Achieving Sustainability in Health Care –

Are co-payments the answer?

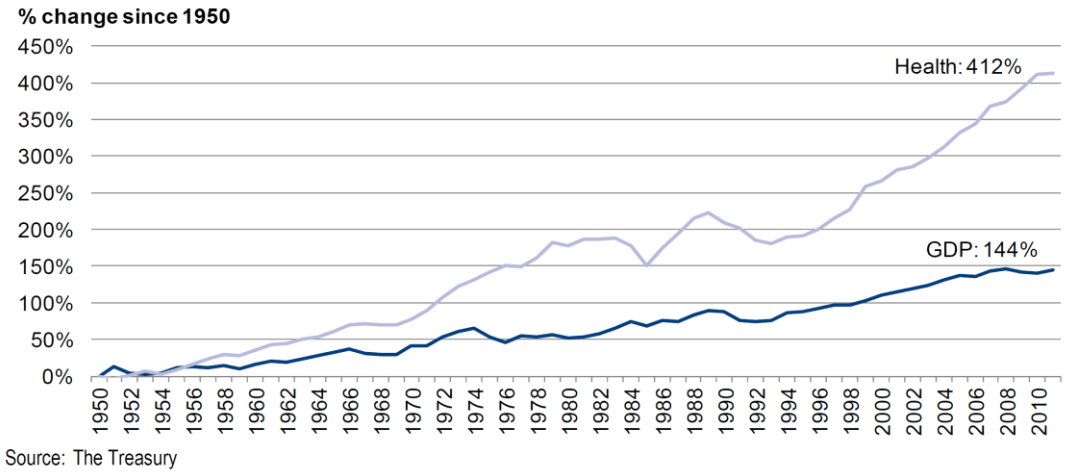
Written by: Rajat Bakshi

PGDipPH, BHSc/BCom, University of Auckland

The current pressures facing health systems worldwide can, at a first glance, appear to be somewhat insurmountable. The increasing prevalence of chronic conditions across populations and the associated increased demand on the delivery of effective health care services has been consistently recognised in literature as a grave concern for the future state of health systems world-wide (RAND and Ernst & Young LLP, 2012). The World Health Organisation estimates that chronic conditions such as stroke, cancer, cardiovascular and respiratory diseases currently account for over sixty percent of all deaths worldwide and equate to approximately seventy five percent of all health related costs (RAND and Ernst & Young LLP, 2012). Two critical issues that emerge are; given this increasing burden on the health system, how is the health system going to be funded, and secondly given that there is a scarcity of resources, how can health care resources be best allocated? The following discussion will explore the first of these two issues with specific reference to the use of co-payments as a lever to ensure fiscal sustainability. The projected financial shortfalls in managing patients with often multiple co-morbidities have placed an imperative on adopting new models of care, and new public-private partnerships in order to maximise our scarce health resources.

The New Zealand health system is a predominantly tax-funded, single-payer system. Eighty three percent of the total health expenditure is publically financed and Vote Health currently makes up 20% of core Crown expenditure (Treasury, 2012). However, with increasing pressures as a result of an ageing population, technological improvements in the delivery of health care and increasing expectations about what the health system can and should deliver, there is a need to explore other avenues of financing. The figure below indicates the rate at which publically funded health expenditure has been increasing, which is faster than GDP (Gross Domestic Product) for most of the last 60 years. This staggering increase in expenditure may reflect our values as a nation for improving the length and quality of our lives and also providing dignity for those with poor health.

Figure 1: Crown Health expenditure per capita and GDP per capita, indexed real growth, 1950-2011



Source: The Treasury

Government intervention in health care is often justified on the grounds that markets for health care have unique characteristics which often result in market failure, as well as other considerations for equity which cannot be met within the historical market models which are primarily concerned with efficiency. Due to the government having direct control over spending in a publically financed health system, such systems have been shown to be comparatively more effective in containing overall health spending (Docteur & Oxley, 2003). Research also suggests that in terms of efficiency, there is little variation between health systems with different or contrasting funding characteristics. On this basis there seems no clear rationale for New Zealand to completely move away from a predominantly tax funded health system at present (Joumard et al, 2010).

Adverse selection and risk segmentation create a strong case for government intervention in the health sector. However the increasing costs with providing public services of health care for the New Zealand government and other countries around the world, suggests that alternative methods of financing must be pursued along with public funding. Such changes can ensure future sustainability of quality health services that are responsive to the needs of the population and to ensure that ultimately the health of our population is not disadvantaged by any means. Increasing co-payments, or extending co-payments to other health services, is potentially one of the key levers that could be employed in the health sector to reduce government expenditure on health care.

Co-payments are a form of user charge (direct cost-sharing) which can be seen on a continuum ranging from full third party payment to full user chargers. They are one of the basic financing models in the relationship between public and private. Through co-payments the majority of the financing of a particular service is through the tax-payer, with the remainder financed through out of pocket payments by the health user (although the proportion of payment by either the government or the user can vary substantially) (Tuohy, Flood & Stabile, 2004). Co-payments as a form of cost sharing, have been utilised in the majority of OECD countries. In New Zealand currently co-payments are in place for general practitioners visits and also for purchasing pharmaceuticals. Co-payments for pharmaceuticals are a major area of cost sharing world-wide. Past literature indicates decreased demand for prescription pharmaceuticals and other over-the-counter products following the introduction of co-payment systems, although the level of decrease has been debated widely (Ruskamp, 2002).

In order to assess the merit of extending the range of services to which co-payments may apply one needs to understand the rationale behind co-payments in health, to reduce demand for services. The intention is to particularly target the overconsumption of health care services which may occur due to moral hazard. Moral hazard is when in the absence of price signals there is a risk of the overconsumption of a particular good. Therefore the key measure which would demonstrate successfulness of the implementation of such a policy would be the effect on utilisation of health care services. There is evidence which shows decreased utilisation in a wide range of service areas in response to increased levels of cost sharing (Robinson, 2002). Although there were several limitations of the randomised trial conducted by the RAND organisation such as its inability to

measure the effect of cost-sharing on overall health expenditure, and for not taking into account the fact that in most contexts clinicians rather than patients are accountable for decisions around health service utilisation. Nonetheless several subsequent (less rigorous) studies have confirmed the inverse relationship between cost-sharing and utilisation (Robinson, 2002). Co-payments also contribute to reducing the direct fiscal cost of a particular service. In some countries the imperative is on using co-payments for generating additional revenue for funding health care, often when alternative funding measures such as taxation are exhausted. However it is important to note that in such countries the emphasis is on cost-containment rather than creating greater efficiencies.

When introducing co-payment systems it is essential to determine the acceptable or adequate level of co-payments for a particular service. If the co-payment is too low then it will not have the intended effect on reducing demand. On the other hand excessive user charges may act as a deterrent for essential care and therefore may run counter to the social objectives of a health system. There is evidence to suggest that the decrease in utilisation as a result of implementing co-payment systems significantly reduces demand for appropriate as well as inappropriate care (Robinson, 2002). As such in certain circumstances co-payments may also have negative impacts on equity and fiscal sustainability if poorly designed. The effect on utilisation of health services by lower income groups in the lowest deciles (according to the New Zealand Deprivation Index), high need users and or other vulnerable groups must be analysed thoroughly before the introduction or extension of any future co-payment systems to health services in New Zealand. In addition it has been argued that the underlying argument for reducing moral hazard is less applicable to health markets than other markets because of the strong 'gate keeping' role of health professionals in guiding patients' choices about which health interventions are necessary (Treasury, 2012). Access to pharmaceutical in New Zealand for example is governed by clinicians' prescriptions, which limits the scope for overconsumption.

Co-payment systems are a regressive way of financing health care since individual contributions are not always related to income or ability to pay (Treasury, 2012). However these can be mitigated by having certain exemptions. Studies assessing the impact of co-payments in primary care in New Zealand have indicated the existence of barriers to access for certain groups and that New Zealanders were less able than the British, Canadians or Australians to have access to basic primary care services (Shoen et al, 2004; Grant, Forest & Starfield, 1997). This can have other unintended consequences as witnessed in New Zealand, where those in need of primary care services may substitute them for secondary or emergency services in hospital emergency departments as they are provided free of cost to New Zealand Citizens. Others may delay seeing their general practitioner to the point at which they become seriously ill, and then treatment may in-fact be significantly costlier to the state than if the condition had been diagnosed and treated earlier. Thus a reduced ability to afford health care may heighten anxiety and result in patient's forgoing necessary services.

The cost and feasibility of administering various cost sharing initiatives such as co-payment systems should also be an important consideration for policy makers if proposing to extend the use of co-payments to other health services. Mossaialos and Le Grand (1999) contend that the administration of cost sharing initiatives can be quite complex and expensive to implement. There are likely to be significant administration costs arising from directing efforts to preserve equity and ensure improved health outcomes through certain exemptions for high need or vulnerable groups. Either those with high needs could be made exempt from cost-sharing initiatives or otherwise co-payments may be targeted at those on higher incomes. It is equally important to consider public acceptability of introducing or extending the use of co-payments for health services as such suggestions are usually met with strong and widespread resistance from the public. From a political perspective, opponents of such policies may see co-payments as a market based approach attempting somewhat to shift responsibility towards the individual (Robinson, 2002).

Increasing the proportion of co-payments for services currently under such a financing arrangement would not be advisable. It was only earlier this year that the co-payment for pharmaceuticals was increased from $3 to $5 per prescription. Anecdotal evidence for the utilisation of pharmaceuticals at a DHB level suggests some decrease in utilisation following the increase to $5 per prescription. Further increases in the level of co-payment should not be envisaged in the short term. Co-payments for general practitioner visits are already at the centre of a debate on whether they significantly hinder access to primary care for some New Zealanders, and contribute to increased health expenditure within secondary care facilities (Rice and Morrison, 1994). The difference between co-payments for visits to general practitioners is that doctors retain the ability to be able to set fees at their discretion, thus unlike pharmacy co-payments, fees for accessing primary care are not standardised. A comparative analysis of five countries found that 28 percent of New Zealanders reported that they have previously forgone medical care because of the cost of a GP visit. These figures were comparable with those of the United States however significantly higher than the other countries such as Australia, Canada and the United Kingdom (UK) (Shoen et al, 2004).

It is important to note that other barriers to access to health care may exist for those with lower socioeconomic status even though there may be no direct fees barrier, as in the case of the UK. These barriers may relate to health literacy, costs involved in travelling and differing health beliefs (Dixon et al, 2003). As such co-payments can play a vital role in reducing demand and generating additional revenue for the state. However, instead of increasing the current level of co-payments for services it may be advisable to extend co-payment systems to other publically funded health services. The impacts of any decision undertaken must of course be analysed thoroughly beforehand to minimise any unintended consequences or adverse health outcomes for our population.

References:

Dixon, A., Le Grand, J., Henderson, J., Murray, R., Poteliakhoff, E. (2003). Is the NHS equitable? A review of the evidence. LSE Health and Social Care Discussion Paper 11. London: LSE Health and Social Care, London School of Economics.

Docteur, E., & Oxley, H. (2003). *Health-Care Systems: Lessons from the Reform Experience* (OECD Health Working Paper No. 9). Paris: OECD.

Joumard, I., Andre, C., & Nicq, C. (2010). *Health Care Systems: Efficiency and Institutions* (OECD Economics Department Working Paper No. 769). Paris: OECD.

Mossialos E., Le Grand J. (1999). *Health Care and Cost Containment in the European Union*. Aldershot: Ashgate.

New Zealand Treasury. (2012). *Health Projections and Policy Options for the 2013 Long-term Fiscal Statement-Draft Paper*.

RAND, E., & Ernst & Young, (2012). National evaluation of the dh integrated care pilots. (Vol. TR-1164-DH, p. 129). RAND Corporation. Retrieved from http://www.rand.org/pubs/technical_reports/TR1164.html

Rice, T., Morrison, K.R. (1994). Patient cost sharing for medical services: A review of the literature and implications for health care reforms. *Medical Care Review, 51*(3), 235-287.

Robinson, R. (2002). User charges for health care. In Mossialos, E et al, *Funding health care: Options for Europe,* 161-183. Buckingham: Open University Press.

Ruskamp, F.M.H. (2002). Experiences with patient charges. *International Journal of Risk and Safety in Medicine, 15*, 93-96.

Schoen, C., Osborn, R., Trang, P., Doty, M., Davis, K., Zapert. K., Peugh, J. (2004). *Primary Care and Health System Performance: Adults' Experiences in Five Countries*. Health Affairs Web Exclusive, W4: 487-503.

Tuohy, C.H., Flood, C.M., Stabile, M. *(2004). Journal of Health Politics, Policy and Law*, *29*(3), 359-396.