Editorials

Patient co-payment for general practice services:

slippery slope or a survival imperative for the NHS?

Patient co-payment for general (family) practice services occur in many countries. In both New Zealand and Australia the pros and cons of universal versus targeted co-payment are openly and robustly debated. It appears that much less public and professional debate is occurring in the UK, despite a widespread recognition of the increasingly unsustainable mismatch between supply and demand for primary care services. There is currently neither sufficient NHS funding nor personnel to meet this demand, and national surveys show the ever-increasing workload is causing burnout and demoralisation in general practice.[1] While some policy discussion documents are now beginning to be considered,[2] there appears to have been relatively little discussion, either in public, among the rank and file of the profession, or in the mainstream primary care literature, on the relative merits and harms of introducing targeted point-of-care co-payment. This seems odd, given the many co-payments already present in other parts of the NHS, for such things as sensory aids, dental care, and prescription medicines.

Is universal zero cost at point of general practice care a time-expired and unaffordable NHS sacred cow? Is it time to question the unquestionable?

International observers of the NHS note increasing despondency within the general practice workforce, with much talk of a broken system tracking an unsustainable trajectory. The increased patient demand is exacerbated and compounded by the burdensome opportunity and transaction costs of a powerful, centrally orchestrated, and financially-incentivised framework. This framework is designed to drive (or buy) 'quality' through a complicated and time-consuming matrix of accountability measurements. As the columns of this Journal and many others (both popular and academic) have detailed, the combination of increased demands from patients and an onerous system of accountability has led to widespread and serious workforce stress, demoralisation, and flight to early retirement.[1] The Royal College of General Practitioners has done well to highlight this parlous situation[3] and has placed the crisis front and centre of the party political debate. In election year, as might be expected, all political parties have reacted by promising thousands more GPs. Even if these could be magically spirited up tomorrow (and numbers exceeded those retiring early), will increased numbers alone, without changing the model of care rebalance the mismatch of demand and supply?

THE ANTIPODEAN EXPERIENCE

Both New Zealand and Australia face similar sustainability challenges and are currently reviewing the way general practice is funded. Both governments are firmly focused on best value for their publicly-funded contribution while preserving and improving equity in health outcomes. Co-payment, 'value' and targeting are central elements in the discourse and engender robust debate. It is unsurprising that across populations, access and use of services is 'price sensitive' and co-payments do influence use; for better and for worse.[4]

New Zealand

In New Zealand, patient co-payments are charged at the point of care. Patients enrol with practices, as in the UK. There is a partial capitation system worked out through a fairly unsophisticated formula with age, ethnicity, and historical frequency of use as proxies for increased need. Capitation payments account for approximately half of practice income. GPs mostly run small businesses and retain the right to set the levels of co-payment to fit their business models. In recent times, by 'agreement' with government and in exchange for increased capitation, co-payments, are generally (but not universally) waived for children <6 years of age (soon to be <13 years). For this age group attendance and access does seem to be price sensitive. Removing co-payments from the under 6s in (the late 1990s) led to an increase in attendances in the first year of between 5–11% across the country.[5] For many worried parents with sick children this allowed additional free access to care. Inevitably this was accompanied by an increase of attendances for very minor ailments not requiring urgent medical review. The forthcoming effect of removing co-payments for those aged 6–13 years on appropriate demand is unknown and a likely further significant increase in such attendances is of concern to those GP organisations planning and providing after-hours care in particular.

There is ongoing and vigorous debate about smarter targeting of the capitation component of general practice funding[6–9] and a review is planned. Any change to more targeted capitation will have differential effects on co-payments. There is a growing feeling among GPs in New Zealand that further more sophisticated mechanisms for targeting subsidies are needed, recognising that ability to co-pay is variable across the socioeconomic spectrum. There is strong support from general practice to retain co-payments both as a mechanism to manage demand and as a way to encourage self-management of minor ailments.

Politically there remains an unresolved tension between universality of subsidy (popular with voters but with the risk of increasing disparities) versus increased targeting of subsidy, aimed at increasing equity of outcome.

Australia

In Australia meanwhile, fierce debate currently rages around healthcare resourcing and sustainability, as the population ages and the proportion with complex chronic disease increases steeply. The 2014 Federal Budget provoked an outcry, with the announcement of a AUS$7 co-payment for all general practice Medicare-funded consulting, pathology, and radiology items, irrespective of the patient's concessional status. By December, faced with a hostile Senate and lambasting by every health and social sector organisation and consumer group, the prime minister changed health minister and announced a commitment to co-payment for non-concessional patients only. By February 2015, Minister Sussan Ley

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had announced the government's co-pay agenda to be 'dead, buried, and cremated' and committed to work with medical groups to find other system savings. That work is ongoing.

This outcome was influenced by a diverse set of events. The Australian community collectively voiced strong support for Medicare as a universal health insurance plan, allowing free-at-the-point of care support for those in need. In addition, the introduction of a co-pay on Commonwealth-funded GPs services seemed likely to result in an escalation of expensive and inappropriate state-funded emergency department utilisation. Medicare spending on general practice was demonstrated to be only slightly increasing; whereas hospital costs were increasing steeply.[10] There was also concern for the viability of the general practice sector, with a profound and unpredictable sudden change to its business case likely to lead to the closure of many practices in rural or low socioeconomic areas. Finally, academics and medical leaders identified limited evidence of the community benefit of co-payment,[11] and instead promoted a system-wide focus on improved care quality, efficiency, and coordination, particularly for the chronic disease care which accounts for nearly 40% of Australian health expenditure.[12]

While very damaging to the Federal government, the robust community discussion around the merits of co-pay has fuelled a wide-ranging and realistic national debate about healthcare sustainability, quality, delivery, and access. We do spend a vast amount on hospital solutions and far less on community capacity building, despite the obvious future needs of an ageing population. We also waste scarce resources in the ping-ponging of cost shift between state-funded and Commonwealth-funded care. Our funding models are now far too heavily weighted to fee for service (FFS) by international standards, and would benefit from bundled payments for episodes of chronic care or quality and access incentives. And we provide minimal incentives for non face-to-face care, despite the considerable opportunities offered by telehealth in a country of our vastness.

Healthcare systems internationally struggle to marry traditional service delivery models with changing community need. Healthcare dollars and human resources are scarce and contemporary models of care and funding drivers need to be aligned to encourage community engagement, personal responsibility, and partnership, and a coordinated all-of-system approach to the delivery of acceptable and accessible care. The decision to adopt or reject co-payment as a demand and supply tool should be made in this context: it is an element to be considered, not a stand-alone solution. Depending on the (often polarised) perspective and on the available funding for and capacity to meet demand, co-payment can drive both positive and negative outcomes. The secret lies in finding the best balance with other funding drivers and incentives, a balance that delivers net benefit to collective users, to providers and to funders, without perverse equity outcomes.

Given the imperative to better match demand and supply of general practice services in the UK (and it is patients and general practice teams who would be most affected) it seems both timely and critical for both groups to forcefully enter the debate on targeted, first point-of-care co-payments.

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