



Copayments, utilisation and health outcomes

Summary of literature review

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Overview

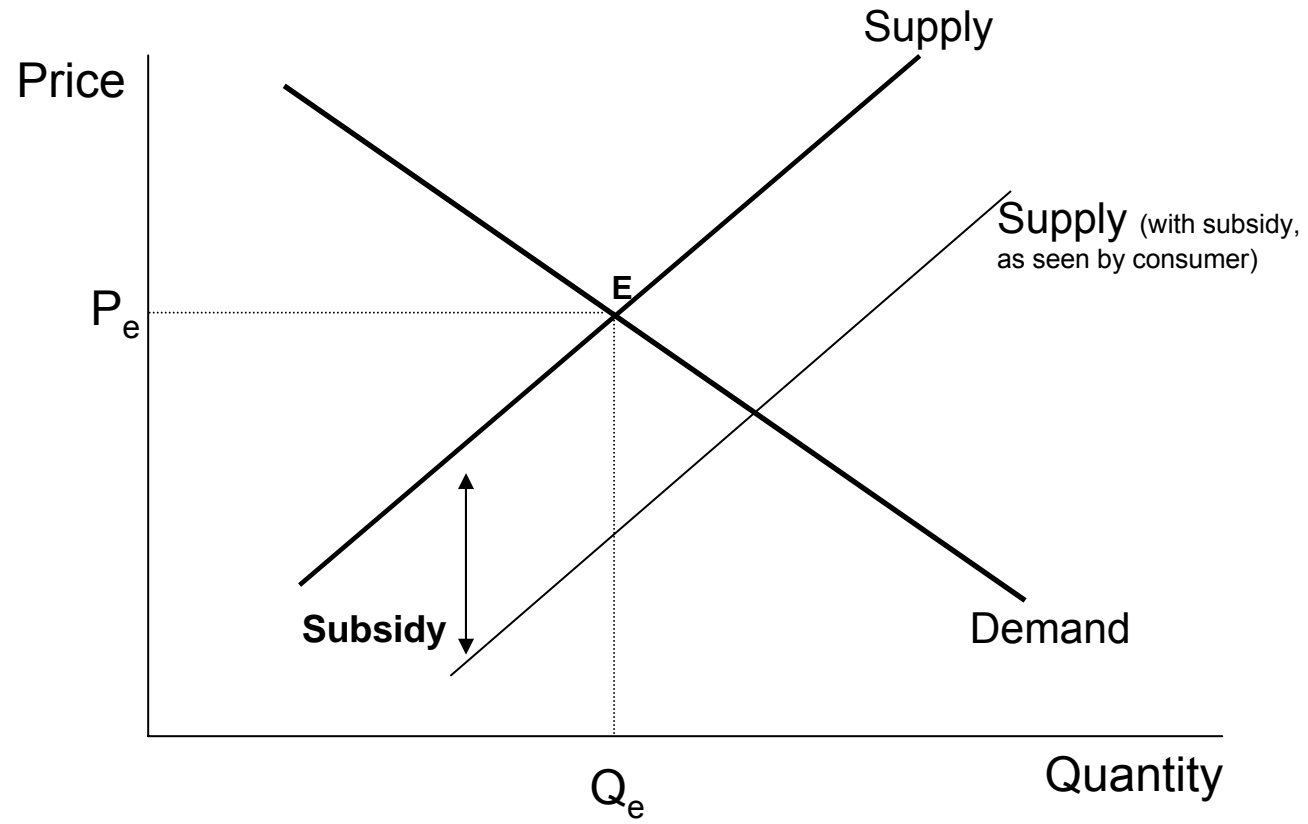
- Subsidies and copayments
- Copayments, access and utilisation
- Copayments and health and independence outcomes
- Recent New Zealand empirical evidence

Background

- The conventional conceptual framework from economics
- Review of empirical research conducted in 2005:
 - identified and reviewed abstracts of 100s of items
 - summary of 60 key pieces in annotated bibliography
 - research is mainly US-based; and mainly physician services
 - results from 1970s RAND experiment are the most authoritative
 - small amount of empirical data from New Zealand

Subsidies and copayments

- $\text{price} = \text{subsidy} + \text{copayment}$
- $\text{copayment} = \text{price} - \text{subsidy}$
- $\text{subsidy up} = \text{copayment down?}$



Copayments, access, and utilisation

- General conclusions that can be drawn from evidence:
 - good rule of thumb: copayments up 10%, utilisation down 2%
 - “The consensus based on the available evidence suggests that it might be in the range of 0.1 to 0.2 for coinsurance under 25% but could be somewhat higher if the coinsurance is raised substantially above this level” Docteur & Oxley 2003, OECD)
 - big impact is from moving from 0 copayments to 25% of costs
 - greater price-responsive for dental and allied health services
 - less price-responsive when people have an urgent/major need
 - poor are more price-responsive

Some specific results

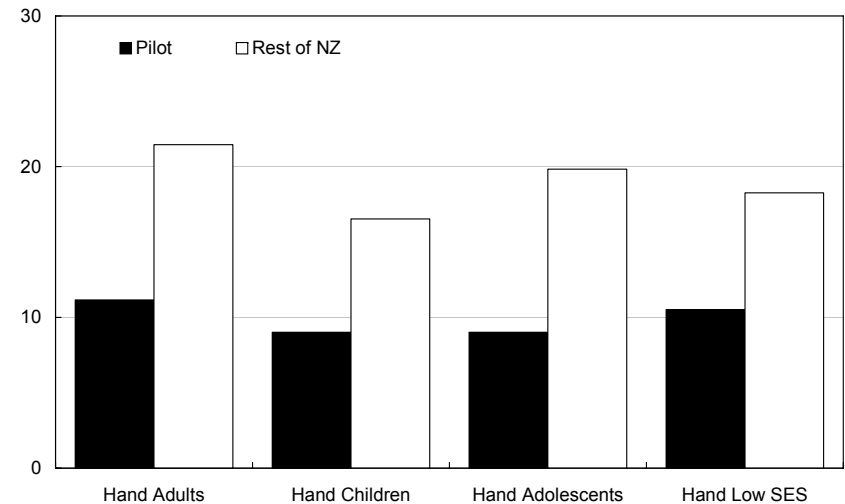
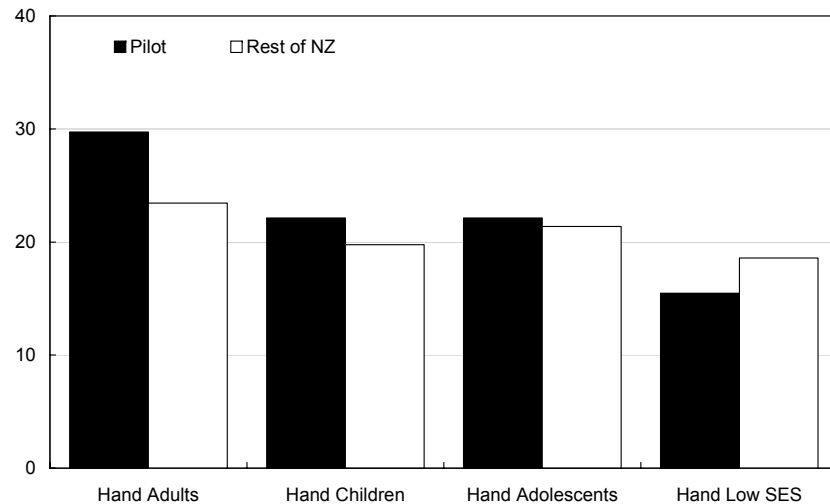
- Physiotherapist visit costs up 10% reduces visits by 1.2% (van Vliet 2001).
- A change in copayments affects the number of visits more than the decision to visit at all (Wedig 1988)
- Those with poor health status were less responsive to price in decision to use or not than those with above fair health status (Wedig 1988)
- Some evidence that 25% copayment for emergency services reduces use for eg minor ankle injuries or burns, but not serious (Ahlamaa-Tuompo 1998), and inappropriate use (Selby et al 1996, Selby 1997). But remains disputed.
- **Health warning: difficulties in comparing different systems**

Some New Zealand findings

- people who **say** that cost stopped doctor visits in last 12 months: 6 % general population; Maori 11%, Pacific 8%, poor 9% 2% of people reporting an injury. Other barriers as 'significant' as copayments (Raymont 2004, analysis of NZ Health Survey 2002/03)
- evidence of a philanthropic approach to the provision of services, as more than 20% of services provided at no or low charge (Dovey 1991, analysis of 98,000 General Medical Subsidy claims)
- number of visits increases as self-assessed health status declines (Gribben 1992, random sample of 290 South Auckland adults)
- Māori and low income grossly underutilise primary care and related services (Malcolm 1996, 1994/95 GMS, lab, pharms, and ACC claims at 8 selected health centres)

ACC GP & Radiology copayment pilot

	To April 05	From April 05	Pilot rate
GP standard	\$26.00	\$32.00	\$42.00
GP under six	\$35.00	\$35.00	\$42.00
Plain film (RVU=1)	\$31.21	\$44.94	\$53.46



Results

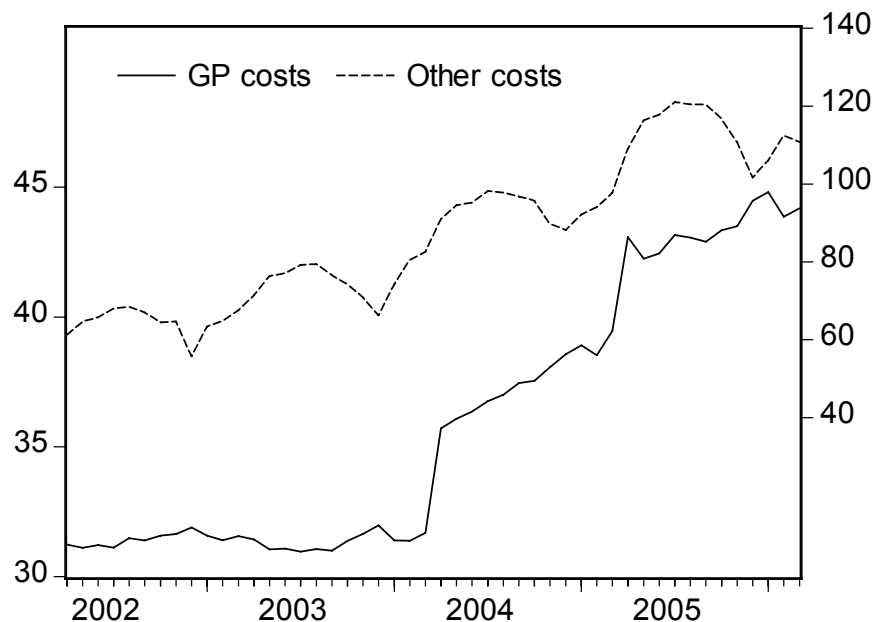
	Claims	Visits per claim	Total
Total	4.5%	-1.5%	3%
Subgroups (univariate, significant results only)			
European	5.8%		6%
Maori	5.7%	3.8%	10%
High SES	5.1%	2.8%	8%
Access PHO	11%		11%

- No evidence of an effect on duration or gap injury and treatment
- Lower visits per claim indicates extra claims less serious

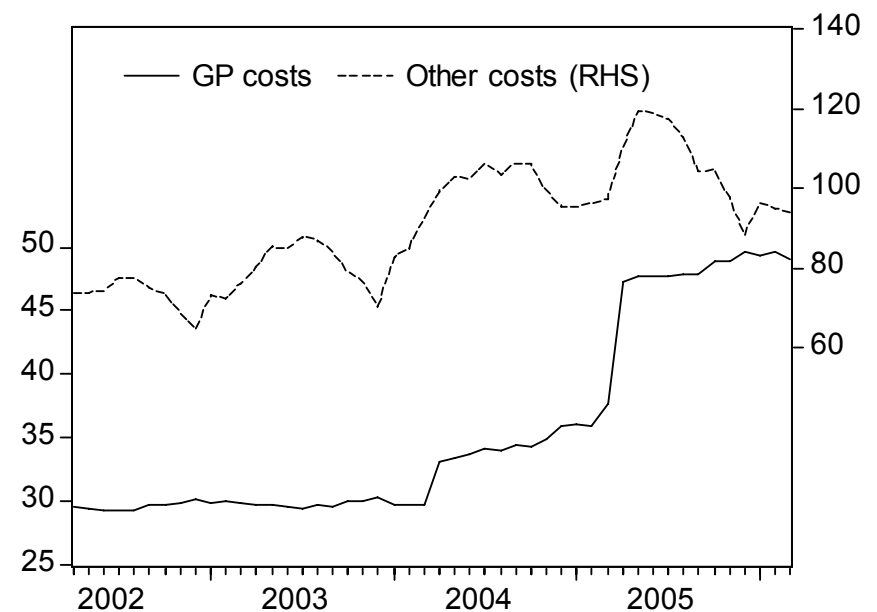
Impact

- GP subsidy up \$10, copayments down \$7.50, use up 3%
- low elasticity (-0.07), compared to literature (but accidents)
- change in price of one type of service affects demand for others

Non-pilot sites



Pilot sites



Copayments and health outcomes

- little conclusive evidence of a link between price and outcomes at the margin
- increase in copayment reduces appropriate and inappropriate services equally
- RAND shows copayments do have some health impacts for the sickly poor
- people still seek care for urgent and major conditions