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Unmet healthcare needs in Ireland: Analysis using the EU-SILC survey

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ABSTRACT

The analysis used the 2013 Survey of Income and Living Conditions to examine the extent and causes of unmet need for healthcare services in Ireland. The analysis found that almost four per cent of participants reported an unmet need for medical care. Overall, lower income groups, those with poorer health status and those without free primary care and/or private insurance were more likely to report an unmet healthcare need. The impact of income on the likelihood of reporting an unmet need was particularly strong for those without free primary care and/or private insurance, suggesting a role for the health system in eradicating income based inequalities in unmet need. Factors associated with the healthcare system – cost and waiting lists – accounted for the majority of unmet needs. Those with largely free public healthcare entitlement were more likely than all other eligibility categories to report that their unmet need was due to waiting lists (rather than cost). While not possible to explicitly examine in this analysis, it is probable that unmet need due to cost is picking up on the relatively high out-of-pocket payments for primary care for those who must pay for GP visits; while unmet need due to waiting is identifying the relatively long waiting times within the acute hospital sector for those within the public system.

1. Introduction

There is increasing interest in the concept of unmet need for healthcare services across Europe. However, there is no universally accepted definition of unmet need and few theoretical models explaining unmet healthcare needs. A useful starting point is the concept of need and consideration of why healthcare need may not result in the appropriate use of healthcare services. Andersen's behavioural model of health services use [1] is a useful starting point in this regard as it considers how health service use is a function of the need for health services and a host of other factors including individual and health system characteristics. The Andersen model assumes that a person's use of health services is a function of what he describes as predisposing, enabling and need factors. Predisposing factors include socio-demographic variables and health beliefs that influence the propensity of individuals to seek care; enabling factors include personal, family and community resources that can facilitate or impede the use of health services, while need factors generally relate to health status.

A range of socio-demographic factors including age, sex and socio-economic status have been found to be associated with unmet need but there are some inconsistent patterns in these associations across studies. Some studies, for example, find higher unmet need among older age groups [2], others find higher unmet need among younger age groups [3–5] and others find no clear relationship [6]. Studies have consistently found higher

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levels of unmet need among socio-economically deprived individuals [5,7,8], although the relationship between socio-economic status and unmet need varies depending on the indicator of socio-economic status used. Consistently a positive relationship has been found between unmet need and poor health status [5,6,9].

At the national level, health system characteristics can facilitate or impede the use of use of health services and may be regarded as enabling factors. Such characteristics include the extent of user charges, population coverage, waiting times and gatekeeping [10]. In Greece and Italy, for example, the most commonly reported reason for unmet need was cost [5,6]; which in the case of Greece, the authors attributed to the unequal access to standard services due to entitlement, geography and ability to pay and the resulting public-private structure of the health system [6]. A cross-country analysis of unmet care needs in Europe found that variations in rates of unmet need could in part be explained by the differences in health financing arrangements with the authors finding a positive association between the share of out-of-pocket payments in total health expenditure and the probability that individuals will delay or forgo treatments [11].

The EU-Statistics on Income and Living conditions (EU-SILC) survey has been used to explore unmet healthcare needs for a number of European countries. While the survey has been used to examine unmet need in Ireland in a comparative context [11,12], it has not yet been used to do country-specific analysis which explores how predisposing, enabling and need factors relate to unmet need in an Irish context. Therefore, the aim of the analysis presented in this paper is to explore the relationship between various predisposing, enabling and need factors and unmet need in Ireland. The following section provides a brief overview of the Irish healthcare system.

2. The Irish healthcare system

Currently, there are two main categories of entitlement to public health services in Ireland. Those in Category I (medical cardholders) are entitled to free public healthcare services including inpatient and outpatient hospital care, general practitioner (GP) care and other primary and community care services. However, they must pay a co-charge of €2.50 (2016) per prescription item, up to a maximum of €25 per family per month. Those in Category II are entitled to subsidised public hospital services and prescription medicines, but pay the full cost of GP services and other primary and community care services. In 2010, the average cost of a GP consultation was estimated to be €51 [13]. In November 2005, the GP visit card was introduced; GP visit cardholders are entitled to free GP visits but otherwise have the same entitlements as Category II individuals. Eligibility for a medical/GP visit card is assessed primarily on the basis of an income means test, with the threshold for GP visit cards about 50% higher than for the full medical card. In certain circumstances individuals who are not eligible for a medical or GP visit card on income grounds may be granted a card on a 'discretionary' basis if they have particular health needs which would cause them undue financial hardship [14]. In 2014, 38.4% of the population had a medical card and 3.5% had a GP visit card [15]. Perhaps unsurprisingly previous research has shown higher levels of poor health and lower income in those with a medical card compared to the general population [16,17].

In July 2001, eligibility for a medical card was extended automatically to all those over 70 years of age; this entitlement was subsequently revoked with means testing for medical cards for the over 70s re-introduced in 2009. However, in the summer of 2015, a GP visit card was extended to all children under the age of 6, as well as to people aged 70 and over.

Many of those in Category II and some of those in Category I purchase private health insurance (PHI). In 2014, approximately 42% of the population held PHI [15]. While those with a medical and GP visit card can purchase PHI, the numbers doing so are relatively small [18]. However not all of those without a medical or GP visit card purchase insurance: for example, among the over 50s, 10% had neither PHI nor a medical or GP visit card [19]. Private health insurance in Ireland is mainly used to provide cover for private or semi-private acute hospital services, delivered in both public and private hospitals; a small number of policies provide partial reimbursement of certain primary care expenses such as GP visits and physiotherapy [14]. A block grant system used to reimburse hospitals for public patients is regarded as an incentive to treat fewer public patients as each patient represents a cost; in contrast, per diem charges for private patients provide an incentive for hospitals to treat more private patients. Similarly, consultants receive a salary for treating public patients and a fee-for-service for the treatment of private patients. These alternative payment methods for public and private patients incentivise "two-tier" access to hospital care, in which the wait time for private patients is significantly shorter [20].

Despite the relatively complex system of eligibility within the Irish healthcare system, there has been relatively little research on unmet healthcare needs. However O'Reilly et al. found that almost 19% of patients in Ireland reported a medical problem in the previous year (4.4% of medical cardholders and 26.3% of non-medical cardholders) but had not consulted the doctor because of cost [21]. While Nolan found that gaining a medical card resulted in a 27–39% increase in the number of GP visits per annum [22], further suggesting an unmet need for primary care services among non-medical cardholders. There has been relatively little work on self-reported unmet healthcare needs in Ireland. While a cross-country analysis of European countries for 2004 found that 2.4% of Irish respondents reported an unmet need [12], this number might be expected to have increased over time given the recent economic downturn and subsequent cuts to healthcare expenditure and activity [23].

3. Materials and methods

3.1. Data

Data for the analysis were derived from the 2013 wave of the Irish sample of the EU-SILC instrument [24]. EU-SILC is a harmonised survey which provides comparable cross-sectional and longitudinal data on income, poverty, social