



**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

PREFACE

This report was commissioned by the Department of the Senate from the Australian Institute for Primary Care, La Trobe University. The Australian Institute for Primary Care (AIPC) promotes quality improvement and best practice in all areas of primary health care. It supports the integration of theory and practice in primary health care and promotes the standing and visibility of primary health care and community health services. The report was prepared by Associate Professor Hal Swerissen, Director of the AIPC, Professor Stephen Duckett, Professor of Health Policy, La Trobe University, and Mr Charles Livingstone, Senior Research Fellow, AIPC.

EXECUTIVE SUMMARY

Key features of proposals

The Government proposes to introduce a “Fairer Medicare” package. The package introduces a participating practice scheme. GP practices that agree to charge a no gap fee to concessional patients will be eligible for increased Medicare rebates for these patients. The level of the proposed increase for the rebate is \$1 in metropolitan city practices, \$2.95 in non-metropolitan city practices, \$5.30 in rural centre practices, and \$6.30 in outer rural and remote areas. The cost of this measure is estimated at \$346 million over four years.

Other measures to implement safety net, insurance, and gap billing procedures are also proposed. The total cost of these measures over four years is \$537 million.

The Opposition proposes to immediately lift the rebate to 95% of the scheduled fee for all bulk billed patients. This is an average increase of \$3.35 per consultation. The Opposition proposes to increase the rebate to 100% of the scheduled fee by the 2006/07 financial year. This would raise the average rebate for a consultation by \$5. The estimated cost of this proposal is \$1.115 billion over four years.

The Opposition further proposes to introduce incentive payments for GPs who meet specified bulk billing targets. A payment of \$7,500 is proposed for GPs in metropolitan areas who bulk bill 80% of their patients. A payment of \$15,000 is proposed for GPs in outer metropolitan and major regional centres who bulk bill at least 75% of their patients. Under the Opposition package all other GPs are eligible for an incentive payment of \$22,500 if they bulk bill at least 70% of their patients. The estimated cost of this measure is \$391 million over four years.

Our analytic model

Our framework proposes that out-of-pocket costs are heavily influenced by GP income aspirations. In turn, the extent to which GPs are able to reach their target incomes are a function of Commonwealth Medicare rebates for GPs, system administrative and regulatory constraints to restrain GP fees, the supply of GPs, and practice costs. Out-of-pocket costs to consumers are also influenced by the impact they have on consumer utilisation of services.

We have canvassed a number of relevant issues and made a number of assumptions in the development of this model, and these are summarised in this section.

In this report, we have utilised the relationship between average weekly ordinary time earnings (AWOTE) and payments by the Commonwealth to GPs to assess the extent to which GPs may perceive that their base

incomes have fallen in comparison to those of the more general community. This is a critical assumption in our model. We believe it to be conservative; that is, alternative assumptions would be that GP income relativity expectations may be related to groups whose income has increased faster than AWOTE. It is likely that GPs will attempt to offset the impact of the comparative decline in payments by the Commonwealth by charging additional amounts to their patients where this is possible. These payments are known as out-of-pocket expenses or co-payments.

Trend data indicate that overall bulk billing increased steadily from the introduction of Medicare in 1984/85 to approximately 70% in the mid-1990s. Bulk-billing rates for GP services have generally been about 10% higher than the overall bulk-billing rates over the last decade, reaching a plateau of about 80% in the mid-1990s. Bulk-billing rates have declined significantly since 2000. Average GP bulk billing fell to 68% by March 2003.

There are significant variations in GP bulk-billing rates across geographic settings, ranging from more than 75% in capital cities to less than 55% in rural and remote areas.

Out-of-pocket payments for GP patients increased overall between 1984–1985 and 2002–2003. In the case of patient billed services only, average patient contributions have risen from \$6.90 to \$12.91, an increase in real terms of about 44.7%. In the case of all services (i.e., patient and bulk-billed services), average patient contributions have risen from \$1.74 to \$3.90, an increase in real terms of about 73.3%.

The supply of GPs per capita generally increased from the inception of Medicare to about 1996. There has been a commensurate increase in the number of Medicare services per capita over the same period.

Since 1996 there are indications that the availability of GP services per capita has declined.

Increased out-of-pocket costs may reduce utilisation of GP services and thereby constrain prices. However, the available literature on the impact of prices on demand for GP services (price elasticity) suggests that the effect of price on demand for services will be marginal when potential GP responses are taken into account.

It would be anticipated that GPs will seek to maintain or, if possible, restore their perceived relative income position by increasing the proportion of their earnings derived from out-of-pocket charges made to patients, and any incentive payments associated with billing practices. The comparative decline in bulk-billing rates in the past three years suggests that this strategy is becoming more widespread across GP practices.

The current Medicare administrative provisions set a significant pricing threshold which makes the application of out-of-pocket charges more

difficult in circumstances where patients have relatively good choice of GP, as occurs in relatively well supplied metropolitan city areas. However, reductions in GP availability suggests that GPs are now in a stronger position to reduce bulk-billing levels and introduce out-of-pocket charges to patients in metropolitan areas, as the availability of GP services per capita has begun to reduce, while demand for services has increased or remained stable.

There is no definitive method for predicting the target income that GPs will seek to achieve. The actions they take are likely to be a function of the options available to them. However, the trend data indicate that bulk-billing rates were relatively stable when Commonwealth expenditure per FTE GP was around 5.2 times average weekly earnings. Over time, as the value of FTE GP Commonwealth expenditure has declined as a proportion of AWOTE, bulk-billing rates have declined and out-of-pocket costs have increased. Current GP behaviour could be interpreted as attempting to restore past relativities.

Maintaining relativity with AWOTE is probably a conservative approach to estimating GP target incomes. It is important to note that estimation of target incomes is likely to be based largely on the perceptions by GPs of movements in relativities, rather than particular calculations. Further, it is very likely that GPs will be more influenced by perceived movements in relativities with specialist medical practitioner incomes. However, trend data on specialist incomes were not available within the constraints of this analysis.

Estimated current net FTE GP incomes from rebates and out-of-pocket charges ranged from \$91,000 in metropolitan city areas to \$110,249 in remote rural settings. Differences across geographic settings are attributable to variations in bulk-billing rates.

We have taken the view that GPs are likely to seek to increase that part of their income over which they exercise most control (i.e., via adjustment of fees charged and/or volume of services provided). We have assumed that CDHA estimates of average GP volume (i.e., 7,000 services per FTE GP per annum) will not change. We have thus assumed that GPs will seek to optimise income via adjustment of fees charged and the incidence of bulk billing in order to increase current income levels by about 10.6%, being the increase required to achieve a target of perceived restored relativity with AWOTE.

Modelling the packages

Our modelling assumes that GPs will seek to increase their incomes to the level that would apply if Commonwealth expenditure on FTE GP incomes were 520% of AWOTE. A uniform increase of 10.6% is applied to current estimated FTE GP incomes to model this effect.

Three scenarios are modelled:

- bulk-billing rates and out-of-pocket charges are assumed to remain at their current levels;
- bulk-billing rates are assumed to fall so that only concessional patients are bulk billed and out-of-pocket charges remain at their current level;
- bulk-billing rates are assumed to fall so that only concessional patients are bulk billed and out-of-pocket charges are altered to ensure that the GP income target is met.

Outcomes of modelling

In summary, based on our modelling and relying on the assumptions we have set out in this report, the likely effects of the packages on consumers would be as set out below.

Government package:

- Reduction in average incidence of bulk billing to the bulk-billing ‘floor’ of around 50% of services.
- Small increase in non-metropolitan bulk-billing rates of between three and six percentage points.
- Reduction in average co-payments for non-bulk-billed services in metropolitan areas, but increases in non-metropolitan areas.
- Increase in average co-payments (across all services) of around 56%.
- Improved convenience for those presently not bulk-billed, with possibility of lower actual out-of-pocket costs for this group.

The ‘target setting’ scenario for the Government package would deliver 100% of targets but would also have the effect, facilitated by the removal of the ‘hard threshold’, of increasing the incidence of co-payments, even though average co-payments for those who are not bulk billed would be likely to decline in metropolitan settings. The increased incidence of such payments, however, would mean that average co-payments across all patients would increase by more than 55%, from around \$3.90 to around \$6.15 on average. However, it is also possible that some GPs will further increase co-payments in order to maximise income, assisted by the removal of the hard threshold, which at present provides a substantial barrier to the implementation of co-payments. As we have already noted, the removal of this hard threshold is likely to substantially modify the patient’s perceptions of actual costs incurred and will also reduce transaction costs by an unquantifiable amount. It will also enable a sensitive capacity for price discrimination between patients attending GPs, whether on a geographic or personal basis, and may lead to substantially

variable out-of-pocket costs for those paying them between regions or localities.

Opposition package:

- Some increase in the incidence of bulk billing to around 77% of services.
- No change to average co-payments for non bulk-billed services.
- Reduction in average co-payments (across all services) of around 25% .

In our opinion the most likely scenario arising from the Opposition package would be for GPs to meet the bulk-billing targets and thus maximise the rebate and incentive payment income offered under the Opposition package. This is because doing so allows GPs in all geographic areas to achieve income targets (as with the scenario described above for the Government package). The achievement of bulk-billing targets would increase the overall bulk-billing rate to around 77%, ensuring that the vast majority of concession cardholders would be bulk billed.

Assuming the income targets we have set, if GPs adopted the Opposition package average, out-of-pocket costs to patients would reduce by about 25%, from an average at present of around \$3.90 to an average of about \$2.95. This would derive from a reduction in the incidence of co-payments because of the increased rate of bulk billing. It is possible that patients paying out-of-pocket costs could pay higher costs than at present, but the maintenance of the hard threshold means that price signals to patients would be very prominent.

Our analysis of both proposals is predicated on the notion that GPs will seek to increase their incomes. The Government's proposal provides additional government expenditure for this purpose and protects concessional patients, but it also makes it easier for GPs to raise their incomes through increased patient contributions. The Opposition package relies on increased public sector expenditure to meet the same goal, while maintaining current administrative constraints on gap fees. The relatively higher level of government expenditure outlined in the Opposition proposals reflect this difference.

Table 1 summarises the impact on FTE GP gross fee based incomes (including incentive payments) of each scenario modelled.

Table 1

Scenario 1				Opp'n package	
Region	Total fees income current	Total target fees income	Govt package Total fees income	Total income @ 95%	Total income @ 100%
Metro CC	221,676	245,174	224,849	239,558	248,498
Metro other	228,725	252,970	238,086	244,771	252,794
Rural	241,196	266,763	258,516	253,995	260,395
Rural/remote	240,925	266,463	263,825	253,795	260,230
Scenario 2				Opp'n package	
Region	Total fees income current	Total target fees income	Govt package Total fees income	Total fees income @ 95%	Total fees income @ 100%
Metro CC	221,676	245,174	252,565	260,057	265,390
Metro other	228,725	252,970	258,753	260,057	265,390
Rural	241,196	266,763	258,516	250,403	257,435
Rural/remote	240,925	266,463	263,825	252,028	258,774
Most likely scenario				Opp'n package	
Region	Total fees income current	Total target fees income	Govt package Total fees income	Total fees income @ 95%	Total fees income @ 100%
Metro CC	221,676	245,174	245,174	244,384	253,795
Metro other	228,725	252,970	252,970	255,226	264,049
Rural	241,196	266,763	266,763	266,068	274,303
Rural/remote	240,925	266,463	266,463	266,068	274,303

INTRODUCTION

This report presents an analysis of what, if any, inflationary effects on health care costs for consumers are likely to emerge from the:

- **Government's 'A Fairer Medicare' package**, including incentives to practices that agree to bulk bill all concession cardholders, the capacity for non-concessional patients to pay only the gap at the point of service, the introduction of a new \$500 safety net for concession cardholders, and the creation of a category of private health insurance for out-of-hospital costs where they exceed \$1000; and
- **Opposition proposal**, including measures to increase the patient rebate to 95% of the scheduled fee for bulk-billed services, and the introduction of incentive payments to encourage bulk-billing target rates in metropolitan, outer-metropolitan and rural and regional areas.

The following sections describe the Government and Opposition proposals in detail. An analytic framework to address the extent to which inflationary effects on health care costs for consumers is then developed and applied to examine the two sets of proposals. Various scenarios are developed and discussed and then the proposals are compared and conclusions about likely inflationary impacts are drawn.

SUMMARY OF PROPOSALS

This section summarises the key features of the Government and Opposition proposals included in the analysis.

Key features of the Government's proposal

The Government proposes to introduce a "Fairer Medicare" package. The package introduces a participating practice scheme. GP practices that agree to charge a no gap fee to concessional patients will be eligible for increased Medicare rebates for these patients. The level of the proposed increase for the rebate is \$1 in metropolitan city practices, \$2.95 in non-metropolitan city practices, \$5.30 in rural centre practices, and \$6.30 in outer rural and remote areas. The cost of this measure is estimated at \$346 million over four years.

Participating practices will continue to have the capacity to determine fees for non-concession cardholders, including the option of bulk billing. However, if they choose not to bulk bill these patients, they will no longer have to charge them the scheduled fee plus the co-payment. Instead they will be able to charge the patient the co-payment and claim the Medicare rebate direct from the Health Insurance Commission through HIC online billing facilities. Non-concession cardholders charged a gap payment by a participating practice will no longer be required to claim the Medicare rebate themselves. The estimated cost of this measure plus support and promotion for online billing is estimated at \$35 million.

A new MBS safety net will be available for those covered by concession cards with out-of-pocket costs greater than \$500 in a calendar year. Charges in excess of the scheduled fee will be included, as will the costs of specialist and diagnostic services. Eighty per cent of out-of-pocket costs above the \$500 threshold will be met through this safety net. The cost of this measure is estimated at \$67 million over four years.

Private health insurers will be able to offer insurance coverage for the cumulative cost of out-of-hospital medical services over \$1,000 for a family in a calendar year. This includes costs above the scheduled fee across a range of out-of-hospital services, including GP and specialist consultations and diagnostic tests. The cost of this measure is estimated at \$89 million over four years. The Government estimates that insurance products for this coverage are likely to cost around \$50 per year for families, and the 30% private health insurance rebate will apply to these products.

The total cost of these measures over four years is \$537 million.

The Government's package also includes proposals to introduce additional medical school places, additional GP training places, additional nurses and allied health professionals in general practice, and measures for veterans.

The impact of these measures on potential inflationary effects on patients, if any, were not considered in this analysis.

Key features of the Opposition proposal

The Opposition proposes to immediately lift the rebate to 95% of the scheduled fee for all bulk-billed patients. This is an average increase of \$3.35 per consultation. The Opposition proposes to increase the rebate to 100% of the scheduled fee by the 2006/07 financial year. This would raise the average rebate for a consultation by \$5. The estimated cost of this proposal is \$1.115 billion over four years.

The Opposition further proposes to introduce incentive payments for GPs who meet specified bulk-billing targets. A payment of \$7,500 is proposed for GPs in metropolitan areas who bulk bill 80% of their patients. A payment of \$15,000 is proposed for GPs in outer metropolitan and major regional centres who bulk bill at least 75% of their patients. Under the Opposition package all other GPs are eligible for an incentive payment of \$22,500 if they bulk bill at least 70% of their patients. The estimated cost of this measure is \$391 million over four years.

The total estimated cost of the Oppositions proposals over four years is \$1.505 billion.

ANALYTIC MODEL

In accordance with the brief provided by the Department of the Senate, the analysis of the Government and Opposition proposals described in this report focused on the impact of the two proposals on direct health care costs to consumers.

In both the Government and Opposition proposals, any inflationary effects on health care costs for consumers will be a function of two factors: the proportion of services which are subject to a co-payment (i.e., not bulk billed) and the level of co-payment (i.e., 'out-of-pocket' costs to consumers) required for these services. This paper reports on likely impact of the Government and Opposition proposals on bulk-billing rates and out-of-pocket costs for those who are not bulk billed.

A conceptual framework to guide the modelling of the impact of the Government and Opposition proposals was developed. The framework draws on the published literature on utilisation and fee setting in fee-for-service systems for GPs and an examination of the current Medicare system.

The framework proposes that out-of-pocket costs are heavily influenced by GP income aspirations. In turn, the extent to which GPs are able to reach their target incomes are a function of Commonwealth Medicare rebates for GPs, system administrative and regulatory constraints to restrain GP fees, the supply of GPs, and practice costs. Out-of-pocket costs to consumers are also influenced by the impact they have on consumer utilisation of services.

The following sections examine each of these parameters of the framework in turn.

Commonwealth expenditure on GPs

Commonwealth expenditure on Full Time Equivalent (FTE) GPs as a percentage of annual Average Weekly Ordinary Time Earnings (AWOTE)¹ increased from the inception of Medicare in 1984/85 until 1992 and then progressively declined until 1997/98. In 1992/93 Commonwealth expenditure on GPs was about 5.2 times AWOTE or about \$160,000 p.a. in nominal dollars. Subsequently, this ratio fell to 4.7 times AWOTE in 2002/03². On this basis in our estimation, Commonwealth expenditure on GPs in 2002–2003 was about \$219,400

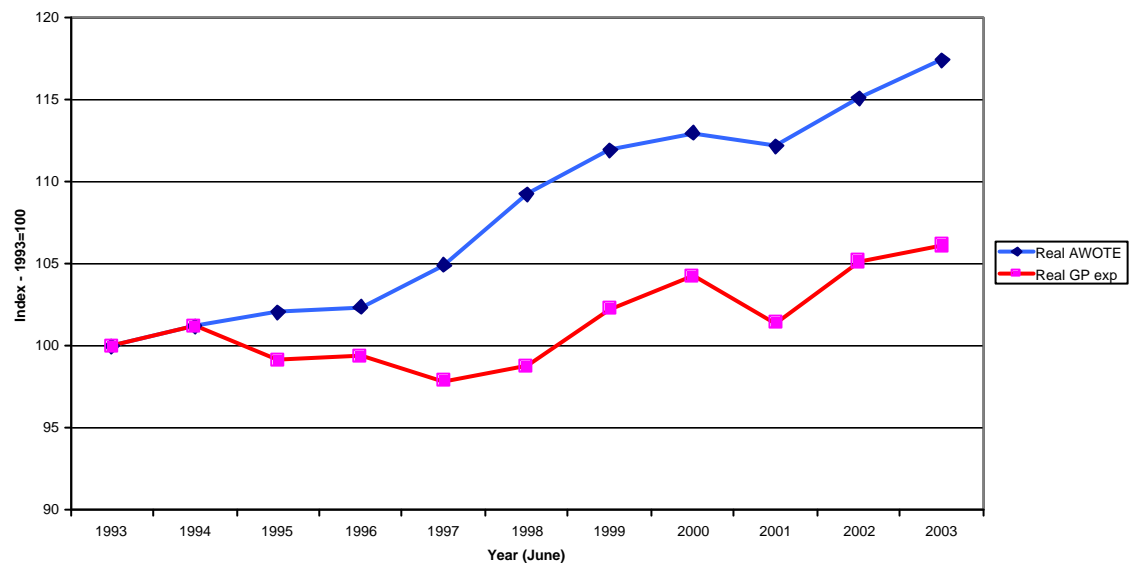
¹ Australian Bureau of Statistics (ABS), Catalogue No 6302.0, May 2003 (released 14/8/03)

² Submission of the Commonwealth Dept of Health and Ageing (CDHA) to Select Committee on Medicare, 2003, p.20

p.a., which is consistent with Commonwealth estimates of about \$220,000 expenditure per annum per FTE GP in 2002.³

Chart 1 compares indices of real (i.e., adjusted for inflation via the Consumer Price Index⁴) Commonwealth expenditure on GPs with real changes in AWOTE. From 1993 to 2003 AWOTE had increased by 10.6% more than Commonwealth expenditure on GPs. Thus, although real expenditure on GPs by the Commonwealth increased over this period, real AWOTE increased by a somewhat greater amount.

Chart 1: Indices of real AWOTE, and C'wealth expenditure on GPs - June 1993 to June 2003



We note that GPs are able to charge patients amounts in excess of the rebate income provided under Medicare, and income derived from these payments is not incorporated in Chart 1. We also note that GPs receive non-fee payments from the Commonwealth, which in 2002 amounted about to an additional 10% approximately of rebate income, or about 9% of total payments by the Commonwealth to GPs.

In this report, we have utilised the relationship between AWOTE and payments by the Commonwealth to GPs to assess the extent to which GPs may perceive that their base incomes have fallen in comparison to those of the more general community. This is a critical assumption in our model. We believe it to be conservative; that is, alternative assumptions would be that GP income relativity expectations may be related to groups whose income has increased faster than AWOTE. The comparative decline in payments by the Commonwealth has some relationship to the extent to which GPs may attempt to recover perceived relative income decline by

³ Submission of CDHA, 2003, p.19

⁴ ABS, Catalogue No 6401.0, June 2003, Table 1a – weighted average 8 capital cities (released 23/7/03)

charging additional amounts to their patients where this is possible. These payments are known as out-of-pocket expenses or co-payments.

Practice costs

Trend data on practice costs for GPs could not be identified. Information on GP practice costs for 1999 are available from the Practice Cost Study conducted by Pricewaterhouse Coopers (2000) for the Medicare Schedule Review Board as part of the Relative Value Study. This study found that practice costs for a three-doctor GP practice were \$113,526 in 1999⁵.

The major categories that influence GP practice costs are salaries and wages of administrative and support staff, occupancy costs, office expenses, and motor vehicle expenses. These costs are likely to move broadly in line with the Consumer Price Index (CPI).

Bulk-billing trends

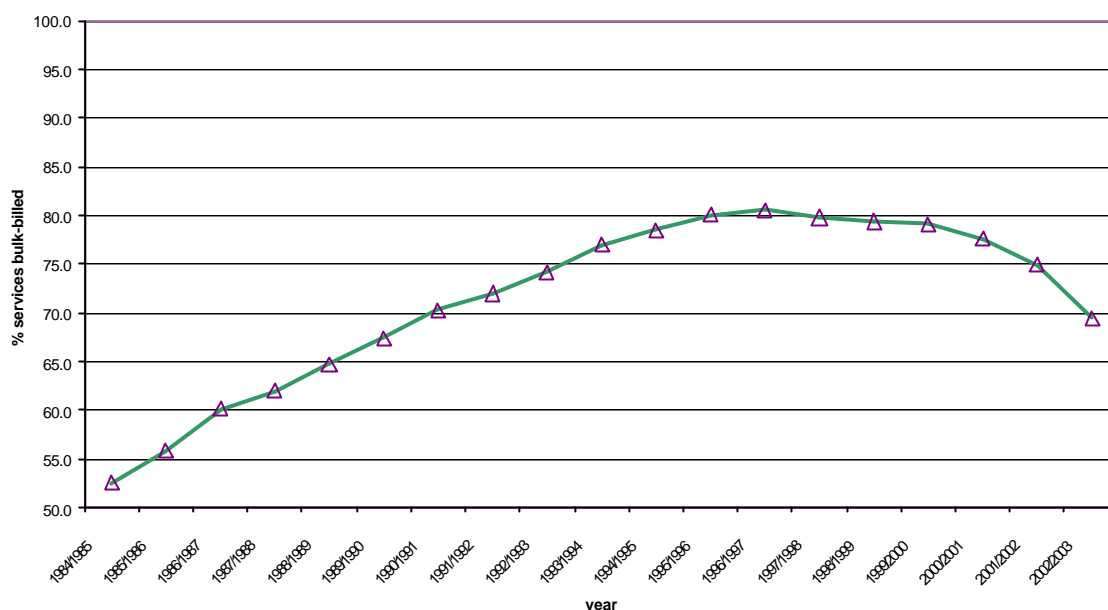
Trend data indicate that overall bulk billing increased steadily from the introduction of Medicare in 1984/85 to approximately 70% in the mid-1990s. Bulk-billing rates for GP services have generally been about 10% higher than the overall bulk-billing rates over the last decade, reaching a plateau of about 80% in the mid-1990s. Bulk-billing rates have declined significantly since 2000. Average GP bulk billing fell to 68% by March 2003.

Chart 2 describes the trend in overall bulk-billing rates from 1984/85 to 2002/03.⁶

⁵ Pricewaterhouse Coopers, Medicare Schedule review Board, "A resource-based model of private medical practice in Australia – final report: Volume 1" (2000), p20

⁶ Source: MEDICARE STATISTICS <http://www.health.gov.au/haf/medstats/index.htm>

Chart 2: Proportion of GP services bulk-billed - 1984-5 to 2002-3



There are significant variations in GP bulk-billing rates across geographic settings.

In 2002/03 (to the December quarter) we calculate that in metropolitan city settings (RRMA 1) 76% of GP services were bulk billed. In other metropolitan settings (RRMA 2) the bulk-billing rate was 68.2%. In rural (RRMA 3 & 4) and remote rural settings (RRMA 5 to 7) bulk-billing rates were 54% and 55% respectively.⁷ We also note that the DHA submission to the Senate Select Committee on Medicare advised that bulk-billing rates for the above categories were (for the 2002 year) 77.9%, 69.8%, 56.6% and 56.4% respectively.⁸ The Opposition package incorporates estimates that bulk-billing rates were 75%, 65-75%, 60-70% and 55% respectively.⁹

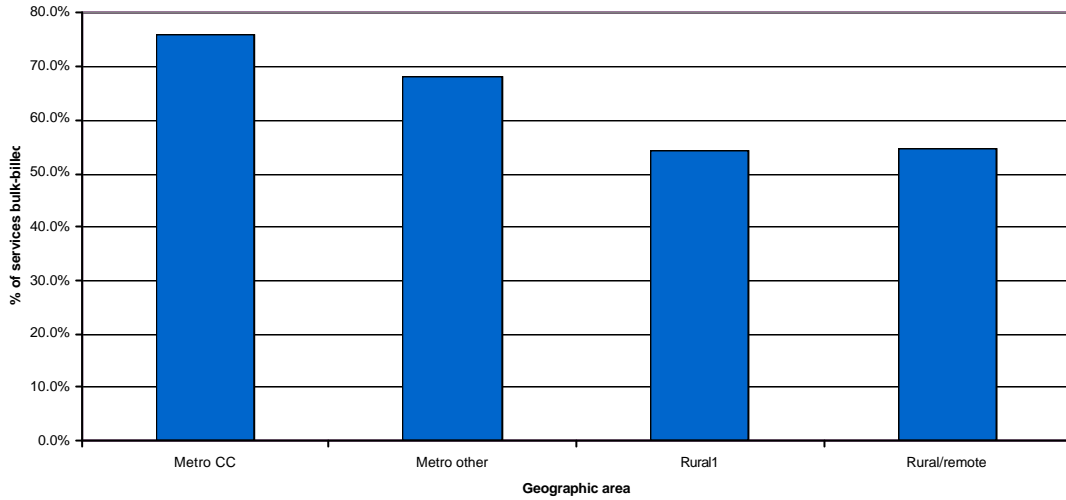
⁷ Sources: Senate Community Affairs legislation Committee - Answers to Estimates Questions on Notice - Health & Ageing Portfolio, Question E03-189 - Senator McLucas - part (a) 'Bulk-billing rates for unreferred services by RRMA

E. Savage & G. Jones, "An analysis of the proposed General Practice Access Scheme on GP salaries, bulk billing and consumer co-payments." CHERE, UTS, 2003, Table 2. We have calculated weighted mean values for bulk-billing rates for RRMA 3 & 4 and RRMA 5, 6 & 7, based on the incidence of services provided within those discrete areas.

⁸ Submission of CDHA, 2003, p.26

⁹ Opposition Medicare package, Fact Sheet2, www.alp.org.au, accessed 13/8/03

Chart 3: Current bulk-billing rates - geographic areas
Source: Answer to q. E03-189

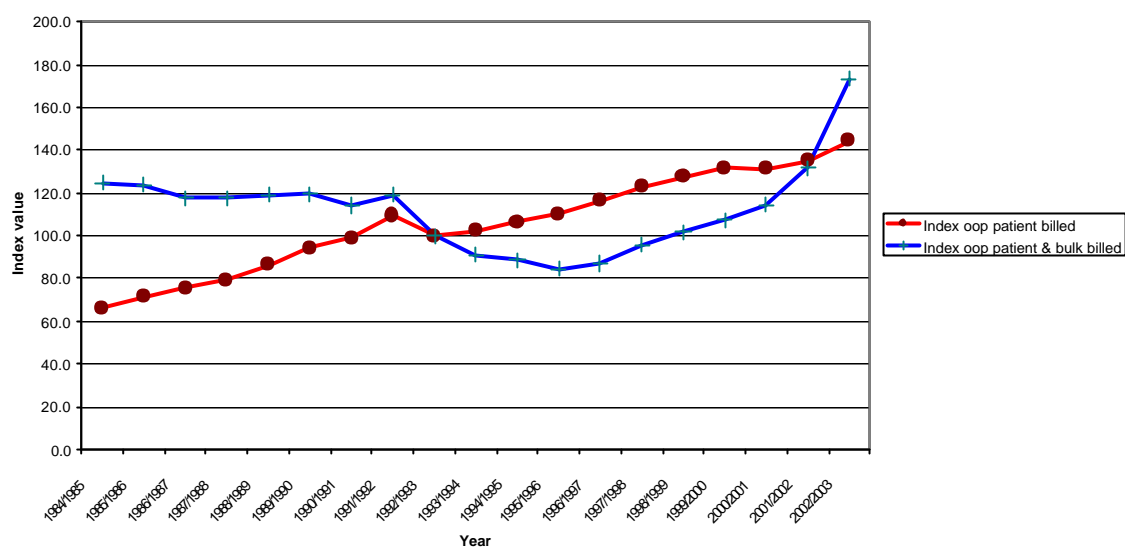


Out-of-pocket costs

Out-of-pocket payments for GP patients increased overall between 1984–1985 and 2002–2003. In the case of patient-billed services only, average patient contributions have risen from \$6.90 to \$12.91, an increase in real terms of about 44.7%. In the case of all services, (i.e., patient and bulk-billed services) average patient contributions have risen from \$1.74 to \$3.90, an increase in real terms of about 73.3%.

Chart 4 sets out indices of average out-of-pocket costs for patient-billed services only and patient- and bulk-billed services. It will, however, be noted that average out-of-pocket costs for patient-billed services only have increased generally in real terms over the period 1984–1985 to 2002–2003,

Chart 4: Indices of out of pocket costs - average oop costs for patient & bulk billed and patient billed only GP services - 1984-5 to 2002-3 - Jun 1993 = 100



whereas average out-of-pocket costs for patient- and bulk-billed services generally declined over the period 1984–1985 to 1996–1997 but then increased markedly over the period 1996–1997 to 2002–2003.

GP supply

The supply of GPs per capita generally increased from the inception of Medicare to about 1996. There has been a commensurate increase in the number of Medicare services per capita over the same period.

Since 1996 there are indications that the availability of GP services per capita has declined.

This trend is partially explained by the ageing of the GP workforce and an increasing proportion of female GPs, which has resulted in fewer hours being provided per GP.

Policy initiatives have also decreased the availability of GPs. These included capping the number of medical school places, reductions in access for overseas trained GPs, and the requirement that GPs undertake training to become vocationally registered for GP Medicare rebates. This latter requirement appears to be of considerable significance, given that since the high point of total GP services per annum (1996–1997) total GP services have declined by an amount almost entirely accounted for by the reduction in ‘other’ attendances.¹⁰

There is considerable variation in the supply of GPs across geographic settings. Overall there were about 85 Full-time Workload Equivalent GPs

¹⁰ Source: MEDICARE STATISTICS <http://www.health.gov.au/haf/medstats/index.htm>

per 100,000 population in 2001/02. However, there were generally fewer than 80 GPs per 100,000 in rural settings and in remote settings this were fewer than 60 GPs per 100,000. On the other hand in capital city areas there were over 90 GPs per 100,000 people.¹¹

Price elasticity and out-of-pocket charges

Increased out-of-pocket costs may reduce utilisation of GP services and thereby constrain prices. However, the available literature on the impact of prices on demand for GP services (price elasticity) suggests that the effect of price on demand for services will be marginal when potential GP responses are taken into account.

In a comprehensive review of the effect of consumer co-payments on medical care Richardson suggested that a 30% to 50% increase in the proportion of the total medical fee paid by Australian Medicare patients would probably reduce service use by 5% to 10%. Similarly, Van Vliet calculated a co-payment elasticity of -0.085 for general practitioner visits in the Netherlands. Thus, as Savage notes, the fall in demand resulting from increased co-payments is likely “to be relatively small”.¹²

Richardson also notes that out-of-pocket charges to patients have differential effects depending on patient incomes. People on lower incomes (and possibly those who have the greatest health needs) are more likely to reduce their use of GPs for both necessary and unnecessary services.¹³

¹¹ Submission of CDHA, 2003, p.17

¹² J. Richardson, *The effects of Consumer Co-payments in Medical Care*, 1991, Background Paper No 5, National Health Strategy; R. Van Vliet, 'Effects of price and deductibles on medical care demand estimated from survey data', 2001, in *Applied Economics* 33, cited in Savage & Jones, 2003; Savage & Jones, 2003, p.12

¹³ Richardson, 1991

Impact on GP incomes

This section discusses how the factors that have been reviewed above together are likely to influence the target incomes GPs set for themselves. GP incomes from patient services are a function of Commonwealth rebates plus non-fee based payments derived from the Commonwealth (including the Practice Improvement Program and others), plus patient out-of-pocket payments, less practice costs. Currently the Commonwealth has significant control over GP incomes through its capacity to set the CMBS fees, the rebate levels and the administrative rules that apply to payments. However, GPs and other medical practitioners are able to exert control over incomes by increasing either the fees they charge patients or by increasing the volume of services provided or both.

GP patients can claim 85% of the Commonwealth Medicare Benefits Schedule (CMBS) for services they receive. Currently the CMBS fee for a standard GP consultation is \$29.45 with a rebate of \$25.05. When bulk billed the patient assigns the \$25.05 rebate to the GP and the Commonwealth makes direct payment of this amount to the GP. The patient is not issued a bill, does not make an out-of-pocket payment and therefore does not claim a rebate.

On the other hand, if the GP charges any out-of-pocket costs to the patient a bill for at least \$29.45 plus the out-of-pocket charge must be issued. The patient then generally pays the GP the full amount of the bill and claims the \$25.05 rebate from Medicare. There is therefore a significant threshold effect in the price difference between the free bulk-billing service and any service which attracts out-of-pocket charges, even when the actual out-of-pocket charge may be small. In circumstances where there is a relative oversupply of GPs and patients have real choice of practitioner the current Medicare administrative arrangements provide a considerable incentive for GPs to bulk bill patients. It is important to note that there a threshold effect operates for GPs administratively in choosing not to bulk bill patients, as well as for patients who must meet transaction costs associated with paying a bill and reclaiming a rebate.

The current geographic variation in bulk-billing rates appears to reflect variations in the supply of general practitioners. As noted above, where there is a relatively high availability of GP services per capita in metropolitan capital city areas, the best available estimate of current bulk-billing rates is approximately 76%. Where there is a relatively more limited availability in rural and remote areas (RRMA 3 to 7), bulk-billing rates are around 55%.

From the inception of Medicare in 1984/85 until 1992/93 there was an overall increase in Commonwealth expenditure on GPs relative to average weekly earnings. Over the same period there was also an overall increase in the supply of GP services and an increase in per capita utilisation of GP services. Subsequently, Commonwealth expenditure per FTE GP has fallen relative to increases in average weekly earnings. This fall has been

most pronounced from 1996/97 to 1998/99. Assuming that costs have continued to increase at CPI then it is likely that GPs have experienced a net income loss relative to movements in average weekly earnings as defined by AWOTE over this period.

It would be anticipated that GPs will seek to maintain or if possible restore their perceived relative income position by increasing the proportion of their earnings derived from out-of-pocket charges made to patients, and any incentive payments associated with billing practices. The comparative decline in bulk-billing rates in the past three years suggests that this strategy is becoming more widespread across GP practices.

The current Medicare administrative provisions set a significant pricing threshold which makes the application of out-of-pocket charges more difficult in circumstances where patients have relatively good choice of GP, as occurs in relatively well supplied metropolitan city areas. However, reductions in GP availability suggests that GPs are now in a stronger position to reduce bulk-billing levels and introduce out-of-pocket charges to patients in metropolitan areas, as the availability of GP services per capita has begun to reduce, while demand for services has increased or remained stable.

Estimating GP target income

We note that there are essentially two approaches to estimating the level at which GPs (or others) will seek to set incomes. The first is income maximisation. The second is income target setting. McGuire and Pauly (1991) “show that target income behaviour and profit (or income) maximisation lie at opposite ends of a spectrum of income effects”.¹⁴ Target setting is essentially a conservative option for modelling, and we have chosen this option for this reason.

There is no definitive method for predicting the target income that GPs will seek to achieve. The actions they take are likely to be a function of the options available to them. However, the trend data indicate that bulk-billing rates were relatively stable when Commonwealth expenditure per FTE GP was around 5.2 times average weekly earnings. Over time, as the value of FTE GP Commonwealth expenditure has declined as a proportion of AWOTE, bulk-billing rates have declined and out-of-pocket costs have increased. Current GP behaviour could be interpreted as attempting to restore past relativities.

Maintaining relativity with AWOTE is also a conservative approach to estimating GP target incomes. It is important to note that estimation of target incomes is likely to be based largely on the perceptions by GPs of movements in relativities, rather than particular calculations. Further, it is,

¹⁴ McGuire, T. “Physician Agency” (2000) in A. Culyer & J Newhouse (eds) *Handbook of Health Economics Vol 1*.

very likely that GPs will be more influenced by perceived movements in relativities with specialist medical practitioner incomes. However, trend data on specialist incomes were not available within the constraints of this analysis.

In this section, current GP incomes are estimated and compared with those that would be required to restore these incomes from the current level of 470% of AWOTE to the level of 520%, which applied in 1992/93. Arguably, all other things being equal, if this relativity were restored, pressure to reduce bulk-billing rates and to increase out-of-pocket charges would be relaxed.

The following parameters were combined in Table 2 to provide estimated average incomes for FTE GPs across four geographic settings:

- The average rebate for all GP Medicare services in 2002/03 of \$28.57.
- The average out-of-pocket payment for non-bulk-billed GP services for 2002/03 of \$12.91.
- Practice costs for a three-doctor GP practice, inflated by CPI to produce an estimated practice cost of \$130,676 for 2002/03.
- Variations in bulk-billing rates across metropolitan city, outer metropolitan, rural and remote rural settings were included.
- Commonwealth estimates that the average FTE GP performs 7,000 services per year.¹⁵

Table 2: Estimates of average baseline GP income

Region	% bulk billed	bulk billed services N	non-bulk billed services N	Est non bulk billed income	Est bulk billed income	Est total fee income	Est net income
Metro CC	76.0%	5,320	1,680	69,686	151,991	221,676	91,000
Metro other	68.2%	4,774	2,226	92,334	136,391	228,725	98,049
Rural	54.4%	3,808	3,192	132,403	108,793	241,196	110,520
Rural/remote	54.7%	3,829	3,171	131,532	109,393	240,925	110,249

Estimated net FTE GP incomes from rebates and out-of-pocket charges ranged from \$91,000 in metropolitan city areas to \$110,249 in remote rural settings. Differences across geographic settings are attributable to variations in bulk-billing rates.

We note that non-volume related payments by the Commonwealth are additional to the income estimates set out in Table 1. However, as have already noted, CDHA estimates that Commonwealth payments to GPs

¹⁵ Submission of CDHA, 2003, p.19

were approximately \$220,000 per GP per annum in 2002,¹⁶ including non-volume related payments, a total amount closely approximated by our calculations based on relativities with AWOTE (see above).

We have taken the view that GPs are likely to seek to increase that part of their income over which they exercise most control (i.e., via adjustment of fees charged and/or volume of services provided). We have assumed that CDHA estimates of average GP volume (i.e., 7,000 services per FTE GP per annum) will not change. We have thus assumed that GPs will seek to optimise income via adjustment of fees charged and the incidence of bulk billing in order to increase current income levels by about 10.6%, being the increase required to achieve a target of perceived restored relativity with AWOTE.

We also note that changes to policy settings provide incentives to GPs to modify their billing and other practice behaviour, and we expect that most if not all GPs will respond to these changes. Estimates of current FTE GP incomes and target incomes are presented in Table 3.

Table 3: Estimates of current FTE GP incomes and FTE GP target incomes

Region	Est gross fee income	Est net fee income	Est gross target income	Est net target income
Metro CC	221,676	91,000	245,174	114,498
Metro other	228,725	98,049	252,970	122,294
Rural	241,196	110,520	266,763	136,087
Rural/remote	240,925	110,249	266,463	135,787

Estimating health card service utilisation

The Government's proposals limit increased CMBS rebates for bulk billing to patients who hold a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Card. It is therefore necessary to estimate the proportion of services these concessional patients will use.

Data from the ABS National Health Survey were used for this purpose. While concessional patients are about 35% of the population they utilise GP services at about 1.43 times average service use, equivalent to about 50% of all GP services.¹⁷ We have further confirmed these estimates by comparison with estimates by the Commonwealth in the "A Fairer Medicare" package of the implied average incidence of service usage by

¹⁶ Submission of CDHA, 2003, p.19

¹⁷ ABS, National Health Survey Catalogue No 4364.1, 2001, Table 26; we were also able to access NHS data on CD-ROM provided by ABS and this analysis confirmed the incidence ratio for HC holders of ~1.43 times the average service incidence

HC holders¹⁸ and by comparison with similar estimates set out in the CDHA submission.¹⁹

The proportion of concessional patients also varies geographically. Table 4 presents the incidence of concessional patients for metropolitan city, regional, and outer regional and remote settings. We note that the geographic categories utilised for reporting data from the Australian Health Survey are distinct from those utilised by other data sources we have drawn upon for this report. We have resolved this by utilising the incidence of HC holders for major cities of Australia (31.7%) in modelling GP incomes for both the ‘Metro Capital City’ and ‘Metro other’ categories. Similarly, we have utilised the incidence reported for Inner Regional Australia (41.8%) in the category of ‘Rural’ and the incidence reported for Outer regional and remote Australia (34.8%) in the category of ‘Remote’.

Table 4: Incidence of Concessional Health Card holders by geographic area

	HC Card	Proportion of GP services used	Current bulk-billing rates
	%	%	%
Major Cities of Australia	31.7%	45.3%	72.3%
Inner Regional Australia	41.8%	59.8%	54.4%
Outer regional and remote Australia	40.1%	57.4%	54.7%
Total	34.8%	49.7%	70.0%

It is worth noting that the current levels of bulk billing which are included in the final column of Table 3 above are close to the estimated levels of service use by concessional patients in rural and remote rural areas, where GPs are in comparative under supply and have considerable scope to levy out-of-pocket charges on their patients.

In areas where there is comparatively greater supply of GP services, bulk-billing rates rise because patients are likely to choose GPs who bulk bill and GPs need to compete for patients in order to maintain their incomes. Again the threshold effect associated with the administrative requirements for charging out-of-pocket costs are also likely to provide an incentive for bulk billing.

¹⁸ *A Fairer Medicare Questions & Answers* – www.health.gov.au/fairermedicare accessed 23/7/03, p.5

¹⁹ Submission of CDHA, 2003, p.36

MODELLING THE GOVERNMENT'S PROPOSALS

This section presents an analysis of the potential inflationary impact, if any, on health care costs for consumers of the Government's 'A Fairer Medicare' proposals. Medicare data for 2002/03 were used for the analysis. Both the Government's estimated average concessional patient rate of 50% and the regional estimates for concessional patients derived from our analysis of the National Health Survey were used in the analysis. The parameters of the Government's proposals described earlier in this report were applied.

The modelling assumes that GPs will seek to increase their incomes to the level that would apply if Commonwealth expenditure on FTE GP incomes were 520% of AWOTE. A uniform increase of 10.6% is applied to current estimated FTE GP incomes to model this effect.

Three scenarios are modelled:

- bulk-billing rates and out-of-pocket charges are assumed to remain at their current levels;
- bulk-billing rates are assumed to fall so that only concessional patients are bulk billed and out-of-pocket charges remain at their current level;
- bulk-billing rates are assumed to fall so that only concessional patients are bulk billed and out-of-pocket charges are altered to ensure that the GP income target is met.

In each of the scenarios, additional rebate income for bulk billing concessional patients of \$1 for metropolitan city practices, \$2.95 for non-metropolitan city practices, \$5.30 in rural centre practices and \$6.30 for remote rural practices were applied. It is further assumed that each FTE GP performs 7,000 services per annum.

Scenario 1: Current bulk-billing levels

In scenario 1, the current bulk-billing rates and out-of-pocket charges have been modelled using the Government's proposals to examine their likely impact on FTE GP incomes. We believe that this scenario is most likely to be representative of the initial period following the introduction of the Government's package, noting that GPs are likely to introduce any changes cautiously, particularly in regions of comparatively high GP supply.

It is of course quite possible that GPs who agree to participate in the GP Access Scheme will implement significant changes to their billing practices immediately after they commence their participation in the scheme. However, it is also likely that a number of GPs will retain current

practice until they are able to ascertain the impact that the reforms will have on their practice and income patterns. Thus, this scenario provides insight into the impacts on GP FTE fee income of participating in the package.

It is also important to note that the Government’s costings include the assumption that an average of approximately 3,500 HC services per annum will be provided by an FTE GP. However, we note that GPs wishing to access the Government’s incentive payments will be required to bulk bill all HC holders and in rural and rural/remote areas, this is likely to require a slight increase in bulk-billing rates (requiring an average increase in the number of bulk-billed patients of between three and six percentage points), which we have incorporated into our estimation on the assumption that GPs will seek to marginally adjust their current billing practice to obtain access to incentive payments. Thus, in our estimation, GPs in these geographic areas would receive no bulk-billing income from non-concessionary patients, but would be able to access the ‘soft threshold’ of direct billing and charging a co-payment to non-concessional patients.

Table 5 presents the estimated income levels for FTE GPs in each of the four geographic settings included in the analysis. The first column presents GP incomes derived using the government’s overall estimate that 50% of services will be incurred by concessional patients. The second column presents GP incomes estimated using the regional variations in concessional patients derived from the National Health Survey. The third column presents gross GP target incomes used for the analysis. The fourth column presents current estimated practice costs. The fifth and sixth column set out the net estimated FTE GP incomes based on average HC usage and regional variations in concessional patients, respectively. The final column presents assumed net GP target incomes..

Table 5: Model of Scenario 1 for Government package

Region	EFT GP gross fee income - Govt estimate	EFT GP gross fee income - LTU estimate	EFT GP estim'd gross fee income target	Practice costs	EFT GP net fee income - Govt estimate	EFT GP net fee income - LTU estimate	EFT GP estim'd net fee income target
Metro CC	225,176	224,849	245,174	130,676	94,500	94,173	114,498
Metro other	238,975	238,086	252,970	130,676	108,299	107,410	122,294
Rural1	259,696	258,516	266,763	130,676	129,020	127,840	136,087
Rural/remote	262,975	263,825	266,463	130,676	132,299	133,149	135,787

Table 5 indicates that there is only slight difference in the use of the Government’s estimate and the regional variations in concessional patients.

For this scenario, FTE GP incomes for rural/remote settings come close to reaching the target income as a result of the higher rebate levels for concessional patients. However, target income levels for FTE GPs

practicing in metropolitan city, other metropolitan, and rural settings are not achieved. This suggests that additional revenue to meet income targets would have to be derived from patient out-of-pocket charges in these areas if the assumed income targets were to be met. This would require individual out-of-pocket rates to increase and/or bulk-billing rates to decline.

Scenario 2: bulk billing concessional patients only

In scenario 2, it is assumed that only concessional patients are bulk billed. Out-of-pocket charges remain at current levels. The Government's proposed payments for concessional patients have been modelled with these parameters to examine the likely impact on FTE GP incomes. We note that this scenario represents a possible response to the requirement of the Government package that all concessional patients be bulk-billed in order for GPs to access increased rebates and the soft threshold of direct billing and charging co-payments to non-concessional patients. This scenario is one adjustment that is available to GPs wishing to assess the impact of the new system on service and income profile, and is modelled in order to assess the impact that partial change of this nature would have on income. It should be noted that the elasticity effect of introducing co-payments will in our view be minor as the soft threshold introduced via the Government's package substantially reduces the 'up-front' cost to patients, and thus minimises the price effect as compared to the hard threshold currently operating. As in scenario 1, above, we estimate that this scenario will require increases on average of the number of patients bulk billed in rural and rural/remote areas of between three and six percentage points, whereas Government estimates are that concessional patients account for around half total services.

Table 6 presents the estimated income levels for FTE GPs in each of the four geographic settings included in the analysis. The columns in Table 6 provide information as set out in Tables 4 and 5.

In this scenario, FTE GP income levels are exceeded for metropolitan areas, and in the Government's estimate for rural/remote. The additional income derived from reducing bulk billing to concessional cardholders only is sufficient to meet income targets.

Table 6: Model of Scenario 2 for Government package

Region	EFT GP gross fee income - Govt estimate	EFT GP gross fee income - LTU estimate	EFT GP estim'd gross fee income target	Practice costs	EFT GP net fee income - Govt estimate	EFT GP net fee income - LTU estimate	EFT GP estim'd net fee income target
Metro CC	248,673	252,565	245,174	130,676	117,997	121,889	114,498
Metro other	255,751	258,753	252,970	130,676	125,075	128,077	122,294
Rural1	263,794	258,516	266,763	130,676	133,118	127,840	136,087
Rural/remote	267,223	263,825	266,463	130,676	136,547	133,149	135,787

Scenario 3: Potential inflationary impact

This scenario models what we believe would be the most likely outcome for the government's proposals if income targets are to be met. In this scenario, concessional patients are bulk billed (necessitating, as above, a modest increase in bulk-billing rates in non-metropolitan areas, but a likely substantial fall in metropolitan areas), and non-concessional patients charged a co-payment. However, the co-payment is adjusted to achieve the income targets we have estimated for FTE GPs in each region. In metropolitan areas, the incidence of the co-payment would rise although the average co-payment for individuals would decline.

As previously noted, the Government's package requires that all concessional patients are bulk billed for GPs to be eligible for enhanced concessional rebate levels. When practices agree to participate in the new arrangements they will also be to charge out-of-pocket payments direct to non-concessional patients, and claim the rebate electronically from the Health Insurance Commission. This removes the hard threshold effect for charging out-of-pocket costs under the current Medicare rules and would, for example, reduce the current perceived average fee when out-of-pocket costs are incurred from \$41.48 to \$12.91.

The incentive provided by the removal of the hard threshold will be to render highly marginal the demand response to actual increases in co-payments, as patients would be able to pay a much more modest up-front fee and avoid the transaction costs associated with claiming a rebate from Medicare. We are unable to cost these transaction costs within the constraints of this project, since they will vary significantly between individuals, with direct costs ranging from the price of a stamp and stationery to the costs associated with attending a Medicare office, and personal costs varying significantly between individuals depending upon their circumstances. However, the removal of the hard threshold is highly likely to induce an increased incidence of co-payments and a concomitant reduction in bulk-billing rates to the minimums required for access to the GP Access Scheme.

Of course, we also believe that some practices will continue to charge co-payments to all patients, or to bulk bill only some classes of HC holder, such as pensioners and veterans. Some practices may also bulk bill all patients. Nevertheless, the scenario presented here is a rational response to the incentives provided by the Government package, assuming a target income hypothesis, and provides GPs with an opportunity to achieve income targets with minor or no impact on service demand, particularly in rural and rural/remote areas where GP supply issues impact on service demand.

Under the proposed arrangements it is likely that most concessional patients will be bulk billed. At present, data provided by CDHA indicate that about a third of services provided to HC holders in non-metropolitan areas are not bulk billed, whereas between 13–22% of services provided to HC holders in metropolitan areas fall into this category.²⁰ However, the new rebate levels that apply for bulk billing concessional patients under the governments proposals will not provide sufficient revenue to reach the FTE GP income targets assumed for the modelling conducted in this analysis. Instead, additional aggregate out-of-pocket charges would be required to meet income targets.

In principle, a range of distributions for out-of-pocket costs is possible. However, for administrative convenience it is likely that GP practices would determine the concessional status of the their patients and levy a standard out-of-pocket charge to all non-concessional patients in order to achieve their income target. Other arrangements, such as levying differential charges on the basis of non-concessional patient income, would introduce additional transaction costs which GPs are likely to avoid. Table 7 presents the results of this modelling.

Table 7: Most likely scenario – Government package

Region	EFT GP gross fee income - BB HC only	% BB	EFT GP gross fee income - non BB income	Total income (=target income)	Average OOP fee req'd to meet target
Metro CC	93,830	45.3%	151,344	245,174	10.98
Metro other	100,017	45.3%	152,953	252,970	11.40
Rural1	141,717	59.8%	125,046	266,763	15.84
Rural/remote	139,967	57.3%	126,496	266,463	13.79
Weighted mean	105,260	48.6%	145,872	251,132	11.99

Bulk-billing levels would, in this scenario, settle at the level of concessional patients. This would require modest average increases in bulk billing for rural and rural/remote areas, but significant reductions in metropolitan settings.

²⁰ Submission of CDHA, 2003, p.26

To meet income targets across settings, average out-of-pocket costs per service would need to be set at \$10.98 for metropolitan capital city practices, \$11.40 for other metropolitan practices, \$15.84 for rural practices, and \$13.79 in outer rural and remote areas. This would result in a reduction in the average out-of-pocket charge currently levied to non-bulk billed patients in metropolitan settings, but a probable increase in average out-of-pocket fees for rural and remote patients.

However, there would be a substantially increased incidence of out-of-pocket costs in metropolitan settings, leading to an overall increase in average out-of-pocket costs. Average out-of-pocket costs would increase by around 56% from \$3.94 to \$6.16. Under this scenario, average bulk-billing levels would fall to about 50%, from their current levels of around 70%. We note however that the incidence of bulk billing for concessionary patients in non-metropolitan areas is likely to rise by between three and six percentage points, depending on locality.

MODELLING THE OPPOSITION'S PROPOSALS

This section presents an analysis of the potential inflationary impact, if any, on health care costs for consumers of the Opposition's proposals to reform Medicare. Medicare data for 2002/03 were used for the analysis. The parameters of the Oppositions proposals for increasing the rebate for bulk-billed patients and providing incentive payments to GPs who meet specified bulk-billing targets described earlier in this report were applied in scenarios modelled in this section. Both the transitional (95%) and final (100%) scheduled fee rebate levels specified in the Opposition's proposals are included in the analysis. The modelling incorporated regional variations in the level of concessional patients.

Scenario 1: Current bulk-billing rates and out-of-pocket charges

In the first scenario applied to the Opposition's proposals, bulk-billing rates and out-of-pocket costs were set at their current levels and the impact of the increased rebate levels (95% and 100% of the scheduled fee) on GP incomes in metropolitan city, non-metropolitan city, rural and outer rural and remote areas were modelled. As with the modelling of the Government's package, this scenario is utilised to provide a 'starting point' for the assessment of the impact of the package on GP fee incomes.

It is possible that GPs may simply maintain their existing service and fee profiles for some time until they have been able to assess the impact of the system, and this scenario is intended to model that situation. The results of our analysis are presented in table 8. We note that the opposition package also contains a series of incentive payments for achieving bulk-billing targets set at variable regionally determined levels. We recognize that in reality variations across practices would ensure that a proportion of practices would reach the proposed bulk-billing targets even when they are not reached on average. However, we did not obtain information on variations in bulk-billing levels across practices. In this scenario, therefore, these payments would not be paid because the targets would not be met. In effect, the scenario reflects only the impact of the Opposition's proposed rebate increases for bulk billing on GP incomes and therefore under estimates the overall effect on incomes.

Table 8: Model of scenario 1, Opposition package

Region	% BB	EFT GP gross fee income - 95% rebate*	EFT GP gross fee income - 100% rebate*	EFT GP estim'd gross fee income target	Practice costs	EFT GP net fee income - 95% rebate	EFT GP net fee income - 100% rebate	EFT GP estim'd net fee income target
Metro CC	76.0%	239,558	248,498	245,174	130,676	108,882	117,822	114,498
Metro other	68.2%	244,771	252,794	252,970	130,676	114,095	122,118	122,294
Rural1	54.4%	253,995	260,395	266,763	130,676	123,319	129,719	136,087
Rural/remote	54.7%	253,795	260,230	266,463	130,676	123,119	129,554	135,787

Note: * includes incentive payments (if applic)

This scenario indicates that the Opposition’s proposed increased rebates for bulk-billed patients approximately meets or exceeds FTE GP income targets for metropolitan practices, but not remote or rural practices at 100% of the scheduled fee. Income targets are not met at 95% of the scheduled fee.

Scenario 2: Bulk bill concessional patients only

In this scenario, bulk-billing rates are assumed to fall to the level of concessional patients only. Out-of-pocket charges are set at their current average level and the impact on GP incomes for metropolitan city, non-metropolitan city, rural and outer rural and remote areas were modelled for the proposed increased rebate levels for bulk-billed patients (95% and 100% of the scheduled fee). This scenario is included in order to assess the impact of a radical alteration of service and fee profiles on GP incomes, and in order to provide a comparison with the equivalent scenario modelled for the Government package. The results of our analysis are presented in table 9.

Table 9: Model of scenario 2, Opposition package

Region	% BB	EFT GP gross fee income - 95% rebate*	EFT GP gross fee income - 100% rebate*	EFT GP estim'd gross fee income target	Practice costs	EFT GP net fee income - 95% rebate	EFT GP net fee income - 100% rebate	EFT GP estim'd net fee income target
Metro CC	31.7%	260,057	265,390	245,174	130,676	129,381	134,714	114,498
Metro other	31.7%	260,057	265,390	252,970	130,676	129,381	134,714	122,294
Rural1	41.8%	250,403	257,435	266,763	130,676	119,727	126,759	136,087
Rural/remote	40.1%	252,028	258,774	266,463	130,676	121,352	128,098	135,787

Note: * includes incentive payments (if applic)

In this scenario, FTE GP income targets are exceeded for metropolitan city, non-metropolitan city and rural areas for both the 95% and the 100% rebate levels. However, income targets are not reached for rural and rural/remote areas.

Comparison of scenario 1 and 2 indicates that in the absence of incentive payments, increased rebates for bulk billing are insufficient in non-metropolitan areas to offset the potential income gain from reductions in bulk billing at current levels of out-of-pocket charges. However, the Opposition proposal does not relax the administrative threshold to out-of-pocket charges that currently applies. Consequently, it is unlikely that bulk-billing rates in metropolitan areas would in fact fall to concessional patient levels only.

Scenario 3: Incentive targets achieved

In this scenario the combined impact of the Opposition’s proposed rebate increases and incentive payments for achieving bulk-billing targets on FTE GP incomes is modelled. The scenario assumes that all bulk-billing targets proposed by the Opposition are met. Rebate effects for both the 95% and 100% CMBS rebate levels are modelled. Out-of-pocket charges are set at current levels, but because bulk-billing targets would be met under this scenario, achieving an overall bulk-billing rate of about 77%, the incidence of these is reduced, and thus average co-payments decline from about \$3.95 to about \$2.95. Under this scenario, it appears almost certain that the majority of concessional patients would be bulk billed. The results of our analysis are modelled for metropolitan city, non-metropolitan city, rural and remote rural area. Table 10 presents the outcomes for this scenario.

Table 10: Most likely scenario, Opposition package

Region	% BB	EFT GP gross fee income - 95% rebate*	EFT GP gross fee income - 100% rebate*	EFT GP estim'd gross fee income target	Practic e costs	EFT GP net fee income - 95% rebate	EFT GP net fee income - 100% rebate	EFT GP estim'd net fee income target
Metro CC	80.0%	244,384	253,795	245,174	130,676	113,708	123,119	114,498
Metro other	75.0%	255,226	264,049	252,970	130,676	124,550	133,373	122,294
Rural1	70.0%	266,068	274,303	266,763	130,676	135,392	143,627	136,087
Rural/remote	70.0%	266,068	274,303	266,463	130,676	135,392	143,627	135,787

Note: * includes incentive payments (if applic)

FTE GP income targets are met (to within \$1000) or exceeded across all geographic settings. However, when compared to scenario 2, the combined impact of incentives and rebates on FTE GP metro incomes is less than would be achieved if GPs reduced their bulk billing to concessional patients.

However, the effects of GP supply issues in metropolitan areas, combined with the maintenance of the hard threshold are likely to mitigate against either increases in out-of-pocket fees or reduced rates of bulk billing.

We also note that the staged introduction of increased rebates for bulk-billed patients (the 100% rebate level commences in 2006–2007) provides

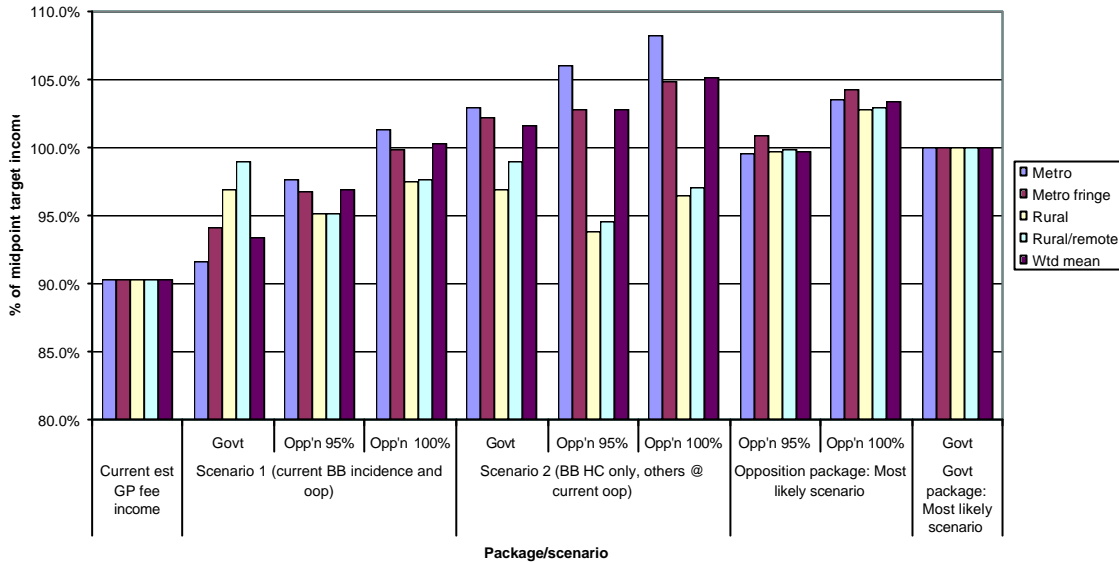
an offset to increased practice costs over the period of the package's implementation, offering GPs the prospect of increases in the range of \$10,000 within a three-year period.

We believe that the approach set out in this scenario represents a rational response to the Opposition package and is likely to have the effect of decreasing the costs to individuals of accessing GP services at the same time as it increases GP incomes.

COMPARISON AND CONCLUSIONS

Chart 5 sets out a comparison of the relationship between GP target incomes and the packages modelled in the above section.

Chart 5: Comparison of scenarios and packages with target income



As noted above we are of the view that the most likely scenarios in response to the Government and Opposition packages are those that allow GPs to optimise their incomes to perceived target levels.

In summary, based on our modelling and relying on the assumptions we have set out in this report, the likely effects of the packages on consumers would be as set out below.

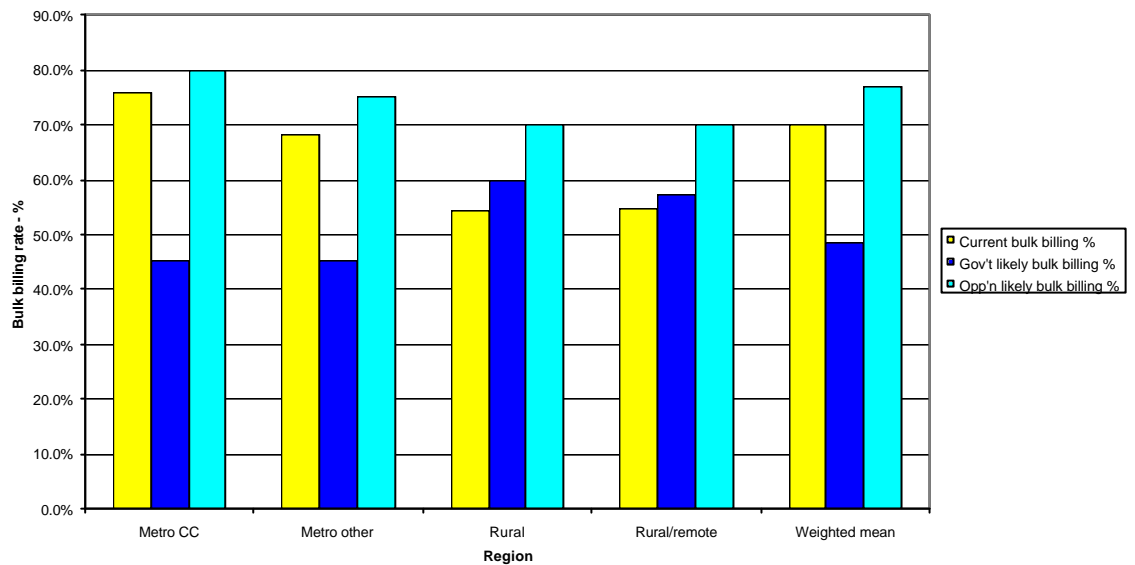
Government package:

- Reduction in average incidence of bulk-billing to the bulk-billing ‘floor’ of around 50% of services.
- Small increase in non-metropolitan bulk-billing rates of between three and six percentage points.
- Reduction in average co-payments for non bulk-billed services in metropolitan areas, but increases in non-metropolitan areas.
- Increase in average co-payments (across all services) of around 56%.
- Improved convenience for those presently not bulk billed, with possibility of lower actual out-of-pocket costs for this group.

Opposition package

- Some increase in the incidence of bulk billing to around 77% of services.
- No change to average co-payments for non bulk-billed services.
- Reduction in average co-payments (across all services) of around .25%.

Chart 6: Comparison of likely effects on bulk-billing of proposals



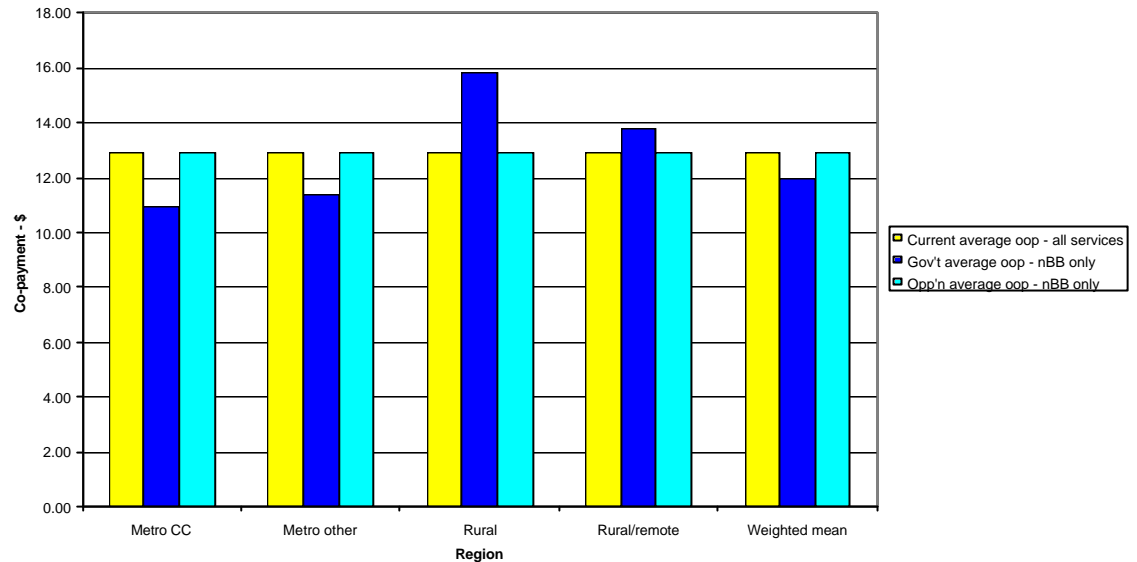
These points are also summarised in Charts 6, 7 and 8.

The 'target setting' scenario for the Government package would deliver 100% of targets but would also have the effect, facilitated by the removal of the hard threshold, of increasing the incidence of co-payments, even though average co-payments for those who are not bulk billed would be likely to decline in metropolitan settings. The increased incidence of such payments, however, would mean that average co-payments across all patients would increase by more than 55%, from around \$3.90 to around \$6.15 on average. However, it is also possible that some GPs will increase co-payments in order to maximise income, assisted by the removal of the hard threshold, which at present provides a substantial barrier to the implementation of co-payments. As we have already noted, the removal of this hard threshold is likely to substantially modify the patient's perceptions of actual costs incurred and will also reduce transaction costs by an unquantifiable amount. It will also enable a sensitive capacity for price discrimination between patients attending GPs, whether on a geographic or personal basis, and may lead to substantially variable out-of-pocket costs for those paying them between regions or localities.

We are of the view that overall bulk-billing rates are likely to decline to around 50% of services provided, even though it is likely that bulk-billing

rates in non-metropolitan areas will rise modestly (by between three and six percentage points). Under the Government’s package, it is likely that the majority of concession cardholders would be bulk billed.

Chart 7: Comparison of likely average co-payments (non bulk-billed services only) by region



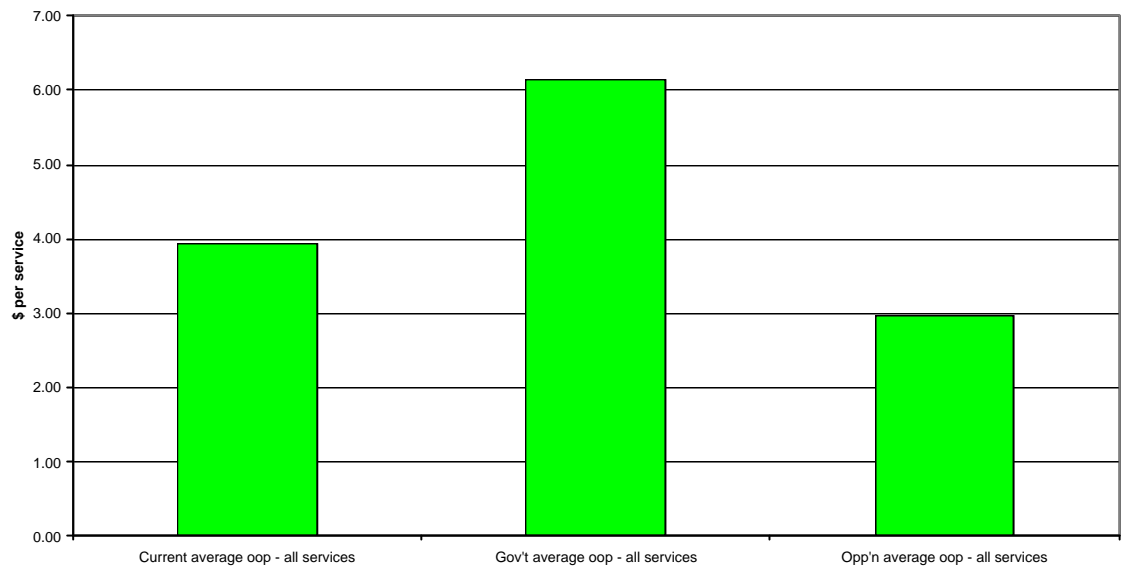
We note that the widespread adoption by GPs of the GP Access Scheme, and the associated availability of direct billing for non-bulk-billed patients, would also permit substantial savings to be made in administrative costs for Medicare, as Richardson has noted in another context²¹. It would theoretically be possible to substantially reduce the number of retail outlets currently required to provide patients with rebate payments, etc.

An additional aspect of the government package is the availability of ‘gap’ insurance to meet out-of-pocket costs in excess of \$1,000 per annum (not indexed). CDHA estimates that about 30,000 individuals or families would exceed this amount of out-of-pocket expenses per annum. It is extremely difficult to assess the actual inflationary impact of such a measure, since the actual cost to individuals will be dependent on the costs of the insurance product, which will also depend on the characteristics of those taking up the insurance product.

Similarly, the provision of a publicly funded ‘safety net’ set at \$500 per annum (indexed) for out-of-pocket costs to concession cardholders may induce some inflationary effects, but it is extremely difficult to assess these. It is unlikely that inflationary effects (if any) arising from these initiatives will impact at the level of GP fees. It is possible that some specialist medical practitioners providing frequent services to regular patients may identify an opportunity to increase fees.

²¹ Richardson, 1991, p.55

Chart 8: Comparison of likely average co-payments (all services)



In our opinion the most likely scenario arising from the Opposition package would be for GPs to meet the bulk-billing targets and thus maximise the rebate and incentive payment income offered under the Opposition package. This is because doing so allows GPs in all geographic areas to achieve income targets (as with the scenario described above for the Government package). The achievement of bulk-billing targets would increase the overall bulk-billing rate to around 77%, ensuring that the vast majority of concession cardholders would be bulk billed.

Assuming the income targets we have set, if GPs adopted the Opposition package, average out-of-pocket costs to patients would reduce by about 25%, from an average at present of around \$3.90 to an average of about \$2.95. This would derive from a reduction in the incidence of co-payments because of the increased rate of bulk billing. It is possible that patients paying out-of-pocket costs could pay higher costs than at present, but the maintenance of the hard threshold means that price signals to patients would be very prominent.

Our analysis of both proposals is predicated on the notion that GPs will seek to increase their incomes. The Government's proposal provides additional government expenditure for this purpose and protects concessional patients, but it also makes it easier for GPs to raise their incomes through increased patient contributions. The Opposition package relies on increased public sector expenditure to meet the same goal, while maintaining current administrative constraints on gap fees. The relatively higher level of government expenditure outlined in the Opposition proposals reflect this difference.

References and data sources

A Fairer Medicare Questions & Answers –

www.health.gov.au/fairermedicare accessed 23/7/03, p.5

Australian Bureau of Statistics (ABS), Catalogue No 6401.0, June 2003,
Table 1a – weighted average 8 capital cities (released 23/7/03)

ABS, National Health Survey Catalogue No 4364.1, 2001

ABS, Catalogue No 6302.0, May 2003 (released 14/8/03)

McGuire, T. “Physician Agency” (2000) in A. Culyer & J Newhouse (eds)
Handbook of Health Economics Vol 1

McGuire, T. & Pauly, M (1991) “Physician response to fee changes with
multiple payers” in *Journal of Health Economics*, Vol 10, pp 385-410

MEDICARE STATISTICS

<http://www.health.gov.au/haf/medstats/index.htm>

Opposition Medicare package, Fact Sheet2, www.alp.org.au, accessed
13/8/03

Pricewaterhouse Coopers, Medicare Schedule review Board, “A resource-
based model of private medical practice in Australia – final report:
Volume 1” (2000), p20

Richardson, J. *The effects of Consumer Co-payments in Medical Care*,
(1991), Background Paper No 5, National Health Strategy;

Richardson, J. (2001) ‘Supply and Demand for Medical Care: Or, is the
Health Care Market Perverse?’ Centre for Health Program Evaluation,
Working Paper 123,

Savage, E. & G. Jones, (2003) "An analysis of the proposed General
Practice Access Scheme on GP salaries, bulk billing and consumer co-
payments." CHERE, UTS,

Savage, E. (2003) "Equity, payment incentives and cost control in
Medicare: An assessment of the government’s proposals", *Health
Sociology Review*, forthcoming,

Senate Community Affairs legislation Committee - Answers to Estimates
Questions on Notice - Health & Ageing Portfolio, Question E03-189 -
Senator McLucas - part (a) 'Bulk-billing rates for unreferred services by
RRMA

Submission of the Commonwealth Dept of Health and Ageing (CDHA) to
Select Committee on Medicare, , (2003) p.20

Van Vliet, R. (2001) ‘Effects of price and deductibles on medical care
demand estimated from survey data’, in *Applied Economics* 33, cited in
Savage & Jones, 2003