

Equity in the Utilisation of Health Care in Ireland

RICHARD LAYTE and BRIAN NOLAN

The Economic and Social Research Institute, Dublin

Abstract: This paper analyses the extent of equity of health service delivery across the income distribution in Ireland – that is the extent to which there is equal treatment for equal need irrespective of income. We find that almost all services, apart from dental and optician services, are used more by those at the lower end of the income distribution, but that this group also have the greatest need for health care. The comparison of health need to health care delivery across the income distribution without standardising for confounding factors suggests that those in higher income groups receive more health care for a given health status indicating inequity. However, need for health care is highest among the elderly and this group also tend to be at the bottom of the income distribution. Once we standardise for age, sex and location we find that hospital services are distributed equitably across the income distribution, whereas GP and prescription services tend to be pro-poor (used more by those with lower incomes for a given health status) and dental and optician services tend to be pro-rich (used more by those with higher incomes for a given health status).

I INTRODUCTION

Most people would agree that good health is a central component of quality of life and that effective health care services can be essential in maintaining this. The difficult question, however, is how such services should be financed and who should have access to which services and at what cost. The Irish health care system has developed a complex answer to this question over an extended period so that Ireland now has what (Barrington 1987, p. 285) has described as an “extraordinary symbiosis of public and private medicine”. For example, although those with a medical card (around 35 per cent of the population) receive free dental, aural, optician and GP care, the rest of the population must pay at the point of delivery. Similarly, although public hospital care is available to the whole population subject to relatively small fees for those without medical cards, almost half of the population now have medical insurance which can be used in both private and public hospitals

with hospital consultants catering for both public and private patients in public hospitals as well as private patients in private hospitals. The importance of private care and the extent of fee paying in Irish health care has led many to argue that the system is not available to all on the basis of need alone, but instead that personal circumstances may well determine the availability, extent of and speed of treatment.

This paper analyses the extent of equity of health service delivery across the income distribution in Ireland – that is the extent to which there is equal treatment for equal need irrespective of income. Although this initially sounds quite a simple problem, in fact there has been a substantial debate in the health economics literature as to how “equity” should be defined and the implications this has for the methodology adopted. In the Irish context there has been surprisingly little work on either a conceptual or empirical level, the main contributions being by Tussing (1985), Nolan (1991) and Nolan *et al.* (1992), all of which used data from the 1980s.¹ There is thus a serious need for new analyses of utilisation patterns in the Irish population and their determinants. One of the reasons for this paucity of analyses is a lack of information available to assess the question. The primary requirement is for information on the utilisation of a wide range of health care services and individual or household level data on income. From these data we can assess whether the extent of usage is roughly similar at different levels of income. However, in doing this we must also take account of differential “need” for health care across the population, and the fact that this may well be correlated with income. The crucial question is whether people at different levels of income, but with the same need for health care utilise services to a similar extent or whether utilisation relative to needs is unevenly distributed across the income distribution. As well as information on health care usage and income then, we also need information on the health status of the individual. Luckily these data are all available to us in the form of the Living in Ireland Survey for 2000.

The paper is laid out as follows. In the next section we discuss the meaning of equity in studies of health care utilisation before outlining the approach that we will be taking. Following this we briefly describe the data used in this paper – the Living in Ireland Survey for the year 2000 (LII) in Section III. In Section IV we examine the distribution of health care utilisation across the income distribution. In Section V we use the level of expenditure on specific types of services to generate a unitary metric of utilisation before examining the measures of health status that we have available in the LIS data file in

¹ More recent, but as yet unpublished work has been carried out by the OECD using ECHP data which is a subset of the data used in this paper (van Doorslaer 2003 forthcoming).

Section VI. In Section VII we compare the utilisation of health care services across the income distribution relative to “need” as measured by several health status measures and attempt to assess whether the level of utilisation in different quintiles is equitable. In Section VIII we adopt a more analytical statistical strategy and examine the equity of health care utilisation relative to need controlling for a number of factors that may confound the relationship. In Section IX we summarise the findings of the paper and attempt to draw out some conclusions.

II EQUITY IN HEALTH CARE DELIVERY

In health and health care as in many other areas of policy, “equity” is often stated as an overarching concern that guides policy and practice.² In the health economics literature, however, there has been a long running debate about what aspect of equity in health care is important and how this should be measured. On the one hand some researchers (Le Grand 1982; Mooney 1983; Mooney *et al.* 1991; Mooney *et al.* 1992) have maintained that equity should be defined in terms of equal *access* to treatment whereas others (Culyer, van Doorslaer and Wagstaff 1992b; O’Donnell and Propper 1991) hold that health economists should be analysing equity in the actual utilisation of health care itself. From the early 1980s Mooney (1983) and Le Grand (1982) have maintained that equity in most policy statements refers to equity of access to health care services in the sense that those with an equal need for treatment have equal opportunity to get it, or to put it another way, face an equal cost of utilisation. The main argument put forward by the advocates of the access approach is that an individual’s level of health care utilisation is determined by a range of factors that often have little to do with health care services *per se* and more to do with factors that shape the individual’s demand for health care. One of these may be the “need” for treatment, but even individuals with equal need may end up consuming different amounts of care if preferences differ (perhaps in the individuals’ perception of the benefits of treatment) and if their marginal utilities of income differ. From this perspective, to attempt to measure the equity of utilisation is to be focusing on the wrong subject (hence the subtitle of Mooney *et al.*’s 1991 paper: “Weighing Heat?”).

Culyer, van Doorslaer, and Wagstaff (1992a; 1992b) on the other hand have argued that although it is self evident that persons in equal need may

² For instance, the Irish Health Strategy – *Quality and Fairness: A Health System for You* (Department of Health and Children, 2001) states that “equity and fairness” is one of the four guiding principles by which the health care system will be shaped.

end up consuming different levels of health care because their demand curves differ, we still need to know why the curves differ and whether the difference may in fact be due to differences in income. They use the example of differences in education between the rich and poor (Culyer, van Doorslaer and Wagstaff, 1992b, p. 94). If the poor have the same opportunities to receive care as the rich but have a lower take up rate simply because they are not as well informed, surely this would be a concern to policy makers and analysts alike? If so, simply examining the extent of and costs of access for the rich and poor would not be the optimal research strategy. Using a measure of utilisation on the other hand we would also be able to analyse the factors that explain the lack of take up of care among the poor. Given this, we would do well to study equity in the utilisation of health care as well as the costs and problems of accessing health care to discover the true source of the inequalities between groups. In this paper we largely adopt the former approach, although in the next section we will be discussing the issue of access and cost. Our overall question is whether the utilisation of health care is horizontally equitable in the sense that those in equal need receive the same level of treatment irrespective of their income. To put the question another way – do those with a higher level of income consume greater levels of health care for the same level of health need? In the Irish context however, we cannot avoid a discussion of the costs involved in accessing health care and how these may vary across the population and between those who are better or worse off financially. The following discussion examines this question.

Much of the research just mentioned discussed the situation in the National Health Service in the UK. Given the structure of NHS financing and delivery this meant that the serious issues were about the indirect costs of accessing care and differences in preferences across socio-economic groups. In the Irish context however there are concerns both about the *indirect* and *direct* costs of gaining access to health care. Inequity in the delivery and utilisation of health care is likely to occur where the incomes and resources available to consumers affects their take-up of available services and the behaviour of health care providers. Where there are financial and non-financial costs in contacting health care providers and receiving care these can influence the individuals decision to seek care. These costs can include out of pocket payments for particular services as well as more indirect costs such as the cost of travelling to services and work time foregone and of course these costs and their impact are themselves likely to vary across income groups. For example, those on lower incomes are more likely to have to use public transport to access medical services and this, particularly for those in rural areas on low income, is likely to impact on their incentive to seek care.

In Ireland charges for general practitioner, dental, aural and optician

visits (at the point of delivery) may be an important influence on seeking care, with the greatest impact on those on low income but without medical card cover, since a fixed charge will have a greater impact on foregone utility for poorer consumers. Although public hospital care is subject to only relatively small or no charges at the point of delivery in Ireland, waiting lists for most forms of treatment mean that one's ability to pay for treatment directly, or having access to medical insurance which can pay will allow individuals to access treatment more quickly and may influence the individual's decision to seek treatment initially. Around 50 per cent of the Irish population are currently medically insured either with VHI or BUPA.

Provider behaviour can also be influenced by the method of payment within the Irish system. The capitation method of payment used to refund GPs treating patients with medical card cover means that GPs have an incentive to see more private patients. Similarly in the hospital context, the fact that hospitals receive a fee for private patients rather than the prospective budget allotted to them from state funding may well influence their behaviour in allocating resources. Together these mechanisms mean that there may well be large differences between the utilisation and delivery of health care services to those in different parts of the income distribution.

As will be seen in Section IV, we will analyse overall utilisation across a range of services by calculating a single metric for aggregating different types of utilisation which weights different services on the basis of an estimated unit cost for each. This is derived from the total expenditure on that service both by the state, private insurance companies and individual households, and divided by the estimated total number of times this service was used. This procedure in effect assumes that the "benefit" derived by individuals from that service was the same for both private and public patients since we are using the average cost across the two. This procedure is only reasonable if one assumes that private and public services, or rather the service obtained by either paying privately or publicly are identical in terms of their health benefits. This would not be reasonable if one were trying to analyse the total utility derived from taking the private rather than the public route since a night in a public hospital ward does not cost the same as one in a private bedroom and the latter is clearly worth more to the private patient, even if only in terms of the "hotel" services provided. In terms of the health care received, however, there is little systematic evidence available for the Republic of Ireland. Evidence from (Fadden 2003) in a pharmacy study of the over 70s before and after the extension of the medical card to this age group has shown some difference in prescribing behaviour between GMS and non-GMS patients. The rate of prescribed generic drugs among GMS patients was roughly twice that among private patients. This is usually good practice since

generic drugs are cheaper and on the whole, just as effective, but specific proprietary drugs can offer less side effects and a better interaction profile for particular patient types. She also notes that some patients complained of an inferior service after the change with GPs restricting GMS patients to certain hours of the day and not seeing GMS patients for regular check-ups. Wren (2003) has also argued that hospital care for public patients is also less effective than among private patients, the latter being given more time in hospital, more attention and a greater range of tests.

III DATA SOURCES

The LII Surveys form the Irish component of the European Community Household Panel (ECHP): an EU-wide project, co-ordinated by Eurostat, to conduct harmonised longitudinal surveys dealing with household income and labour situation in the member states. As well as extremely detailed information on income levels and sources, the LII data also includes information on other important topics of relevance to this paper including several self-assessed health status measures, health care utilisation and a wide range of socio-demographic characteristics. The first wave of the ECHP was conducted in 1994, and the same individuals and households were followed each year. The wave conducted in 2000, therefore, was the seventh wave of the survey. In 2000, the Irish sample of individuals and households followed from Wave 1 was supplemented by the addition of 1,500 new households to the total, in order to increase the overall sample size which had declined due to attrition since 1994. The objective of the sample design was to obtain a representative sample of private households in Ireland. Those living in institutions such as hospitals, nursing homes, convents, monasteries and prisons, are excluded from the target population, in line with the harmonised guidelines set down by Eurostat and standard practice adopted in surveys of this kind (such as the Household Budget Survey conducted by the Central Statistics Office).

The sampling frame used was the Register of Electors. This provides a listing of all adults aged 18 years and over who are registered to vote in the Dáil, Local Government or European Parliament elections. This means that the target sample selected using the ESRI's RANSAM procedure was a sample of *persons*, not of *households*. Since the probability of selection is greater for households with a larger number of registered voters, this means that the resulting sample will tend to over-represent larger households. This was taken into account in reweighting the sample for analysis.

The total number of households successfully interviewed in 1994 was 4,048, representing 57 per cent of the valid sample. The number of households

and individuals being interviewed declined with attrition over time so in 2000 the original sample was supplemented with an additional 1,500 households selected using the same procedure.

The sample supplementation exercise, together with the follow-up of continuing households, resulted in a completed sample in 2000 of 11,450 individuals in 3,467 households. Individual interviews were conducted with 8,056 respondents, representing 93 per cent of those eligible (born in 1983 or earlier). This sample was reweighted to take account of sampling error from the actual population in 2000 and these weights are used throughout this paper, thus the data is fully representative of the Irish population in private households in that year.

IV HEALTH CARE UTILISATION BY INCOME

In this section we examine the pattern of health care utilisation across a range of services across the income distribution. The LII survey included questions (given to all survey respondents) on their use of health care services including consultations on their own behalf with GPs (including home visits), medical specialists (including outpatient services), dentists and opticians in the last twelve months. The survey also asked about nights spent in hospital over the same period. Unfortunately, the LII survey did not include information on the number of prescriptions filled for respondents. To fill this gap, econometric models of the number of prescriptions were estimated using the 1987 Survey of Income Distribution, Poverty and Usage of State Services also carried out by the ESRI, and used to produce estimated numbers of prescriptions for each person.³

Similarly, questions on usage of services were only asked of adult interviewees in 2000. To estimate service usage for children in the household, models were estimated of all services and prescriptions using the 1987 data which did contain information on children and these estimates were applied to the 2000 data.⁴ Using this information we gain a relatively detailed picture of utilisation in the last year and give some descriptive statistics on utilisation in Table 1.

³ The models included variables for age, number of GP visits, whether the person had a chronic illness, rural/urban location and medical card status, all of which were found to be highly significant. Comparisons of the proportion of all prescriptions accruing to different income quintiles in the 1987 data compared to 2000 data showed substantial similarity. For example, whereas 10.7 per cent of all prescriptions accrued to the highest quintile in 1987, 11.4 per cent did so in 2000. Only in the lowest quintile was the gap more substantial at just over 6 per cent.

⁴ These models included terms for the child's age, household income level, medical card status and parents' GP usage, as well as the child's GP usage in models of other service use.

Table 1: *Use of Specific Health Care Services in Twelve Months Previous to Interview in 2000*

Service	% Visiting <i>N</i> times						Mean
	0	1-5	6-10	11-20	21-50	50+	
Inpatient Nights	87.7	6.7	2.5	1.7	0.9	0.4	10.13
Doctor Visits	28.4	53.4	9.2	7.3	1.3	0.2	4.76
Dentist Visits	58.9	39.2	1.3	0.3	0	0	1.98
Optician Visits	72.7	27.1	0.1	0.0	0	0	1.23
Outpatient	75.5	21.6	2.0	0.6	0.1	0	2.96

Table 1 shows, as expected that the vast majority (88 per cent) of people did not have any inpatient care in hospital in the last year. Of those that did have some, the largest proportion had between 1 and 5 nights in hospital with the average for those who experienced 1 or more nights being just over 10. This is one night less on average for those having any stay than found by Nolan (1991) using survey data from 1987, which is consistent with the downward trend in length of stay shown by administrative statistics.

For visits to the general practitioner, on the other hand, the 2000 data show that over 70 per cent see a doctor at least once in the year, with 53 per cent attending between 1 and 5 times and a substantial 9 per cent attending more than 10 times in the last 12 months. The mean number of doctor visits across the whole sample is almost identical to that found in 1987 at 3.4, with the mean for those attending at least once being almost 5.

When we look at visits to dentists, opticians and outpatients we see substantially lower figures with a large 59 per cent not taking their dentists advice and staying away for the year and more than 70 per cent not seeing an optician or attending an outpatient clinic at a hospital, having day surgery or attending an accident and emergency department.⁵

Our central concern is how this pattern of utilisation is distributed across the income distribution, and this can be illustrated by first categorising people in terms of their position by income quintile. With one-fifth of persons in each quintile, we can then look at the share of total utilisation for each service attributable to each. For practicality, we first give the distribution using unequivalised income quintiles, that is, not adjusting for differences in the number and composition of households. Table 2 shows that the bottom 40 per cent, the two lowest income quintiles, have over half of all hospital nights and GP visits.

⁵ Unlike in the 1987 ESRI survey, the LII 2000 questions did not differentiate between day surgery and outpatient visits and this has implications for the allocation of costs since day surgery is more expensive.

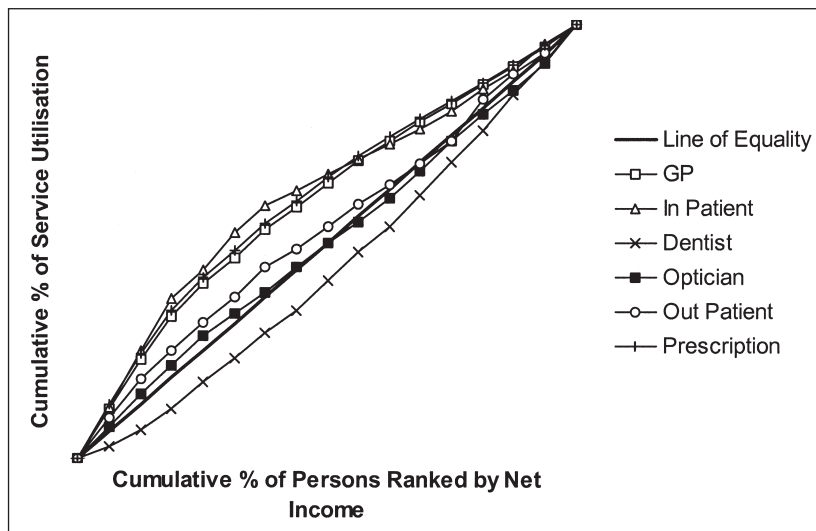
Table 2: *Shares of Service Utilisation by Disposable Income Quintile*

<i>Income Quintile</i>	<i>Inpatient Nights</i>	<i>Doctor Visits</i>	<i>Dentist Visits</i>	<i>Optician Visits</i>	<i>Outpatient Visits</i>	<i>Prescriptions</i>
Lowest	31.5	33.8	13.6	21.6	26.5	41.4
2	20.9	20.8	18.5	19.0	18.8	19.5
3	12.4	16.9	20.4	17.9	16.2	15.2
4	15.9	14.0	24.1	20.0	18.0	11.5
Highest	19.3	14.5	23.3	21.6	20.5	12.4

The bottom one-fifth has 32 per cent of inpatient nights and 34 per cent of all GP visits. The high share of the lowest quintile is particularly pronounced in the case of prescriptions where the lowest 20 per cent of the income distribution have over 41 per cent of all prescriptions and the lowest two quintiles have over 60 per cent. When we look at the distribution of dentist and optician visits on the other hand we see the opposite pattern, with over 23 per cent of dentist visits and 22 per cent of optician visits occurring in the top income group. The rather different distribution of dentist visits across the population is not wholly surprising since dental work could be regarded in some sense as an investment, both in appearance and dental health status. Given this, it is likely that dental utilisation will be more positively associated with income. Table 2 also shows that outpatient hospital services tend to be more bimodally distributed, with the two bottom quintiles accounting for around 45 per cent of all visits and the top quintile 21 per cent. Given that outpatient services here refer to both attendance at accident and emergency and visits to medical specialists for both consultation and day surgery (both in private and public hospitals), it may be that we are seeing different types of utilisation – use of hospital consultants among those in the highest quintile and use of accident and emergency among those in the lower quintile.

One way of capturing the pattern of utilisation across the income distribution, pioneered in this context by Wagstaff *et al.* (1991), is by using the ‘concentration curve’. This is produced by ranking individuals (or groups) by income and charting the cumulative proportion of the population (from lowest to highest income) against the cumulative proportions of service use. If use is equally distributed across income groups then the curve will coincide exactly with the diagonal, or line of equality. On the other hand, if service use is concentrated in lower income groups the line will lie above the diagonal, and vice versa.

Figure 1 shows the concentration curves for the different types of service utilisation for Ireland in 2000. It illustrates that GP care, inpatient nights and prescriptions are concentrated among lower income groups, with prescriptions

Figure 1: *Health Service Utilisation Concentration Curves*

being most concentrated in this way followed by GP visits. On the other hand both dentist and optician visit curves lie below the diagonal, showing concentration among higher income groups. Interestingly, the curve for outpatient visits cuts across the diagonal from above to below in the upper reaches of the income distribution again suggesting different types of usage across the income distribution.

This is also true of optician visits, although this line crosses the line of equality much lower down the income distribution again suggesting high rates of usage in the top and bottom of the distribution. Older people have the highest use of optician services and one interpretation of this pattern may be that the heavier usage that we see at the bottom of the income distribution is in fact older people whereas heavier use at the top of the income distribution is much more a function of greater affordability for this group.

Wagstaff *et al.* (1991) have put forward the concentration index (CI) as a useful summary measure of the distribution of service utilisation across the income range. This is calculated as minus twice the area between the concentration curve and the diagonal and ranges from -1 (all service use is among the most disadvantaged) to $+1$ (all use is among the most advantaged). As mentioned above, the quintile estimates shown in Table 2 were based on unequivalised disposable household income (attributed to each individual in the household), but the composition of households at different points in the income distribution may well influence our results. Given this, Table 3 gives

CI estimates and standard errors⁶ for net income and for income equivalised using two different equivalence scales so that we can judge the impact that different weightings for adults and children has on results.

Table 3: *Concentration Index for Different Utilisation Types, 2000*

	<i>Inpatient Nights</i>	<i>Doctor Visits</i>	<i>Dentist Visits</i>	<i>Optician Visits</i>	<i>Outpatient Visits</i>	<i>Prescrip- tions⁷</i>
Net Income	-0.116	-0.183	0.110	0.009	-0.059	-0.276
S.E	0.058	0.016	0.020	0.024	0.044	0.016
Equiv. A	-0.141	-0.152	0.159	0.076	-0.022	-0.270
S.E	0.048	0.017	0.019	0.021	0.036	0.014
Equiv. B	-0.138	-0.152	0.153	0.078	-0.026	-0.268
S.E	0.048	0.016	0.019	0.021	0.036	0.014

Equivalence scale A weights the first adult by unity and all other adults by .66 and all children (aged >14) by .33. Equivalence scale B on the other hand weights all subsequent adults by .6 and children by .4.⁸ Scale B is particularly useful for analytical purposes because of the greater weight it gives to children relative to other scales that are used. Unlike in Table 2 and henceforth in this paper we also base the estimations in Table 3 on the individual/household data rather than aggregating within quintiles.

Table 3 shows that the direction of the CI coefficients across income measures is consistent. Inpatient nights, doctor visits, outpatient visits and prescriptions are all negative suggesting that utilisation is greatest among the more disadvantaged. This is most pronounced for prescriptions with CIs of around -.27. For dental and optician visits on the other hand the coefficients are positive showing greater utilisation among the better off, although this is only marginal for optician visits. The CI estimates change substantially if equivalisation is used, although not in a uniform direction. For hospital inpatient nights the pro-poor distribution is increased, whereas for GP visits, outpatient visits and prescriptions it is attenuated somewhat. It is interesting to see though that the use of a different equivalence scale does not significantly alter the results with only marginal differences between scales A and B being found.

⁶ All CI standard errors in this paper are calculated using the methodology outlined by Kakwani, Wagsatff and van Doorslaer (1997).

⁷ It should be borne in mind that the stated SE for prescriptions are not adjusted for the fact that the index for prescriptions is itself calculated on the basis of fitted values using the 1987 survey. Adjusting for this would substantially increase the standard errors.

⁸ Scale A approximates the relationships implicit in major Irish social welfare schemes and scale B has been widely used in analyses of poverty and income distribution in the UK.

V AGGREGATING DIFFERENT TYPES OF UTILISATION

Having examined the extent of utilisation of a range of different health services across different income groups, we would like to be able to relate overall service use to the “need” for services, as well as position in the income distribution. To do this we have to bring together two elements: a measure of health which summarises the “need” which an individual has for health care services, and a measure of utilisation which aggregates the different types of service use so that comparisons can be made between overall utilisation and need. In the next section we examine three different measures of health, but here we deal with the issue of finding a method for combining utilisation of different services into a single measure.

Although one could think of different methods for combining the measures of service utilisation, the most simple and consistent method is to derive a unit cost for each service, and use these as the weighting factors. We can then use these weights together with reported service use in the last 12 months in our survey to produce a measure of overall utilisation for each person in our sample. To estimate unit costs, expenditure on each health care service, by government, insurers and households, is aggregated and divided by the total usage of that service as reported in the LIS 2000. No differentiation is made between use of private and public services, with implications to which we return below.

5.1 Estimating Unit Costs

To estimate unit costs for different types of services, we begin with state expenditure on health care distinguishing:

- GMS spending on GPs and prescriptions.
- The subsidy for drug purchase for non-medical card holders and drugs refunds for long-term illness.
- Dental, ophthalmic and aural services funded under GMS.
- The general hospital programme spending on Regional, Public Voluntary and Health Board County Hospitals as well as a proportion of spending on District Hospitals.

We include only non-capital costs and do not include expenditure on income maintenance programmes administered by the Department of Health and Children. Similarly, expenditure on long-stay hospitals and homes as well as psychiatric hospitals is not included, as our sample covers only private households. Expenditure on day care for the disabled or psychiatric treatment are also excluded since information was not gathered in the survey which would allow these to be allocated to households. To avoid double counting,

charges accruing from private and semi-private accommodation in public hospitals are deducted from the overall acute hospital expenditure total.

Expenditure on the general hospital programme includes both inpatient and outpatient care, so establishing the separate cost of outpatient care becomes very difficult. To derive an estimate of expenditure on outpatient care, which includes day surgery, we estimated that the cost was six times greater than the current cost of a GP visit which amounted to €193.50. This estimate is speculative, but varying the amounts was found to not affect the overall patterns and moreover is the same cost ratio as used in Nolan (1991) and so facilitates comparisons. It should also be borne in mind that this unit cost is the average of day surgery cases and outpatient visits, the former being considerably more expensive. Unfortunately, the wording of the LII question conflated day surgery and outpatient visits.

Expenditure by VHI on hospital care was taken from published figures with an estimate for BUPA expenditure derived from the average VHI expenditure multiplied by the current number of BUPA policyholders that we estimate to be 5 per cent of the VHI total. This is probably an over estimate of BUPA expenditure given the younger profile of BUPA policy holders.

Household health care spending on GP, dentist, medical specialist and optician visits as well as out of pocket expenditure on nights in hospital was derived from the Household Budget Survey for 1999/2000. That is, we derived the households total out-of-pocket expenditure on health care services and then divided this by the number of visits to each service type during the period of interest.

Combining these different sources of current expenditure and dividing them by service use among individuals in the LIS data we get the following estimates of the unit cost, in terms of overall resource use, for each type of utilisation:

- €32.25 per GP visit.
- €325.12 per night in hospital.
- €30.74 per prescription.
- €99.44 per visit to a dentist.
- €27.54 per visit to an optician.
- €47.67 per prescription under the long-term illness scheme.
- €193.50 per outpatient visit.

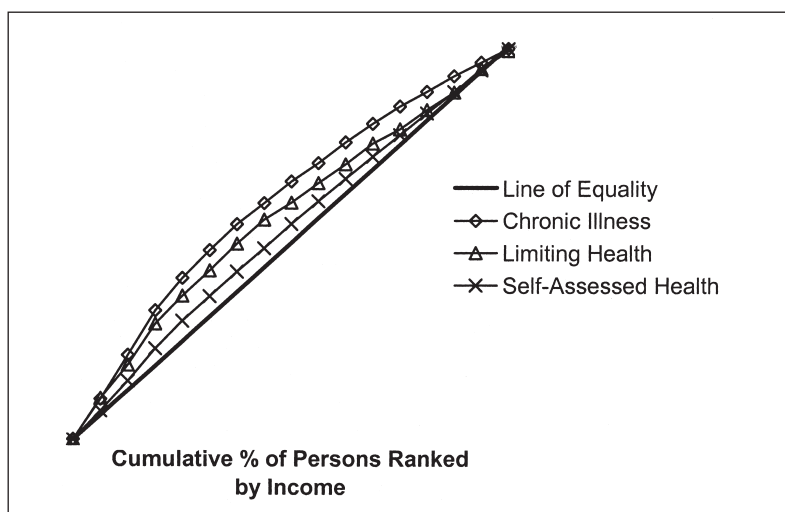
VI MEASURING HEALTH STATUS

Blaxter (1989) has classified morbidity measures as falling into three main types depending on the underlying conceptual model: the *medical*, the

functional and the *subjective*. The first defines health in terms of deviation from some physiological norm, the second defines ill health in terms of lack of ability to perform “normal” tasks and roles and the last is defined in terms of the individual’s perception. The LII 2000 data includes an example of all three of these different types of measures which we could use. In terms of the medical model, the LII survey includes a variable on whether the person has a chronic physical or mental health problem, illness or disability. It also includes a question which asks whether the respondent has “cut down” or not done any of the things which they would normally have done due to a physical or mental health problem which allows us to construct a functional measure of limiting illness. The LII survey also includes a measure based on the individual’s subjective assessment in the form of a question asking “in general, how good would you say your health is?” with outcomes from ‘very good’ to ‘very bad’ via ‘fair’. Whilst these measures are certainly simple, there is good evidence (for example in Blaxter) that such measures are close analogues of clinically assessed health status and good predictors of outcomes such as mortality.

A more serious problem would seem to be the possibility that particular groups may respond to the measures in different ways. For example, there is evidence (Bowling 1991) that women are more negative about their health status and more likely to seek help for a given condition than men. It is also possible that comparator groups are an important aspect of self assessed health and thus we may find that the reported health of those in groups where

Figure 2: *Illness Concentration Curves*



the average health status is lower may well be “standardised” in comparison to the group rather than to an overall societal standard.

In this paper we will be controlling for various factors in our analyses and, as described above, are fortunate in that the LIS data has three different measures of health that can be used. Using these techniques we should be able to limit the impact of any such reporting biases.

Table 4: *Distribution of Ill Health by Equivalent Income Quintile*

<i>Income Quintile</i>	<i>% of those with Chronic Illness</i> %	<i>% of those Limited by Illness</i> %	<i>Self-Assessed Health</i> %
Lowest	33.25	31.36	24.29
2	24.06	22.42	20.78
3	18.88	15.93	19.37
4	12.78	15.18	17.93
Highest	11.02	15.12	17.63
CI	-0.226	-0.149	-0.065
SE	0.021	0.035	0.006
P	<0.0001	<0.0001	<0.0001

The relationship of each of these measures of health to income can once again be illustrated by graphing the concentration curves, as shown in Figure 2. Previous research (Wagstaff and van Doorslaer, 1994) has shown that alternative dichotomisations of multiple category health variables such as the self-assessed measure (SAH) mentioned above can lead to different levels of measured inequality. To avoid this problem, here we follow Wagstaff and van Doorslaer (1994) and transform the SAH using the assumption that the SAH categories represent an underlying continuous distribution. Figure 2 and Table 4 show that all three measures are concentrated among those in the lower part of the income distribution (the lines all being above the line of equality), but the extent of concentration varies. The self-assessed health measure is least concentrated among the poor with around a quarter of ill health among the poorest income quintile, followed by the functional measure where this group have over 31 per cent of illness. The medical measure of chronic illness is the most unequally distributed across income groups with over 33 per cent of all chronic illness being among the lowest 20 per cent of the income distribution and only 11 per cent among the richest 20 per cent.

As with the measures of utilisation we can also derive the concentration index to get a more precise measure of inequality for the health measures and these are shown in the bottom three rows of Table 4. This confirms that the

self-assessed health measure is the least concentrated among the worse off, with a Concentration Index of -0.065 . This is followed by the functional measure of limiting illness (-0.149), with the chronic illness measure most unequal at -0.226 . It is clear that different measures lead to rather different results, although all are unevenly distributed to the detriment of those on lower incomes. Any of these measures of health is of course a rather crude indicator of those aspects of the person's health that would require medical intervention and the take-up of services, but in the current context they do allow us to produce a benchmark on which to improve subsequently with more in-depth information about health.⁹

VII COMPARING UTILISATION TO NEED

Having computed an aggregate utilisation figure for each individual we can now compare this to the health measures, by computing for each the proportions of utilisation/imputed expenditure found in each equivalised income quintile group. This is shown in the left hand column of Table 5.

We see that the bottom quintile has a higher share of utilisation than the other quintiles, at 26 per cent, with the third, fourth and fifth quintiles having a below-average share. This pattern is broadly similar to that found by Nolan (1991) using data for 1987, although the proportion accruing to the top quintile is now considerably higher at 17.5 per cent compared to 15.4 per cent in 1987.

If we compare the distribution of utilisation to that of our illness measures, Table 5 shows that the latter are considerably more concentrated towards the bottom of the income distribution, except for the SAH measure. Whereas 26 per cent of utilisation is concentrated among the lowest income quintile, as we saw before, this is true of over 33 per cent of chronic illness. On the other hand, whereas the top quintile receives over 17 per cent of health care, it has around 11 per cent of chronic illness. The SAH health measure on the other hand is less skewed in its distribution than the utilisation measure with 24 per cent of poor self-assessed health in the lowest quintile compared to over 26 per cent of utilisation. As both utilisation and the illness measures are concentrated among the more disadvantaged, the concentration indices are all negative.

⁹ It could be argued that any of our three health variables are poor measures of the respondents need for dental or optician services. Although these measures would certainly not be ideal measures of need on these dimensions, we would argue that there would be a high correlation between poor general health and poor dental and optical health, particularly in lower income groups.

Table 5: *Distribution of Health Care Expenditure and Chronic Illness by Equivalent Income Quintile*

<i>Income Quintile</i>	<i>% of Utilisation</i>	<i>% of those with Chronic Illness</i>	<i>% of those Limited by Illness</i>	<i>Self- Assessed Health</i>
	<i>%</i>	<i>%</i>	<i>%</i>	<i>%</i>
Lowest	26.03	33.25	31.36	24.29
2	21.54	24.06	22.42	20.78
3	19.53	18.88	15.93	19.37
4	15.48	12.78	15.18	17.93
Highest	17.43	11.02	15.12	17.63
CI	-0.1	-0.226	-0.149	-0.065
S.E	0.023	0.021	0.035	0.006
P	<0.0001	<0.0001	<0.0001	<0.0001
HI	-	0.126	0.049	-0.035

Wagstaff *et al.* (1989) have suggested that these concentration indices can be used to derive an overall summary measure of equity, or health inequality measure (HI):

$$HI = C^{\text{exp}} - C^{\text{ill}}$$

Where C^{exp} is the concentration index for expenditure and C^{ill} is the index for illness. If health care expenditures are allocated across income groups in proportion to their share of those reporting illness, then $C^{\text{exp}} = C^{\text{ill}}$ and $HI = 0$. If HI is positive this implies that there is inequity favouring the better off and if negative, inequity favouring the worse off. Table 5 shows that HI is positive for two of the health measures – chronic and limiting illness, suggesting that the distribution of utilisation relative to ill-health favours the more advantaged, but is negative in the case of the SAH measure. The HI for 2000 for chronic illness is substantially larger than that found for 1987 in Nolan (1991), where the figure was 0.088 compared to 0.126 in 2000, suggesting that inequity on this measure at least, has increased. The increase stems both from a growing inequality in the distribution of chronic illness and a movement of expenditure toward the better off.

We can look at the patterns of utilisation and illness in more detail in Table 6, which gives the imputed expenditure per person chronically ill as well as the total imputed expenditure by quintile. Rather than produce figures for all three measures here we use the chronic illness measure. While the lowest quintile has the highest utilisation of health care, we see that the lowest quintile actually has the lowest imputed expenditure per person ill, because of the large proportion of respondents in this quintile with a chronic illness. On

the other hand, the small number of ill respondents in the highest quintile means that this group receive the highest imputed expenditure per person ill, around twice that of the lowest quintile.

Table 6: *Distribution of Health Care Expenditure, Chronic Illness and Imputed Expenditure Per Person Ill*

Quin- tile	Popula- tion	Chronic Illness	Rate/ 1000	Per- centage %	Cumula- tive % Ill	Expenditure Per Person	Expenditure Per Person Ill	% Exp %	Cumulative % Exp. %
1	1611	535.66	332.5	33.3	33.3	1273.1	3693.6	26.0	26.0
2	1611	387.61	240.6	24.1	57.3	1043.6	4228.4	21.3	47.3
3	1611	304.16	188.8	18.9	76.2	969.8	4937.6	19.8	67.1
4	1611	205.89	127.8	12.8	89.0	758.0	5638.8	15.5	82.5
5	1611	177.53	110.2	11.0	100.0	856.1	7492.9	17.5	100

VIII TESTING FOR INEQUITY

It seems clear from these descriptive analyses that the higher rate of morbidity in lower income groups means that the higher level of health care utilisation and expenditure among these groups is not equivalent to their ‘need’. However, in analysing the impact on income on service use controlling for need, we also need to control for other factors that may confound the relationship. A number of factors may well influence the take up of health care. For example, previous Irish research (Nolan, 1991) has shown that sex and urban or rural location, social class, income, health status as well as age all significantly influence the probability of visiting a GP and the annual number of visits. These factors are also significant predictors of use of inpatient hospital services.

Given this, here we adopt a more analytical approach by standardising the measure of expenditure on health care (our service use measure) to take account of variations in the distribution of factors that may confound the relationship between income and usage. It would be possible to use a large number of variables to predict utilisation, but here we simply want to standardise for those factors that may confound the relationship between income and utilisation. Nolan (1991) found that age, sex and rural location¹⁰

¹⁰ Nolan (1991) showed that rural location impacted on the use of a range of services, most probably because of the greater distances and thus cost in using these services for people living in rural areas.

were important in this respect and so these are adopted here. Our aim is to re-estimate the concentration index used earlier (C^{exp}), but this time control for factors which may confound the relationship between the health status of the individual and expenditure on health including age, sex and location. That is, we want to estimate the partial correlation of the confounding variables sex, age and location on total health expenditure conditional on health status. After the concentration index of utilisation has been standardised, the HI index is computed as the unstandardised CI minus the standardised CI. If after this procedure HI is still positive we will have evidence that the distribution of health expenditure is actually skewed toward the better off even when we have controlled for health status.

To estimate the concentration index we use an indirect method of standardisation based on OLS regression as shown in Equation (1):

$$y_i = \alpha + \beta \ln inc_i + \sum_k \gamma_k \chi_{k,i} + \varepsilon_i \quad (1)$$

where use of health care (y_i) is predicted by log of household equivalised income ($\ln inc$) of individual i and a set of k need and confounding variables (χ_k). α , β and γ are parameters and ε_i is an error term.

Equation (1) can be used to generate need-predicted values of y , i.e. the expected use of medical care by individual i on the basis of their need characteristics. It indicates the amount of medical care they would have received if they had been treated as others with the same need characteristics on average. Combining OLS estimates of the coefficients in Equation (1) with actual values of the χ_k variables and sample mean values of $\ln inc$, we can obtain the need-predicted, or “ χ -expected” values of utilisation, \hat{y}_i^x as:

$$\hat{y}_i^x = \hat{\alpha} + \hat{\beta} \ln inc^m + \sum_k \hat{\gamma}_k \chi_{k,i} \quad (2)$$

Estimates of the indirectly need-standardised utilisation, \hat{y}_i^{IS} are then obtained as the difference between actual and χ -expected utilisation, plus the sample mean (y_m):

$$\hat{y}_i^{IS} = y_i - \hat{y}_i^x + y_m \quad (3)$$

Table 7 gives the resulting figures from this standardisation, though here we only show results for two of the health measures – chronic illness and self-assessed health, which cover the range for the health measures.

Table 7: *Standardised Health Inequality Indices for Total Health Care Utilisation*

	<i>Chronic Illness</i>		<i>SAH</i>
CI (Standard Error)		-0.1 (.024)***	
HI (Standard Error)	0.0125 (.022)		0.017 (.021)

**=P<0.001

It shows that once we standardise for age, sex, location and level of health need (measured either as chronic illness or self-assessed health) the health inequality index (HI) is positive, suggesting that the better off use health care marginally more for a given level of health need. However, both the indices are statistically insignificant at the 5 per cent level suggesting that the result cannot be reliably differentiated from a zero or “neutral” result.

It would be useful to decompose these standardised measures of total expenditure on health care into its components, so that we can evaluate whether this pattern of inequity is common across all the elements, or more pronounced among some than others. Here, as before, we standardise by age, sex and location as well as the two measures of health need that we are using (as well as equivalised income).

Table 8: *Distribution of Standardised Imputed Health Care Expenditure on Specific Services by Equivalent Income Quintile Controlling for Age, Sex, Location and “Need”*

	<i>CI</i>		<i>Chronic Illness</i>		<i>SAH</i>	
	<i>CI</i>	<i>S.E</i>	<i>HI</i>	<i>S.E</i>	<i>HI</i>	<i>S.E</i>
Inpatient	-0.141**	(0.05)	0.028	(0.047)	0.039	(0.046)
GP	-0.152***	(0.016)	-0.049***	(0.014)	-0.044***	(0.013)
Outpatient	-0.022	(0.036)	0.064	(0.034)	0.063	(0.035)
Prescriptions	-0.183***	(0.013)	-0.09***	(0.011)	-0.092***	(0.011)
Dentist	0.16***	(0.019)	0.125***	(0.019)	0.128***	(0.019)
Optician	0.076***	(0.021)	0.115***	(0.021)	0.113***	(0.021)

**=P<0.01

***=P<0.001

Table 8 shows that the HI for nights spent in hospital and use of outpatient services are essentially neutral as the coefficients are not significantly different from zero. For GP consultations on the other hand the

HI is significant and negative for both the measures of health need suggesting that use of GP services is pro-poor in the sense that those at the lower end of the income distribution visit the GP more than average for someone of their health status.¹¹ As with GP services, number of prescriptions filled is pro-poor using both health measures, whereas if we look at the HI coefficients for use of dental and optician services we see that both are substantially positive indicating a higher use of these services than average among the better off in the light of their health need.

IX SUMMARY AND CONCLUSIONS

In this paper we have examined the distribution of health care service utilisation in Ireland and attempted to evaluate whether that utilisation was equitable across income groups. This is an important question that has generated a great deal of debate in media and policy circles, but which has not been examined systematically using recent empirical evidence. The analyses performed here were based on the Living in Ireland Survey for 2000, a nationally representative sample of individuals and households.

By deriving measures of utilisation from the LIS data we were able to describe the use of different health care services. However, to analyse whether the use of these services was equitable across the population we needed to do two things: first find a way of combining the different measures of utilisation into a common metric that would allow us to measure equity in use across all services across the income distribution. Second, we also then needed a measure of health status that could be used to control for the health “need” of individuals since our concept of equity is that those at different levels of income, but with the same health needs should receive the same level of treatment. Before going on to examine the relationship of utilisation to need we first examined the use of different services across the income distribution and found that use of inpatient hospital services, GP, outpatient hospital services and filled prescriptions were used substantially more by those at the lower end of the income distribution. On the other hand, dental and optician services were used substantially more by those higher up the income distribution.

To construct a unitary measure of utilisation we obtained data on expenditure on health care from a number of different sources including official publications and the Household Budget Survey for 1999/2000 and estimated the unit cost for different health care services that could be used to

¹¹ van Doorslaer (2003) using ECHP data has found similar results to these, although the coefficient varies because of the different methodology employed.

impute overall utilisation per person. We then compared the utilisation among individuals ranked by their income with levels of health need in the form of three different health measures.

The results showed that a relatively high share of imputed expenditure went to lower income quintiles, but this was still substantially less than the proportion within these quintiles who were experiencing a chronic illness or were limited by their health. By using the methodology developed by Wagstaff *et al.* (1991) we were able to derive an index to describe this inequality, and the results showed that levels of utilisation/imputed expenditure favoured the better off.

However, those analyses did not standardise for socio-demographic characteristics and a number of other factors that may confound the relationship. In the final part of the paper an indirect standardisation method was employed for this purpose. After standardising the measures we found that, although overall health care expenditure was skewed toward the better off, this difference was not significantly different from zero. Decomposing this overall measure of health utilisation we found that inpatient and outpatient services in hospitals were essentially neutral in their distribution across income groups whereas use of GPs and number of prescriptions filled were significantly skewed toward the lower end of the income distribution. Use of dental and optician services on the other hand were significantly skewed toward the more advantaged income groups after standardisation.

The three health measures used in this paper were useful as they differed in the extent to which they were skewed toward the lower end of the income distribution (lower income groups have higher levels of ill health, but the level of inequality varies between measures). Using these measures we found that the large difference in usage between different income groups could largely be accounted for in terms of “need” factors, except for GP services where lower income groups made greater use of services than would be predicted from their health need. However, we should be aware that the measures of “need” that we have used are limited and based solely on the self-reports of respondents and thus may well underestimate the true “need” of these respondents since self-assessed health is likely to be influenced by comparator groups, i.e. those peers who are likely to have similar health disadvantages. It would be valuable in the future to carry out the same type of analyses using internationally standardised measures of health such as the SF-36 or 12, or even clinical measures of health. It should also be borne in mind that our results assumed that there are no differences in quality between public and private care, which would also benefit from further investigation.

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