



Poor Prescriptions

Poverty and Access to Community Health Services

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Executive Summary

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Introduction

The development of policies to address health inequalities and inequities in access to primary healthcare services needs to be informed by up-to-date and reliable data. Combat Poverty commissioned the Economic and Social Research Institute (ESRI) to undertake a study to examine health inequalities and to investigate the use of primary health care services among the Irish population.

The study uses household survey data, including the Living in Ireland Survey (1995 & 2001), the Quarterly National Household Survey (2001) and the EU Survey on Income and Living Conditions (2004).

This is a summary of that study: *Poor Prescriptions: Poverty and Access to Community Health Services*.

Health is central to quality of life. Yet a great deal of research - both Irish and international - now shows that those who are disadvantaged in terms of income, education and social class are more likely to have worse health and to die earlier. The reasons for these inequalities are diverse and complex. But it is now clear that these inequalities are real. It is clear also that they reflect underlying inequalities in the incomes and living standards of different groups in Irish society.

Health care and primary health care, in particular, is one way in which these inequalities in health can be improved. The report: *Poor Prescriptions: Poverty and Access to Community Health Services*, examines health inequalities and the way in which use of primary health care services are distributed across the population. The report is made up of a number of distinct elements:

- An analysis of household survey data to shed new light on the social determinants of health in Ireland
- An examination of what household survey data reveal about how GP services (and to a more limited extent other primary care services) are used by people on different incomes
- An analysis of the factors which seem to affect these utilisation patterns, including age, gender, health status, entitlement to free primary care via the medical card and location
- A consideration of the role which the structure of financial incentives for GPs plays in influencing equity of access and location. This is informed by the experience of GP practices in disadvantaged areas.
- An assessment of the extent to which there is equitable access to primary care services for those on low income
- Implications of the research findings for policy and for further research to be undertaken by Combat Poverty.

The study gives the clearest picture yet of the relationship between health; use of primary health care; and poverty and disadvantage.

Poverty, Class and Health

There is a clear link between lower social class, lower educational qualifications, lower incomes and poor health.

EU-SILC (2004) shows that:

- 85% of the non-poor report good or very good health. Only 66% of those experiencing income poverty report good or very good health.
- If we use the consistent poverty measure the differences are even wider. Only 57% of those living in consistent poverty have good or very good health. The figure for the rest of the population is 84%.
- 3% of those who are not poor report bad or very bad health. By contrast, the figure is 9% for people who are income poor.
- Differences are wider again if we consider chronic illness as the measure of health. 23% of the general population report a chronic illness. 47% of the consistently poor and 38% of the income poor report a chronic illness.

Differences in health status are not confined to groups in poverty. Those with the highest incomes, social class or education have the best health. Health declines uniformly as income, class and education decrease.

Analysis of EU-SILC (2004) found that:

- 11% of men in the highest income decile have a chronic illness. The figure for men in the middle of the income range is 20%. For men with the lowest incomes it is 42%.
- 16% of men in the higher professional and managerial class have a chronic illness. This rises to 27% among men in the unskilled manual social class. The pattern is similar for women, although the class differential is even higher (14% versus 31%).

The Influence of Early Life Disadvantage

Research in other countries strongly suggests that differentials in health begin from a young age. In Ireland, as elsewhere, babies of unskilled manual working class parents are lighter at birth than the children of professional and managerial parents.

There are two views in the literature about the path to adult social class inequalities in health.

The question revolves around whether they are caused by:

- the direct influence of parents' environment at birth, or
- a more indirect influence through the person's own education and occupational attainment.

Analyses of the LIIS (2001) show that the class and educational level of an individual's parents are important influences on health. However, this influence does not appear to work directly. The class and education of the parent influences the child's education and career opportunities in later life. This, in turn, influences his or her health, mainly through the level of income and resources which a higher social class brings.

The Use of General Practitioner Services

GP services are the main focus of primary care services in Ireland. The extent to which these services are equally accessible by all sections of society has been the focus of much recent discussion.

While variation in visiting rates due to 'need' factors such as age and health status are to be expected, it may also be the case, in Ireland, that patients' incomes are influencing their GP visiting rates because of how GP care is structured.

Analyses of the LIIS (1995; 2001) showed that the average number of GP visits per year was 3.3 in 2001.

The proportion attending a GP in the last year increased marginally between 1995 and 2001 (from 70% to 74%).

Several factors affect GP attendance. Figures for 2001 show:

- 63% those aged 16 to 24 attended a GP in the last twelve months. The visiting rate for those over 75 was 95%.
- Women were far more likely than men to attend their GP. 81% of women attended their GP during the previous 12 months, compared to 67% of men.
- The average number of visits for women was 4. For men it was 2.6.
- Health status is a very important driver of GP visits. Those with very good health had 1.7 attendances, on average. This rose to over 15 for those with very bad health.
- Both physical and mental health are important. People with mental health problems had more than twice the level of GP visits.
- Patients with a chronic illness reported 7.4 visits to the GP. This fell to 2.2 among those without a chronic illness.
- Income is also important. Patients in the bottom income decile had 5.6 visits on average. This fell to 2.3 among the highest income group.
- The higher level of GP utilisation among medical card holders can be partly explained by the higher age and worse physical and mental health of this group. However, other factors clearly play a role. Even controlling for other characteristics, including level of health, having a medical card remains a very strong predictor of GP utilisation. Patients with a medical card had an average of 6 visits in 2001. This compared with 2.3 visits for those without a medical card.

Medical Card Eligibility, Income and Access to GP Services

Having a medical card influences how often a patient visits the GP. Analysis of the same individuals over time using the LIIS (1995 & 2001) shows that those who gain a medical card use GP services more frequently. Those who lose a card decrease their frequency of use.

This might suggest that those just above the income threshold are less likely than those further up the income distribution to use GP services, but this effect is not simple. Analyses showed that having a higher income (among those without a medical card) made the probability of a visit to the GP in the last year more likely.

However, higher income does not increase the frequency with which the person visits their GP. This suggests that having a lower level of income significantly decreases the chance that a person will seek out any GP care at all rather than suppressing the frequency of visiting.

The Supply of GP Services in Deprived Areas

It is possible that the current payment system for GPs encourages them to locate in areas with more favourable health and social profiles and a higher proportion of private patients. Analyses of the LIIS (1995 & 2001) provide some support for the view that GP utilisation is significantly lower in disadvantaged areas of Dublin city.

However, it is debatable whether this pattern reflects:

- A 'population composition' effect
- The availability of alternative health services, or
- A 'true' GP availability effect.

The use of Dental and Optician Services

Analysis of the LIIS (1995 & 2001) showed that, in 1995, the average number of dental visits was just under one a year. This remained stable up to 2001 (the latest data available). However, the proportion visiting the dentist at least once increased significantly from 35% to 44% over that time. The frequency of dental visits is influenced by a number of factors, but figures from 2001 show a different pattern to the pattern of GP attendance:

- The frequency of visits to the dentist increases until age 35-44 and then falls as age increases. 46% of those in the 16-24 age group attended the dentist at least once. This increased to 55% among those aged 35 to 44 and fell again to 14% among those over 75.
- Women attend more frequently than men. 47% of women saw their dentist at least once in 2001 compared to 40% of men.
- Health status also has a role. People who are healthier are more likely to attend at least once.
- The frequency of visits also increases with income and education. 33% of those in the bottom income decile visited their dentist at least once. This rose to 63% among those in the highest income group.

- People with medical cards visited the dentist less often. (31% of medical card holders visited at least once compared to 50% for people without medical cards.)

The pattern of optician visits is also different from GP visits. The take-up of optician services increased between 1995 and 2001 from 22% attending at least once to 29%.

Figures from 2001 show that:

- Frequency of use increases with age. 16% of men aged 16 to 24 visited the optician at least once. For men aged 65 to 74 the rate was 38%.
- Among women the age gradient is less steep and more complex. Women aged 45 to 54 have the highest levels of use. (46% visited in the last year in 2001).
- Women are more likely to attend than men. Thirty-three percent of women reported visiting at least once, compared to 25% of men.
- Use is higher among those with worse health. 27% of those with very good health reported visiting at least once, compared to 46% of those with very bad health.
- As with dental care, use of opticians increases with education and income. 27% of those in the lowest income decile reported visiting the optician. This compared with 36% of those in the highest income group.

Equity in the Use of Primary Care Services in Ireland?

GP utilisation is highest among lower income groups. These groups also appear to be older and to have much worse health. This suggests that medical card holders and lower income groups, in particular, have a higher 'need' for health care than higher income groups. The important issue is whether their use of primary care services is proportional to their health need or whether they use a higher level of services for a given health status.

Analyses of the LIIS (1995;2001) show that, even if we standardise for the higher level of health need in lower income groups, we still find that the level of GP visits for these groups is higher than an equitable distribution would suggest (i.e. lower income groups have a higher number of visits for a given level of health than higher income groups). This may be because our measures of health-need overestimate the true health of low income groups.

Analyses also showed that low income groups are less likely than higher income groups to receive specialist care. It may be, then, that higher income groups are more likely than lower income groups to be passed on for specialist care, or that they spend less time waiting for this care, although we have no direct evidence for this.

For dental and optician visits on the other hand, the distribution of visits across the income distribution clearly favoured those in higher income groups. The reasons for this differential are not clear and require further research.

Policy Implications

The pattern of health in the population closely follows the pattern of social inequalities in terms of income, education, social class and poverty. Policies to reduce socio-economic inequalities in health cannot be dealt with by the Department of Health and Children alone. Health services can only intervene after health inequalities have formed elsewhere in society.

- Policies to reduce inequalities will need to be developed and implemented on a cross-departmental basis, preferably with strong inter-departmental co-ordination.

Addressing Underlying Inequalities

Health inequalities stem largely from differences in the life circumstances of different sections of the Irish population. Although health behaviours such as smoking, nutrition and exercise do influence outcomes, their impact is small compared to the influence of basic differences in living standards.

- This suggests that those policies which focus on supporting and increasing the incomes of the disadvantaged should be a priority.
- Low earners should be taken out of the tax net. Resources should be allocated to establishing a system of in-work benefits which are simple and transparent, in order to ensure a reasonable level of basic income, particularly for families with children.
- This approach should be accompanied by efforts to redistribute resources, primarily through the tax system, to those who, for reasons of age, circumstances, or disability, are unable to work.

Increasing Equality of Opportunity

Individuals who are born into disadvantaged households are far less likely to have higher levels of education and good jobs than their peers from higher income families. This inequality of opportunity not only wastes the valuable talents of those who happen to have been born into poor households. It also has the indirect effect of giving them worse health throughout life and contributing to their earlier death.

- Early interventions to break the link between family of origin, educational attainment and job outcomes would be a far more effective and efficient way of trying to equalise health outcomes than supplementing income or using health services in adulthood.

Education and Pre-School Education in Particular

Investing in education and improving educational outcomes for disadvantaged children is crucial:

- Since the disadvantages of poorer children begin early, investment in pre-school education would yield considerable dividends later.
- Government funding mechanisms for schools should take account of the higher level of need within schools in disadvantaged areas and fund them more favourably.
- More innovation and higher levels of resources should be directed at keeping young people in school, both before and after the minimum leaving age.

Reforming Primary Care

The mix of private and public payment in the Irish primary care system may produce distortions in both the supply and demand for care that give rise to inefficiency in primary care. This may be detrimental to individual health outcomes. The impact of GP fees persists right up through the income distribution and suggests an unmet need for care, even in higher income groups.

- There are strong arguments from an equity perspective for GP care being free to all Irish citizens at the point of care.
- A more incremental approach would be to substantially increase the number covered by the current medical card structure by increasing the income thresholds determining eligibility¹.
- Another approach would be to extend eligibility to certain vulnerable population groups, regardless of income, for example children or large families.

Further Research

The evidence-base in Ireland for examining both the extent of socio-economic inequalities in health/health care utilisation and the processes leading to these inequalities is very poorly developed. There is not enough data around the provision of primary care. EU-SILC, the main survey instrument with data on health, healthcare use and income, only asks for information on free GP visits.

National administrative databases cannot be linked at the individual level because of the absence of a personal identifier. National figures on death rates use a different social class schema to that used in the census.

- Improve the data available on socio-economic inequalities in health by ensuring that consistent socio-economic measures are available in data sources and that data bases can be linked, using a personal identifier.

¹ The Irish Medical Organisation has recommended that medical card cover be extended to 40% of the population (IMO 2005).

Glossary

Consistent poverty	<p>A measure of poverty which combines being income poor (see below) with being deprived (lacking an item because of income constraints) of any one of eight (in the old definition and eleven in the new) items or activities. The eight item definition is used in this report and this asks about the enforced deprivation of:</p> <ol style="list-style-type: none"> 1. Two pairs of strong shoes 2. A meal with meat chicken or fish every second day 3. A warm, waterproof overcoat 4. A roast or equivalent once a week 5. New, not second hand clothes 6. A substantial at any time in the last two weeks 7. Gone without heating in the last year 8. Gone into debt in last year to meet living expenses 	<p>In the new 11 item definition, items 2 and 8 are dropped from this list and the following added:</p> <ol style="list-style-type: none"> 1. Been able to keep house adequately warm 2. New not second hand furniture 3. Family or friends for a drink or meal once a month 4. Able to afford an afternoon or evening out 5. Presents for friends or family once a year
Equity of access	The equal availability of health care to individual's taking into account their need for health care	
EU-SILC	European Union Survey of Income and Living Conditions	
Income decile	The distribution of incomes across households, ranked in order of size, divided into ten equal sized groupings	
Income poverty	Poverty defined as being under a specific income amount, often 60% of median income	

Health inequalities and difficulties with access to good quality health care services are among the most pressing issues facing policy-makers in Ireland today. Those living in poverty and social exclusion are more likely to have worse health and to die earlier. The reasons for these inequalities are diverse and complex and reflect underlying inequalities in the income and living standards of different groups in society.

Poor Prescriptions: Poverty and Access to Community Health Services enhances our understanding of the link between poverty and ill health. The study uses household survey data from the Living in Ireland Survey (1995 and 2001), the Quarterly National Household Survey (2001) and the EU Survey on Income and Living Conditions (2004) to examine health inequalities among the Irish population.

The study also investigates the level of utilisation of GP services and other primary care services by people at different levels of income and analyses different factors which seem to affect these utilisation patterns.

The findings of this study will contribute to the debate around the most appropriate way to tackle health inequalities in Ireland. They will also inform health service providers on how equity of access to effective primary health care services can be addressed. This study is of relevance to policy-makers, health service providers, organisations working with low-income groups and researchers concerned with health issues.