

Co-payments must go!

YES

Stephen J Main

MB BChir, PhD,
FRNZCGP; GP and
RHMO for Hokianga
Health, Rawene Hospital,
Hokianga, Northland

Poverty kills.

Absolute poverty kills people in the third world in their millions, but even relative poverty in the richest societies kills people in their thousands. Poorer people die younger—often as much as 13 years younger in relatively wealthy societies such as New Zealand (NZ) or Britain.

These socioeconomic adverse gradients in health are well described and have been increasing rather than decreasing in recent years, and NZ is no exception.^{1,2} Worldwide, a strong primary care sector is a key feature of any of the more effective health services³⁻⁶ and the crux of much health care in the developed world is now the management of chronic conditions, often in people with multiple comorbidities. While the overall health of the population is primarily a social rather than a medical issue, there is no doubt that modern Western medicine can make a major contribution to extending life and quality of life for individuals. Several specialist teams may be involved, but each covers only one aspect of the overall care of a person. This is where the generalist comes in, not only to act as the gatekeeper to specialist services but, as the patient's advocate, to coordinate and monitor the effects of multiple medicines and other treatments.

The chronically sick often have increased expenses relative to the well and equally often have less money to pay with. Often, too, those in most need of acute medical help are the hardest up.

In the state hospital sector in NZ, services are still provided without direct charges to patients as originally intended for the whole service. Now, however, the hospital-based specialist may advise certain medications or other treatments that require close monitoring and may write a letter to the patient's general practitioner (GP) advising such action. Unfortunately, to obtain such follow-up and any ongoing treatment, the patient will be faced with a bill, not only for the prescription charges for medicines, but also for the services of the doctor charged with the follow-up.

Well-intentioned initiatives such as Accident Compensation Corporation, and more recently such programmes as Care Plus and diabetes Get Checked, help only a little and cost a lot to administer and police. More recently, general medical subsidies based on socioeconomic profile within areas have been set up, but there is now a confusing proliferation of 'access', 'low cost access' and 'very low cost access' practices.

There is little consistency. In some areas the cost of a visit to a GP varies from zero to \$50 or more, with added fees for out-of-hours calls, including fees for children. These complicated schemes waste money in management fees and may result in patients 'shopping around', often attending the

Main SJ. Co-payments must go!—the 'yes' case. *J Prim Health Care.* 2011;3(3):228–230.

BACK TO BACK this issue:



Stephen Main



Tom Marshall

While evidence can help inform best practice, it needs to be placed in context. There may be no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. There are areas of uncertainty, ethics and aspects of care for which there is no one right answer. General practice is an art as well as a science. Quality of care also lies with the nature of the clinical relationship, with communication and with truly informed decision-making. The **BACK TO BACK** section stimulates debate, with two professionals presenting their opposing views regarding a clinical, ethical or political issue.

free hospital emergency departments inappropriately which helps neither their long-term care nor the income security of GPs. From the patients' point of view this is understandable. It costs money to walk into a GP surgery while it doesn't to walk into an emergency department, so there is an obvious disincentive to consult a GP even though s/he may be the most appropriate clinical person. A final absurdity can be seen in some NZ hospitals where GPs provide out-of-hours services from the same building that houses a hospital emergency department. See a doctor (possibly the same one in some places) at one end of a corridor and you get treated without charge. A few metres down the corridor in the same building, see a doctor and you get a bill—which could run to well over a hundred dollars if it's the middle of the night.

The 'elephant in the room' that is blocking the most effective implementation of the coordinator role of the GP is the patient co-payment—in plain English, the doctor's fee. Along with GST and other flat-rate taxation, the user charges in the GP sector of the health service disproportionately disadvantage the poor, who already suffer worse health outcomes.

There is a fear that an entirely 'free' health service is impracticable; that without the barrier provided by charges the demand would be such as to overwhelm the ability of the service to cope; that it would be abused and overused.

Agreed, there is evidence that demand rises where charges are removed, but where this has been looked at, the extent of this increase ranges from six to 28%.⁷ This, although hardly negligible, is scarcely overwhelming. Equally, there is US evidence that even small co-payments (US\$2–\$3) have measurable effects in reducing uptake of medical services, both essential as well as less essential, with consequent potential for adversely affecting the already poorer health of the least well off.⁸ It is of interest too that there is recent official advice from the World Health Organization that direct fees to patients for medical services greatly disadvantage the poor and should be abolished.³

Of course primary care is not only provided by doctors. The complexities of modern medical care require teamwork between health professionals

both in community and hospital sectors. The health care team may include community nurses (salaried), practice nurses (salaried), specialist outreach nurses (salaried), occupational therapists and physiotherapists (salaried), mental health and social work personnel (salaried) and hospital-based doctors (salaried) as well as GPs (the only non-salaried team member in the whole shooting match!) What's going on there? Doctors may effectively be competing against each other as well as against other health professionals. Even within group practices such competition exists. Where income depends too directly on the number of consultations rather than their content, doctors will be tempted either to rush and to cut corners or to take on too much themselves and fail to involve the health care team adequately in patient management.

Fundamental changes are needed. Here are two suggestions:

Firstly, remove patient charges completely. That way we might just be able to break down at least the financial barrier to access to GPs. There will be a cost,^{7,8} and this would have to be met from general taxation. Perhaps this will be a platform on which future parliamentary elections will be fought.

Secondly, employ all medical, nursing and allied professionals on contracts paying a salary and not a fee per patient seen. Just about all NZ GPs will have experienced working both for a salary in a hospital where no charges are made as well as in community practice where they are. Having the privilege as I do of working as a GP where services are actually already free to our enrolled population, I have noticed that locum, trainee and new doctors to the service comment almost universally on how much they prefer not having to charge. There is a contradiction inherent in providing support, compassion and sympathy as we try to do for people in distress, and then billing them for our time.

Health care is too complex and varies too much from case to case to allow the current business model of primary care to continue. The situation of medical staff on annual salaries works well enough in the hospital sector. Why not in organisations providing community medical services as well?

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 through 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

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 abil-

ity 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 infinity³ 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.

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