emergencias 2007;19:32-35

Point of View

Advantages and disadvantages of copayment in funding and management of emergency health care

E. Moreno Millán

PHD. ECONOMICS, BSC. MEDICINE, MASTERS DEGREE IN ECONOMICS OF HEALTH, SEVILLE.

INTRODUCTION

Spain has had a National Health System (NHS) funded by public taxation for the last two decades- although co-funded until 2000 with employee and employer contributions – with a mixed service provision based on the fundamental principles of equity and solidarity[1]. Despite clinical indicators showing positive health results[2] – to the extent of being considered a model for export – the same is not true of economic indicators, which show a gradual and worrying increase in public health expenditure (HE)[3] as a result of both aging and growth of the population[4], chronification of diseases and disabilities, lack of coordination and near-absence of social and healthcare resources, high and unjustified consumption of pharmaceutical products, a poorly assessed introduction of new technology and an increase in prices[5].

All states in the European Union (EU-25) and in the Organization for Economic Co-operation and Development (OECD), albeit with different health care models, also began some time ago – and basically for the same reasons – to find it difficult to contain the increase in public HE (PHE) and achieve financial sustainability[3,6]. Since 1996 expenditure in Spain has remained between 5.4% and 5.6% of the gross national product (GNP) - despite the progress of our economy – and the PHE per capita is quite a distance away from the averages for both organizations, namely 10% lower than what would pertain to the level of income. As a result, the viability of our public health system (PHS), currently funded through government budgets transferred to the different regional health care services for management thereof since 2002, is becoming increasingly unsustainable[3,7].

Although the PHE of the various countries and their health care indicators are frequently compared, the truth is that the large differences which exist between the various models-funding, insurance, management, coverage, provisions, list of services provided – and the various expenditures in social protection and absolute value of each GNP, make it very difficult to draw any valid conclusions both from a health care and an economic perspective. Nevertheless, it seems that a certain budgetary shortage exists in all states with a PHS (particularly those of the NHS type)[3,6] and experts are wondering how such a funding deficit might be resolved.

HEALTH CARE INSURANCE AND ITS EFFECTS

Economic theory offers the option of insurance as a rational response to the risk and uncertainty of citizens suffering from ill-health, obviously with no foreknowledge of the time and intensity of such processes[8-10]. The existence of an insurance system against adverse events which is fiscally funded by all individuals in a specific society can lead to opportunist or abusive behaviour such as moral hazard, which translates into excessive consumption of a specific asset[11-15], which in turns leads to the frequent imbalance between resource supply and health care demand, justified in such health care models by poor identification of real need.

It is clear that no ratio between contribution and service consumed is exhibited in direct or indirect taxation supporting public sector activities. Moreover, the absence of opportunity cost – due to no charges made at the time service is rendered – leads to an over-demand not arising from a true need for health care[8,11-13].

Correspondence: E. Moreno Millán
Urb. Aljamar II, casa 6, 41940 Tomares (Sevilla)
E-mail: emorenomillan@terra.es

Received: 5-10-2006
Accepted: 8-1-2007

When demand exceeds supply, under budgetary restriction, rationing can either affect the amount of services available (restricted access) or that of cost thereof, which would lead to inconvenient and dangerous waiting lists (WL) in the first case, or to the incorporation of new sources of funding in the second. Citizen cost-sharing would lead to a direct relation between the cost and the benefit of services used – thus distinguishing those who use the asset from those who globally maintain it – insofar as the fiscal revenue affected would be independent from its use[11-14].

Leaving aside the aspect of restricted accessibility (WL)[16], cost can be a decisive tool in the exchange and exhibition of individual preference. Its absence leads to inefficiency due to excessive consumption, whereas its presence means an additional source of funding, has a deterrent effect, improves responsibility and reduces the need for raising taxes[17,18].

PRIVATE COPAYMENT

What exactly does copayment mean? In the case of health care it means patient participation in the cost of the service received. There are many modalities- some are associated with consumption, others with right of use, franchises, etc – and they range from percentage contribution to fixed amounts, or else mixed versions thereof, and can likewise be applied either to a social group or to specific individuals, depending on the patient or the product[19,20].

Some opinions and questions- many lacking any scientific grounds – have succeeded in confusing the citizens as well as the experts. Must copayment schemes be introduced in our health care system? What are the benefits and drawbacks of copayment? How and how much will the use of a service, or any other alternative services, be modified? Are such schemes really efficient from a financial perspective and effective from a clinical one? Do they lead to inequality of access or in taxation? Can differences arise between the various socioeconomic groups? Can they lead to deterioration of health, whether individual or collective? Do they reduce or deter from consumption in equal measure? What operational costs do they imply? Are there any other possible formulae?

Copayment is present in all OECD countries, including Spain, as seen in the NHS medication benefit (40%) and MUFACE (MUFACE: Spanish General Mutual Insurance Society of State Civil Servants) (30%) for all actively employed patients[21,22]. Although it was already addressed in the report from the NHS Analysis and Evaluation Commission ("Abril Report")[23], since the second half of 2004 repeated demands have been made from various circles and experts to contain PE due to an excessive demand for drugs and health care services, particularly in emergency care and high technology. With regard to the first, data had been gathered from Health Maintenance Organizations (HMOs)[24-28] in the United States, in light of the dangerous upward trend observed in such costs[29].

The problem is that, despite some of the advantages of cost-sharing schemes seeming obvious, many adverse effects have also been pointed out. In this regard, it has been suggested that the most appropriate circumstance to be applied might be that price elasticity of demand (marginal variation in the cost of a product which affects the amount demanded, depending on such terms as the nature of the need met by the product demanded, the availability of alternatives and the proportion of income used to obtain it) should not be null, that it should affect products of low cost effectiveness, that access thereof by the needier citizens should be guaranteed and that the costs of processing (administrative) should enable its implementation[8,30-32]. In other words, it should concern products with elastic demand, proportionally reducing the percentage of consumption instead of that of price increase.

But how and in what way does copayment alter the consumption of a product? What effect does it have in the face of incentives? How do individuals respond, particularly those less fortunate and with a greater degree of ill-health, in terms of their income? Could difficult access have a bearing on the health of the individual or of the population and be maintained in the medium to long term? Are there any other alternatives which might lead to the same benefits at a lower cost?

Economic theory maintains that copayment should be lower for services with less price elasticity (those with low sensitivity of demand to changes in price), greater effectiveness or lacking any specific alternatives. If the idea is to reduce excess demand, it should be applied on the most elastic services, but if what is sought is an increase in funding it should be applied on the least elastic. There is little evidence regarding the effect of cost-sharing on health, but worsening of health in the most vulnerable section of the population with the lowest income has been proven, given that the higher the marginal productivity of a service, the lower the level of health[19,20,33]. Reduction in consumption has been regarded in objective terms, though the same has not happened with suitability of clinical response nor total health care cost; furthermore, access by all patients appears to be affected, whether or not they are excess consumers, even in preventive resources, which could lead to negative outsourcing of community health care.

COPAYMENT AND EMERGENCY SERVICES

One of the specific areas in the management of Public Health Systems is the Hospital Emergency Department (ED),

which exhibits special characteristics due to its high level of frequentation, lack of competitiveness and high cost. Such resources are too often used as an entry into the system, as emergency services are exceptions to the normal imperfect agency relations of the rest of health care services: in the ED access decisions are left in the hands of the citizen-patient as opposed to the professionals. As a result, 50.2% of those polled by the Survey of the Ministry of Health used this method of entry in the year 2005, with 70.5% due to their own initiative (37.3% because "their requirements were not met by the timetable of the local GP surgery" and 36.4% because "hospitals have more means and are better equipped to solve problems") with a high level (78.6% good or very good) of satisfaction with the quality of the care received[34-36].

Some publications point out that copayment delays care given in EDs, which could be particularly serious among complex patients, although this situation seems not to be the case, at least, among patients with myocardial infarction[26]. What has indeed been proven is that some patients prefer not to go to hospital, or even seek out alternative possibilities (consultation, primary care)[38,39].

Efficacy is not increased with private cost sharing: the patient is clearly pressured without having been provided with the right information, neither the duration nor the number of services seem to be reduced when access to the system has been gained and, in summary, the risk is transferred onto the patients, penalizing the sick person more than the healthy one and the deprived in favour of those with higher incomes and, if not part of a private scheme, redistribution is regressively modified. In short, copayment is not equitable.

From a funding perspective, there hardly exists any empirical evidence; on the contrary, countries belonging to EU-25 and the OECD with the highest rates of cost sharing have the highest percentages of public health expenditure in relation to their GNP. Furthermore, the methods needed to raise funds – which are minimal, unless private reinsurance takes place alongside cost sharing – are complex and involve high processing costs which often deter politicians from putting them in place, particularly when they additionally lead to professional and general public dissatisfaction[19,20].

WHAT CAN BE DONE?

Possible solutions involve an improvement in efficiency (to achieve more with the same resources), an increase in public funding (to achieve more with more funding), an increase in funding via private schemes (copayment) or the rationing of available services (waiting lists). It is clear that we are still some way away from achieving, at least in Spain, a more efficient health care system (inappropriate use of income, hospital stays and technology; over-expenditure on drugs; poor coordination of hospital and primary care management; non-existence of social health-care network; non-assignment of risk to the agents, etc.)[5,19,20,32,33].

An increase in funding should address the opportunity cost of services and restrict those which offer poor effectiveness and which offer no benefit to the global health of the population, but it should likewise increase fiscal pressure on clearly damaging items, such as cigarettes – more than 52,000 deaths in 2001 – with taxes thereon in 2004[40] having increased public revenue by 7,400 million Euros – although an uncontrolled increase against the habit of smoking could lead to a rise in unemployment and inflation.

What remains crystal clear is that benefit rationing can only take place in systems in which demand, though high, is matched with a real need for health care and in which there is an adequate number of suppliers, which is not the case in Spain. Waiting lists continue to be the worst social indicator in our health care model, particularly when these are addressed under dangerously overloaded conditions, far from the levels of quality and satisfaction which are vital to a public service we all pay for.

In summary, a miraculous solution seems[41] not to exist to the problem of budgetary shortage: politicians, managers, professionals and citizens must be informed, made aware and made responsible so that they have a good understanding of the difference between demand and need. And when the first should exceed the supply, we may know how to seek out the best option, which does not appear to be – most certainly – either the inefficient and unequitable copayment system or inhumane access restrictions. In any event, the decision – within a democratic framework – must be made by the individuals at the ballot box, thus enabling the model of choice to be selected and allowing us to defend our most precious right as people: our Health.

The introduction of cost sharing in the current ES of our Public Health Service would go hand in hand with a considerable degree of social dissatisfaction, poor fundraising capacity with high cost of processing, and simply partial deterrence of patients – possibly chronic or decompensated, habitual hyperfrequenters- who would seek out other alternative accesses (in which the marginal cost would be almost certainly much higher) – additionally contributing to a probable worsening of their condition. This financial tool does not therefore appear to be profitable from either a clinical or economic and, least of all, social perspective. Important studies, which would be difficult and dangerous to carry out, would be required to be able to emphatically defend such hypotheses.

REFERENCES

1- Ley 14/1986, General de Sanidad, de 25 de abril de 1986. BOE de 29 de abril de 1986.
2- OECD Health Data, OECD, 2005.
3- OECD Health Data (Public health expenditure), OECD, 2005.
4- INE, Demografía española, 2006.
5- López G, Pellisé L, García A. El control del gasto sanitario. Ed. Masson, Madrid, 2001.
6- Eurostat. Total expenditure in social protection, 2005.
7- Ley 21/2001, de 27 de diciembre, por la que se regulan las medidas fiscales y administrativas del nuevo sistema de financiación de las Comunidades Autónomas de régimen común y Ciudades con Estatuto de Autonomía.
8- Albi E, González-Páramo JM, Zubiri I. Economía Pública (vol. I), Ed. Ariel, Barcelona, 2000.
9- Stiglitz JE. La Economía del Sector Público. Ed. Antoni Bosch, Barcelona, 2000.
10- Utrilla A, Urbanos RM. La Economía Pública en Europa. Ed. Síntesis, Madrid, 2001.
11- Pauly M. The economics of moral hazard: comment. Am Econ Rev 1968;58:531-537.
12- Zweifel P, Manning WG. Moral hazard and consumer incentives in health care. En Handbook of Health Economics, North-Holland, 2000.
13- Lundin D. Moral hazard in physician behavior. J Health Econ 2000;19:639-62.
14- Manning WG, Marquis M. Health insurance: the tradeoff between risk pooling and moral hazard. J Health Econ 1996;15:609-40.
15- Nyman JA. The economics of moral hazard revisited. J Health Econ 1999;18:811-24.
16- Moreno E. Servicios de Urgencias y listas de espera. Emergencias (en prensa).
17- González-Páramo JM, López G. El gasto público: problemas actuales y perspectivas. Pap Econ Española 1996;69:2-38.
18- López G, Wagstaff A. Eficiencia y competitividad en los servicios públicos: algunas consideraciones relativas a la asistencia sanitaria. Moneda y Crédito 1993;196:181-218.
19- Puig-Junoy J. Los mecanismos de copago en servicios sanitarios: cuándo, cómo y por qué. Hac Publ Española 2001;158:105-34.
20- Gené J, Planes A, Berraondo I. Copago y accesibilidad a los servicios sanitarios. Documentos SEMFYC nº 14, Madrid, 1999.
21- Harris BL, Stergachis A, Ried LD. The effect of drug copayments on utilization and cost of pharmaceuticals in a health maintenance organization. Med Care 1990;28:907-17.
22- Puig-Junoy J. Propuestas de racionalización y financiación del gasto público en medicamentos. Documento de trabajo 50/2004, Fundación Alternativas, Madrid, 2004.
23- Informe de la Comisión de Análisis y Evaluación del Sistema Nacional de Salud, Ministerio de Sanidad y Consumo, Madrid, 1991.
24- O'Grady KF, Manning WG, Newhouse JP, Brook RH. The impact of cost sharing on emergency department use. N Engl J Med 1985;313:484-90.
25- Selby JV, Fireman BH, Swain BE. Effect of a copayment on use of the emergency department in a health maintenance organization. N Engl J Med 1996;334:635-41.
26- Magid DJ, Koepsell TD, Every NR, Martin JS, Siscovick DS, Wagner EM, et al. Absence of association between insurance copayments and delays in seeking emergency care among patients with myocardial infarction. N Engl J Med 1997;336:1722-9.
27- Soumerai BS, Ross-Degnan D. Insurance copayments and delays in seeking emergency care. N Engl J Med 1997;337:1247-8.
28- Selby JV. Cost sharing in the emergency department – is it safe?, it is needed? N Eng J Med 1997;336:1750-1.
29- Williams RM. The costs of visits to emergency departments. N Engl J Med 1996;334:642-6.
30- Navarro V. Análisis para la Asociación de Federaciones para la Defensa de la Sanidad Pública, Salud 2000, nº 33, 1991.
31- Murillo C, Carles M. Diseño de indicadores de capacidad adquisitiva de los usuarios para mejorar la racionalidad y la equidad en la financiación sanitaria. Ministerio de Sanidad y Consumo, y CRES, Madrid, 1999.
32- Ortún V. Sistema sanitario y estado del bienestar: ¿todo, para todos y gratis? En JR Amor Ed (Ética y gestión sanitaria), Sanitas-Icade, Madrid, 2000.
33- López-Casasnovas G, Puig-Junoy J, Ganuza JJ, Planas I. Los nuevos instrumentos de la gestión pública. Colección Estudios Económicos, nº 31, Caja de Ahorros y Pensiones La Caixa, Barcelona, 2004.
34- Barómetro Sanitario, Ministerio de Sanidad y Consumo, 2005.
35- Aranaz JM, Martínez R, Gea MT, Rodrigo V, Antón P, Gómez F. ¿Por qué los pacientes utilizan los servicios de urgencias hospitalarios por iniciativa propia? Gac Sanitaria 2006;20:311-5.
36- Braun T, García L, Krafft T, Díaz-Regañón G. Frecuentación del servicio de urgencias y factores sociodemográficos. Gac Sanitaria 2002;16:139-44.
37- Reed M, Fung V, Brand R, Fireman B, Newhouse JP, Selby JV, et al. Care-seeking behaviour in response to emergency department copayments. Med Care 2005;43:810-6.
38- Hsu J, Reed M, Brand R, Fireman B, Newhouse JP, Selby JV. Cost-sharing: patient knolewdge and effects on seeking emergency department care. Med Care 2004;42:290-6.
39- McConnell KJ. What do health savings account mean for the emergency department? Ann Emerg Med 2005;46:536-40.
40- OECD Health Data (Tobacco consumption), 2005.
41- Duque M. La sanidad necesita con urgencia otro "Informe Abril". El Médico, 2001.