

CHAPTER 3

General Practice Incomes and the viability of Practice in Australia

Abandonment of bulk billing is a huge step for GPs and their patients ... but it reached the point where we had to either start charging or close down.¹

Introduction

3.1 Term of Reference (a) requires the Committee to examine:

[T]he impact of the current rate of the Medicare Benefits Schedule and Practice Incentive Payments on practitioner incomes and the viability of bulk billing practices; ...

3.2 The extent to which general practice is viable at the current level of Government subsidy of primary health care is a central question when addressing this Term of Reference. The Committee received considerable evidence that practice income was inadequate to both meet practice costs and provide a reasonable income for practitioners. Many witnesses believed that bulk-billing all patients was financially unsustainable, because increases in the Medicare rebate had failed to keep pace with the rise in the costs of running a GP service.

3.3 This chapter looks at the various models of payment used to remunerate doctors, the quantum of that income, the costs of running a practice, the outcomes of the Relative Value Study, and the viability of general practice in Australia.

Viability

3.4 It is important to note at the outset that viability is an inherently subjective concept, as it incorporates not only a recognition that income must exceed costs, but that profit must be sufficient to meet the highly variable needs and wants of the individual practitioner. Like any group of professionals there are differences of opinion amongst GPs about what constitutes a reasonable net income. In other words, what remuneration is sufficient for a GP to feel it is worth his or her while to continue in practice, and under what conditions s/he will choose to bulk-bill, are infinitely variable.

The viability of General Practice

3.5 The average full-time GP income and practice costs in Australia vary widely depending on location, patient profile, local market conditions, individual practice

1 Dr Matthews, Submission 110, p. 3

costs, and clinical style. At the roundtable hearing, Dr Bain of the AMA commented that due to this disparity, net GP incomes were:

...extremely variable across the board. When we did a survey of GPs we found a range of net hourly incomes between \$30 and \$60. That would encompass most GPs — there would be some above that and a few below it.²

3.6 Current net (post-expenses, but pre-income tax) FTE GP incomes are estimated by the AIPC at between \$91,000 for a metropolitan doctor, and around \$111,000 for a rural doctor. Differences across geographic settings are largely attributable to variations in bulk-billing rates.³

The viability of exclusively bulk-billing General Practice

3.7 Throughout the Inquiry, the Committee heard from practitioners and others reporting the diminished viability of general practice in Australia, and the near impossibility of running one as a bulk-billing operation.⁴

3.8 One doctor captured the tension between his commitment to bulk-billing as an important component of universal health insurance system, and the pressure to charge patients in order to compensate for the longer working hours required due to failure of Government policy to maintain some parity between GP supply and demand. He expressed the quandary in these terms:

I am a bulk-billing GP, and there are four or five of us. We are barely surviving on bulk-billing, but we are determined to keep doing it because it is the only way we can be doctors, if you like. One doctor is threatening to leave. He is non-VR. He gets \$18 fully bulk-billed. That will never increase, because he is a non-VR doctor. We cannot get locums, because the number of doctors in training has been reduced – until the recent initiative. So there are no doctors out there; all of them have been soaked up by the entrepreneurs. We are stuck there with no relief.⁵

3.9 However, there were other views. A number of economists gave evidence that the opportunity cost of bulk-billing has been over-estimated by many practitioners, because they do not fully realise the cost savings of billing through that system. The fact that there are fewer debts and lower administration costs associated with bulk-billing in high numbers was put by Professor Marley of Newcastle University, for instance:

2 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 17

3 AIPC Report to Select Committee on Medicare, p.20. Dr Mackey of the RDAA, while pointing out the higher costs associated with rural practice, accepted that higher incomes are earned. See *Proof Committee Hansard*, Canberra, 28 August 2003, p. 115

4 See, for example, Darebin Community Health Service Inc, Submission 40, p. 1

5 Dr Costa, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 52

If GPs stopped listening to the rhetoric, they would see that they actually make more money by bulk-billing, and we have clear evidence that that is the case. That happens because people who do not bulk-bill usually discount for pensioners and disadvantaged people anyway. There will be a proportion that they do bulk-bill, and they are overrepresented in people attending practices. They have to employ more staff, they have bad debts and there is evidence that doctors do not use the higher consultation levels, which they could legitimately charge — the levels C and D advanced consultations — if they are giving a bill to the patient, whereas if they bulk-bill they do. If you bulk-bill you do not have any cash flow problems—the government always pays.⁶

3.10 The AIPC Report compared doctors' incomes from the MBS with average weekly ordinary time earnings (AWOTE), both now and in the past. Average Commonwealth expenditure on GPs in 1992-93 was about 5.2 times AWOTE. Subsequently, this ratio fell to 4.7 times AWOTE in 2002-03. From 1993 to 2003, AWOTE increased by 10.6 percent more than Commonwealth expenditure on GPs.⁷ This analysis is particularly relevant to viability of bulk-billing, as the Commonwealth provides the sole means of income for those practitioners. Where doctors charge above the level of the rebate, income is supplemented by the patient. Therefore, AWOTE provides a useful point of comparison between increases in medical incomes as opposed to increases in overall earnings.

3.11 The critical issue for most medical witnesses was the diminished value of the MBS rebate. Many doctors illustrated the degree to which they considered the rebate fell short of requirements by analysing the number of patients seen in a given hour to derive sufficient income. For example, Dr Alexander, a Tasmanian GP, currently consults on average four to five patients per hour. He commented that:

In our practice, for me to generate the same amount of money through bulk-billing [as is earned currently with a co-payment], I need to see nine patients per hour.⁸

3.12 Rising relative costs were also a primary complaint:

Bulk-billing rates do not reflect the growing costs of running a practice, including the financial burden of increasing administrative and bureaucratic responsibilities. Practices are being forced to increase income through various strategies including increasing patient throughput and charging the patient a gap amount above the rebate.⁹

6 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 30

7 AIPC Report to Select Committee on Medicare, p. 11

8 Dr Alexander, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 39

9 Queensland Divisions of General Practice, Submission 146, p. 2

3.13 Dr Powell illustrated the tension between financial necessity and optimal patient care:

There is a point in the consultation process where bulk-billing is sustainable; that is, at about eight minutes. The further that you move away from that eight-minute time frame the more disparate the income versus looking after the population with charity and compassion equation becomes.¹⁰

3.14 Practice viability is also threatened by the doctor shortage which is discussed in chapter 4. Where they are unable to attract sufficient medical staff, practices face fixed costs while practice income and the number of consultations decline.¹¹

Models of Payment

Fee-for-Service

3.15 The fee-for-service model is the basis of the current Australian system, which operates on a payment made in return for each specific medical service rendered by a practitioner. The payment may be derived from more than one source, as is the case when GPs are remunerated through out-of-pocket charges as a supplement to the Medicare rebate.

3.16 Support for this model is widespread among health professionals, although Evidence was presented that many younger doctors find other models more attractive due to the flexibility they provide.¹²

Capitation

3.17 The capitation model remunerates practitioners with a uniform payment for the number of patients on their books, regardless of the number of consultations required by the group. The remuneration may also be geographically determined, whereby practitioners are responsible for delivering the health services required by all patients within a given boundary.

3.18 Capitation payments have characterised GP remuneration in the United Kingdom under the National Health System (NHS).

Salaried Doctors

3.19 General practitioners may also choose to work in salaried positions for a variety of reasons including not wishing to be involved with the business aspect of private practice, preferring to limit their work hours for personal or lifestyle reasons, or desiring flexibility in their future employment options. In Australia GPs are

10 Dr Powell, Proof Committee Hansard, Bundaberg, 25 August 2003, p. 19

11 Dr Powell, Proof Committee Hansard, Bundaberg, 25 August 2003, p. 19

12 Professor Andrew Wilson, Proof Committee Hansard, Canberra, Monday 21 July 2003, p. 19

employed on negotiated salaries in community health centres or with large corporate primary care providers.

3.20 There are reports of growing support for this model by GPs, particularly among the younger and recently graduated doctors:

The young graduate is much more interested in lifestyle than income. They are not interested in owning practices and buildings. They want to walk into a well-managed environment, do the job and go home. They would work in a salaried environment; many of them choose to do just that—work on salaries in general practices and so on. So the nature and shape of the work force is really changing quite dramatically.¹³

Blended payments

3.21 Blended payments comprise a mixture of these models, but may also reflect complementary incentive payments targeted at improving health outcomes.

3.22 The Practice Incentives Program described in chapter 2 is a good example of a blended payment, whereby practitioners are rewarded with incentive payments for improving their practices through modernisation of technique and infrastructure, as opposed to servicing more patients.

General Practice incomes

3.23 Critical to the issue of viability is the income of individual GPs and practices, about which the Committee heard a range of views in evidence. It should be noted that this section deals simply with gross income to GPs, not the remuneration that flows to them after costs, tax and other expenses have been paid.

3.24 GPs receive remuneration not just from the MBS through the Health Insurance Commission, but also from patients (through out-of-pocket costs), the Department of Health and Ageing (through blended payments), the Department of Veterans Affairs and other sources.

3.25 The Australian Institute for Primary Care (AIPC) in research commissioned by the Committee estimated gross annualised incomes per full-time equivalent (FTE) GP to range between \$221,676 in a metropolitan area or capital city, and \$241,196 in a rural region. The variation in these estimates is due to different relative proportions of bulk-billed services and is exclusive of income received from Worker's Compensation claims, insurance claims, payments through public hospitals, and payments from the Department of Veteran's Affairs.¹⁴

13 Professor Marley, Proof Committee Hansard, Newcastle, 23 July 2003, p. 30

14 AIPC Report to Select Committee on Medicare, pp. 20-21 (see Appendix 3).

3.26 Using similar parameters, a figure of \$242,000 was provided by the Department of Health and Ageing, comprising of:

- \$196,000 (81%) derived from MBS payments;
- \$24,000 (10%) derived from patient contributions; and
- \$22,000 (9%) derived from blended payments such as PIP.¹⁵

3.27 The Committee heard from various witnesses that rural GPs often earn more than their city counterparts.

Rural doctors are split. There are a lot of rural doctors who are ideologically committed to the private practice model ... some of Australia's richest GPs are rural GPs ... [s]o it is not true that all rural doctors are poor. Unfortunately, where there are so few doctors and there is so little competition, they can charge a lot, and they do.¹⁶

3.28 This is acknowledged by the Rural Doctors' Association, although it is argued that the extra income is earned through longer hours, and is offset by extra costs (see 'Practice costs', below).

Sure, the doctors may earn more, but they are doing a lot more work in the rural areas. They are called on, they are doing a lot more of the after-hours work and they do a lot more of the hospital work. Income is up, but they are working a hell of a lot more as well.¹⁷

Practice costs

3.29 The Department provided modeling of average practice costs, based on the Relative Value Study (RVS).¹⁸ One of the important components of the RVS was to develop fair and reasonable estimates of practice costs for each of the medical specialist groups that participated in the review. The estimates differ markedly depending on the specialty and number of practitioners operating within a practice.

15 Department of Health and Ageing, *GP Income – Australian Government and patients*, tabled documents, roundtable hearing, Canberra, 21 July 2003

16 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 50.

17 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 115

18 The RVS is a review of the General Medical Services Table of the MBS. The guiding principles of the review include introducing equity into the MBS, providing common structure across professional groups, and promoting and appropriately rewarding good clinical practice. 27 specialty groups participated in the conduct of the RVS. The review resulted in the development of a revised core consultation item structure and the completion of three studies: Practice Costs Study, Professional Relativities Study and Remuneration Rates Study. For further information see www.health.gov.au/rvs/index.htm and discussion in chapter 12.

For general practice the estimated costs of practice vary from \$127,330 in a sole doctor practice, to \$111,007 per doctor where four doctors practice together.¹⁹

3.30 These findings created substantial controversy at the time they were released.²⁰ The methodology of the study and many of its assumptions were widely criticised within the medical profession. The Australian Medical Association (AMA) argued that the costings in the RVS Practice Costs Study underestimate the actual costs of running a practice. According to the AMA the study is:

... based on unreasonable working hours and lack of provision for sick, long service or study leave ... the study also failed to allocate funds for locum provision ... [and] recommended costs to buy practice equipment were also inadequate to meet accreditation standards.²¹

3.31 The RVS Study figures form the basis of analysis on practice costs by the Australian Institute for Primary Care, which estimates that a practitioner in a three doctor surgery would incur costs inflated by CPI of \$130,676 in 2002/03.²²

3.32 However, a study conducted by the AMA and Access Economics in 2001 puts costs significantly lower, at approximately \$115,000 and \$75,000 for a one and three doctor practice, respectively. This study found that practice costs fell 'significantly from a solo practice to a two-doctor practice, and continued to diminish with increased practice size, although after six FTE GPs the data limitations made the relationship unstable'.²³

3.33 If an average gross income of around \$230,000 and practice costs of around \$130,000 are accepted, this represents costs running at around 56 percent for a three doctor practice. The Committee heard that it is not uncommon for practice costs to be as low as 15 percent of total revenue, where minimal extra services are added in the delivery of care.²⁴

19 Department of Health and Ageing, Costs of General Practice, tabled documents, roundtable hearing, Canberra, 21 July 2003, sourced from the RVS study *A resource based model of private medical practice in Australia – final report, Volumes 1 and 2* (Price Waterhouse Coopers December 2000). All costs have been adjusted to values current as at 31 December 1999.

20 See also chapter 12, where the contentious assumptions are elaborated on.

21 Cathy Saunders 'GPs seething at faults in practice cost study', *Australian Doctor* 30 April 1999

22 AIPC Report to Select Committee on Medicare, p. 20

23 AMA, *Primary Health Care for All Australians; An Analysis of the Widening Gap between Community Need and the Availability of GP Services* (Access Economics February 2002), p.16. See also Department of Health and Ageing, Costs of General Practice, tabled documents, roundtable hearing, Canberra, 21 July 2003.

24 Dr Djacic, *Proof Committee Hansard*, Hobart, 21 July 2003, p. 70

Costs of rural practice

3.34 A number of rural-based practitioners contend that their practices are more expensive to operate than those in metropolitan areas, a fact that should be taken into account for statistical analysis of incomes and viability. Dr Mackey, a doctor from South-Western NSW, and speaking for the Rural Doctors Association of Australia (RDAA) told the Committee that:

RDAA research which is soon to be published indicates that the cost of providing medical services is considerably higher in rural and remote Australia. The Medicare rebate is based on urban cost structures. It is indexed ... to the generic formula of WC15²⁵ and does not take into account specific costs, for example, equipment, continuing medical education, accreditation, the rural industrial awards of employing staff and, of course, indemnity insurance.²⁶

3.35 Some of these costs were elaborated on by Dr Slaney of the RDAA:

If we take a rural doctor who provides a range of specialist services, including obstetrics, anaesthetics and radiology, all those skills need to be maintained within the requirements of the relevant colleges. That costs a lot more money for a rural doctor, compared with your average urban general practitioner who does not need to access those skills. The cost structures in running any business in a rural environment are higher than in an urban environment. You have increased telephone costs – most of the calls made to specialists are long distance. You have costs in visiting people at home, costs of transport are higher, and costs of computer software support are extremely expensive because in most cases you need to pay people fees to come out and visit your practice. All those costs are significantly higher than in an urban environment.²⁷

3.36 The equipment costs can be significant. Some rural practices requiring equipment more usually found in a small casualty department, including for example a defibrillator, an ECG, a dynamap, an oximeter, and an X-ray machine (worth around \$50,000).²⁸

In an urban environment, a lot of serious issues can be immediately flicked to a nearby casualty department or a specialist, whereas in a rural environment they are our problem and we have to deal with them.²⁹

25 For a discussion on WC15, see chapter 12

26 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 107

27 Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 114

28 Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 114

29 Dr Maxwell, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 115

3.37 Information technology costs are a significant burden for rural and regional practices, and the elevated price of facilities such as broadband access in remote rural locations. As Dr Mackey explained:

It is fairly disgusting that for three days there is no access in or out – you can ring around town because you use the local exchange. We will not say whose fault that is. The situation is that to have something reasonable, you need ADSL or some other fast mode of access. Really, what we are saying [is] that that should be put onto every rural practice and onto every rural community of substantial size.³⁰

The cost of accessing blended payments

3.38 The high costs of administration and access to the series of blended payment schemes was a recurrent theme among medical witnesses who indicated that this has a direct impact on both practice costs and practice income, and also on viability. The prevailing view was that most of the income sources were viably accessed only by larger practices with sufficient IT and staff resources to handle the heavy administrative demands of the programs.

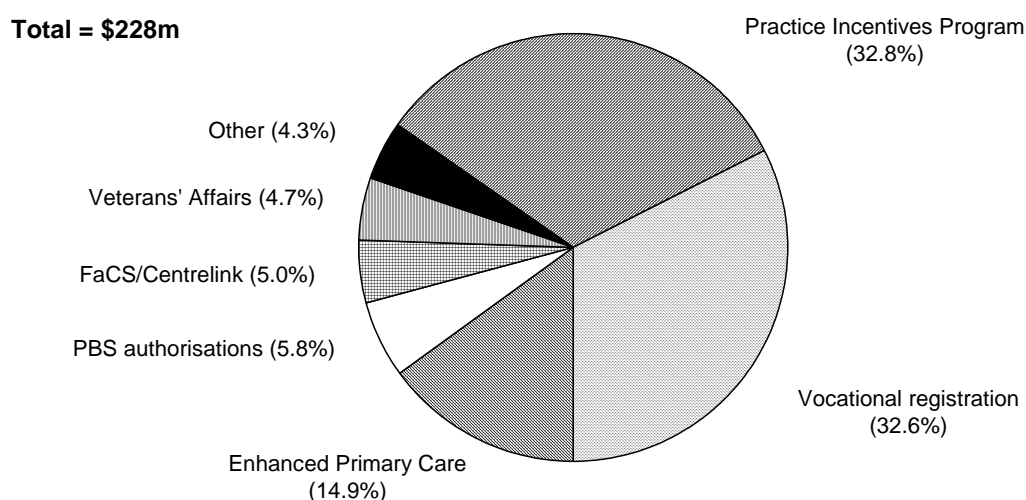
3.39 The Committee accepts that this is true: in other words that the principle of economy of scale applies to GPs as it applies to other professional groups and industries. Rural GPs, GPs in outer metropolitan areas, and those in towns and cities who practice by themselves or with a small number of other doctors are at a comparative disadvantage when it comes to accessing Government subsidy and incentive programs.

3.40 The March 2003 Productivity Commission Report *General Practice Administrative and Compliance Costs* found that the total administrative and related costs for all GPs associated with accessing Commonwealth policies and programs was approximately \$228 million in 2001/02, which is 5 percent of total GP income, or about \$13,100 per year per GP.³¹

30 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 117

31 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, p. 57

3.41 **Table 3.1 - Estimated GP Administrative Costs 2001/02³²**



3.42 Table 3.1 demonstrates that under the base case examined by the Productivity Commission, the Practice Incentives Program, Enhanced Primary Care and Vocational Registration accounted for over 75 percent of administrative costs. About 39 percent of the Commonwealth outlay on PIP was accounted for by costs associated with administration.

3.43 The other primary complaint from practitioners, which was also supported by the Commission's findings, was the 'fragmentation' of payments from various sources, including the Department of Health and Ageing and the Health Insurance Commission. This 'silo' approach added further layers of administration and increased practitioner frustration.³³

3.44 In contrast, Dr Moxham does not consider this to be a major issue:

It is about 15 minutes a day, and I think it is part of the consultation. If I see a patient and do a blood test, part of that consultation is looking at the result of that blood test when it comes in the next day and making a decision about what to do about it. I do not think you can then complain that that is non-billable; it was billable, it was part of the original consultation. It is the same as filling in forms for Centrelink – it is all part of a consultation.³⁴

32 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, p. xxi

33 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, pp. xxiii and xxx

34 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 10

Practice Incentives Program

3.45 The primary aims of PIP were described in chapter 2, and broadly include enhancing the delivery of medical services through changes to practice and approaches to patient care.³⁵

3.46 The majority of general practices in Australia participate in PIP.³⁶ In May 2001, there were 5,260 practices participating in the program, covering 80 per cent of patients. Following the introduction of accreditation requirements on 1 January 2002, by May 2002 there were 4,482 PIP practices covering 76 per cent of patients, of which 4,189 had achieved full accreditation. Therefore, PIP practices continue to cover the majority of patients attending general practice in Australia.³⁷

3.47 The effectiveness of the PIP scheme as it currently operates was questioned by a number of witnesses who cited excessive 'red tape' as a severe limitation on a practitioner's ability to access the payments. The view was expressed that PIP discriminated in favour of larger practices that could devote the necessary resources required to make claims under the scheme.³⁸ While criticism of the program was mainly directed to administrative costs, there were expressions of support for the rationale behind PIP and the potential benefits stemming from it.³⁹

3.48 However, there was also doubt that the program was worth the effort for the outcomes it achieved. Dr Gault articulated this view:

For all its stated aims, this scheme has in my mind, and I guess in the minds of many other GPs, functioned in main as a bribe to continue bulk-billing. Without P.I.P, the current crisis would have occurred five years ago. We are therefore very wary of extensions to P.I.P. given its ever-increasing red tape and the fact that it aims to avoid the thorny issue of co-payments.⁴⁰

Enhanced Primary Care

3.49 The Enhanced Primary Care (EPC) scheme as outlined in chapter 2 provides a framework for a multidisciplinary approach to health care through a more flexible, efficient and responsive match between care recipients' needs and services.⁴¹ However, some concerns were expressed in relation to EPC. For example the South

35 Refer to 2.32

36 For information on PIP see http://www.hic.gov.au/providers/incentives_allowances/pip.htm

37 Department of Health and Ageing, Annual Report 2002, Outcome 2, p. 7

38 See, for example, Dr Matthews, Submission 110, p. 6

39 See, for example, Australian Council of Social Services, Submission 106, p. 4

40 Dr Gault, Submission 6, p. 1

41 Enhanced Primary Care information sheet, www.health.gov.au/epc. Accessed on 16 September 2003.

Kingsville Health Cooperative noted the time constraints associated with accessing supplementary incentive payments:

For an under-funded, over-worked practice, the notion of moving towards new types of payments seems an uncertain and difficult luxury, and does not seem appropriate in the light of the immediate medical needs that will not be met as a result of this type of organisational change.⁴²

3.50 The Department of Health and Ageing commissioned an evaluation of the effectiveness of the EPC program in achieving its policy objectives, and this was conducted through the course of 2002.⁴³ The Report concluded that the EPC program had made a significant contribution to improving management of patients with chronic illness and complex care needs. However, it also found that many of the practical requirements of claiming EPC items under the MBS were difficult to achieve in the clinical setting. Some of these difficulties included the complexity of paperwork, the disallowance of delegating to a practice nurse, and the logistics of co-locating health professionals for a case conference.⁴⁴

3.51 Costly administrative procedures act as a disincentive. The Productivity Commission Report calculated that, in order to receive EPC payments of \$63 million in 2001-02, participating GPs had to outlay \$34 million in administrative costs.⁴⁵ The Report noted that case conferences were particularly underutilised, with 3,121 participating GP's claiming for just 10,727 services in the year 2001-02.⁴⁶ The fragmented nature of the EPC items and the complex claiming requirements were illustrated by Dr Carter:

If I vaccinate a child I get a vaccination incentive. If I check a diabetic's health in a particular way I get another payment, case conferences within specific guidelines earn a little more, and dozens of other schemes from asthma to pap smears earn little bits of cash, but all these bits must be chased and paperwork rears its ugly head and reduces the effective benefit to the point that many GPs just don't bother.⁴⁷

3.52 The sheer volume of paperwork required was a source of constant criticism in evidence. The Committee notes that the Government has established a 'Red Tape'

42 South Kingsville Health Cooperative, Submission 80, pp. 1-2

43 Professor David Wilkinson *et al*, *Evaluation of the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) Items and the General Practice Education, Support and Community Linkages Program (GPESCL) Final Report*, July 2003, Department of Health and Ageing

44 *Ibid*, pp. 3 - 4

45 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, p. 60.

46 Productivity Commission, *General Practice Administrative and Compliance Costs*, 31 March 2003, p. 24.

47 Dr Carter, Submission 19, p. 2

taskforce in response to recommendations made by the Productivity Commission, and this taskforce is due to report in November 2003.⁴⁸

Conclusion

3.53 The evidence indicates that real incomes for GPs who exclusively bulk-bill, relative to average weekly ordinary time earnings, have fallen in the past ten years, and that an increase in net earnings of about 10.6% would be required to retain relative parity.⁴⁹

3.54 It is more difficult to ascertain historical changes in real terms to the income of doctors who do charge at least some of their patients above the rebate level. However, the clear evidence that out-of-pocket charges to patients have been rising quite markedly (see chapter 4) suggests that the majority of GPs have been receiving income growth at a rate closer to AWOTE than those GPs relying solely on Commonwealth payments.

3.55 While knowledge of historical changes in GP income is important, it is not possible to externally regulate GP remuneration. As a result, the extent to which GPs *perceive* their income to be sufficient or otherwise at any given time is important. The vast majority of practitioners and associated organisations who submitted to the Inquiry expressed the view that incomes for GPs had fallen substantially over recent years. This decline, coupled with a shortage of doctors, caused an increase in the number and quantum of out-of-pocket charges and a decrease in bulk-billing.

3.56 The Committee received evidence that the cost of running a general practice ran at approximately 50% of GP gross income, and that the proportion of income absorbed by running expenses had increased over recent years. However, the Committee heard no compelling evidence that GP running costs had outgrown the CPI, and the question of viability has been determined with reference to the most conservative cost figures available.⁵⁰ The Committee acknowledges that costs of rural practices are higher than average, but notes the solid evidence that practice incomes in rural areas outstripped those in more populated areas.⁵¹ There is no evidence that rural practices' extra costs exceed their extra income.

3.57 With respect to the effectiveness of blended payments such as PIP and EPC, the Committee is mindful of the many benefits which can be obtained through their

48 See <http://www.health.gov.au/redtape/index.htm> for further information on the Taskforce.

49 As outlined at 3.10.

50 Australian Institute for Primary Care, *An analysis of potential Inflationary effects on health care costs for consumers associated with the Government's 'A Fairer Medicare', and the Opposition proposal*, September 2003, La Trobe University, p. 20

51 The Committee notes the evidence provided by the Department of Health and Ageing relating to income earned by FTE GPs by RRMA, but is swayed by the extent and consistency of evidence to the contrary.

use. The Committee supports an examination of the effectiveness of the PIP program, to complement the work already undertaken on the usefulness of EPC. These analyses should form the basis of a further examination of the optimal role of blended payments in remunerating doctors. Pending the outcome of such a study, the Committee believes that the role of the 'Red Tape Taskforce' is critical in laying the foundations for an analysis of what part blended payments should play in the future. The bulk of complaints to the Committee related to unwieldy and unreasonable administrative requirements. The Committee therefore recommends that the Taskforce addresses the procedural as well as the structural components of the system and recommends substantive reforms.

3.58 It is the view of the Committee that practitioners who exclusively bulk-bill are clearly relatively worse off now than they were a decade ago. This decline in remuneration in real terms for GPs who bulk-bill around 80% of their patients is of serious concern, and the Committee concludes that the relative under-remuneration is a primary factor, along with practitioner shortage, in the falling rates of bulk-billing in Australia.

Recommendation 3.1

The Committee recommends that the Commonwealth Government undertake a review of the Practice Incentive Program (PIP) with a view to assessing its effectiveness in meeting its policy objectives.