

IMPROVING ACCESS TO PRIMARY CARE IN IRELAND: DO GP CHARGES MATTER?

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Introduction

Media coverage of health care in Ireland tends to focus almost exclusively on hospital services, waiting lists and patients waiting on trolleys in accident and emergency departments. Hospital care is certainly an important component of health care but research evidence shows that investment in primary care is more important for maintaining and improving population health. Routine access to primary care improves primary prevention and disease avoidance, while also allowing for early intervention and amelioration. Such activities improve population health more effectively and cost efficiently than expensive hospital intervention at later stages of illness. The potential role of primary care can only become more crucial as the Irish population ages over the next two to three decades and chronic diseases which can be managed but not cured increasingly dominate. As the most important component of primary care, GP services have a vital and increasing role to play in maintaining and improving population health, and it is this component of primary care that we focus on in this research overview.

Access to Primary Care in Ireland

The effectiveness of primary care depends on its structure and interaction with other health services; this remains a concern, particularly in the light of the slow implementation of the Primary Care Strategy since its publication in 2001. GP care is important in its own right but GPs also act as gatekeepers to secondary care, and as such, are the first point of contact for most individuals' interactions with other health services. Unfortunately, the Irish system of financing of primary care gives rise to particular concerns over equity of access to GP services. While 30 per cent of the population on low incomes are entitled to free primary care (medical card patients), the remaining 70 per cent must pay the full cost (private patients). This leads to concerns that the extent of co-payment required by private patients leads to significant barriers to access, while medical card patients face no constraints on use. Recent work by ESRI researchers provides important evidence about the impact of this structure of primary care financing on access to GP services. Here we examine published evidence on the impact of income and medical card eligibility on access to GP services in Ireland.

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The Irish system of eligibility for free primary care services is unusual among OECD countries in the extent to which access to free services is restricted to a small proportion of the population. Eligibility for a medical card is decided primarily on the basis of an income means test which is currently set at €184 for a single person under 66 years and €201.50 for those aged 66-69 years.¹ These figures should be put in context. In 2007, the latest year for which figures are available, the income level at which individuals were said to be at risk of poverty was €229, while the average industrial wage in June 2007 was €627, so the threshold is set at a low level relative to average income. Between 2001 and January 2009 over 70s in Ireland were eligible for a medical card without a means test but since January those with an income of over €700 a week have had their eligibility for a medical card revoked. Up to 2005, the proportion of the population with a medical card fell steadily (from 38 per cent in 1987 to 27 per cent in 2005), as income thresholds increased annually in line with price inflation, while incomes grew at a faster rate. A 25 per cent increase in the income thresholds in 2005 increased the proportion of the population with a medical card slightly, but as of 2007, the proportion of the population with a medical card has remained under 30 per cent.

The major concern with the current medical card system is that whilst 30 per cent of the population face no financial disincentive to visit their GP, the rest of the population pay the full fee (which varies between €45 and €60), plus the first €100 of the prescription fee per family per month. Does this financial disincentive influence an individual's decision to visit their GP? To answer this question, we need to control for other factors such as age, health problems, household location, education and employment status that may also affect an individual's decision to visit their GP. Doing so reveals that those without a medical card are significantly less likely to visit their GP and visit less often on average than medical card patients. It is hard to say whether this difference in visiting is a result of under utilisation among those without a card or over utilisation among those with² but it is clear that charges (or the absence of them) do influence GP visiting behaviour.

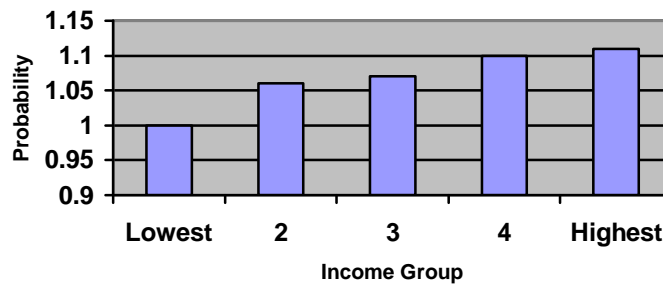
¹ Those who previously held a medical card but who participate in specific training and employment schemes are also allowed to retain their card for a period of up to 4 years. Other smaller numbers of individuals with particular health needs are also granted a 'discretionary' medical card.

² The extent of 'inappropriate' use of primary care is a thorny issue. Although medical card patients appear to have higher numbers of visits for the same observed characteristics including health, other analyses suggest that this may be due in part to lower access to secondary care on their part. Higher GP use may thus reflect an inability to access specialist care because of public healthcare queues.

**The Cost of
Care
Influences
Patient
Choices**

There is real concern that those just above the income threshold are in a particularly difficult position and this led to the implementation of the ‘doctor only’ medical card in October 2005 which has income thresholds 50 per cent higher than the standard medical card. Unfortunately take-up of the doctor only card has been disappointing, so does the level of income influence choices regarding GP attendance for those above the medical card thresholds? ESRI research (Nolan, 2008a) shows that relative to medical card patients, private patients are significantly less likely to visit their GP, with private patients on the lowest incomes having the lowest probability of visiting. Moreover, if we leave medical card patients out of the analysis we find that the probability of visiting the GP is lowest for those on low incomes and increases with the level of personal income (see figure below).

**Probability of Visiting a GP in the Last Year
by Income Group (Private Patients Only)**



Source: Nolan 2008a.

These analyses show clearly that the primary differentiation is between those with a medical card and those without since the latter never attain the same levels of visiting even at the highest income levels (controlling for health and other factors). However, among those without a card income clearly matters and leads to inequities between groups in terms of their utilisation relative to need.

We get another measure of the impact of the medical card on GP visiting behaviour if we follow the same individuals through time and observe what happens if they either receive or lose access to a medical card. Research using this approach showed that those gaining a medical card increased the annual number of GP visits by approximately 27 per cent to 39 per cent per annum after controlling for a large range of other factors including the person’s health. The fall in GP visits on withdrawal of a medical card appears to be even higher with the average number of annual GP visits falling by between a third and a half (Nolan, 2008b).

The Over 70s Medical Card

The extension of the medical card to all over 70s in 2001 offered another opportunity to examine the impact of charges on GP visiting behaviour, although this time only among older patients. Older individuals are far more likely to have a chronic illness and to be in need of quality health care but old age is also accompanied by decreasing income and mobility, both of which may limit access to primary care. Given this, it was important to examine the impact which the change in medical card eligibility had on GP visiting among older Irish people. Research shows (Layte et al 2009) that although the average number of GP visits by the over 70s had not increased three years after the change in eligibility, the overall probability of visiting in the last year had, with the proportion visiting in the last year increasing by over 4% between 2000 and 2004. However, this change was not significantly different from the similar increase in the probability of visiting observed for the under 70s over the same period, although the rise among over 70s was larger. Abolishing GP charges for the over 70s may not have led to clear increases in GP visits among the over 70s, although it is possible that other barriers to access, such as transport, may be relatively more important for the older population.

Does Use of Primary care Influence Health?

As a society, we are concerned with ensuring equity of access to health care, and with ensuring that access to health care is distributed on the basis of need for care, rather than other considerations such as ability to pay. Distributing health care on the basis of ability to pay would simply exacerbate the existing differentials in health across Irish society which stem from differences in income, social class and education. Ultimately, we are interested in how financial incentives and the structure of eligibility for free health care impacts on health status. Evidence on the impact of access to free primary care on health is hard to come by as we need data gathered over an extended period and this is expensive and difficult. For instance, even the extensive RAND Health Insurance Experiment in the US, which randomly assigned individuals to different insurance plans over the period 1972-1981, found significant effects of charges on use of health services, but little effect on overall health status. However, the extension of the medical card to all over 70s in 2001 did present some opportunities to speculate on the link between access to free GP care and health status. Layte et al (2009) showed that levels of disability among older people in Ireland fell between 2000 and 2004 even though levels of chronic illness actually increased. The fact that older Irish people were more likely to see their GP during this period could suggest that increased GP care lessened the impact of illness and reduced disability. This question is still under investigation but there is little doubt from previous ESRI research that the way we finance primary care in Ireland influences access and utilisation and this has implications for equity across groups. It would be surprising if this did not have an impact on health.

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