References

1. Thomas P. Integrating primary health care. In: Wilkinson RGW, editor. The impact of inequality: how to make sick societies healthier. Oxfordshire: Routledge Publishing; 2006. 355p.
2. Wilkinson R, Pickett K. The spirit level: why equality is better for everyone. Penguin; 2010.
3. World Health Organization. The World Health Report 2008. Primary care: now more than ever. WHO; 2008.
4. Harris M, Haines A. Brazil's Family Health Programme. BMJ. 2010;341:c4945.
5. Hidden cities: unmasking and overcoming health inequities in urban settings. WHO; 2010. And see Zarocostas, J. BMJ. 2010;341:c6715.
6. Lee A, Kiya A, Milman HM, Jimenez J. Improving Health and building human capital though an effective primary care system. J Urban Health. 2007; 84(Suppl 1):75–85.
7. Robinson T. The cost to the New Zealand Government of providing free primary medical care: an estimate based on the Rand Health Insurance experiment. NZ Med J. 2003;116(1173).
8. Ku L, DesChamps E, Hilman J. The effects of co-payments on the use of medical services and prescription drugs in Utah's Medicaid Program. 2004. Available from: http://www.cbpp.org/cms/index.cfm?fa=view&id=1398

Co-payments must go!

NO

Tom Marshall
MBChB, FRNZCGP, OBE,
Mt Eden Medical Centre,
PO Box 67044, Auckland
1024, New Zealand
t.marshall@memc.co.nz

Marshall T. Co-payments must go!—the 'no' case. J Prim Health Care. 2011;3(3):230–231.

Co-payments, or fees charged to patients, have been an essential component of the funding of health services, particularly general practitioners' services, throughout the Western world since the emergence of medical care. Why would one contemplate their abolition?

If it were demonstrated that such an action improved either access to, the choice of, or the quality of health services, then investigation of the feasibility of abolition may be worthwhile.

Sadly, demonstration of these desiderata is lacking.

It is instructive to note that frequently general practitioners do not charge co-payments or charge discounted co-payments.[1] These instances are rational business decisions influenced by the strong thread of altruism that pervades general practice. It is a commercial practice that is seldom found in other service industries!

We may look at two areas of health services where co-payments have not been charged for many years and consider if any evidence of improvements to access, choice and quality can be found. Or possibly may the reverse apply?

The two areas that immediately spring to mind are immunisation and maternity. In both these cases, general practitioners have foregone the ability to charge fees in favour of full payment for their services by the government.

In the case of immunisation, it is widely recognised that the payments made are not adequate recompense for the services provided.[2] This may have been a factor in New Zealand's relatively poor immunisation rates, which until quite recently apparently have been at almost third world rates.

Free-to-user service has not led, as predicted by supply-demand propositions of economics, to the wished for high immunisation rates. Classical supply-demand graphs suggest that, as the price of a good falls towards zero, demand tends toward infinity[3] and that has clearly never occurred with zero-priced immunisation.

Turning to maternity services, which when provided by general practitioners have been free-to-user as a consequence of an agreement finally reached between the government and the New Zealand Division of the British Medical Association in 1941, is informative. Those general practitioners who practised obstetrics under these arrangements will agree that their incomes could only be sustained by returns from their general medical services, which of course included patient co-payments and government subsidies.

Another effect of this mechanism, aligned with the passage of the Nurses Amendment Act 1990, has eventually been the exit of general practitioners almost completely from intrapartum maternity care and antenatal care beyond the first trimester.[4] Only the most biased observer would consider this a beneficial consequence of the arrangement.

An obvious failure for the community has been disappearance of choice for many women. Most pregnant women no longer have the choice of their general practitioner's involvement in their maternity care.[5]

While subsidisation of the cost of medical care is currently delivered via capitation funding, most general practitioners value the mixed model of fee-for-service that is associated with the current arrangements. Indeed historical events have shown the extent to which many have been prepared to go to, in order that a fee commensurate with the service provided should be available to doctors.

The era following the Great Depression and the Second World War was a tumultuous time and saw the introduction of the Social Security Act 1938.

During the late 1930s and the early 1940s, vociferous opposition to government control of general practice incomes (that is implicit in a no co-payment arrangement) was demonstrated by the British Medical Association.[6] This opposition received widespread public support and eventually led to modification of the first Labour government's original proposals, as the Social Security Amendment Act 1941. The compromise adopted, as indicated above, allowed charging of co-payments by doctors for general medical services, but prohibition of co-payments for obstetric services provided by general practitioners.

For the next 43 years things muddled along, until, in 1984, the incoming government—as promised in the preceding election campaign—attempted to cap co-payments for general practitioners. In addition, an intention to extend such capping to other areas of medical practice had been foreshadowed.

This proposition caused huge controversy within the general practice community, but also alarm amongst parents of young children. It culminated in an Application for Judicial Review of a decision by Dr Michael Bassett, Minister of Health, by general practitioners Drs Michael Cooper, David de Lacey and Tom Marshall. Mr Justice Vautier heard evidence from such luminaries of general practice as Drs Selwyn Carson, Murdoch Herbert, David Kerr and John Richards that fixing fees, by way of a controlled co-payment (and what could be more controlled than a co-payment of zero?) would not improve access for children and, by encouraging over-servicing, would be likely to have a detrimental effect on the quality of services.

The judge found their evidence persuasive and Dr Bassett's attempts to control fees were found to be ultra vires and were stopped in their tracks.[7]

As a final consideration, the whole New Zealand economy should be given cognisance. In the dire financial predicament that New Zealand finds itself in following the collapse of the world financial system in 2008 and the calamities of Pike River followed by the heartbreaking tragedies of the Christchurch earthquakes, it is difficult to see how a system of general practice remuneration without co-payments could succeed.

Any increase in capitation payments to compensate for loss of co-payment effects, given that available resources are finite, must lead to a reduction in the provision of other essential publicly funded health services. That would be unacceptable to many, including most general practitioners, and would be unlikely to happen.

The consequence of this negative effect on general practitioners' incomes would undoubtedly lead to a deterioration of the dire situation facing recruitment to the general practice workforce that currently exists.

My conclusion, therefore, is unsurprisingly that the abolition of co-payments is neither desirable, nor beneficial, nor affordable and needs be considered no further.

References

1. Tilyard M, Dovey S. General practitioners' actual and scheduled charges for consultations with children and the elderly in South Island PHOs. NZ Fam Phys. 2006;33:184–187.
2. Turner N, Rouse P, Airey S, Petousis-Harris H. The cost of immunising at the general practice level. J Prim Health Care. 2009;1(4):286–96.
3. Marshall A. Principles of economics, 8th edition. London: MacMillan; 1920.
4. Exton L. The baby business. Nelson: Craig Potton; 2008.
5. Hutchison P. New Zealand House of Representatives, Petition 2008/23 of Jennifer Maree Hooper, Report of Health Committee, October 2010.
6. Lovell-Smith J B. The New Zealand doctor and the welfare state. Auckland: Blackwood & Janet Paul; 1966.
7. Vautier J. In the High Court of New Zealand, Auckland Registry, Judgement A.No.182/85, Marshall & others vs The Minister of Health.