialist incomes have gone. That would provide a higher target income. Again, we have taken the conservative approach of the average weekly ordinary time earnings. If we had gone for specialist earnings, we would have had a higher rate of target income aspirations and, consequently, a higher rate of out-of-pockets.

**CHAIR**—I know you got the data only last night; is there any way to tell us what would be that higher aspirational level in relation to the relativity with surgeons?

**Prof. Swerissen**—At the moment, the number is a 7½ per cent decrease over five years versus a 10.6 per cent decrease over 10 years. If we had a time series that took us back over the same period and looked to see what the relativities had been, we could give you a view about that. On those sorts of numbers it is likely that it would be somewhat higher, but without knowing what the time series was—for example, it is entirely possible that, in the five years before, they had improved their position relative to the surgeons.

**CHAIR**—I would be surprised.

**Prof. Swerissen**—It would be surprising. It is difficult to speculate beyond that it looks as though they are falling behind when compared with their surgical colleagues and faster than they are in relation to average weekly ordinary time earnings.

**Senator FORSHAW**—I would like to follow that up. Did you consider the results of the relative values study which said, I think, that GPs would need to charge \$50 a consultation?

**Prof. Swerissen**—We did, and we read the government's submission on the relative values study. We agree with the government's submission that that is probably a somewhat optimistic view of what would be required. I would say that it would be at the high end of the aspirations.

**Senator FORSHAW**—Your model is conservative.

**Prof. Swerissen**—We thought that the government submission was good in terms of presenting the facts of the case, and we used their arguments in relation to—

**Senator FORSHAW**—But if that was at least seen as an indication of what GPs might like—

**Prof. Swerissen**—It would further increase the numbers.

**Senator FORSHAW**—Yes.

**CHAIR**—We have had lots of evidence from doctors talking about their income relative to that of other medical professions. We have also had doctors talking about their income relative to that of other professions, like law—but certainly not teaching or nursing.

**Prof. Swerissen**—No. They do not benchmark against teachers!

**Prof. Duckett**—In this report we could have modelled all sorts of income aspirations. In relation to the average weekly ordinary time earnings, in our discussions we were basically saying, ‘Who are they going to be looking at?’ The one group they could look at was their own employees and how they have gone, relatively. So, in a sense, I would stress that this is the most conservative estimate. We could have given you scenarios of other income aspirations, but we have kept it to the bare minimum.

**CHAIR**—That leads me to practice costs. From the evidence the committee has received about practice costs, I think that your estimate is probably very conservative, again.

**Prof. Duckett**—We have escalated practice costs by the CPI from the PricewaterhouseCoopers data. That is an extremely conservative estimate. Wages have gone up faster than the CPI and so, again, we have taken a very conservative approach.

**Senator LEES**—Have you included the increase in insurance costs in the practice costs?

**Prof. Swerissen**—We have not included the recent increase, which is about \$3,500 for GPs, as a specific item. So, again, it is a conservative estimate. We have been careful not to push this, because that would have increased what would have happened to out-of-pocket costs as a result. We have tended to stay on the side of keeping this within parameters that do not push it any further than we think we have data for.

**Senator LEES**—When you looked at who doctors employ, did you just look at the employment of reception-type staff or have you included the employment of nurses and allied health professionals as part of the practice?

**Prof. Duckett**—It is based on a practice study of 1996.

**Prof. Swerissen**—For this we have used secondary data provided by PricewaterhouseCoopers, which included those factors in their analysis. We have just indexed it up. It would have been nice to have been able to do a full survey of this, but in the time available it was not possible to get primary data. So we have stuck with the best available estimates that are on the published record and indexed them for the comparative purposes that we wanted in relation to—

**Senator LEES**—Does the data you have used include for rural GPs what they tell us about needing to update equipment and items that, for city GPs, will be found in the nearest hospital? For rural GPs the expectation is that that equipment will not be there.

**Prof. Swerissen**—That is an interesting question. We took our work to a group of economists and had a debate with them before we sent it to you. That was one of the questions that were raised. Although there is a lot of anecdotal information that people produce about differences

between rural and city settings on costs, we do not have any empirical evidence to suggest that that is true. At least amongst ourselves we were having a debate as to whether costs would in fact be higher in rural settings. It may be the case that they are lower, because of rent, land values, setup costs and so on, compared to inner-city practices. So it is a swings and roundabouts argument as to which way you go on that. Without some data, we have just used the best available data, which was the PricewaterhouseCoopers study.

**Senator ALLISON**—Just on that point: I think that most of the GPs who have appeared before us have indicated that practice costs were about half their income or less—

**Prof. Swerissen**—Which is about what we have.

**Senator ALLISON**—and significantly less where there were three GPs in a practice. So how do you account for the variety of practice sizes? I presume that most in the metro area are three-GP practices, but in the more remote areas the average would be fewer than that.

**Prof. Duckett**—This is based on the three-GP practice. As you point out, in remote areas they would be much smaller on average, but in regional areas it is not clear that they would necessarily be smaller.

**Prof. Swerissen**—The way that this analysis is done is on averages. Clearly, if you disaggregate beyond what we have done for those broad categories and you start to conduct more detailed studies, you will get a more variegated picture of what is there. We think we have got the averages about right in terms of the analysis that we have done, but there is no doubt that if you blew this out into a more detailed study there would be more variability.

**Prof. Duckett**—The other point is that we are comparing before and after, so, in a sense, practice costs are not being influenced by either the government's or the opposition's proposals. What we have made in looking at target income is an additive model, so whatever your practice costs are, it is essentially a baseline. So it actually does not matter too much how variable the practice costs are. The practice costs are derived to get the net income and, if we are wrong on the practice costs—that is, if we have underestimated practice costs in rural areas—then we have accordingly overestimated current net income and again it flows through to additional out-of-pocket costs. It is a conservative assumption.

**Senator ALLISON**—I am not sure that I quite followed all of that. Are you saying that, when you get a GP increase in expected income, the practice costs go up accordingly?

**Prof. Duckett**—No. If you look at any of these tables, essentially we have deducted practice costs from the gross fee income to get the net income. We have not made any assumption about practice costs changing in any of these models.

**Prof. Swerissen**—That is right. If practice costs were higher, let us say, what would be the impact? Let us say we have got that wrong. Then the impact would be that GPs would have to seek more income to offset those practice costs, so the out-of-pocket costs would be higher than they are and the average out-of-pocket costs would increase in the model. But we think it is probably at the margins. Even if you add in those insurance costs that Senator Lees was talking about earlier, it is probably in the order of something like a \$10,000 margin. It is not going to

double the practice costs; it will be at the margins. So the sensitivity of that particular issue is probably marginal in the overall analysis.

**Prof. Duckett**—But it might have an impact in rural—

**Prof. Swerissen**—It might.

**Prof. Duckett**—Through both of your lines of questioning is the sense that we have probably underestimated practice income in rural and remote areas, which would further, as I said, increase the out-of-pockets.

**Senator ALLISON**—Sorry—underestimated practice costs or income?

**Prof. Duckett**—Practice costs in rural and remote.

**Prof. Swerissen**—It may be, Senator Allison. The probable effect, though, is this: because supply is already tight in rural areas and because GPs therefore have a significant capacity to set incomes because they are in a monopoly provider situation or a monopsony provider situation, it is probably the case that already the bulk-billing rates reflect health care card holder status and their out-of-pocket costs already reflect the fact that they are achieving their target incomes reasonably successfully, so it is questionable whether either of the packages is going to have a very significant impact in terms of those bulk-billing rates—except if the opposition's package actually achieves the incentive targets.

**Senator FORSHAW**—I am assuming that what you are saying is that there are a number of constants in your model, before and after—that is, on average, the number of patients, the size of the practice, costs and the number of services that would be delivered—even though it is possible that some of those things might get changed if out-of-pocket costs go up. Some people might be less likely to go to the doctor when they need to. But they are constants so it does not really matter if the variations—

**Prof. Duckett**—We are assuming no change in those, before and after.

**Senator FORSHAW**—You have to, I suppose, to then look at shifts in bulk-billing, target incomes—

**Prof. Duckett**—There are enough variables in the model already.

**Senator FORSHAW**—But they are essentially the ingredients of both the government's and opposition's packages—that is, doing something about bulk-billing rates by providing incentive payments and so on.

**Senator STEPHENS**—Gentlemen, I was looking at your slides again and trying to find in your report where you had picked up that, in the government's package, it is the practice that must opt into the GP access scheme, whereas with the opposition's proposal it is the individual doctors that receive those incentives. Have you acknowledged that in your considerations?

**Prof. Swerissen**—I am not sure that we have been explicit about that effect, but we are certainly aware that the government's scheme is a participating practice scheme and the opposition's package is, essentially, automatic payments. The slide shows that there are automatic payments made directly to doctors so that there would be an immediate flow of income under the opposition's package. Under the government's package, there is a period of having to bring GPs into the scheme because it requires GPs to agree to participate at a practice level, which presumably would mean contracts between practices in order to achieve that outcome.

The government's budget estimates reflect that ramping up over a period of three or four years, as those numbers come in. I think their final estimate, from memory, is that the government's scheme is about \$115 million in a full year. The opposition's package is more like a quarter of a billion dollars a year just on the rebate side, and that begins immediately. What that means in practical terms is that it would take some time for the government's scheme to roll out in a practical sense. That would be the implication of their scheme. The most likely initial environment would be the current bulk-billing rates and the current out-of-pocket arrangements, which is what we modelled in that first analysis.

**Prof. Duckett**—The fact that the government's scheme is practice based and they do not have targets for bulk-billing rates—except for concession card holders—does not make any difference to the modelling. The fact that they do have requirements about concession card holders is about all concession card holders in the practice, which is effectively all the concession card holders in the region in the way we have modelled it. So it does not impact on the modelling decisions we have made—except, as Hal said, we have assumed this is the full roll-out of the package and their package assumes a slower take-up and then a full roll-out. This is based on the assumption that the package is fully rolled out, which it may not be, of course.

**Senator STEPHENS**—I am struggling with the issue of the government's targeted roll-out as opposed to the evidence that we have received from the doctors' organisations, which is that that there will be a very slow take-up.

**Prof. Duckett**—The government's package assumes a phasing in. I think the evidence you get is that it is a much slower phasing in for the government package and there may not be the take-up that you would think. The government's package does have incentives, in the sense of what we have called the soft threshold that they could bill. So there are incentives on practices to sign up, just as there are disincentives.

**Prof. Swerissen**—Although we have not heard the evidence provided by GPs to the committee, our assumption is that, if GPs are seeking to achieve restoration of their income relativities and the government's package rolls out, they would seek to participate in the scheme because it does offer them some attractive incentives for doing that.

At the end of the day, it allows them to move from a situation where they are forced to issue a bill of, say, \$40 on average to one where they can—if they participate in the scheme—issue a bill for \$15 and then claim the rebate as the alternative. That is a very attractive proposition in terms of being able to adjust price signals for patients in a very sensitive way. At the moment they are forced into a very high threshold situation in order to achieve that, which is a very strong constraint on price because it is a non-marginal price signal. They would be able to move

to marginal price signals, which, as I said in the presentation, have much less impact on utilisation.

Going from, effectively, zero bulk-billing and a zero price signal to patients to a situation where you are no longer bulk-billing those patients and suddenly issuing \$40 price signals is a very big jump. Moving from a situation of zero price signals to a situation where you are handing patients a \$10 or \$15 copayment, out-of-pocket charge, is a much more marginal price signal and likely to have much less of an impact on who comes your practice. It is quite likely that it would be attractive to GPs to take that option up and to utilise that opportunity to use a much more sensitive set of charging arrangements for the patients that are not being bulk-billed. I think it would be attractive to GPs.

**Senator STEPHENS**—In your modelling of the government's package, did you take into account the issue of practice nurses and the costs of engaging practice nurses?

**Prof. Swerissen**—Only insofar as PricewaterhouseCoopers included those sorts of staffing costs in the work that they did for the relative values study. We have not factored in increasing practice costs in the government's package. There are some elements of the government's work force package which may well have a longer-term impact on supply issues, but they are not directly relevant to what would happen to the out-of-pocket costs and the bulk-billing rates, which is the principal focus of this study that we have done.

**CHAIR**—I have had a request from the press gallery for the media to have an opportunity to meet with you after the presentation. Are you happy to do that and is here a reasonable place for that to occur?

**Prof. Swerissen**—Yes, we are happy to do that.

**CHAIR**—Senator Barnett is participating by teleconferencing.

**Senator BARNETT**—First of all, the slides were great! Well done on the slides. I will go back a step to the introductory comments from the chair and respond to those in part. The chair indicated that the majority of the committee supported the research. Just to put it on the record—and I think you are aware of this—the government senators strongly opposed the undertaking of this research. We opposed it for two reasons. Firstly, we thought it was an improper use of the \$22,000 of taxpayers' money, because it was based on certain assumptions. Obviously, you have outlined some of the assumptions this morning and they are set out in your report, which I am happy to comment on shortly.

Secondly, we opposed it because a number of the people involved in the study have been on the public record strongly criticising the government's A Fairer Medicare package. Professor Swerissen, for example, who has worked for Carmen Lawrence, has made a submission to the inquiry, and we have a copy of that submission. It is a public submission which is critical. Professor Duckett, you have made some public comments and in fact you have written reasonably extensively about the government's A Fairer Medicare package. For example, in the *Age* on 5 March 2003—

**CHAIR**—Senator Barnett, I urge you to get the point of your question, please.

**Senator BARNETT**—The point of the question relates to independence and objectivity. It appears to me—based on what I have read and the research undertaken, which I am about to advise you and the professors about—that there is a bias towards, and a link with, the philosophy and approach of the ALP. On 5 March 2003 in the *Age*, Professor Duckett is reported as saying:

Despite a promise to “maintain Medibank”, the Fraser government dismantled it over six years, leaving a sense among many Australians that Liberal governments could not be trusted on health policy.

**CHAIR**—Senator Barnett, there is some disquiet here amongst your colleagues. I would like you to get the point of the question. There is no point reading an article out of the *Age*, from whatever date it was. I will now hand over to Professors Duckett and Swerissen to respond to what I think are quite serious allegations that you are making, and then I would like to respond on the first point you make. I call Professor Duckett—

**Senator BARNETT**—I have written a letter to Professor Swerissen dated 9 September—

**CHAIR**—I am sure Professor Swerissen will respond to that in his comments.

**Senator BARNETT**—I have sent you a copy and I have not received a response as yet. I am looking forward to hearing from Professor Swerissen.

**CHAIR**—Thank you. I call Professor Duckett.

**Senator FORSHAW**—Chair, just before you do, could I place on the record that I think this is most inappropriate. Whatever your views are, Senator Barnett, you have an opportunity, when the matter is debated in the parliament—and you have already had that opportunity—to canvass those issues. But I do not think it is appropriate that we do it at a public hearing with witnesses who are here to answer questions on their research. I point out that the President of the Senate approved the decision of the committee to request this research to be undertaken.

**Prof. Duckett**—As it turns out, in my career I have worked for both sides of politics. I worked for the Kennett government in Victoria and was in fact promoted by the Kennett government following the change of government in Victoria. I have worked also for Labor governments. I also value my integrity very highly. We have made it clear what the assumptions are that we have made in this report. As I have said so far in answers and as Professor Swerissen has said so far in answers, we have taken the most conservative assumptions that one could in making the estimates. I would be very keen to be challenged on the basis of any of those decisions we have made.

I think you will find that there is no evidence whatsoever of bias in this. My job is as an academic and I have to be prepared to stand by what I write in the face of the evidence. Academics criticise other academics on the basis of evidence. I do not think you will find any evidence in this report that we have allowed any of what you might think are our political opinions to influence the decisions we have made.

**Prof. Swerissen**—Firstly, just to correct the record, I have not made a formal submission to this committee, so I am not sure what Senator Barnett is referring to there. On the issue of my previous work experience, it is the case that I did work for the previous federal Labor

government but it is also the case that I have briefed coalition ministers at the state government level on projects that I have done. I have done a number of projects for the Kennett government. I have done a number of reasonably sensitive projects and I have always taken the view that my personal political views and my affiliations have nothing to do with the integrity and the rigour of the work that we do. I think this report should be judged on the basis of the analysis which is in it, the assumptions which are made and the conclusions which are drawn. I am happy to defend those. I am not sure that the other points which Senator Barnett is raising are relevant to the report which is before you.

**CHAIR**—Senator Barnett, in terms of your allegation that this is not an appropriate use of the Senate's money, I remind you of the discussion between the department and the Senate Community Affairs Legislation Committee during last estimates, where we requested the department to provide us with the analysis that I presumed they would have had to have done in order to inform the decision making the government was undertaking. As you would remember, the department declined and in fact said that that discussion—not modelling but discussion—that had been held was between the Department of Health and Ageing and the Department of the Treasury and therefore was cabinet-in-confidence and not able to be provided. It is my personal view that that is not an appropriate use of the cabinet-in-confidence protocols. However, the majority of this committee made a decision to commission the institute to undertake this research. I am sorry that you are not happy with that, but if you would like to ask some questions about the assumptions or about the content of the submission I would welcome them.

**Senator BARNETT**—Thank you, I would. I have already asked about my letter of 9 September, of which you have a copy, Madame Chair, because I sent a copy to you. You are aware of the letter. I have asked Professor Swerissen two questions in that letter relating to the issue of inflationary impact in the terms of reference and the admission in his letter of 25 August to you in regard to the words 'if any'. The second question related to advising what work and research they had done in regard to Medicare. Those questions have not been answered as yet. I am very happy to table that letter and would like to table that letter for the committee so that they are aware of those two questions. I am still looking forward to a response from Professor Swerissen on behalf of the institute.

**Prof. Swerissen**—I would like to comment on that. On the issue of the terms of reference, that was simply a shorthand response. The words 'if any' suggest that inflation may not occur and we always took that into account—that there may not be an inflationary impact. Inflation in general academic terms can be seen to go up, go down, be zero or be negative. In a sense that was simply me assuming that we were using the term in the normal sense. I just saw the words 'if any' as redundant. There was no assumption that we would not take the possibility that there may be no inflationary effects or negative inflationary effects. Rest assured that we were quite open minded about which direction that might go in.

In relation to the question in the letter to me about our previous comments on Medicare, Professor Duckett and I have an extensive publication record and we are happy to provide you with a list of our publications—we are collecting our list of publications. Any publications you would like a copy of we are happy to provide so that you are able to examine what we might have said on the record in the past. It is difficult for us to go back over a 20-year academic and work history and dig out every single comment that we have ever made on Medicare but we are

very happy to provide you with anything from the lists that Professor Duckett, Mr Livingstone and I will provide to you shortly so that you can review our academic and public statements.

**Senator BARNETT**—When will the second report be available? Secondly, as the chair knows, the letter speaks of your writings with respect to the government's or the opposition's proposed Fairer Medicare packages specifically and then all Medicare more generally. Obviously, I am interested in your comments on the Fairer Medicare package and I think it is only a reasonable question to ask to know what is on the public record and the criticisms that have been made. When would that be available?

**CHAIR**—Senator Barnett, I think we have to be reasonable about asking people who have been involved in academia for 20 and more years to provide a full list of their publications. We have to be sensible about these sorts of questions and recognise the time it would take to fulfil your request. When I received your letter I did think that it was somewhat unreasonable to ask academics to list every publication that they have written about Medicare or the health system over that period of time.

**Senator BARNETT**—I have put those questions on the record. I have not heard a response as to when they will be answered. I would like to ask a question about the assumptions of the report, and Senator Humphries is interested in doing that as well. I will kick off with the assumptions regarding the GP salaries. There is an assumption that there is a 10.6 per cent differential over that 10-year period in the aspirations of income of GPs and you have apparently been advised that relative to specialists it is a 7.5 per cent relative decrease over that five-year period. I am confirming that that is one of your assumptions. You said earlier that it was the most conservative assumptions used, yet you have advice that says it is a 7.5 per cent decrease over five years. I would like to clarify that and seek a response from you. Can you confirm for the committee the net full-time equivalent salary for GPs—what it is now and what it would be based on your assumptions? Finally, you asked about the HIC providing information to you last night. I assume that information would have been very helpful to you during the course of your study. What was the impact of not having the HIC research when you were undertaking your study?

**Prof. Duckett**—On page 12 of the submission we show the movement in average weekly ordinary time earnings and Commonwealth expenditure on GPs. Those data are from the Commonwealth's submission and they show 10.6 per cent over a 10-year period. The specialist relativity figures that Professor Swerissen quoted were over a five-year period. So although it is 7.5 per cent over five years for specialist relativity and it is 10.6 per cent over 10 years for average weekly ordinary time earnings, we do not have the 10-year figures for specialists so we cannot actually tell you. On the surface it looks as though they are falling further behind at 7.5 per cent over five years than against average weekly ordinary time earnings but, because we do not have the figures over exactly the same period, we cannot say what the precise impact would be. That is to clarify the first part of your question.

The second part of your question was about the impact of not having those figures. As I said, we were trying to make the most conservative position about income aspirations. Obviously it would have been nice to have had the HIC figures in time to factor them in and to be able to make a choice about what was the most conservative. But we did not have those figures, and we still do not have those figures for the same time period as we have for average weekly ordinary

time earnings, so we cannot make that comparison. With respect to what are the current estimated incomes, we have that in table 2 on page 20. That table provides our baseline estimates.

**Senator BARNETT**—I have two other questions related to the assumptions. The first is that one of your assumptions on page 5 says, ‘Only concessional patients are bulk-billed.’ I wonder on what basis you could possibly have come up with that assumption. The second is that the government’s Medicare package is, as you know, a total package of \$917 million, but I think your report talks about \$537 million in terms of the bulk-billing incentives et cetera. Based on an injection of over half a billion dollars and based on your assumptions, you are still of the view that there would be an increase in average copayments across all services of around 56 per cent. That leads one to the question: what if there had been no increase in injection of funding of half a billion dollars? What would the increase have been if there had been no injection of funding at all? So there are three questions.

**Prof. Duckett**—Referring to page 5, we modelled a number of different scenarios. One of those scenarios was the issue of only concessional patients being billed. So that was just a scenario we modelled.

**Senator BARNETT**—That is my question: why did you use that model?

**Prof. Swerissen**—The answer is that you need to ask the question: if GPs are going to restore incomes, what are the options available to them? Clearly the two options for restoring their incomes were either through Commonwealth expenditure contributing to restoring their incomes to the levels we had calculated on the basis of those average weekly ordinary time earnings or through out-of-pocket costs. If out-of-pocket costs were going to be charged, the question would be: who would the out-of-pocket costs be charged to? So we asked ourselves the question: logically, what would be the behavioural response of GPs faced with a situation where they were seeking to achieve their incomes and who would they charge?

The government’s package is very explicit in that the advantages are all there for GPs who charge concessional patients, because, if you do not charge all of your concessional patients, the advantages do not accrue to you—that is, you neither get the rebate payment nor have the opportunity to charge gap payments only; you do not go to a soft threshold arrangement. So, behaviourally, it seems quite likely that GPs would operate in a rational fashion and set that as their decision point for deciding whom they would charge and whom they would not. We asked ourselves the question: are there other logical ways of doing that? Any other approach that you adopt would in fact increase transaction costs for GPs, because they would then have to have a number of ways of selecting patients. That increases their costs and the difficulty of running their practice. So it seemed to us that, logically, under the government’s arrangements, it made sense—because of the way that the package has been structured—that they would in fact move toward that choice.

**Senator BARNETT**—What are the bulk-billing rates under that scenario?

**Prof. Swerissen**—The bulk-billing rates under that scenario would be that figure of 1.43 times the concessional patients which are there. The way that the department has modelled that for the government says that around 50 per cent of patients would be concessional patients.

Under the scenario that we have used—which was the data from the Australian health survey—that varies a little, depending on whether you are in a metropolitan city area or a rural area, because the proportion of concessional patients varies slightly from one setting to another.

**Senator BARNETT**—So profitable services are a 50 per cent bulk-billing rate?

**Prof. Duckett**—We present our estimates of bulk-billing rates in table 7, on page 27 of the submission.

**Senator BARNETT**—And the other two questions?

**Prof. Swerissen**—You asked about the other funds which are available in the government's package, and you are quite right, there are additional funds beyond those which we have outlined in the report, but they relate to the work force proposals which the government has introduced. We have included the relevant funds which are related to the rebate arrangements and the changes to the billing arrangements for the HIC, so I think that they are reasonable. You asked the question: what would happen if there were no injection of funds into the scheme? Undoubtedly that trend line we have in the report, which shows the bulk-billing rates, would continue to fall, so there is no doubt that there would be a fall over time in the bulk-billing rates, because—

**Senator BARNETT**—But what would be the impact on average copayments?

**Prof. Swerissen**—They would go up.

**Senator BARNETT**—You said there was a 56 per cent increase under this scenario; if there were no funding at all, presumably it would be a far greater increase.

**Prof. Swerissen**—No, I do not know that it would be far greater, but it would continue to increase.

**Senator BARNETT**—Could it be a higher increase?

**Prof. Duckett**—We have not done that modelling.

**Senator BARNETT**—Would it be a higher increase?

**Prof. Duckett**—We have not done the modelling, but one of the issues is that in the current arrangements there is a hard threshold so that, if a doctor wants to move away from bulk-billing, they have to charge the full price and there may then be an impact on utilisation. We have not done that modelling, so we really cannot say what the impact would be.

**Senator BARNETT**—So you do not know whether there would be a higher increase or a lesser increase if there were no funding injection into Medicare?

**Senator FORSHAW**—If you wanted that research to be done, Senator Barnett, you could have asked for it. Maybe the government or the department could provide you with that research.

**Senator BARNETT**—I am asking a question of the witness, Senator.

**Senator FORSHAW**—It is an unfair question, because they were not asked to do that research.

**Senator BARNETT**—Let the witness answer the question. I am just asking: is it higher or lesser?

**Senator FORSHAW**—He has just answered it and said they did not do that modelling.

**Senator BARNETT**—I said, is it higher or lesser?

**Prof. Swerissen**—Senator Barnett, it is likely that, in the country areas—because of the supply shortages which are there at the moment—GPs have already moved to a situation where they are optimising their income arrangements in relation to out-of-pocket costs, because they have dropped their bulk-billing rates to the levels which are at around the levels of the health care card holders. From discussions that we had, we suspect that there is a non price effect which occurs in relation to professional behaviour—that there is a point where GPs find it difficult to charge people who do not have the wherewithal to pay—and that probably has plateaued in the country now. We suspect that that is why that rate is where it is, because of the supply impact.

In relation to the city, it is difficult to know where the trend will go because there is that hard threshold under the current Medicare arrangements. Even so, there has been a fall—as you know from the data that we have provided. If I had to speculate, I suspect that it would take some considerable period of time for it to fall to the rates that we are projecting under the government's package, and it is likely that it would take a considerable period for those out-of-pocket costs to reach that percentage that we have modelled. Without doing the work in detail, it is difficult to say more than that.

**Senator LEES**—I would like to look specifically at practice costs. Can I say that I have found your presentation most helpful. Those of us in the Senate who are still trying to find our way through the government's package were quite disappointed that there was not any modelling in it. It is good to have something to work with to look at what the likely impact would be, particularly on doctors' incomes, and at what their likely response to the changes in income would be. I am concerned that you have just used an average. Could I ask you for some general comments on the potential for there to be quite considerable differences in practice costs. I am looking at some of your typical city practices where you have five or six GPs and cardholders are perhaps only 30 per cent of their patients. In rural areas it seems that doctors tend to work on their own quite a bit and 60 per cent of their patients may be cardholders. If the requirement is to bulk-bill cardholders, I am amazed that you seem to have found that city GPs will actually be worse off—even though there are fewer of them—but that rural GPs should be reasonably comfortable with this package.

**Prof. Duckett**—What is important is this: the country GPs by and large are bulk-billing almost all the cardholders now. That is on average. The government's package in particular targets its incentives at cardholders.

**Senator LEES**—You are saying that that is basically what they are doing now, so they will not have to change behaviour much.

**Prof. Swerissen**—Perhaps an easy way of looking at it is this. The current income levels that GPs in the country are achieving are achieved with relatively high out-of-pocket costs on average because they bulk-bill less. When you look at the way the incentives work in the government's package in particular, you see that, because there are \$6 and \$5 packages versus a \$1 package, they must do better. They get health care card holders now and that immediately introduces a very significant payment, whereas in the city, because there is only a \$1 effect for the GPs who bulk-bill, it has a relatively marginal impact. For the city GPs, it is clearly in their interests to sign up because it gives them the ability to drop away the hard threshold and then have a much more sensitive set of arrangements in place for how they charge gap payments. That is the tremendously attractive part of the government's package for GPs in achieving income targets. They are then in a position where they no longer have that very hard threshold, from \$0 to \$40; they can go to a much more sensitive proposal. In the country, they are already getting \$6.30, which lifts their incomes and will most likely protect the health care card holders. In that sense, the government's package is very likely to protect health care card holders in the country.

**Senator LEES**—I have one last question. Professor Duckett, you mentioned that you had not really looked at things like nurses in terms of the impact on practice costs. In the government's package—and the opposition have kept it—there are nurses in outer metro. Will that reduce practice costs? In the country they have already them, so it will not affect that part of it.

**Prof. Duckett**—Since the Pricewaterhouse study was done, the government has had some initiatives with respect to practice nurses and so on and it has given some incentives to increase the use of practice nurses. We have not factored in any of that. We have just assumed that practice costs have gone up with inflation. You could assume that practice costs have gone up faster than inflation because a higher proportion would be spent on salaries and there is a richer mix—that is, there are more nurses versus receptionists. But to some extent they have been subsidised, so it might not change. The impact then begins to be more speculative, and we tried to minimise speculation.

**Senator ALLISON**—I turn back to table 2 and the assumption you have made about total fee income, which is \$220,000 for metro GPs. Why did you not include in those figures the non-fee payments, which the government says are about \$20,000 per annum? Can you explain your reasoning for that?

**Prof. Swerissen**—I am happy to do that. It is interesting because, when you include the out-of-pocket costs, the practice incentive payments and so on, the numbers trade off a bit. That is by way of a little segue. What that means is that the out-of-pocket costs included with the government's fees and rebate income, versus the rebate income included with the PIP payments, tend to be roughly the same. We could have included them, but for the sake of simplicity we looked at those areas where the rebate and the out-of-pocket costs would together make up the income. If you add the \$20,000 back in, which is there for the practice incentive payments, it does not actually matter, because in the end it is that relative difference that the GPs will be seeking to make up. In the numbers we have for the full-time equivalent in that graph, we have just calculated—

**Senator ALLISON**—I will try to put this in lay terms. You are saying that half of that extra \$20,000 on average per practice would be taken up by extra practice costs. Is that the rationale?

**Prof. Swerissen**—No. What we are saying is that the practice incentive payments essentially are not related to volume activity. So we were interested in the 7,000 consults that GPs do. We modelled that. Part of what they earn will be the rebate that is provided by government and part of it will be related to the out-of-pockets that they charge. They are the two bits that they have some control over, because they can do either more or less work, and their incomes will fluctuate depending on the volume of activity that they engage in. The practice incentive payments and so on are income which they can obviously earn.

In a sense, we have calculated the difference between the rebate and the out-of-pocket earnings, and looked at average weekly ordinary time earnings and said, ‘They’ll want to restore about a 10 per cent gap.’ The only way that they can really restore that, given the way that they work, is through the volume of activity that they do and the relative amount that they get for the rebate or for the out-of-pocket costs. It is those two things together that will determine what their ultimate outcome is. What happens in relation to practice incentive payments is a matter for government to determine, in the end. For example, one way that government could restore their incomes would be simply to double the practice incentive payments, if it chose to, but that is not in this package. So we essentially took that out as a neutral. We could have put it in and left it in the whole modelling, but we just took it out, as an item which did not affect the final results of the analysis.

**Prof. Duckett**—I will try to phrase it another way. The practice incentive payments are the same before and after, and my understanding is that the real GP expenditure in chart 1 on page 12 incorporates the practice incentive payments. So the effect of practice incentive payments is already incorporated into that graph. If we took them out then in a sense there would be double counting. If you took them out of that graph, the gap between fee income and average weekly ordinary time earnings would be greater, and so they would have to increase their incomes by more than 10.6 per cent. So we have just assumed that they are in the baseline in making our 10.6 per cent increase in aspirations. I will phrase that again: the graph in chart 1 shows Commonwealth expenditure on GPs, including practice incentive payments. Including practice incentive payments, you need to have a 10.6 per cent increase to restore your relativity to average weekly ordinary time earnings. The 10.6 per cent drives our modelling. So, if we put practice incentive payments back into the spreadsheet, we would be double counting.

**Senator ALLISON**—It does not sound right to me. Is that counting on the non-bulk-billed income, for instance?

**Prof. Swerissen**—We had the same sort of debate on which way to do this. We looked at what the Commonwealth’s contribution was to income, and the answer was that red line in the graph. Then we asked: ‘Has that gone up or down in relation to average weekly ordinary time earnings?’ and there was a 10.6 per cent difference. Given that the bulk-billing rates are falling—that is what is driving this whole debate—in that earlier graph and GPs seem to be trying to achieve an income to restore relativities, what do they have control over to restore that income? Obviously, where they have a capacity to restore income is on out-of-pocket costs and whatever incentives and changes in the rebate levels that the government has. So we modelled the two things together—those changes in the rebate costs and those changes in the out-of-pocket costs

and asked: ‘What would GPs have to do to get back that 10 per cent which is missing from the relativities?’

**Prof. Duckett**—They cannot achieve their income relativity expectations by doing anything about the practice incentive program because that has already been done. It does not change in the package. It is neutral across before and after, government and opposition, so it does not have an impact.

**Senator ALLISON**—In your assumptions in scenario 2 you say, ‘Out-of-pocket charges remain at the same level.’ Can you indicate whether that is the cost of out-of-pocket charges or do the incidents themselves remain at the same level? Did you find any evidence to suggest that incidents might—

**Prof. Duckett**—Is this on page 25, under the heading ‘Scenario 2: bulk billing concessional patients only’?

**Senator ALLISON**—Yes.

**Prof. Duckett**—In that scenario, we have said that only concessional payments are bulk-billed and out-of-pocket charges remain at the current levels. The impact of that is shown on the next page. In scenario 3, we have said what the impact would be if, instead of keeping out-of-pockets at their current level, they change out-of-pockets so they need only meet the income target. So one scenario is saying: keep out-of-pockets at their current level per billed service and the other scenario is saying: let it fluctuate, so they meet their income target. In fact, in most cases the fluctuation is downwards.

**Prof. Swerissen**—That is right. It is a price-volume equation: the more people you have that you are charging out-of-pockets, the less you have to charge them in order to achieve the final income figure that you have got. So there is a trade-off between the bulk-billing rate and the average out-of-pocket charge which is actually there. So across all patients it goes up; across those patients who have actually been charged, it might well come down.

**Prof. Duckett**—To achieve their income target.

**Prof. Swerissen**—To achieve their income target, because they are not bulk-billing more people.

**Senator BARNETT**—I am scratching my head here. It seems that all the assumptions that have been made are based on the doctors’ income target. I am asking myself what is stopping the doctors’ income target being achieved now, given that they can raise their copayments today and drop their bulk-billing rates today? Secondly, what is in the government’s package that will make them change their behaviour?

**Prof. Swerissen**—The major point in the government’s package is the dropping of the hard threshold. Currently, what happens is, as you know, a GP who wishes to charge a patient any copayment at all has to charge both the copayment and the full Medicare fee. That is a substantial bill which is delivered to the patient. The patient then has transaction costs in going off to get a rebate et cetera, whereas under the government’s package what effectively happens is

that doctors could, if they chose to, charge simply an additional \$1 and then claim the whole of the rebate from the HIC. That then gives them much greater price sensitivity and allows them to charge patients in a much more sophisticated way, if you like, than what is currently there because of the administrative regulations.

The evidence in the literature is that, when you have a substantial price increase, there is an effect on utilisation—that is, if you suddenly go from bulk-billing to charging patients \$40 it is quite likely your patients will either reduce their demand for services or look elsewhere for someone who is available at a lower cost or who bulk-bills, whereas if you have a marginal increase in price of, say, \$2, \$3, \$5 or \$10 there is very little impact on utilisation by patients. So the government's package is quite attractive to doctors in that they would then be able to finetune their out-of-pocket charges much more than they are able to at the moment.

**CHAIR**—But essentially the health consumer does not actually know the total cost of the product they are purchasing.

**Prof. Duckett**—Because they do not face the full costs, their responses might not be as significant.

**CHAIR**—It struck me that there is a contradiction in what the government is saying about pharmaceuticals in that we have to tell people what pharmaceuticals actually cost, and that includes the actual cost of delivery, so that people will regulate their use. It is a completely different philosophy from people dealing with cost.

**Senator ALLISON**—In your comparisons with the current rate of bulk-billing and the current rate of copayments and so on, were you at any stage able to make a judgment about a do-nothing scenario, say, several years out?

**Prof. Swerissen**—As I think Senator Forshaw indicated, we were not asked to do that research. We are in the realm of speculation. As I said earlier, the best predictor of the trend is the trend.

**Prof. Duckett**—On the trend, if you look on page 16 at chart 4, it looks as though, in 2001-02 to 2002-03, the trend line is changing to a much steeper growth. I do not like projections on one year's data on two data points—it is very hazardous. Was this year an aberration or not? The bulk-billing graph is nice in the sense of being a geometrically nice picture, but making projections on that is speculative.

**Prof. Swerissen**—The other thing that we do not have graphed there is the changing nature of supply, which is the other parameter that needs to be taken into account.

**Senator ALLISON**—That leads me to my next question. On page 17 of your submission you say that you do not expect much by way of price elasticity. Is that merely a function of the shortage of GPs because demand is presumably not being met now and that those people who can pay will continue to do so? Doesn't it actually say that the government has a point in expecting increased fees because people will bear them?

**Prof. Swerissen**—If you have, say, a 10 per cent increase in the price of GP services, what would be the effect on demand? The literature says that the effect on demand for price increases for GP services is relatively modest—that is, if you have a marginal change in the price so that the fees go up, there is only a very modest effect on people deciding they will not go to see a GP. Technically, what that means is that if you have small increases in price, you are unlikely to get much of an impact on the utilisation of services by people. The other question comes in there as well: how is price affected by supply? In other words, if you reduce the supply of GPs what happens then? The effect is that technically you would expect that as supply decreases you would increase price, which is in fact what turns out to be the pattern of responses across geography in the current data.

One of the possible drivers of the change in bulk-billing patterns which is there at the moment is the changing level of availability of GP services, which we have been seeing since the mid-1990s, because of the changing nature of the way we have restricted access to medical school, we have restricted access to general practice through the vocational training program for general practitioners, we have restricted access on the basis of overseas trained doctors not being able to move into these areas, and we are seeing an ageing of the general practitioner population. We are also seeing women enter general practice—I do not want my comment here to be misinterpreted—and it appears they have a different practice pattern, they are more interested in part-time practice and so on, so that reduces the overall availability of practitioners. That may be having an impact in the way the system has moved over the last five years.

**Senator ALLISON**—Can you briefly expand on why you think scenario 2 in the government package will not work?

**Prof. Swerissen**—The government scenario in a sense is the base case for what we think probably would happen, which is, in effect, bulk-billing rates dropping to the level of cardholders and the out-of-pocket costs remaining as they currently are. That scenario is there to ask the question: ‘Would just dropping the bulk-billing rates to what looks like being a logical arrangement for the government’s package achieve their income targets?’ The answer to that is that largely it would achieve their income targets. But in our modelling what we have said is that scenario 3 is what we think would really happen. To be logically consistent with our own argument, we have asked, ‘What would happen if they achieved their income targets?’ In a sense, that would see a slight fall in the out-of-pocket costs for those people in metropolitan areas who are charged out-of-pocket costs for the government’s package. In the interest of fairness we have modelled it in such a way that we have not distorted it beyond the actual income targets that we have set.

**Prof. Duckett**—The other way of looking at it is that scenario 2 assumes the current levels of out-of-pocket costs. Many GPs are bulk-billing, so they are not charging the current levels of out-of-pocket costs. So we have said, ‘If they stop bulk-billing and try to reach their target income, what level of out-of-pocket fees do they need to charge?’ and that is where scenario 3 cuts in. It may be that those who currently are charging out-of-pocket costs keep their out-of-pocket costs where they are and the new ones only charge what is required. But we did not model that intermediate scenario; we just modelled everybody going for target income.

**Senator HUMPHRIES**—I am trying to ascertain the basis of the assumption on which a great deal of this research rests—that doctors need to earn 5.2 times the average weekly

earnings, ordinary time, in order to be able to stay in practice and keep doing what they are doing. You say on page 4 of your paper:

... trend data indicate that bulk-billing rates were relatively stable when Commonwealth expenditure per FTE GP was around 5.2 times average weekly earnings.

The presentation you have given today has identified that period as 1993-94, and everything seems to flow from that—that if we get back to the state we had in 1993-94 everything will be all right. Looking at your chart of the rates of bulk-billing on page 14, I have to say that 1993-94 does not stand out as a period of relative stability in the rate of bulk-billing. There was an increase, as there had been for the previous six years, and there was to be for another two or three years after that. So what is the magic in the figure 5.2 times average weekly earnings?

**Prof. Duckett**—Can I compare page 14 and page 12? If you look at page 12, it is ‘average weekly ordinary time earnings and real GP expenditure per capita’. As you rightly pointed out, it drifts apart from 1993-94, but it really begins a big drift apart in about 1996-97 and then it keeps getting wider. If you then look at page 14, 1996-97 is when the turnaround starts in bulk-billing.

**Senator HUMPHRIES**—I would say 1997-98, but all right.

**Prof. Duckett**—Roughly. I think 1996-97 was the peak year for bulk-billing. Maybe it was 1997-98, but I think it was 1996-97.

**Senator HUMPHRIES**—What you said was when it started to go down.

**Prof. Duckett**—That is right.

**Senator HUMPHRIES**—It was 1997-98 when it goes down.

**Prof. Duckett**—The maximum was reached in that year. So it is consistent with that hypothesis, with doctors saying: ‘Our income is drifting too far from average weekly ordinary time earnings. We need to do something about it.’

**Senator HUMPHRIES**—If I can interrupt there, I accept that the gap is contributing to the problem, but what I am trying to get to is: how do you determine that 5.2 times average weekly earnings is the desirable target, that doctors will aim for that rather than 5 or 4.9 times average weekly earnings or some other figure?

**Prof. Swerissen**—It is a restoration.

**Prof. Duckett**—That is a reasonable question. If you look at the cycle, that was the high point on their cycle.

**Senator HUMPHRIES**—What cycle?

**Prof. Duckett**—On the relativity of average weekly ordinary time earnings to FTE GP earnings. So 5.2 was where they had reached a relative high point on the cycle of the relativities. After that it began to drift downward, then you see the stabilisation in that period where the

bulk-billing rate changes. We needed to pick a point. As you are quite rightly pointing out, you have to make an assumption here. What is the assumption—should it be 4.9 or 5.2? Clearly we could have picked another point on the graph but we thought that, in the sense of them optimising their incomes, that was a reasonable point in relation to those trends. If you look at that bulk-billing line up to the point of about 5.2, it is actually up. As their incomes are improving relative to average weekly ordinary time earnings, they appear to be comfortable in increasing their bulk-billing rates. After it falls, it stabilises and then, as it falls further, the bulk-billing rates begin to decline. So it seemed to us that 5.2 was a reasonable assumption to make at the high point of their income earnings.

In a sense, although we would not want to characterise it this way too dramatically, it is a bit like what would happen in any sector of industry where wage movements started to shift relative to average weekly earnings. Although clearly GPs do not negotiate in the same way as other sectors of industry do—the government may have a different view about this—analogously you might say that they started to look for alternative ways of restoring their incomes through some mechanism. And the mechanisms that are available to them are the bulk-billing rate and out-of-pocket costs.

**Senator HUMPHRIES**—There are other factors that we have identified in this committee that contribute to bulk-billing rates. One of those is the availability of doctors in particular areas of the marketplace. You have described your costings at a number of points in today's hearings as being quite conservative, but you have in fact chosen the point where there was the greatest gap between doctors' incomes and average weekly earnings as the target against which you are measuring both sets of proposals. Conveniently, the Labor proposal, which puts more money into doctors' pockets, meets that target better than the government proposal. If an assumption were chosen that less maximised doctors' incomes, that differential between the two sets of proposals would be less, wouldn't it?

**Prof. Swerissen**—If a different target were chosen there would be a different outcome. If a higher target were chosen then there would be a relatively higher inflationary effect or a greater degree of subsidy from government would be required to meet that income target. If a lower target were chosen then clearly there would be a lower impact. The question is: are the assumptions reasonable for choosing that particular target? As we have explained, the target was chosen because that is the moment when there is a change in the graph, a stabilisation. That seems to be about the level of income which was associated with a relative period of stability and it seemed a reasonable assumption to make.

**Senator HUMPHRIES**—I cannot see the stability—given that the bulk-billing rate was changing at that time at about the same rate it was changing throughout the previous seven years and the next three or four years.

**Prof. Swerissen**—It stabilises at that point, if you look at the curve.

**Senator HUMPHRIES**—It stabilises several years after that actually. Moving on to another point, in the most likely scenario, scenario 3, in table 7 you say that for the government proposals you have made the assumption that the percentage of people bulk-billed will be the percentage of people, approximately, that represents the proportion of take-up by concession card holders of bulk-billing rights. For the opposition proposal you say that the scenario assumes

that all bulk-billing targets proposed by the opposition are met—and that is 80 per cent, 75 per cent and 70 per cent. Why the difference between those two sets of assumptions? You have assumed that the government's proposals will only achieve the bulk-billing of concession card holders and nobody else but you have assumed that the opposition's targets will be met up to 80 per cent in metropolitan areas.

**Prof. Duckett**—That is part of the design of the packages. The government's package is designed to ensure that all concession card holders are bulk-billed.

**Senator HUMPHRIES**—But not that only concession card holders will get bulk-billed. You have assumed that only concession card holders will get bulk-billed.

**Prof. Duckett**—That is exactly right. The government's package puts very, very strong incentives on practices to participate and in order to do that puts strong incentives on practices to bulk-bill all their concession card holders. Then there is the question: would they bulk-bill anybody else? If they are trying to restore their target income they cannot do that.

**Senator HUMPHRIES**—Assuming it is 5.2 times average weekly earnings.

**Prof. Duckett**—What is the best way to do that? The answer is that, as we showed earlier, the most likely way they can achieve that is to not bulk-bill anybody else and then have an average out of pocket. Obviously, you can have another scenario where bulk-billing rates are different. They might decide to bulk-bill people with blue eyes, in which case the average out-of-pocket fee to reach their target income would have to be correspondingly higher. You end up with a different set of numbers with higher out of pockets for those who are not bulk-billed. But it is all driven, as you rightly pointed out, by the target income. That is in the government's package—that is what they are trying to do and that is how we have modelled it.

In the opposition's package, on the other hand, there are two components. If you bulk-bill you get a higher rebate for everybody but then they put strong incentives to reach those targets, so that is what we have modelled as well. The choice of scenarios is driven by the design of the packages.

**Senator HUMPHRIES**—It seems to me that you put enormous weight on this question of the hard threshold, as you call it, being the incentive that keeps doctors bulk-billing. You suggest that if you take that away as the government proposal does then you will see doctors simply increasing copayments because it is easier.

**Prof. Duckett**—It is easier to do so.

**Senator HUMPHRIES**—With great respect, it does seem as though there are a number of personal assumptions being dressed up here as scientific research. The committee has heard, almost universally, from doctors that they identify the needs of the patients coming through their surgery door—not just their medical needs but also their financial capacity. They have argued against a compulsory bulk-billing of concession card holders under the government's package because they want the flexibility to be able to charge people what they feel they can afford. Your assumption is that if doctors are encouraged to bulk-bill concession card holders they will bulk-

bill nobody else. In fact, doctors are saying to us that they pay a great deal of attention to the needs of their patients and that they will bulk-bill other people.

**Prof. Duckett**—That is, indeed, a possibility. If you look at table 4 on page 22—if you look at outer regional and remote Australia, where there are the fewest doctors per capita, and so doctors are in the strongest market position—you will see that doctors are making choices about whom they bulk-bill. Indeed, they are not bulk-billing all concession card holders. One way of interpreting those figures—and there may be other ways—is to say that 54.7 divided by 57.4 per cent of concession card holders are bulk-billed. Alternatively, you could say that 80 per cent of concession card holders and 20 per cent of another group are bulk-billed. But, by and large, what we are seeing here is that doctors in rural Australia, who have the greatest level of market power, have decided to bulk-bill more or less all their concession card holders. That is what we are seeing in the numbers. So, regardless of what they say to you in the evidence, what we are seeing in the numbers is that, by and large, they are bulk-billing all the concession card holders and not bulk-billing anybody else.

**Senator HUMPHRIES**—I can only say that that does not accord with much of the evidence that the committee has heard from doctors, who say that they can and do determine the position of individual patients coming through the door. Your model is making an assumption which doctors say to us cannot be made.

**Prof. Duckett**—But table 4 is not an assumption we have made; that is data.

**Prof. Swerissen**—It is just data.

**Senator HUMPHRIES**—On page 27 you do make that assumption. You say:

... for administrative convenience it is likely—

you do not explain why—

that GP practices would determine the concessional status of their patients and levy a standard out-of-pocket charge to all non-concessional patients in order to achieve their income target.

**Prof. Duckett**—Yes.

**Prof. Swerissen**—We based that on the numbers in that table we have just gone through. That is a reasonable assumption to make on the basis of what has happened in the country.

**Senator HUMPHRIES**—But there is no scientific basis for that. That is just Mr Swerissen and Mr Duckett making that assumption.

**Prof. Swerissen**—No, because the empirical evidence in rural settings where doctors have market power suggests that that is in fact what is happening. So in a situation where incomes need to be achieved—where there has been a 10.6 per cent decline in relative incomes compared to average weekly ordinary time earnings over a 10-year period—you would expect that, if they are going to restore those incomes, they will have to make a decision about whom they will charge and whom they will not charge. Notwithstanding the evidence which doctors individually

may be projecting to the committee, the best available evidence in the numbers is that they would have a threshold for health care card holders. That is what it looks like on the basis of the data in areas where they have relative market power.

**Senator HUMPHRIES**—What proportion of non concession card holders are being bulk-billed presently in rural and remote areas, are you saying?

**Prof. Duckett**—The HIC just does not collect that data.

**Senator HUMPHRIES**—Then how do you know that there are not already significant levels of compassionate bulk-billing going on by doctors, notwithstanding—

**Prof. Duckett**—That is exactly what I said: one of the ways you can interpret that table on page 22 is that only 80 per cent of concession card holders are being bulk-billed and 20 per cent of people with blue eyes are being bulk-billed. We just do not know that. The picture looks like that more or less all concession card holders are bulk-billed but, you are quite right, we do not know.

**CHAIR**—Professor Duckett, we also had a lot of evidence from doctors saying that they thought that the health care card was no indicator of health need and that—we have talked about this a bit—the quality and expense of the car the person drives is more of an indicator of their level of income.

**Prof. Duckett**—That could all be true.

**CHAIR**—So people are not necessarily using a health care card as an indicator of income at all. The other point that doctors made to us is that doctors are leaving the profession in droves because of their lack of ability to make the income that they believe they are due.

**Prof. Swerissen**—Yes, but I have two points about that. The government's scheme is a participating practice scheme which requires you to sign that you will bulk-bill health card holders, so in a sense the discretion has been taken away. You then look to see what is likely to happen beyond that in terms of normal behavioural responses. One of the things that happen in normal behavioural responses is that services will seek to minimise their transaction costs. Introducing the requirement—to use Professor Duckett's comment of 'blue eyes will qualify but brown eyes will not'—then introduces a transaction cost. On the assumption that practices will seek to reduce their transaction cost, the most parsimonious assumption to make is that they will follow what the government's package actually requires them to do, which is to bulk-bill concession card holders.

**Senator HUMPHRIES**—Are you seriously saying to the committee that the taxpayer spends another billion dollars above what is being spent at the moment on GPs in Australia and for that investment of \$1 billion we get a 56 per cent increase in out-of-pocket payments and a decline bulk-billing rates?

**Prof. Swerissen**—Yes.

**Prof. Duckett**—Yes.

**Senator HUMPHRIES**—That seems to defy intuition, doesn't it?

**Prof. Duckett**—Do not forget that a lot of the government's package, as we pointed out, is directed to work force reforms and actually does not impact directly on the bulk-billing rate or the out of pockets. So when you look at the component of the package that directly impacts on bulk-billing and out of pockets, it is obviously a much smaller amount. The difference between the two packages is that, by and large, to restore their income doctors have to go with the out of pockets, whereas, under the Labor package, to restore their income it comes through the rebate.

**Senator HUMPHRIES**—Assuming it is 5.2 times average weekly earnings.

**Prof. Duckett**—Assuming it is 5.2 times average weekly earnings.

**Senator FORSHAW**—If we go to the graph on page 12 which you have just been discussing with Senator Humphries and this 10.6 per cent gap between average weekly ordinary time earnings, is that the gap between AWOTE and Commonwealth expenditure on GPs?

**Prof. Duckett**—Per capita.

**Senator FORSHAW**—Per capita.

**Prof. Duckett**—Per GP, I mean.

**Senator FORSHAW**—So it is not an actual measure of the gap between average weekly ordinary time earnings and doctors' incomes, is it?

**Prof. Duckett**—No, that is five times!

**Senator FORSHAW**—Exactly. If we looked at that graph pre 1994, what would it look like? Would it be in the other direction?

**Prof. Duckett**—We do not have that in front of us but, by and large, GP fees were indexed in line with the consumer price index over the previous five years. I have not done it prior to that. I would imagine that the graph would have been fairly close.

**Prof. Swerissen**—The government submission, Senator, is that GP incomes were increasing in the period up to 1992 relative to average weekly ordinary time earnings, and there has been a decline subsequently. That decline has been in the order of 10.6 per cent.

**Senator FORSHAW**—I want to go to an argument that has been put on a number of occasions throughout this hearing, not by witnesses but actually by government senators—and that is, in the period when bulk-billing was trending upwards, the level of the rebate was actually increasing at a lower rate than it has increased since 1996. Up to 1996 bulk-billing rates were trending upwards to about 80 per cent and the rebate was increasing at the same time. However, from 1996 onwards, the bulk-billing rates traded downwards but the increase in the rebate had actually gone up even more than it had done pre 1996. It is then said that, because of this conundrum, if you like, there is no relationship between the level of the rebate, bulk-billing rates and how doctors respond. Doctors have been saying to us that the rebate just has not kept pace

with doctors' costs and that their incomes are not enough. Is the level of the rebate relevant to doctors' incomes and to bulk-billing rates?

**Prof. Duckett**—I have not seen that Commonwealth analysis. It is not consistent with the data I have seen. I have done analysis not reported here which indicated that the GP rebate went up in line with inflation up to around 1996, then went slower than inflation for the next few years and then caught up again. I do not have that data in front of me and I have not seen the Commonwealth analysis. What we are assuming in this analysis is that GPs are looking for a target income. The way they can achieve a target income is through different revenue sources and different choices. The key revenue source is income from patients—that is, either bulk-billed income from the Commonwealth or rebate plus out-of-pocket payments. We are saying that, like everybody, they have an interest in a target income.

**Senator FORSHAW**—That is the only thing they can themselves impact upon, isn't it? They can vary that.

**Prof. Duckett**—Yes. And under the government proposal and the opposition proposal they have different opportunities in terms of the impact of out of pockets and so on.

**Senator FORSHAW**—I think the thing that comes through from what you are saying is that the critical aspect of the government package is the removal of the hard threshold. With all of this talk about copayments, at the moment technically you cannot charge a copayment. You either charge the rebate as bulk-billing and accept it as the total fee or you present a bill.

**Prof. Swerissen**—That is right.

**Senator FORSHAW**—The removal of that obstacle, if you like—

**Prof. Swerissen**—Has a significant impact.

**Senator FORSHAW**—has a huge impact.

**Prof. Duckett**—It also has a significant impact on the patient. At the moment, if the patient is given a bill, to get the rebate they have to either go to the chemist shop and send off the Medicare claim form or go to a Medicare office; whereas under this new proposal that is handled at the participating practices and patients have to pay only the \$10 or \$15—or whatever it is—out of pocket. It is much easier on the patients but much more costly, of course.

**Prof. Swerissen**—I suppose what we are saying—and this is the critical feature of this—is that GPs have observed a relative decline in incomes compared to average weekly earnings. That is what is driving their desire to achieve greater incomes, and they will do that either through out of pockets or if they get additional funding from government. So the two things have to be looked at together in relation to the income aspirations. If we look at that in our modelling, we see the threshold effect of charging as an administrative constraint on their ability to adjust their out-of-pocket payments. When that is gone, that increases their ability to change their out-of-pocket costs.

**Senator FORSHAW**—I have two other questions on bulk-billing. I do not think this is taken up in your research. Are you able to say how important the influence of government policy is on bulk-billing? I put it to you that the trend to increasing levels of bulk-billing through a period when the government was actively promoting that the essence of the Medicare scheme was bulk-billing suggests that that ultimately has to have some influence upon doctors' attitudes, given that they were initially opposed to bulk-billing. Whereas, if you have more options available in terms of bulk-billing, that in itself must have some impact. I am not asking you for a political observation.

**Prof. Swerissen**—Perhaps one way of answering that question is to say that policy is inevitably made up of a series of particular actions, rules, incentives and payment arrangements, and it is the mix of those incentives, rules and payment arrangements which affects GP behaviour. We think that, on average, GPs will act rationally. If the incentives are structured in particular ways they will behave in a particular direction. So it is a matter of what the policy parameters actually are as to what the outcomes are likely to be in relation to bulk-billing.

**Senator FORSHAW**—You mentioned the proposal to introduce private health insurance cover for the over \$1,000 out-of-pocket expenses, but do you have any further comment about how that might play out in the system? Is it significant? It certainly appears that it would apply to a very small number of patients.

**Prof. Duckett**—We have not done that analysis, but if there were an average \$10 out-of-pocket expense, you would need 100 GP visits a year to hit the \$1,000 threshold, and that is a relatively small proportion of the population.

**Prof. Swerissen**—We think that it is a relatively small impact in the overall scheme of things. In the current arrangements, the \$1,000 threshold is sufficiently high—and the government's estimates themselves suggest, I think, 30,000 people will be in that position, which is likely to be only two, three or four per cent of the overall number of consultations that are provided by GPs—that it is not likely to be a major impact in the system. So it was not particularly important for the modelling work that we did.

**Senator FORSHAW**—Professor Duckett, if you are able to do so, would you mind providing that information you mentioned about what had happened with levels of the rebate?

**Prof. Duckett**—I have it on an Excel spreadsheet in my office.

**Senator FORSHAW**—If you could send us that, that would be very helpful. Thank you.

**CHAIR**—I will complete this discussion by thanking you, Professor Duckett and Professor Swerissen, for giving us a lot of your time—we have gone long over time. We very much appreciate that.

**Senator BARNETT**—Are we over time, or is there an opportunity to ask two more questions?

**CHAIR**—We are actually over time. I was just going to ask whether, if there were further questions that the committee had—within reason, of course—you would be prepared to receive them in a written form?

**Prof. Duckett**—Yes.

**CHAIR**—Thank you. I formally declare this final hearing of the committee closed.

**Committee adjourned at 11.23 a.m.**