ARE CO-PAYMENTS A PUBLIC HEALTH ISSUE?

In the August Federal Budget1 the Government announced a reduction in the rebate for general practitioner services. What raised more concern, though, was the proposal that this reduction could be passed on to patients, including those who were bulk-billed. The introduction of this co-payment stimulated strong professional and public reaction, almost all unfavourable. The ensuing outcry united the Public Health Association, the Australian Hospitals Association, the Australian Council of Social Services, Community Health Forum, the College of General Practitioners, the AMA — and much of the Labor Party.

In this article, I want to explain the issue of co-payments and explore its public health implications.

Even the terminology is confusing. Although the issue has been called one of co-payments, the Government insisted it was about rebate reduction. The Government planned to reduce the rebate on general practitioner services by $3.50 (after a Caucus review this was cut to $2.50); therefore, GPs would receive $3.50 less for each consultation. Should they choose to absorb that reduction in the rebate, they would incur a reduced fee; should they pass it on to patients, there would be a co-payment introduced.

A co-payment is where patients are asked to pay a contribution to the cost of their medical care. Patients visiting doctors who do not bulk-bill (or accept rebate only) already face a co-payment. Those covered by health care cards would be protected from any co-payment. The group affected are those without health care cards who visit bulk-billing general practitioners.

What problem is this rebate reduction designed to address? “The Government believes that price signals can act as a counter-balance to over-servicing”4.

Certainly, there have been steady increases in health care expenditure and the use of medical services grew by 33 per cent over six years5. But the growth in health care expenditure has not exceeded the growth in Australia’s GDP until the recession of this year. And the growth is associated with the increase in the doctor supply. Whatever the causes of these increases, they are not sudden; and are probably more related to the supply of medical services than the demands of patients.

In all the debate about co-payments, and indeed in most of the debate about health care financing, there has been little or no discussion of the impact on health. Yet for those of us interested in public health this is very important.

Co-payments can be expected to reduce the use of general practitioner services, and those on low incomes will reduce their use of services proportionately more. A similar scheme of co-payments was introduced in Saskatchewan, Canada, in 1968 (and reversed in 1971 with a change of government). As here, welfare recipients were exempted from the co-payment. The poor reduced their use of health services by three times the average reduction for all families. But the co-payment did not alter the underlying rate of increase in the use of medical services. The National Health Strategy has released a paper of the effects of co-payments6; it concluded that “the importance of co-payments has been overstated in Australia. They are unlikely to play a significant role in solving any of the major problems facing the health sector.”

This has been acknowledged by the Government7. It seems to be accepted that, while co-payments will reduce the services used by the poor, service use by other groups may increase, so there is little or no overall change. What will have happened is a shift in costs from public expenditure to private expenditure.

Studies of the effect of co-payments on utilisation generally point to a reduction in the use of services, both those judged medically as “necessary” and “unnecessary”. The poor are less likely to seek medical attention for their children and less likely to seek ante-natal care. The effects on health outcomes are more difficult to judge. Only one study has systematically investigated the relationship between co-payments and health outcomes. This is the randomised controlled trial of health insurance plans conducted by the Rand Corporation in the United States in the 1970s8. The Rand study used an impressive array of health status measures. Co-payments had no statistically significant effect on most measures of health status.

The results were similar when analysed by income group but it may be that important differences in health outcomes were not detected in the sub-group analysis due to a lack of power. However, this study showed that low-income individuals with a high risk of dying (based on the risk factors of smoking status, cholesterol level and blood pressure) did reduce that risk under free care. On balance, I believe this suggests that barriers to the use of medical services can have deleterious effects on health.

Co-payments can be considered inequitable in that they impose barriers to the use of medical service with potentially negative health consequences for an already disadvantaged group. This is inconsistent with the move towards concerns with health outcomes as measures of health system performance and the goal of reducing differences in health status across social groups9.

Herein lies the public aspect of co-payments. As Peter Baume has queried10, what is the purpose of discussing the means of financing with no concern for the ends, i.e. for what the health system produces in health outcomes.

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