

Pros and cons of copayment in sustaining health care

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As Spain grapples with its sovereign debt crisis, many are calling for copayment to help stem the growing deficit in the country's health-care system.

The economic crisis has rekindled the debate over whether the current health-care model is sustainable. Health care, which accounts for close to 10 percent of Spain's GDP, has become an obvious target for spending cuts.

Between 2007 and 2009, total health-care spending as a proportion of GDP went up by a percentage point. Demographic data suggest things will only keep rising, as dependents and those with chronic diseases represent bigger proportions of the population.

As such, many people are calling for the introduction of copayment. Spain already uses this model for prescription medicine sold in pharmacies, but most European countries also apply copayment to primary and secondary care, as well as hospital stays.

Could such a system help to stem the tide? How should it be applied? Most importantly, how would it affect patients' health?

IESE Prof. [Núria Mas](#), together with research assistants Laia Cirera and Guillem Viñolas, uses empirical evidence to [draw lessons from the copayment models](#) used in other European countries, as well as in Canada and the United States.

Rising social cost

As has happened in most developed countries, Spanish health-care spending has risen in line with per capita income.

According to data from the World Bank, from 1995 to 2009 health-care spending rose at the same rate as GDP per inhabitant, a trend that is no longer sustainable, given the current economic climate.

What's more, demographic forecasts point to a gradual increase in the ratio of dependents, i.e., people under the age of 16 or over 64.

In Spain, the ratio of dependents — currently around 48 percent — is estimated to reach 90 percent by 2050.

The ratio of dependents who are sick or suffer from chronic illnesses will also increase, especially after the age of 65.

The authors identify three main policy options for tackling the health-care deficit.

1. *Change the Health-Care Model.* This will boost efficiency in spending, as well as address the needs of chronic patients. It means identifying what is working correctly, establishing a protocol of best practices, and integrating primary and specialized care.
2. *Prioritize the Services Offered.* This means limiting and clearly defining what type of treatments are covered by the public health-care system.
3. *Extend the Copayment Mechanism.*

Sharing the burden

According to the authors, making people share responsibility for health-care expenditure would make them more aware of the costs involved when it comes to deciding whether to seek treatment.

Copayment would contribute to rationalizing health-care spending and moderate the use of the system, especially for services that have the least effect on patients' health.

However, the experience of countries such as the United States shows that copayment reduces the consumption of medication and health-care services, especially preventive

appointments and less essential services. This might lead to less use of both valuable and less valuable health-care services.

The challenge is to design a system in which the services that people stop using as much are those that are less vital to their health.

Furthermore, an international comparison shows that implementing copayment only in primary care can prompt people to use emergency room (ER) services more, a habit that could lead to an overall increase in health-care costs.

Risks to bear in mind

On the whole, copayment systems do not seem to translate into worse health.

That said, if the system introduced is not designed properly, there are two groups that will be left particularly vulnerable: lower-income patients and high-risk patients, such as chronically ill people or ER patients.

For this reason, the design of any copayment mechanism must take these groups into account.

One controversial issue is that of the effect of copayment on ER services: Some research shows that it reduces ER visits, both for mild and serious cases.

However, copayment does not seem to reduce ER use in truly critical situations.

The way forward

The authors believe that if Spain opts for a broader copayment system, policy makers should keep the following three points in mind.

- *Income Levels.* Lower-income people should be protected with some kind of formula, such as stop-loss clauses, in order to limit patients' maximum outlay. The copayment model currently used for prescriptions should be avoided, because it works the same for everyone, regardless of income.
- *ER Care First.* It makes more sense to apply a copayment model to ER visits than to primary care.
- *Differential Copayment.* It is also a good idea to apply a different copayment fee, depending on the kind of service provided. Costs should be minimal or nonexistent

for preventive care, to avoid a reduction in preventive measures such as periodic checkups. It may also be worth setting higher copayment levels for services that are less efficient or beneficial.

The authors acknowledge that copayment is just another tool in the overall rationalization of health-care spending. In no way can it take the place of thorough health-care reform that addresses the long-term challenges of a graying population.

Clearly what's needed is a radical rethink of how we coordinate and manage the disparate elements of the health-care system, with a particular emphasis on improving efficiency.

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