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Co-payments keep Medicare healthy

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Potential savings to the health budget from reduced demand for Medical Benefits Schedule services

Number of MBS services used per year	Percentage of total poulation	Total cost per group ($m)	Total cost per group (%)	Annual savings ($m)
FROM 0 – 8	51.3%	2029	10.5%	62
FROM 9 – 55	44.7%	12,455	64.4%	324
FROM 56 – 99	3%	2830	14.6%	21
100 OR MORE	1%	2021	10.5%	–
TOTAL	**100%**	**19,334**	**100%**	**407**

Author's estimates of savings from copayment ($7) and reduction in MBS rebate ($5), based on an assumed price elasticity of demand of -0.15. Analysis based on 2012-13 financial year

Source: Department of Health & Ageing and Commonwealth Budget Papers

Potential health savings. Source: TheAustralian

IT'S not a tax, it's a charge. A tax is an unrequited payment governments secure by compulsion. A charge is the fee paid for a service. And the proposed GP co-payment isn't even mandatory: whether doctors impose it is up to them.

To see the difference, try telling the Australian Tax Office you've decided to waive paying income tax and exempt your friends from the GST.

But you're right to feel a "so what" coming on. Whether the co-payment is a tax or a charge is irrelevant; what matters is whether it's good policy. And on that, the rhetoric has flown thick and fast.

In a predictably crowded field, the ''Julia'' for hyper-bowl goes to Con Costa, national president of the Doctors' Reform Society. Peculiarly overlooking Bob Hawke's move to introduce a GP co-payment 22 years ago, Costa bemoaned the co-payment as "the worst health policy decision in over 40 years" while lambasting it as "the murder of Medicare".

As Costa spluttered with rage, Byron's immortal lines sprang to mind: "Dear Doctor, I have read your play/Which is a good one in its way,/It purges the eyes and moves the bowels,/And drenches handkerchiefs like towels".

But however loud the wails, charging co-payments for GP visits is hardly unusual, even in health systems hailed for equity of access.

After all, the socially-minded Swedes do it, with co-payments that range from $20 to $30; so do the Finns, where consumers pay about $20 per visit; and even those diehard defenders of social security, the French, rely extensively on co-payments to “moderate” demand.

As for our Kiwi cousins, they have had co-payments for years. And far from services being retrenched, access to primary health services is generally very good, with 84 per cent of New Zealanders reporting that they are able to see a GP within 24 hours, as compared to about 65 per cent of Australians. Moreover, with co-payments boosting GPs’ incomes, after hours services are more readily available, with only 6 per cent of those surveyed finding surgery hours too limited.

But that isn’t to deny the co-payments will affect demand. Of course they will: the issue is by how much and with what effects.

Assessing those impacts is complex, because use of primary health services is so skewed: the top 4 per cent of users account for 25 per cent of demand. Almost all of those users are likely to be covered by the Medicare Safety Net, while concessional patients and children under 16 will only incur the co-payment for their first 10 visits each year.

As a result, while those consumers’ total outlays on primary care will rise, few of them will face a higher price when they decide whether or not to make an additional visit. Their average cost per visit will increase, but not the price they pay at the margin, reducing the impact on demand.

And there are complexities too in calculating the extent of the price increase for those who will be charged the co-payment. Even with bulk billing, going to a GP involves a cost in terms of time and hassle; the greater those costs are, the less is an additional $7 as a proportion of a visit’s real cost, and so the smaller the demand effects will be. And then there are the 19 per cent of instances of care that are not bulk billed: their initial price is higher but may not rise by the full $7.

In short, many assumptions must be made; but cranking the handle suggests the number of “connections”, as they are referred to in the Medical Benefits data, would fall by 7.3 million, yielding annual savings of some $407 million. That is 2.1 per cent of spending on the MBS, with the savings growing over time.

Not massive perhaps, but certainly well worth having: so long, that is, as it doesn’t harm population health. In addressing that question, the evidentiary “gold standard” remains the RAND Health Insurance Experiment, which over a 10-year period examined the impact of insurance on the health care use of a very large random sample of Americans. Imposing co-payments much greater than those the government proposes, it found demand reductions that caused “little or no measurable effect on health status for the average adult”.

Nonetheless, the study did identify some adverse impacts, concentrated mainly on low income consumers in poor health, and notably those with high blood pressure.

Yet the RAND team concluded those effects could be offset at very low cost: finding, for instance, that “a one-time blood pressure screening (for poor adults) achieved most of the gains in blood pressure that free care achieved.” The carve-outs it suggested were therefore substantially less generous than those Medicare will continue to provide.

But that doesn’t mean one should be relaxed about the possible consequences. The RAND study imposed similar cost-sharing rates on all forms of treatment; our system has a jumble of co-payments, including

for medicines, that can undermine the efficacy of care, especially for chronic conditions.

Unless the co-payment regime takes those risks into account, outcomes could be less benign than the RAND study suggests. Explaining how it will manage those risks should be the government's next step.

Even with that done, co-payments will never be a cause for celebration: they interfere with the fundamental goal of insurance, which is to protect us from the risk of illness, and can inflict high administrative costs to boot. Unfortunately, the alternative of a health system which compromises its sustainability by wasting resources on inefficient use is surely worse.

So come on, Dr Costa: give co-payments a quiet cheer. And then return "with tears that, in a flux of grief,/afford hysterical relief,/to the shatter'd nerves and quicken'd pulses/ which your catastrophe convulses".