



EQUITY IN HEALTH CARE: A VIEW FROM THE IRISH HEALTH CARE SYSTEM

Samantha Smith

APRIL 2009



University of Dublin, Trinity College

An Adelaide Health Policy Brief

FOREWORD

The Adelaide Hospital Society is pleased to publish the first in a new series entitled Adelaide Health Policy Briefs. It is appropriate that the first Brief concerns EQUITY IN HEALTH CARE : A VIEW FROM THE IRISH HEALTH CARE SYSTEM as the Adelaide Hospital Society, which exists to advance healthcare, is committed to all citizens receiving equal care and treatment upon the basis of their healthcare needs rather than upon their financial means. The purpose of the series of Adelaide Health Policy Briefs is to provide short evidence-based treatments of key issues or topics in Irish healthcare. It is hoped that the series will contribute to the health policy process in Ireland and thereby help improve the health care of our people. The series is being developed as part of a wider and exciting new initiative by the Adelaide Hospital Society in conjunction with the Department of Public Health and Primary Care in Trinity College, Dublin. This will involve the appointment of two Adelaide Lecturers in Health Policy and in Health Sciences Research in 2009. In addition the Board of the Society has appointed a Health Policy Advisory Board with a wide range of expertise in relation to health policy issues. The Adelaide Hospital Society believes that it is important to bring the contributions of experts and agencies to bear in seeking to advance healthcare and to advocate improvements upon the basis of the best available evidence.

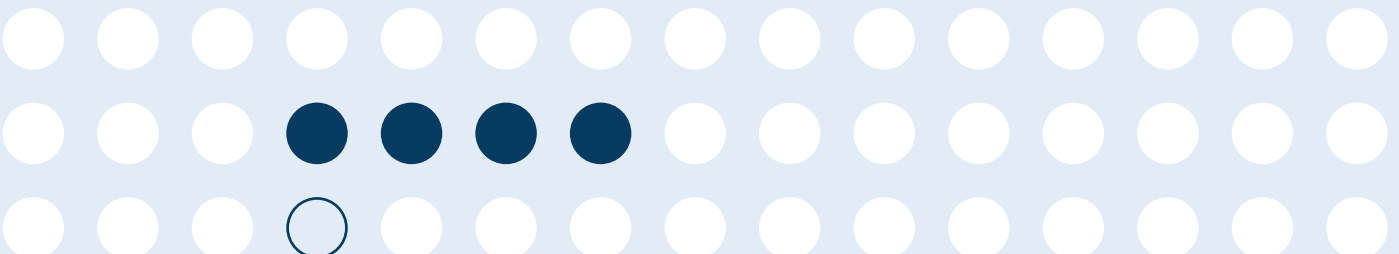
We wish to thank Dr. Samantha Smith for producing this ground-breaking paper in the Irish context. We believe it will be a substantial contribution to greater clarity both as to the meaning of 'equity' and as to the 'flow of funds' in the Irish health system. As Dr. Smith shows 'the devil' of unfairness is often hidden in the 'detail'. This Brief provides an essential roadmap to help develop a more coherent and transparent national commitment to equity and in ensuring this in the way our health funding flows. There is a central contradiction around private financing in Irish healthcare in that private sources of financing account for a relatively small proportion of total healthcare resources. However it has a system defining role unlike in other European countries: we end up with our unique 'two-tier' system which is so obviously inequitable and with primary care being very dependent upon 'out of pocket' payments. There is nothing immutable about our financing of healthcare, which had produced this current situation, and this well-researched paper will assist in changing to a fairer and more effective flow of funds.

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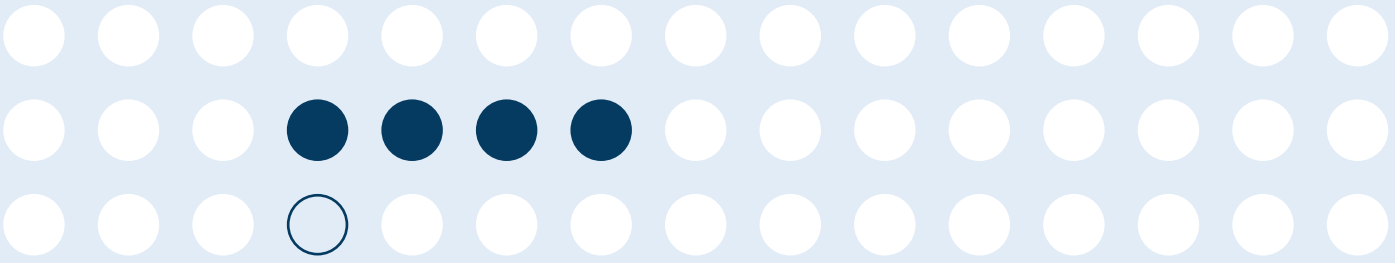
This publication may be cited as: S. Smith Equity in Health Care:
A View from The Irish Health Care System. An Adelaide Health
Policy Brief (Adelaide Hospital Society, Dublin, 2009)

EQUITY IN HEALTH CARE:

**A VIEW FROM
THE IRISH HEALTH CARE SYSTEM**

Samantha Smith

April 2009



OVERVIEW

This brief examines equity in the Irish health care system. Equity is examined in Irish policy, in the structure of the health care system, and in how the health care system is financed and implemented.

EQUITY IS.....?

Equity is an important goal for many health policymakers and is one of the four guiding principles in the current Irish national health care strategy. However, equity itself is a complex concept and has **no universally agreed definition**. There are a number of different philosophical theories on what equity means.

EQUITY IN HEALTH CARE IS.....?

In health care, a range of different goals on equity can be identified in policy statements and strategies:

- Ensure **equal access** to health care for all in the population?
- Distribute health care according to **need**?
- Ensure **equal distribution of health**?
- Distribute health care on the basis of **willingness to pay**?

Each of these goals reflects a valid philosophical perspective on equity. **The central problem is that these goals (and the underlying philosophical theories) can conflict with each other.** To illustrate, if health care is structured so as to achieve equal access to health care, this will not necessarily mean that health care is distributed according to need, or that health status is equalised across the population. Similarly, allowing health care to be distributed according to willingness to pay risks it being concentrated in the hands of those who are rich enough to pay for it. This would not necessarily ensure equal access or that health care is distributed in line with need, and could give rise to a very unequal distribution of health outcomes.

The philosophical debate on the meaning of equity, and by extension, equity in health care, is unlikely to be resolved. **Awareness and understanding of the potential for conflicts between different goals for equity can inform and improve health policy decision making.**

EQUITY IN IRISH HEALTH POLICY?

Given there are different ways of defining equity in health care, it is important to identify which definition is adopted in national policy statements. Equity is a central goal in many national health care policies, but it is more difficult to find examples of policy statements on equity in health care that embody clearly identifiable ethical principles.

This is observed in Irish health policy. Equity is a central principle in the national health care strategy but the definition is unclear and inconsistent and thus cannot be uniquely aligned with any one philosophical ideology. At one point, the strategy is concerned with equality in access and opportunity (to achieve full health potential), at another it is concerned with equality in health status, and at yet another it is concerned with distributing resources according to need. **It is difficult to identify the overall equity principle underpinning Irish health care policy.** As a first recommendation, the definitions of what is meant by equity in health, and in health care, need to be revisited in Irish national health policy.

EQUITY IN IRISH HEALTH CARE STRUCTURES?

Different definitions of equity in health care have implications for how the health system is structured. In a system governed by libertarian principles, health care is distributed in the private market according to willingness to pay (i.e. using out-of-pocket or private health insurance funds). Other, non-libertarian, principles

require non-market oriented systems where consumption of health care is separated from payment for that care. In these systems, revenues from the population (e.g. taxes) are pooled to finance health care services which are in turn distributed to the population on the basis of some criterion (e.g. need). There are no examples of health care systems whose structures are consistent with a purely libertarian or purely non-libertarian/'egalitarian' perspective. **The structures of the Irish system embody a complex mix of libertarian and egalitarian principles:**

Primary care

- Egalitarian - public funding of primary services for medical card holders (<29% of the population).
- Libertarian - private funding for primary services by non medical card holders (>71% of the population).

Secondary care

- Egalitarian for public hospital care. All individuals are eligible to receive public hospital treatment (medical card holders are treated free of charge while non medical card holders are required to make co-payments).
- Libertarian for private hospital care. Private hospital care (e.g. private/semi-private beds, direct consultant care etc.) is provided on a willingness to pay basis in both public and private hospitals.

This mix of principles in a health system has been described as 'horrific' in the literature (Williams, 1988):

- **Differential pricing structures for primary and secondary care** give rise to varied incentives that can lead to complicated patterns of utilisation and unintended interactions between the different levels of health care.
- **Libertarian principles apply** not just to supplementary private hospital services, but also, for specific individuals, to **basic primary care services**. Use of GP care by non medical card holders is influenced (amongst other factors) by their ability/willingness to pay for it. The libertarian structure suggests that policy makers are indifferent to how much these individuals do/don't purchase.

The complexity of the equity concept makes it difficult, but not impossible, to outline a coherent statement on equity in health care policy, and to subsequently align health care structures with the policy objectives. The analysis of the different definitions of equity, and their potential conflicts, provides a **useful roadmap for developing more coherent and transparent health policy commitments and health care structures.**

MEASURING EQUITY?

The way in which the health sector is implemented may differ from the intended structures so it is important to examine equity in the context of how the health system operates on the ground. This is the focus of Part II.

A range of internationally accepted methods for measuring equity in health care have been developed. To get around the problems in defining equity, researchers have focused on two broadly agreed principles. Adherence to the following two principles has been analysed in a range of OECD countries: a) health care should be financed according to people's ability to pay and b) health care should be delivered according to people's need for health care (i.e. regardless of ability to pay). This captures the idea that what people pay into the health system does not determine the amount of health care they are entitled to receive in return.

Previous analysis has separately examined these two principles. In the Irish context, this overlooks important patterns on equity. Part II of this brief adopts a newer approach of **looking at the financing and delivery of health care together** to examine equity.

FLOW OF IRISH HEALTH CARE RESOURCES

The complete flow of health care resources in the Irish health care system is traced. Individuals contribute to public and private health care resources (via tax contributions, out-of-pocket payments etc.), these resources are used to pay for health care from a range of providers (e.g. hospitals, GPs etc.) and these health care services are in turn distributed across the individuals. **By unpicking the details in the resource flows, the analysis identifies equity patterns behind how the health system is financed and delivered in practice.**

A range of data sources are used to trace the flow of non-capital public and private health care resources through the Irish health care system in the year 2004.

Individuals are categorised by health care entitlement status:

- 'Medical card' – individuals who hold only a medical card (25%). The average income of this group is low, with a relatively old age profile.
- 'Dual cover' – individuals with both a medical card and private health insurance (3%). The average income of this group is low, but higher than in the medical card group, with an older age profile.
- 'Non-covered' – individuals with neither a medical card nor private health insurance (23%). The average income of this group is higher than for the medical card holders but lower than for those with private health insurance, with a relatively young age profile.
- 'Privately insured' – individuals with private health insurance only (49%). The average income of this group is higher relative to the other groups, with a middle age profile.

EQUITY MESSAGES FROM THE FLOW OF FUNDS?

A central message from the analysis is that in order to understand equity in the Irish health care financing system, **the devil really is in the detail.**

Existing measures of equity in Irish health care financing hide sources of inequity that are identified from the more detailed flow of funds analysis.

There is evidence of cross subsidisation in the system. For some groups in the population, their contributions to health care resources are higher than the value of health care services that they receive, and vice versa for other groups. Resource contributions by some individuals are used to subsidise the cost of health care for others.

The amount of cross subsidisation varies by health care service.

The direction of cross subsidisation varies by health care service. It is not always the case that the rich subsidise the poor and the healthy subsidise the sick. For some health care services and types of expenditure, there is evidence of cross subsidisation in the opposite direction.

The financing mix for health services varies across entitlement groups. A mix of public and private resources is used to finance health care for all individuals in the population, but the proportional mix varies across groups. **In particular, the non-covered group relies to a greater extent on out-of-pocket payments to finance health care relative to others in the population, particularly for primary care.**

Important lessons on equity can be learnt from small details in the system. The National Treatment Purchase Fund (NTPF) accounts for less than 1% of total health care resources, but its existence highlights key problems in the rest of the system. The NTPF creates a complicated resource flow whereby some of the contributions made by individuals to public resources are allocated to purchasing health care in the private sector, at private sector rates, for public patients. The NTPF is a symptom of the wider problems in the system caused by complex supply and demand side incentives that operate to favour the treatment of private patients over public patients within the public hospital system, regardless of health care need or socio-economic status.

The analysis also explains a central contradiction around private financing in the Irish system. Private sources of financing account for a relatively small proportion of total health care resources, but their role in the system is not marginal. Private sources represent an important source of financing for specific health services, and for specific individuals in the Irish system.

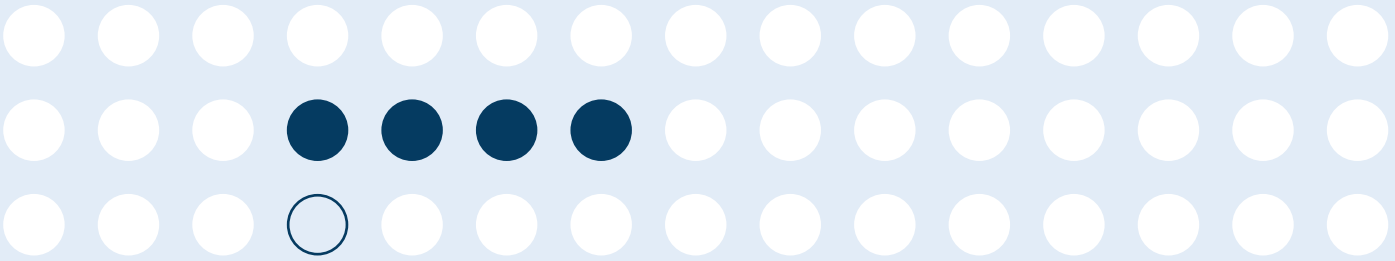
Ultimately, analysing equity in health care is a difficult task. The concept itself is complicated with no universally agreed definition. From the perspective of the Irish health care system, the picture is further complicated. A mix of principles on equity are identified both at the level of health policy, and in the structures that govern the system (Part I). At the level of implementation, analysis of the complete flow of resources through the system reveals a number of complex flows that have implications for equity (Part II).

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PART I

UNDERSTANDING EQUITY: IN IRISH HEALTH CARE POLICY AND STRUCTURES

Introduction

The recent joint policy paper by the Adelaide Hospital Society and the Jesuit Centre for Faith and Justice (2007) identifies a set of key values that are believed to be important in underpinning a central vision for the Irish health sector. Justice (equity) is included in these key values, and equity is also a central objective in the national health care policy. Despite these policy commitments to equity, in reality there is concern with inequitable patterns in the financing and delivery of Irish health care and this is where much of the empirical work in this area has focused (e.g. Layte and Nolan, 2004).

However, the concept of equity is complex. There is no universal agreement on how it should be defined and different definitions can conflict with one another. This has obvious implications for what is meant by equity in health care and how it can be pursued in a health care system. The structure of the Irish health care system has a number of unusual features. Layte and Nolan (2004: 111) describe as “complex” the response of the Irish health care system to the central questions of how a health service should be financed, who should have access to it, and at what price. The authors note with surprise the lack of conceptual work on defining equity in health care in the context of this complex system.

In response, Part I of this brief aims to unpick the fundamental equity principles that underpin Irish health care policy and structures. The analysis shows that the way in which equity is defined changes from one part of the system to another. By drawing on the theoretical background to equity, the discussion helps to clarify the choice of justice principles that is available for governing the structure of the Irish health care system.

To help assess the equity goals in the Irish system, section 1.2 outlines a range of different theoretical definitions of equity, and of equity in health. Section 1.3 examines how equity has been defined in international health policies and the implications for health care structures. Section 1.4 focuses on how equity has been defined in Irish health care policy and examines the equity principles underpinning health care structures. Section 1.5 assesses how the health care structures are implemented in practice. Section 1.6 discusses preferences on equity in Irish health care, and section 1.7 concludes Part I.

1.2 Defining equity

EQUITY IS.....

Equity can be defined in a number of ways. Different philosophical perspectives have different views on what ‘equity’ means. These different views can conflict with each other. This section briefly outlines the definition of equity from each of the following philosophical viewpoints: libertarianism, utilitarianism, Rawls’ theory of distributive justice, equality of opportunity theory, and Sen’s theory of equality.

Libertarianism emphasises rights, and claims that if everyone is entitled to the goods they possess, a just distribution is whatever distribution results from people’s free exchanges of those goods. The only legitimate government intervention is to finance the background institutions that are required to protect the system of free exchange (e.g. policing and justice systems).

Utilitarianism judges actions to be right or wrong by assessing their impact on total utility. The central idea is that the morally correct action is the one which produces the greatest amount of happiness for society (Kymlicka, 2002). A just society is achieved when the major institutions are arranged to yield the greatest net balance of satisfaction summed over all individuals in the society (Rawls, 1971).

Rawls’ theory of social justice (Rawls, 1971) assumes that all individuals are equal, rational, and self-interested. The theory describes a hypothetical ‘original position’, where no-one knows his or her place in society, in which these individuals choose the principles to govern distribution in society. Rawls proposes that behind this “veil of ignorance” (Rawls, 1971: 12) individuals will adopt the ‘difference principle’. Under this principle, all inequalities are judged in terms of securing the benefits for the least advantaged person in society.

The idea of ‘**equality of opportunity**’ is described as the prevailing justification for economic distribution in our society (Kymlicka, 2002). This theory proposes that people should not be “advantaged or hampered by their social background and that their prospects in life should depend entirely on their own effort and abilities” (2004: 25). Inequalities in income, power and other domains are justified if there has been fair competition in achieving those positions. Inequalities are unfair if people are disadvantaged/privileged by arbitrary and undeserved differences in their social circumstances (Kymlicka, 2002).

Sen provides a useful method for comparing the above theories with each other (Sen, 1992). Each of the theories are looking for equality in some thing (e.g. libertarians demand equality of rights and liberties, utilitarians assign equal weights to everyone’s utility, Rawls’ theory requires equal liberty and equal distribution of social primary goods). If all people were identical, equality in one space (e.g. income) would be congruent with equalities in other spaces (e.g. well-being, utility). It is a consequence of human diversity that equality in one space tends to go with inequality in another. Sen therefore argued that the most important issue is to agree on the space in which equality is required: “‘Equality of what?’ is indeed a momentous – and central - question” (Sen, 1992: 21).

Sen’s theory of equality is developed on the basis of his own answer to that ‘momentous’ question. The theory requires equality in the space of people’s capabilities to achieve valuable beings and doings that make up their well-being. These ‘beings and doings’ are labelled ‘functionings’ and range from elementary items such as adequate nourishment and being in good health to more complex items of happiness, self-respect, community participation (Sen, 1992).

EQUITY IN HEALTH IS....

Equity in health care has been defined in a number of ways, in terms of seeking equal health care for people with equal needs, or ensuring equal access to health care, or removing inequalities in health outcomes etc. (Culyer and Wagstaff, 1993, Culyer, 1995). Given the varying definitions of equity, it is not surprising that there are different definitions of equity in health. To compare alternative conceptions of equity in health, it is useful to link the different definitions back to their underlying philosophical perspectives. This can be done by using the 'equality of what?' question as a guide. Table 1.1 summarises the linkages between the philosophical theories and the definitions of equity in health.

Focus on equality in rights and allowing health care to be purchased in the market according to individuals' willingness to pay fits with the libertarian perspective (Culyer, 1995).

Distribution of health care according to need can be linked with utilitarian or Rawlsian theory depending on how need is defined. A utilitarian perspective would place equal weight on the health of everyone and would seek to achieve the maximum level of health in the society. Where need is defined in terms of capacity to benefit, the utilitarian might seek distribution of resources in favour of those with the greatest capacity to benefit from that care.¹ A Rawlsian perspective is assumed to be concerned with the health of the worst off individual. If need is defined as initial health state, the Rawlsian policy maker will apply the 'difference principle' and direct resources to those with the worst health status (Olsen, 1997).²

Equality of access to health care fits with the general principle of equality of opportunity. Equality of health can be linked with Sen's theory. Where health is an important functioning in a person's capability set, pursuit of equality in the distribution of health will be an important goal.³

Theoretical analysis has emphasised the conflicts that can occur between these different definitions of equity in health (Culyer and Wagstaff, 1993, Culyer, 1995). This is not surprising given their linkage with underlying ideologies that are known to conflict. Allowing health care to be distributed according to willingness to pay risks it being concentrated in the hands of those who are rich enough to pay for it. This would not necessarily see health care distributed in line with need (however defined), would not ensure equal access, and could give rise to a very unequal distribution of health outcomes. Thus, where people are not identical in every way, pursuit of equal rights and allowing health care to be distributed according to willingness to pay is likely to conflict with the other principles such as needs, access, and equal health.

Distributing health care according to need embodies two generic concepts, horizontal and vertical equity. Horizontal equity requires equality in the treatment of those with equal needs while vertical equity looks for unequal treatment of unequals.⁴ Distributing health care according to need has different implications for the resultant distribution of health status, depending on how need is defined. Two people may have the same initial health status but one has more capacity to benefit from health care than the other. Where need is defined in terms of initial health status (i.e. degree of ill-health), distribution according to need between these two individuals employs the horizontal equity principle (equal care for equal need) and the resulting health distribution is equal. However, where need is defined as capacity to benefit from health

care, distribution according to need in this example will employ the vertical equity principle where unequal care is required to meet unequal capacity to benefit. In this case the resulting health distribution between the two individuals would be unequal. The example demonstrates that application of the principle of distributing according to need can give rise to different distributions of health depending on how need is defined (Culyer and Wagstaff, 1993) and will also not necessarily yield equality in other spaces such as health, rights, access.

The distributions of health status and capacity to benefit from health care are not necessarily identical across the Irish population. There is evidence that poor health status is more concentrated amongst the lower socio-economic strata (e.g. Layte, 2004). Capacity to benefit from health care can be influenced by a range of factors (e.g. access to health complementary factors such as nutritional diet, health-promoting behaviours) that could be more prevalent in higher income groups.

Ensuring equality of access to health care (by equalising costs of utilisation or the maximum attainable consumption of health care), would not automatically give rise to equality in the other spaces. Allowing everyone the same costs of utilisation does not guarantee that each person will use the amount of health care required to yield an equal distribution of health (Culyer and Wagstaff, 1993), or that health care will be distributed in line with need.

These observed conflicts between policies that pursue equality in different health-related spaces are consistent with Sen's (1992) analysis of conflicts between philosophical perspectives where pursuit of equality in one ideological space requires acceptance of possible inequalities in others. For each of the above definitions of equity in health, unless people have equal willingness to pay, equal health endowments, and equal capacity to benefit from health care, acceptance of equality in one space (e.g. rights, needs, access, health) will potentially lead to inequality in the other spaces. As long as the underlying ideology of the distribution principle is acceptable, an unequal distribution of health outcomes is not necessarily inequitable.

¹ Utilitarians would also argue that because of disutility from seeing other people ill, this would adjust the allocations and would not lead to as unequal a distribution of health as might be expected from pure utilitarian, health maximisation goals.

² Although Rawls has acknowledged some difficulties with applying the 'difference principle' to health and some authors have argued that this distributive theory cannot be applied to health.

³ Sen's theory is ultimately concerned with pursuing equality in capabilities to function rather than equality in the functioning itself. However, it has been noted that applied work relating to Sen's theory has focused on equality in actual achievements (i.e. functionings) rather than on capabilities to function (Wagstaff and van Doorslaer, 2000).

⁴ To clarify, vertical equity is concerned with ensuring that where two people have unequal needs for health care, the treatment will be appropriately unequal (i.e. the individual with greater need for health care will receive more treatment than the individual with a lower need for health care).

Table 1.1 Summary of linkages between philosophical perspectives on equity and equity in health/health care

Philosophical perspective	Equality of what?	Equality of what in health?	Implications for health care system
Libertarianism	Rights	Rights	Health care distributed in the private market (no government intervention)
Utilitarianism	Utility	Health care need (capacity to benefit)	Health care distributed according to capacity to benefit from health care
Rawlsian	Liberties and social primary goods	Health care need (health status)	Health care distributed according to health care needs of the individuals with worst health status
Equality of opportunity	Opportunity	Access to health care	Health care organised to ensure equality of access to health care
Sen's theory of equality	Capabilities to function	Health	Health care organised to achieve equality in health across individuals

1.3 Equity in health care policy and structures

EQUITY IN HEALTH CARE POLICY....

Equity is a central goal in many national health care policies. The above theoretical discussion underlines the importance of clearly specifying which definition of equity is adopted if the goal is to coherently guide policy decisions. In practice it is difficult to find examples of policy statements on equity in health and in health care that embody clearly identifiable ethical principles.

In many cases, conflicting principles are espoused within the one policy where the country seeks to reduce inequalities in access, while also aiming to reduce inequalities in health outcomes (Oliver et al., 2005). The core objective of the English National Health Service is to ensure equal access for equal need. This conflicts with other objectives to narrow health outcomes inequalities although commentators have described these as secondary to the overriding objective of securing equal access (Oliver, 2005). Equity is one of the central core values on which the Canadian system is based and there is a strong emphasis on universal access, and on ensuring distribution of care on the basis of need rather than any other factor (e.g. wealth, region etc.) (Commission on the Future of Health Care in Canada, 2002), although need itself is not defined. As outlined in theory, ensuring equal access to care can conflict with efforts to distribute care according to need.

In other countries, it is more difficult to identify the principles underpinning the health care system. In the US, there has been less obvious commitment to equity compared with other OECD countries (Wagstaff and van Doorslaer, 2000). However, in more recent debates there is increasing concern with growing inequalities in access to care. The US Dept. of Health and Human Service expresses a specific concern with those who are worst off, and identifies its mandate as “protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves” (US Dept. of Health and Human Service, 2008). A central priority within this mandate is to ensure access to basic health insurance at an affordable price for the whole population which is consistent with an equality of opportunity perspective.

EQUITY IN HEALTH CARE STRUCTURES....

Different definitions of equity in health care have implications for how the health system is structured.

In a system governed by libertarian principles, health care is distributed in the private market according to willingness to pay (i.e. out-of-pocket or private health insurance funds).⁵ There is a direct link between payment for, and consumption of, health care. Individuals have exclusive rights to consume the health care that they have paid for.

Non-libertarian principles require non-market oriented systems where consumption of health care is separated from payment for that care. In these systems, revenues from the population (e.g. taxes) are pooled to finance health care services which are in turn distributed to the population on the basis of some criterion (e.g. need). Each of the non-libertarian ideologies discussed earlier require some degree of government intervention and can be loosely labelled ‘egalitarian’ theories, defined in terms of breaking the link between paying for and accessing health care (Williams, 1988).⁶

In practice there are no examples of health care systems whose structures are consistent with a purely libertarian or purely ‘egalitarian’ perspective. The way in which the principles are mixed in health systems can be more or less complex and three archetypes have been identified (Williams, 1988).

In a ‘mixed motives’ system, egalitarian principles govern some aspects of the system and libertarian principles direct others. Access to hospital treatment might be delivered on the basis of need, while access to primary care is determined by willingness to pay. Williams identified problems with this arrangement because of the inter-linkages between the two levels of care (e.g. primary care cases attending hospital emergency departments, interferences with gatekeeping role of primary carers). Alternatively, Culyer and Wagstaff (1993) give some examples where different principles can operate within a single system. Complementary services provided by hospitals (e.g. ‘hotel’ benefits of private/semi-private rooms) could be allocated on a libertarian basis. Yet Williams (1988) warned that separating amenity aspects of care from the clinical aspects of care is complicated and concluded that trying to cope with conflicts like these “in a single organisation would seem to be rather a horrific task” (1988: 180).

⁵ Willingness to pay for health care is complex and will vary depending on the seriousness of the health care need (e.g. if an individual is not ill, there is no immediate need for health care, and willingness to pay for health care would thus be low).

⁶ The use of the term ‘egalitarian’ to group the non-libertarian principles discussed earlier does not quite fit with Sen's proposal that all theories of justice (i.e. including libertarian) are concerned with equality in some or other space. However, it is used in this context in order to distinguish between libertarian and non-libertarian approaches to health systems.

In the second archetype, two independent systems operate alongside each other. The success of such a system will depend to some degree on who is required to contribute to the costs of the public system and who uses the public system. Richer people will opt out of the public system if standards in the private system are higher. Medical professionals may have an incentive to ensure that standards in the public system are kept relatively low if they can make more money in the private system. Consumers in the private system may also wish to keep standards in the public system low (in order to minimise their contributions) if they don't intend to use the public system. Although characterised as a parallel system, the two are inter-linked and the existence of one system has implications for the functioning of the other. The profit motive of the private system can lead to cream-skimming, shifting the most complex and expensive cases back onto the public system (McPake and Normand, 2008). It is difficult to find examples of such systems although many Latin American countries have large private sectors operating alongside public (and social insurance) systems.

The third archetype allows one system to predominate while permitting the other a minor role. According to Williams (1988), most health systems gravitate towards this type of system. A predominantly private system will “moderate the ruthlessness of the ‘if you can't pay, you can't have’ rule by organising a small public system to take care of the poorer people” (1988: 181). The US system has similarities with this approach. A large part of the health care system is driven by market forces but there are publicly funded schemes in place to provide care for the very poor, and for the elderly. A predominantly public system may allow a small private system to function in order to allow richer people to be able to purchase health care that is not available in the resource-constrained public system (e.g. a non-essential procedure; a more expensive treatment). The UK National Health Service is publicly funded from which everyone is entitled to seek care. There is also a small parallel market for private health care catering for those who are willing to pay privately for specific services (European Observatory, 1999).

1.4 Equity in Irish health care system

EQUITY IN IRISH HEALTH CARE POLICY....

Equity has been an important goal in Irish health policy and is one of four guiding principles in the current national health strategy.⁷ The aim of this section is to examine how equity is defined in this strategy.

The definition of equity is adopted from the World Health Organisation (WHO): “Everyone should have a fair opportunity to attain full health potential and, more pragmatically no-one should be disadvantaged from achieving this potential, if it can be avoided. Inequity refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust” (DOHC, 2001b: 17). It is interesting that in this overall definition, conflicting principles can be identified. The first statement indicates a concern with equal opportunity (i.e. to achieve full health potential). On the other hand, the second statement (distinguishing between avoidable and unfair differences in health), focuses on disparities in actual health achievements suggesting a concern with equality in health status.

Conflicting principles are also identifiable in subsequent statements on equity in the strategy. “Equity means that: health inequalities are targeted; people are treated fairly according to need” (DOHC, 2001b: 17). The first part of the statement implies a concern with an equal distribution of health in the population, but this does not necessarily fit with the second part of the statement, that people are treated according to need.

The goal of reducing socio-economic inequalities in health status is repeated a number of times throughout the strategy (e.g. DOHC, 2001b: 18, 36, 39). This has resonance with the Rawlsian concern with improving the status of those who are least advantaged in society. Yet at the same time, the strategy also makes frequent reference to fairness in access (e.g. DOHC 2001b: 18, 43, 61).

Although equity is a key principle in Irish health policy, the answer to Sen's ‘equality of what?’ question varies throughout the national health care strategy. At one point, the strategy is concerned with equality in access and opportunity (to achieve full health potential), at another it is concerned with equality in health status, and at yet another it is concerned with distribution of resources according to need. As a first recommendation, the definitions of what is meant by equity in health, and in health care, need to be revisited in Irish national health policy.

EQUITY IN IRISH HEALTH CARE STRUCTURES....

While it is difficult to interpret what ideological principle underpins the Irish policy statements on equity, it is more straightforward to eliminate specific candidates, for example libertarianism. The concern with establishing a ‘fair’ opportunity for achieving health potential, and avoiding disadvantages in this opportunity, indicates an aversion to the libertarian viewpoint and acceptance of some degree of government intervention. If the structures of a health care system are to reflect the equity principles as defined in policy, the general structure of the Irish health care system is therefore expected to be egalitarian (of some form), rather than libertarian.

In fact, the general structure of the Irish health system is complex with libertarian and egalitarian principles operating for different people and for different services. The Irish system therefore resembles the ‘mixed motives’ system described by Williams (1988).

At the primary care level, egalitarian principles apply only to a proportion of the population for GP services. GP visits are provided free of charge to medical card⁸ holders (<29% of the population). The rest of the population are exposed to a libertarian, market-oriented system, paying 100% of the private charge for GP visits. Prescription services are provided on a more egalitarian basis. All individuals are eligible to benefit from publicly funded prescription services although the non medical card holders are required to make relatively high co-payments (the first €100 per month).

In hospital care, public hospital services are structured on an egalitarian motive. All individuals are eligible to receive public hospital treatment (medical card holders are treated free of charge while non medical card holders are required to make co-payments). Libertarian principles apply to services over and above this baseline. Private hospital care (e.g. private/semi-private beds, direct consultant care etc.) is provided on a willingness to pay basis in both public and private hospitals.

It is not hard to see how this system contains many of the features described as ‘horrific’ by Williams (1988). Differential pricing structures for different parts of the health care system give rise to varied incentives that can lead to complicated patterns of utilisation and unintended interactions between the different levels of health care (discussed in more detail below). Libertarian principles apply not just to parallel private hospital services, and non-essential ‘hotel’ benefits, but also, for specific individuals, to basic primary care services. Use of GP care by non medical card holders is influenced (amongst other factors) by their ability/willingness to pay for it. The libertarian structure suggests that policy makers are indifferent to how much these individuals

⁷ The other three principles include people-centred service; quality of care; clear accountability.

⁸ See Part II of this brief for a detailed description of the categories of eligibility in Irish health care.

do/don't purchase. Yet this contrasts with the stated goals of the national primary care strategy (DOHC, 2001a) to ensure that primary care becomes the first point of contact in health care, meets 90%-95% of health needs, and is "readily available to all people" (2001a: 7).

Even where egalitarian principles apply in the system, the answer to the 'equality of what?' question is hard to identify. In primary care, separation of direct payment for GP visits into those who pay nothing and those who pay full costs suggests a concern with equalising access between those who are financially inhibited from GP care and those who aren't. This would be consistent with an underlying ideology concerned with equality of opportunity, where access is defined in terms of the direct costs of utilisation. Eligibility for a medical card is mainly determined on the basis of a means test. The group includes the worst off in society in socio-economic terms which suggests a concern with promoting health care access for the poorest in the population, consistent with a Rawlsian perspective.

However, medical cards can be granted on the basis of ill-health, and from 2001-2008 they were also issued to all those who are aged 70 and over (some of whom could afford to buy their own health care). Thus, low health status might be the characteristic that most medical card holders have in common (e.g. low socio-economic status and older age are both linked with poor health status). This further suggests consistency with a Rawlsian perspective where direct costs of utilisation are removed for the group with the worst health status in the population. Alternatively, the structure could indicate concern with improving access for individuals with a high capacity to benefit from health care (consistent with a utilitarian perspective). Within the medical card category, the objective may be to equalise access for those with equal need, defined either as ill-health or capacity to benefit. However, it is unlikely that the criteria for medical card eligibility are sufficiently sophisticated to divide the population into two internally homogenous groups, those with equally low health status/high capacity to benefit and those with equally high health status/low capacity to benefit. It is thus difficult to identify the 'what' that the egalitarian approach in GP care is seeking to equalise. This is even more difficult in light of the recent changes in medical card eligibility for individuals aged 70 and over (introduction of means-testing in January 2009). The same line of reasoning can be applied to the egalitarian approach in prescription medicines and public hospital care.

To summarise, the general structures of the Irish health care system operate on a mix of libertarian and egalitarian principles. Libertarian principles apply both to non-essential and parallel private services, but also, for some people, to basic primary care services that are not provided elsewhere in the system. Public finance is directed at specific services and at specific groups in the population, indicating some level of concern for inequality that justifies a role for government intervention in the system. Yet it is difficult to identify which inequality is the focus of attention. Access is improved (by removal of direct costs) for those who are socio-economically deprived, those in very poor health, and until recently, the elderly. This suggests a concern to increase access (but not necessarily utilisation) for those who are most deprived in health and economic terms, or those with greater capacity to benefit from health care. There are elements of Rawlsian and utilitarian ideologies here but neither are fully consistent with a known ideological principle. It is also not clear why the mix of libertarian and egalitarian principles differs between the primary and secondary levels of health care.

1.5 What happens in practice?

The imposition of libertarian values in GP care for more than 70% of the population is expected to influence utilisation. Econometric analysis finds that medical card status, and hence free access to care, has a positive and significant impact on the probability, and frequency of GP utilisation (Nolan and Nolan, 2007). Cross-border comparisons of GP utilisation between Northern Ireland and the Republic indicate that charges (in the Republic) deter a large proportion of poorer and less healthy patients from seeing their GP (O'Reilly et al., 2007).

The differential pricing structures for different levels of care is expected to influence the interaction between primary and secondary care in the system. GP and hospital emergency care act as the two main gateways into the Irish health care system. Hospital emergency care might be used as a substitute for primary care in order to avoid GP charges although a GP visit is currently estimated to cost approx. €50-€60⁹ compared with the statutory charge of €100 for a self-referred Emergency Department (ED) visit (DOHC, 2009). However, preliminary evidence from EDs in the Dublin area indicate that individuals who have no medical card, and are on relatively low incomes, may be using emergency services as an alternative to primary care for non urgent complaints (Smith, 2007b, Smith, 2007a). This is supported by survey data which indicate that the ED charges are not as well established in the public mind as are GP fees (Red C, 2004).¹⁰

Practical implementation of the health care structures may in turn undermine the ethical principles that underpin those structures. Part II of this brief examines equity in the context of how the Irish health care system is implemented in practice.

1.6 What do the Irish people want?

As suggested earlier, the definitions of what is meant by equity in health, and in health care, need to be revisited in Irish national health policy and by extension, in the structures of the system.

The presentation of the different theoretical perspectives emphasises the complexity of the concept of equity. The complexity makes it difficult, but not impossible, to outline a coherent statement on equity in health care policy, and to subsequently align health care structures with the policy objectives. The analysis here has provided a roadmap through the various different conceptions on equity. This can be used to systematically guide policy makers on the choices available between different principles to underpin the health sector.

In an implicit hierarchy of choices, the first choice can be made between a libertarian and a non-libertarian viewpoint. If the libertarian viewpoint is preferred, the society focuses on the rules that govern behaviour. As long as those rules (e.g. right to purchase health care according to willingness to pay) are adhered to, the actual outcomes (e.g. distribution of health) are not considered to be important by libertarians. If the alternative, non-libertarian, or egalitarian perspective is adopted, the society indicates that it cares about consequences of actions. Within that perspective, the details on which outcomes are important are complicated and a range of different philosophical choices are available. However, the basic egalitarian focus is very different to the libertarian focus and in the Irish context, making a decision on this high-level choice already advances on the complex mix of libertarian and egalitarian principles observed in the health care structures.

A general preference for egalitarianism is implied within the various objectives for equity outlined in the Irish national strategy (e.g. reducing socio-economic inequalities in health, ensuring

⁹ GP out-of-hours co-operatives in the Dublin area charge €60 per visit suggesting this is close to the average GP charge, at least in Dublin.

¹⁰ However, the increase in the charge for a self-referred ED visit by 52% between 2008 and 2009 may change this.

equal access etc.). The adoption of an egalitarian criterion is also reasonable in the context of European and other national health care systems which embody general egalitarian principles. It is equally possible that the broad assumption of a preference for egalitarianism is too prescriptive and there is a role for psychological/sociological research in this area. The presence of libertarian values for a large proportion of the population for baseline primary care services indicates there may be respect for the view that if people are willing and able to pay more for more health care, they have a right to do so. However, historical accounts of how the libertarian structure to primary care came about suggest a different story. Barrington describes the powerful resistance at various junctures by the Catholic hierarchy and the medical profession to proposals to introduce universal free primary care in Ireland (Barrington, 2000). The incremental way in which the entitlement and payment structures in the Irish health care system have developed over time highlights the need to question the fundamental principles on which Irish society would like the health sector to be based.

The presence of libertarian values governing private health care services is unlikely to be controversial in future Irish health care structures. The Government is unlikely to interfere with an individual's right to pay more to access private care if he/she wants to.¹¹ However, in the high-level choice between libertarian and egalitarian values, it is more difficult to justify the use of public funds to subsidise private health care resources, or to allow priority to private patients within the public health system. As will be discussed in more detail in Part II, examples of these are observed in the Irish health care system in practice.

At the next stage in the hierarchy of choices on equity principles, policy makers can make more detailed choices amongst alternative egalitarian perspectives. Again, these are not simple decisions, but the 'equality of what' framework provides valuable guidelines on which routes are available. Practical choices can be linked with philosophical perspectives to identify underlying preferences of individuals. Where there is a choice to be made between two individuals who are eligible for a specialised, expensive operation, policy makers may find it hard to choose between someone who is sick, but with relatively low capacity to benefit, and another who is less sick, but with relatively high capacity to benefit. However, where the capacity to benefit of the first individual is just 30 minutes, the choice may be easier to make. A preference for the principle of distributing according to need, with need defined as capacity to benefit, is identified in this latter example but it is recognised that for other less stark contrasts, need as initial health state is also important. The issues here are no less complex than in the earlier discussion of how equity is defined in the Irish health care system, but because of the structure provided by the theoretical context, there is less confusion. The linkage to philosophical equity principles clarifies the decisions involved and helps to identify whether, and in what circumstances, preferences are weighted more towards equalising outcomes, or opportunities to benefit, or capacity to benefit etc.

1.7 Conclusion to Part I

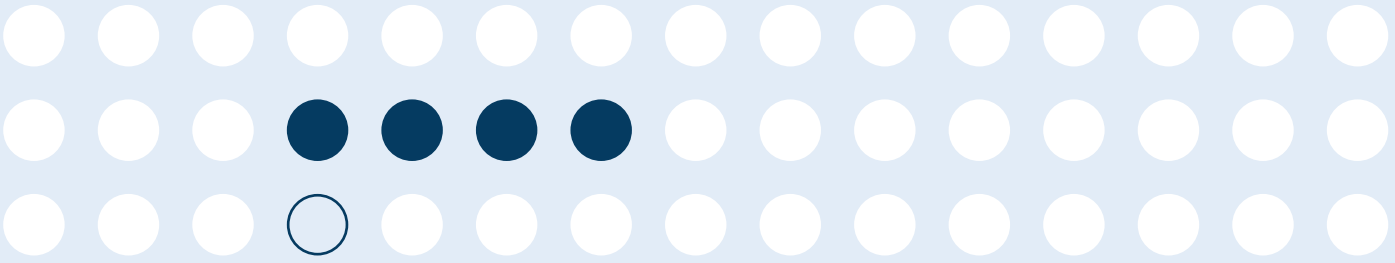
In conclusion, policy makers and health system commentators are concerned with the values underpinning the Irish health care sector, as illustrated by the joint Adelaide Hospital and Jesuit Centre for Faith and Justice paper (2007). Commitment to equity in health care is complicated by the lack of agreement on how it should be defined.

In Part I, the sources of conflicts between different views on equity have been outlined using linkages with underlying philosophical perspectives on equity. The theoretical basis also

provides a useful roadmap for guiding the development of more coherent and transparent health policy commitments and health care structures than are currently adopted in Ireland.

Unless the goal of equity in health care is clearly defined in policy, this interferes with the ability to guide how the health system should be structured. In turn, practical implementation of the structures can further deviate from an agreed definition on equity. Much of the debate on equity in health care has focused on measuring and quantifying the amount or degree of inequity in a system in practice (van Doorslaer et al., 1993, Wagstaff and van Doorslaer, 2000, Layte and Nolan, 2004), and this is the focus of Part II.

¹¹ Even if a private system did not exist in Ireland, there is no law preventing an individual who is willing to pay for it, to travel abroad to seek additional health care. Unless there are specific laws preventing the purchase of private health care, libertarian principles will operate to some extent in most countries.



PART II

EQUITY IN IRISH HEALTH CARE FINANCING: UNCOVERING THE DETAILS

2.1 Introduction

Part II of this brief examines the equity implications of how the Irish health care system is implemented in practice, with specific focus on how fairly the system is financed. Available analysis of equity in health care financing has been limited and refers to financing patterns of the late 1980s (Nolan, 1993, Wagstaff et al., 1999). More up-to-date assessment is particularly important in light of current health policy debate. Options for changing the structure of Irish health care financing have been discussed throughout the political history of the state (Commission on Health Funding, 1989; Barrington, 2000). There are now ongoing intra- and inter- political party discussions on whether or not to replace existing health financing structures with a social health insurance based system (Labour Party, 2008). Yet these debates have been taking place in the absence of comprehensive Irish data on health financing patterns, and on the equity implications of existing and new financing patterns.

The aim of Part II is to provide an up-to-date and detailed analysis of equity in the Irish health care financing system, to underpin the current discussions. This is compatible with, and builds on, recent work by Thomas et al. (2006, 2008) who initiated the process of updating the evidence base on Irish health care financing patterns. The complete flow of Irish non-

capital health care resources is traced from individuals to financial intermediaries, from there to health care providers, and from there to individuals. This differs from the standard international method for analysing equity in health care financing that was previously applied to Irish data. However, results from the earlier analysis produced relatively benign conclusions about inequity in Irish health care that are at odds with common perceptions of widespread inequities in the system (e.g. Wren, 2003, Tussing and Wren, 2006). This problem is not unique to Ireland and international researchers are also introducing changes into the methods used to measure equity in health care financing in a range of countries (O'Donnell et al., 2008, Leung et al., 2009).

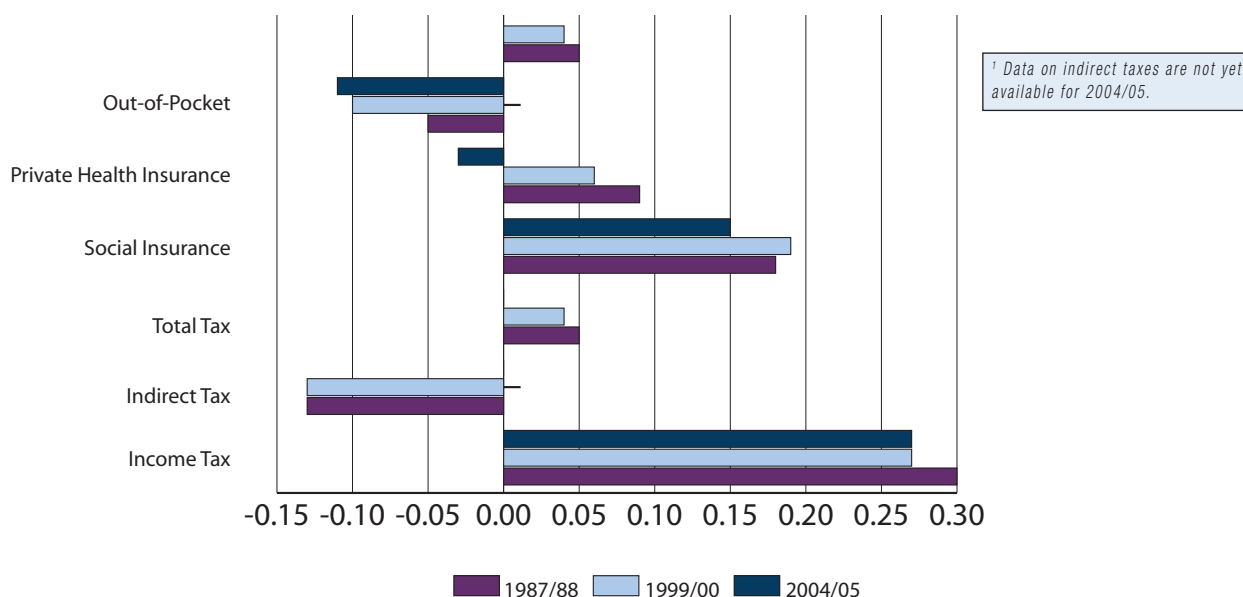
Section 2.2 summarises the background literature on measuring equity in health care financing and section 2.3 introduces an alternative perspective on analysing equity. Section 2.4 outlines the data and methodology for a flow of funds approach to analysing equity in Irish health care financing. Sections 2.5-2.7 present and interpret results from the flow of funds approach. Lessons and conclusions are outlined in sections 2.8 and 2.9.

2.2 WHAT IS EQUITY AND HOW HAS IT BEEN MEASURED?

As outlined in Part I, the answer to the question 'what is equity?' is complex and there is no universally agreed definition. The complexity of the equity concept has implications for how it is to be measured. In health care, empirical investigation of equity has focused on adherence to two principles: that health care should be financed according to ability to pay, and delivered according to need.

To assess equity in ability to pay, much of the existing analysis has focused on progressivity (van Doorslaer and Wagstaff, 1993, Wagstaff et al., 1999, Wagstaff and van Doorslaer, 2000). Research has concentrated on vertical equity in financing, where people of unequal ability to pay (measured by pre-tax income), pay unequal amounts. This captures the idea that rich people should pay more towards health care than the poor. Measuring the progressivity of financing investigates this further by looking at how much more the rich are (or could be) paying. Progressive financing involves health care payments rising as a proportion of

Figure 2.1 Index of progressivity by source of finance (Ireland 1987/88, 1999/00, 2004/05¹)



Data Sources: Central Statistics Office, 1988, Central Statistics Office, 1999, Central Statistics Office, 2005

income as income rises. Regressive financing occurs where payments fall as a proportion of income as income rises. Payment is proportional where individuals pay the same proportion of their income on health care regardless of their level of income.

The degree of progressivity in a source of health financing can be summarised using indices. The Kakwani index measures the extent to which a given financing source departs from proportionality. Positive values indicate progressivity, negative values indicate regressivity and zero indicates proportionality. An index of progressivity for total health care financing can be calculated from a weighted sum of Kakwani indices for each source of health care finance. The weight refers to the share of each source of financing in total resources.

Figure 2.1 presents Kakwani indices for each of the main sources of Irish health care financing based on data from 1987/88-2004/05. Results for 1999/00 indicate a marginally progressive system overall, driven by progressive patterns in the largest sources of finance (income tax and social insurance contributions).

Cross-country comparisons have been conducted using Kakwani indices. In a sample of OECD countries¹², Switzerland and the US had the most regressive structures and these systems have the largest components of private financing. The next most regressive systems were in the countries with large social insurance components, namely Germany and the Netherlands. France was an exception with an overall progressive system, largely due to the progressivity of the structure of its social insurance system. The most progressive indices were found in those countries which rely mainly on general taxation as a source of health financing (Finland, UK) (Wagstaff et al., 1999).

However, measuring progressivity falls short of the ultimate objective of analysing equity in a health care financing system. Progressivity results need to be interpreted differently for public and private financing sources. For public sources, it is assumed that all contributions are pooled to fund the public health system, from which everyone is entitled to receive care. Contributions to the system are not linked to benefits received from the system. For private sources, this assumption cannot hold because expenditure is directly linked with consumption. A low proportion of private expenditure at low incomes (i.e. progressive) may reflect non-affordability of the good/service in question. High expenditure by higher income groups could be reflecting purchase of non-essential health care services. As a result, apparent improvements or otherwise in progressivity in private sources are likely to be inconsistent with intuitions about what is or is not equitable. In Ireland, a reduction in the price of GP care may improve access for mid-low income people previously unable to afford to see their GP. Yet this might be reflected as an increase in regressivity of out-of-pocket payments as expenditure by this group rises.

In addition, the use of summary indices hides important information in the distribution of health care payments across incomes. Uneven patterns that may be of interest to policy makers are not picked up in the indices where the emphasis is on general progressive/regressive trends. Index results are typically complemented by analysis of the underlying distributions. In the Irish context, the distributions of out-of-pocket and private insurance premium payments are uneven across income deciles. Moreover, individuals within the income distribution are grouped into different health care entitlement groups (e.g. medical card holders, privately insured etc.). These groups are associated with different health care financing patterns. Focusing on the distribution of the health financial burden across entitlement

groups could highlight important patterns on equity that are not otherwise visible.

The following sections outline a whole systems approach to examining equity in Irish health care financing. As will be shown throughout the analysis, there are a number of unfair details in the Irish health financing system that don't show up in existing measures of equity.

2.3 A FLOW OF FUNDS FRAMEWORK FOR IRISH HEALTH CARE

The inter-linkage between financing and consumption in private health care payments provides motivation for developing a framework that incorporates both the financing and delivery elements in the health care system. This is in line with the literature where researchers are now beginning to look at the distribution of health care payments alongside the distribution of utilisation (e.g. O'Donnell et al., 2008, Leung et al., 2009).

Figure 2.2 outlines the flow of funds framework for this analysis. Resource flows are traced from individuals to public and private financial intermediaries (plus direct out-of-pocket payments), from there to health care providers, and from there distributed to individuals. To examine some of the uneven patterns of payments across the income distribution, individuals are categorised by health care entitlement.

There are two broad eligibility categories in the Irish system. Individuals in Category 1 are issued with a medical card which grants the recipient (and dependents) free access to public hospital care, GP and pharmaceutical services, and other primary and community care services.¹³ Individuals in Category 2 are required to pay out-of-pocket for GP care and pharmaceutical services. They are eligible for public hospital care subject to statutory charges. Individuals in this category can also avail of a range of public assistance schemes (e.g. drugs payment schemes). Eligibility for a medical card is granted to those earning an income below a specified threshold level, and all people aged 70 years and over (regardless of income¹⁴). A small number of discretionary medical cards are issued on the basis of ill-health.

Many people in Category 2, and a small proportion of those in Category 1, purchase supplementary private health insurance. Thus, the population can be categorised into four broad entitlement groups: medical card only with no supplementary insurance ('medical card', 25%); privately insured only with no medical card ('privately insured', 49%); individuals with both medical card and private health insurance ('dual cover', 3%); individuals with neither medical card nor private health insurance (i.e. 'non-covered', 23%).

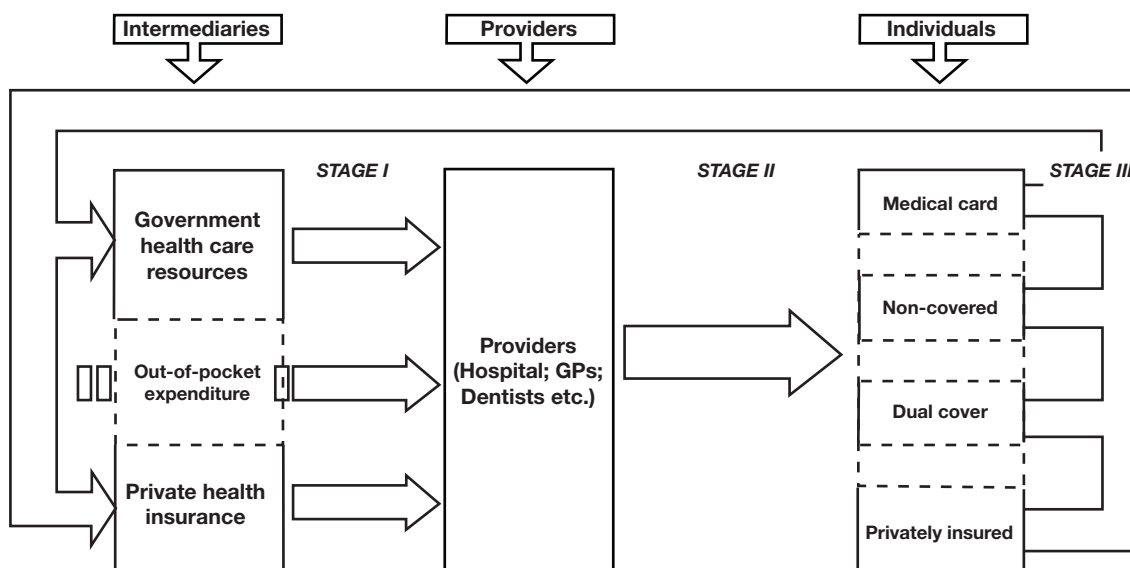
Based on descriptive survey data, these entitlement groups can be broadly ranked in terms of socio-economic and health status from the medical card (lowest) to the privately insured (highest) (ESRI, 2001). Mean gross incomes are statistically significantly different ($p < 0.01$) across the groups and the privately insured and non-covered groups are both more likely to be engaged in employment than the medical card and dual cover groups. Non-covered individuals have the lowest mean age (<35), followed by the privately insured group (40.5). Individuals in the medical card group are older (52.7) and the mean age for those with dual cover is 61. Measures of health status indicate a higher proportion of ill-health amongst the medical card and dual cover groups relative to their respective population shares. It is important to note that overlaps in the deprivation and socio-economic measures suggest that these do not describe mutually exclusive socio-economic categories.

¹² Denmark, Finland, France, Germany, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden, Switzerland, UK, US.

¹³ In 2005 the 'GP (family doctor) Visit' medical card was introduced. This card grants the recipient (and dependents) access to free GP services, not including prescriptions or any other primary/secondary care. Analysis in this policy brief is based on data from 2004 prior to the introduction of this additional medical card.

¹⁴ From January 2009 individuals aged 70 and over will be means tested for a medical card.

Figure 2.2 Flow of funds framework for Irish health care system



NOTES: Arrow indicates direction of resource flow. Resource flows at stage II refer to the value of health care services provided by health care providers.

2.4 DATA AND METHODOLOGY

2.4.1 DATA

The flow of funds traces the flow of total non-capital¹⁵ health resources in the Irish system in the year 2004. The primary data source for public health expenditure is the Department of Health and Children (DOHC) which publishes an annual breakdown of non-capital public health expenditure by health programme. Annual expenditure records of individual programmes are used to supplement these core data. Tax relief on health expenses and on private health insurance premiums are included in public health resources. Private health insurance claims expenditure by the largest private health insurance company is factored up by the estimated market claims share to give an estimate for total private health insurance expenditure for the market.¹⁶ The DOHC publishes annual summary estimates of national private out-of-pocket health expenditure. Expenditure patterns in the 2004 Household Budget Survey (HBS) guide the allocations of out-of-pocket expenditure across health providers and functions in the flow of funds framework.

2.4.2 METHODOLOGY

At stage I, public and private financing sources are categorised by health care provider (and function) according to the OECD International Classification System for Health Accounts (ICHA). This is the first application of Irish data to the OECD System of Health Accounts (SHA).

Stage II examines the distribution of public and private health care resources across individuals. Benefit Incidence Analysis (BIA) is used to estimate the distribution of a large proportion of these resources across individuals. BIA estimates the monetary cost of providing a good/service and combines this with information on utilisation of that good/service to examine how that monetary cost is distributed across the population (Castro-Leal et al., 2000).¹⁷ Utilisation data are available for GP, in-patient, out-patient, dental, and optician services in the 2001 wave of the Living in Ireland Survey.¹⁸ Resources linked to utilisation of these services are included in this part of the analysis. Not all of the resource envelope can be allocated on the basis of observed

utilisation data. In many cases public health expenditure is non-rival (e.g. health promotion activities) and cannot be readily assigned to individuals. However, there are other data that can be used to estimate the distribution of the remaining expenditure across the entitlement groups.¹⁹

Stage III identifies the ultimate contributions made by individuals to total health care resources. Public health resources are generated from income, consumption, and other tax and non tax revenues. The proportional contribution of each entitlement group to the income tax and social insurance components of public health resources is estimated from the Irish section of the 2004 European Survey on Income and Living Conditions.²⁰ Additional data are used to estimate the proportional contribution by each entitlement group to consumption and 'other' tax components of public health resources. Payment records from the 1999/00 Household Budget Survey are used to allocate private health insurance premiums expenditure across the dual cover and privately insured groups.²¹ Out-of-pocket expenditure is directly linked to consumption and has already been identified in stage II of the methodology.

2.5 OVERVIEW OF RESOURCE FLOWS AND FINANCING COMPOSITION

The total net non-capital health care resource envelope for 2004, according to the OECD definition of health care, is estimated to be €10.9bn. This represents 8.8% of GNP (or 7.4% of GDP)²² and lies just below the EU 15 average as reported by Tussing and Wren (2006).

Data were available to trace 91% of total non-capital resources through the complete resource flow in Figure 2.2 (i.e. stages I to III).²³ Public sources account for the largest proportion of resources (75%), followed by out-of-pocket payments (13%), and private health insurance resources (8.8%).

Figure 2.3 presents a more detailed version of the flow of funds and shows the variations in the resource flows by financing source.

¹⁵ Capital expenditure is not included in the analytic focus.

¹⁶ In the complete resource flow, net insurance claims are estimated to equal net insurance premiums (OECD, 2000).

¹⁷ The standard methodology for BIA is adopted, as described by O'Donnell et al. (2007).

At stage I, public resources are separated into earmarked and non-earmarked funds. As indicated by the size of the arrows, a small proportion (less than 9%) of total public resources are allocated to services for which there are no eligibility restrictions and no cost sharing requirements.

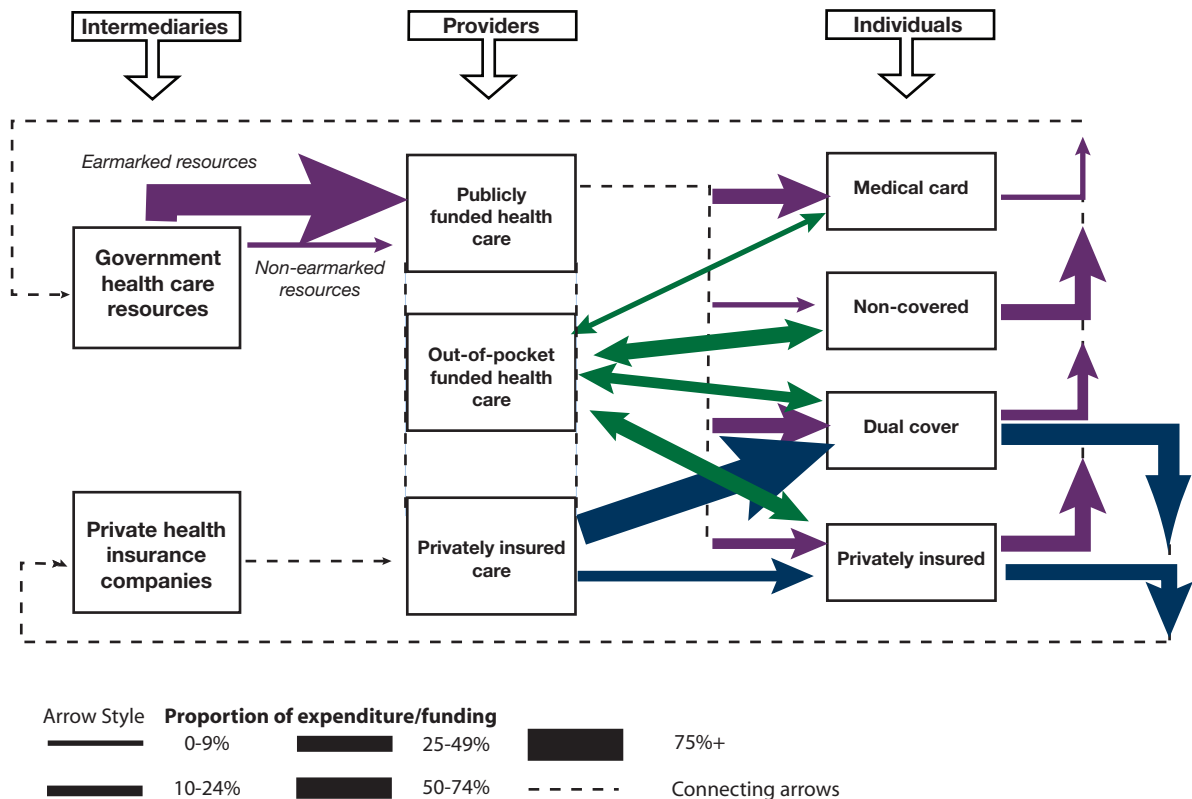
At stage II, the diagram identifies the allocation of each source of funding to each entitlement group. The size of arrow represents the proportion of mean health care resources. Mean public resource allocations are concentrated on the medical card and dual cover groups. Out-of-pocket payments are concentrated on the non-covered and privately insured groups. A higher proportion of mean private health insurance resources are allocated to the dual cover than to the privately insured group. Health care resource allocations to the four entitlement groups can be standardised for need. Separate assessment of horizontal equity in health care resource allocations has shown that even after standardising for health need, the distribution of mean total health care resources by entitlement is not uniform (Smith, 2008) and is biased towards the group with dual cover and away from the non-covered group.

The contributions made by each entitlement group to each source of funding at stage III are also identified in Figure 2.3.

Figure 2.4 gives a summary picture of how health care services are funded for each entitlement group. Where eligibility for public resources is limited, there is a role for private resource supplementation. Joint analysis of contributions and allocations shows that where this is the case, private resources can account for a higher proportion of allocations than of contributions. In particular, private resources account for less than 24% of total mean health resource contributions made by the non-covered but almost 37% of total mean allocations received by that group. A similar pattern is observed for the privately insured group. While the former group relies on out-of-pocket payments to supplement available public resources, the latter uses a mix of private insurance and out-of-pocket payments.

A key point emphasised by this part of the analysis is that the total 'cost' of health care services includes not just the out-of-pocket or private insurance payments but also the public resource contributions, regardless of whether or not an individual is eligible to benefit from those public resources. To illustrate, the full cost of primary care for a non-covered individual includes not just the GP charges but also the contributions made by those individuals to subsidise primary care for the medical card groups.

Figure 2.3 Flow of funds – detail



¹⁸ This survey forms the Irish component of the European Community Household Panel Survey. The sample size in 2001 included >6,000 individuals and is re-weighted to ensure the data are fully representative of the population of individuals in private households in Ireland (ESRI, 2001).

¹⁹ To illustrate, public expenditure on domiciliary maternity services is available to all women regardless of entitlement status. Only women of reproductive age will avail of the services. The expenditure is allocated across all groups, based on estimates of the proportion of 15-44 year olds in each group, where 15-44 approximates the average reproductive age period.

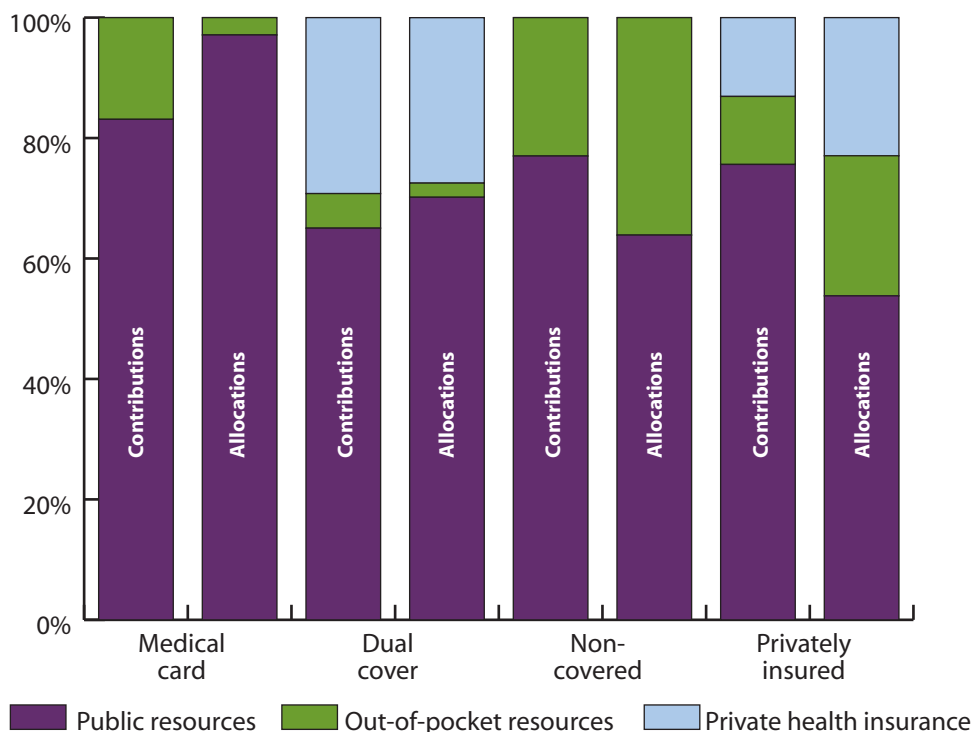
²⁰ The 2004 wave covered a sample of 14,433 individuals and results are re-weighted to ensure representation of private households in the country (Central Statistics Office, 2004).

²¹ The 1999/00 HBS was conducted between June 1999 and July 2000, covering a sample of 7,644 households (Central Statistics Office, 1999). Results are re-weighted to take into account possible differences in non-response rates across different categories of households.

²² GDP and GNP are at current market prices for the year 2004 (Central Statistics Office, 2006).

²³ Excluded resources refer to public expenditure on disability and mental health programmes (€974.8 million). Data on the health care entitlement status of individuals benefiting from these resources are not available.

Figure 2.4 Resource composition of contributions and allocations for each entitlement category, 2004 (%)



The graphical presentation is useful as a general guide but other important information on the patterns of equity in the system is contained in the complexities in these resource flows. The following results unpick these details and emphasise the value added of taking a complex systems approach in assessing equity in Irish health care.

2.6 RE-ASSESSMENT OF PROGRESSIVITY IN CONTRIBUTIONS

To date, analysis of equity in Irish health care financing has focused on the data captured at stage III of the framework. As outlined earlier, contributions to health care financing sources are examined in terms of their distribution across income groups. The focus in the flow of funds is on the distribution of contributions across entitlement rather than income.

Figure 2.5 identifies the mean contributions made by each entitlement group to each of the major sources of finance. To assess progressivity, the distribution of mean contributions by entitlement can be compared with the distribution of mean incomes. A progressive source of finance is one where the share of total health care payments borne by lower income groups is less than their share of total income. The entitlement groups have been broadly ranked according to socio-economic status from the medical card group (lowest mean income) to the privately insured group (highest mean income). The non-covered and dual cover groups lie in between these two groups, earning 26.3% and 22% of total mean pre-tax income respectively (ESRI, 2001).

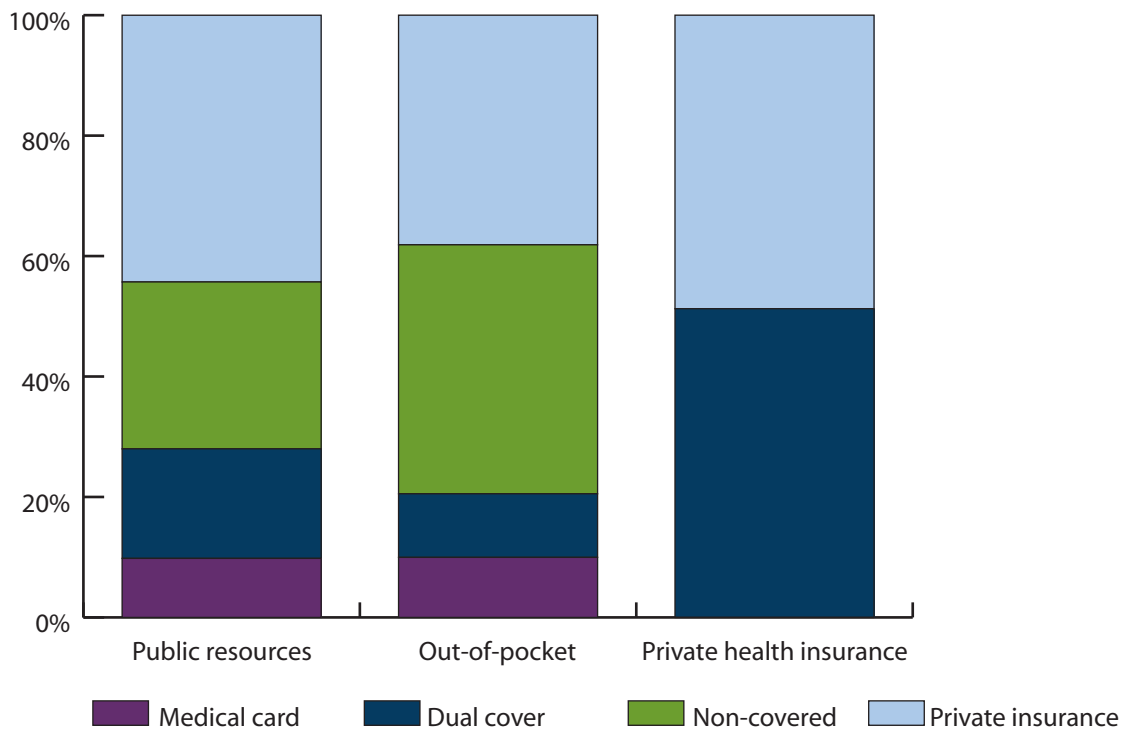
The overall pattern of health care contributions looks progressive, consistent with the results in Figure 2.1. The progressive pattern is here reflected at the extremes of the income distribution. The privately insured (richest) group contributes more than 44% of total mean health care resources compared to its share of income (36.8%). Conversely, the medical card (poorest) group pays for 8.5% of mean health care resources compared with a 14.9% share of mean pre-tax income. The mean contribution shares by the dual cover and non-covered groups are in between these extremes, and are similar to their relative shares of total income.

As suggested by Figure 2.5, the progressivity patterns vary by source of finance. The burden of private resource contributions is unevenly spread across the entitlement groups and it is more difficult to identify progressivity patterns.

The highest proportion of mean out-of-pocket payments is made by the non-covered group, and the share contributed (41.3%) exceeds the group's share of total mean pre-tax income (26.3%) by a large amount. The proportion of mean out-of-pocket expenditure made by the privately insured group is also higher relative to the group's share of mean pre-tax income. Progressivity indices for out-of-pocket health expenditure in the Irish context indicate an overall regressive pattern (Figure 2.1). Analysis by entitlement indicates that the out-of-pocket burden is concentrated on specific entitlement groups, in particular on the non-covered group at the middle of the income distribution. This highlights a key drawback of index measures that focus on pro-poor or pro-rich patterns without picking up on important patterns that occur at the middle of the income distribution.

The proportion of mean contributions made by the privately insured (richer) group to private insurance premiums is estimated to be slightly lower than the proportion contributed by the (poorer) dual cover group. Pooling the income of these two groups identifies a regressive pattern. The contributions by the higher income group are lower relative to their share of this pooled income than those of the lower income, dual cover group (37.4% of pooled mean pre-tax income versus 51.3% of pooled mean insurance payments). The regressive pattern is consistent with community rated premiums, where all individuals are charged the same premium for a given insurance product, regardless of income, health status or any other factor. A flat rate (community rated) premium poses a relatively larger burden on a lower income. Alternatively, the result is consistent with the purchase by the older age (and poorer health) dual cover group of more comprehensive and more expensive insurance products relative to the younger (and healthier) privately insured group.

Figure 2.5 Percentage share of contributions by entitlement groups to total mean resources by source of finance (2004)



2.7 SUBSIDISATION IN THE SYSTEM

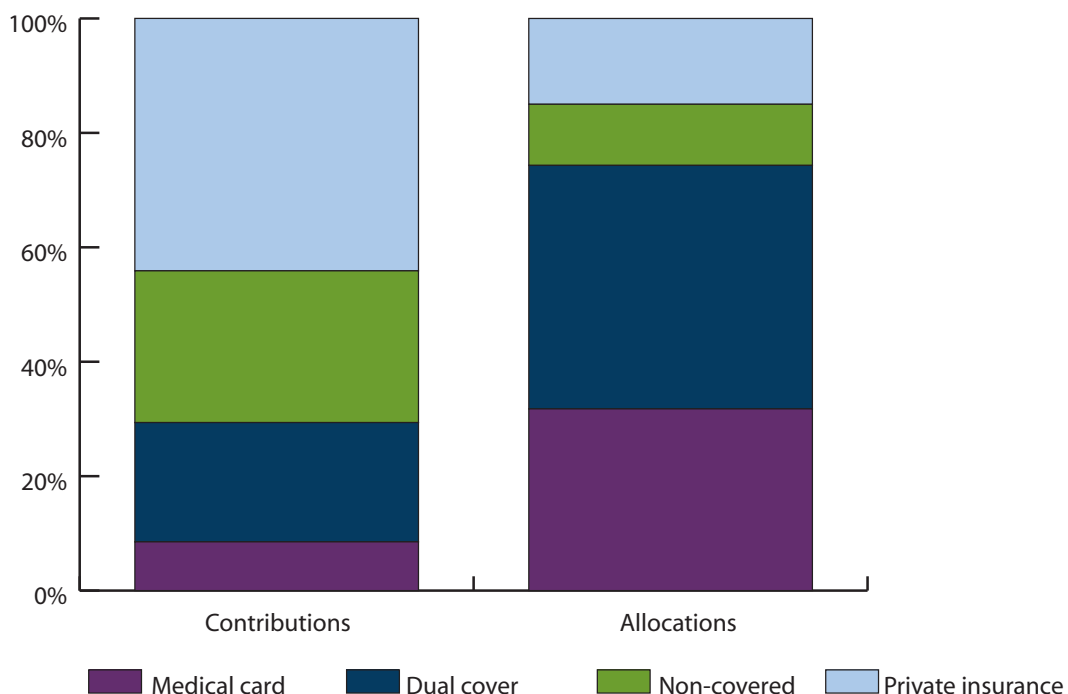
2.7.1 AGGREGATE PATTERNS

Figure 2.6 compares the distribution of mean resource allocations (at stage II) with the distribution of mean contributions made by the four entitlement groups (stage III). The largest proportion of total mean resources is allocated to the medical card (32%) and dual cover groups (43%) and smaller proportions are allocated to the non-covered (11%) and privately insured groups (15%). The largest mean contributions (>70%) are made by the privately insured and non-covered groups.

This gives the overall net balance of resource flows which suggests a transfer of resources in the system from the privately

insured and non-covered groups to the dual cover and medical card groups. Mean resource allocations received by the medical card and dual cover groups are higher than their mean contributions. These allocations are cross subsidised by individuals in the non-covered and privately insured groups. This summary picture suggests that in aggregate terms there is income and health risk pooling in the system. This is evidenced by the subsidisation of health care resource allocations to the two entitlement groups that on average have lower socio-economic and health status, by the two entitlement groups with higher average incomes and better health status. However, more detailed assessment shows that the patterns of cross subsidisation are not as straightforward as indicated in the aggregate picture.

Figure 2.6 Percentage share of total mean contributions and allocations by entitlement, 2004



2.7.2 SUBSIDISATION BY PROVIDER/FUNCTION

The SHA structure allows the resource flows in Figure 2.3 to be disaggregated by health care provider/function.

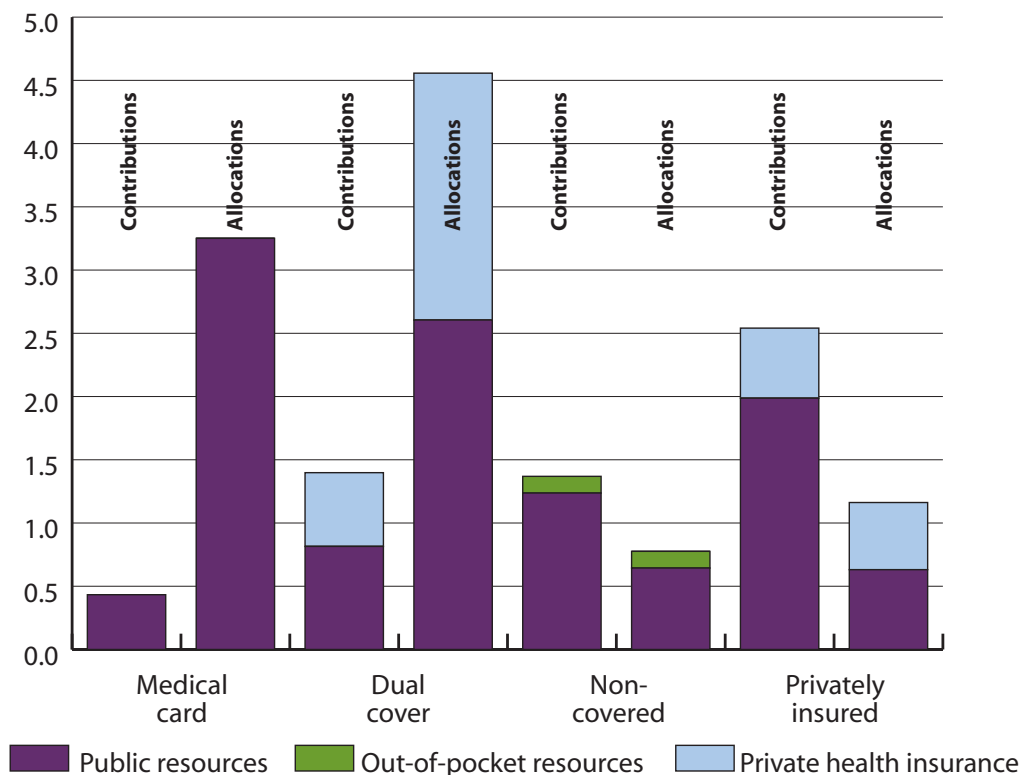
Figures 2.7-2.10 identify the mean contributions and allocations (broken down by financing source) for key health care services in the system. For non-prescription medicines, there is no separation between ability to pay and need for health care. Non-prescription medicines are fully funded by out-of-pocket resources and only those who make payments receive the benefit of the services. Mean contributions are equivalent to mean allocations for each entitlement group.

Separation between ability to pay and need for health care is observed for other health care services. For hospital care, GP visits, and prescription medicines, mean contributions by the medical card and dual cover groups are smaller than the mean resource allocations received and the opposite is observed for the non-covered and privately insured groups. However, the differences between mean contributions and allocations vary by health service.

GP visits and prescription medicines for the medical card and dual cover groups are mainly funded by public resources where contributions to the public budget do not influence the level of service received. In these cases, the non-covered and privately insured groups contribute to public resources which are used to finance health care services for the medical card and dual cover groups. The non-covered and privately insured rely on private resources to supplement what is available from public sources. It is estimated that more than 86% of contributions by the non-covered and privately insured to public GP resources are used to subsidise GP services for the two medical card groups.²⁴

More than 52% of mean contributions by the non-covered and privately insured groups for hospital in-patient services are allocated to the medical card and dual cover groups. Given the reliance on varied sources of data to populate the flow of funds, strict interpretation of the gap between mean contributions and mean allocation is not possible and these proportions are to be used as indicative of general patterns only.

Figure 2.7 Mean contributions and allocations of hospital (incl. other residential) resources for each entitlement group, 2004 (€000)



²⁴ Non medical card holders are eligible to benefit from publicly funded GP health services (e.g. the Heartwatch programme; the Methadone Treatment Scheme; services provided under the Health Amendment Act (1996) for those who have contracted Hepatitis C from the use of Human Immunoglobulin-Anti D/other blood product or transfusion), and from tax relief on GP expenses.

Figure 2.8 Mean contributions and allocations of GP resources for each entitlement group, 2004 (€000)

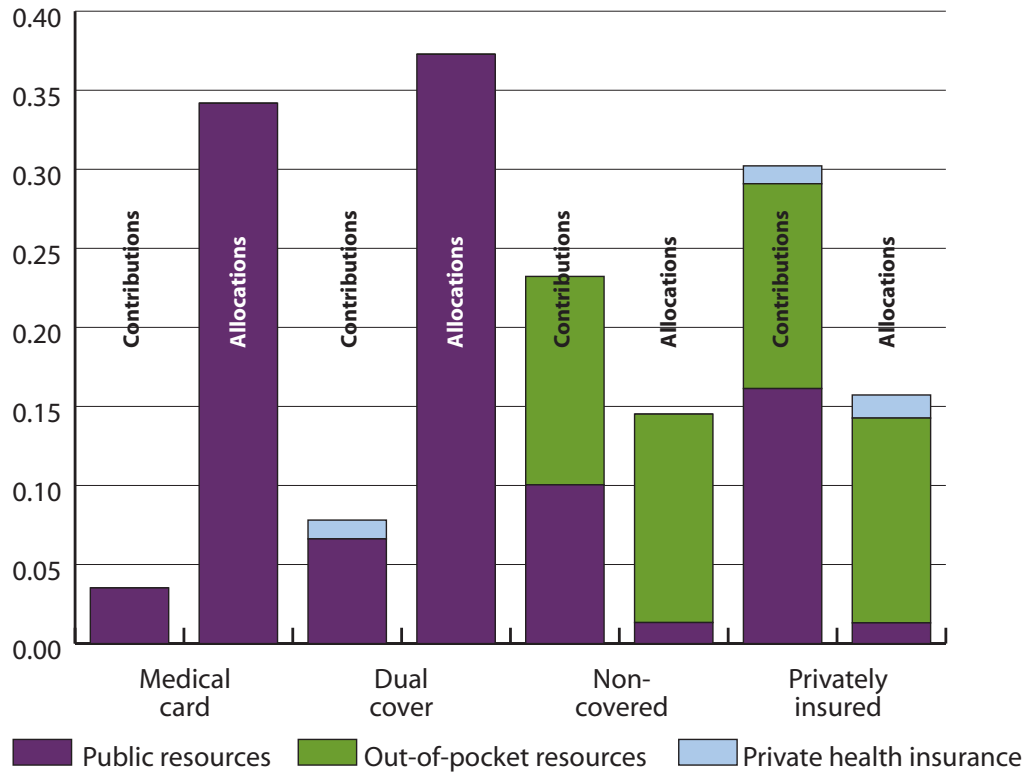


Figure 2.9 Mean contributions and allocations of prescription medicine resources for each entitlement group, 2004 (€000)

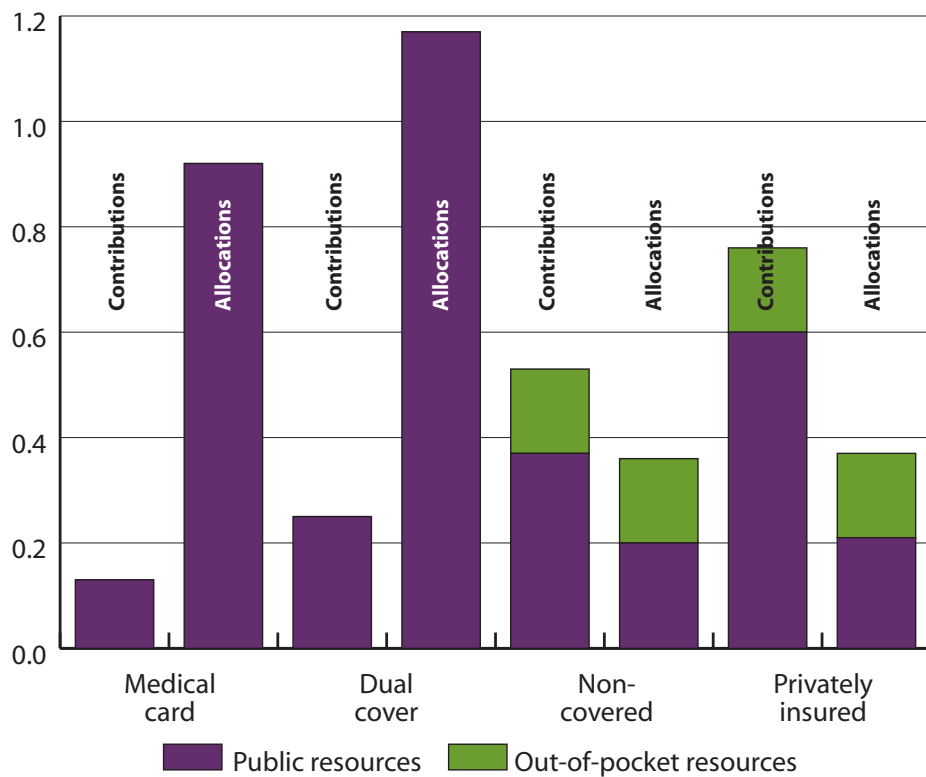
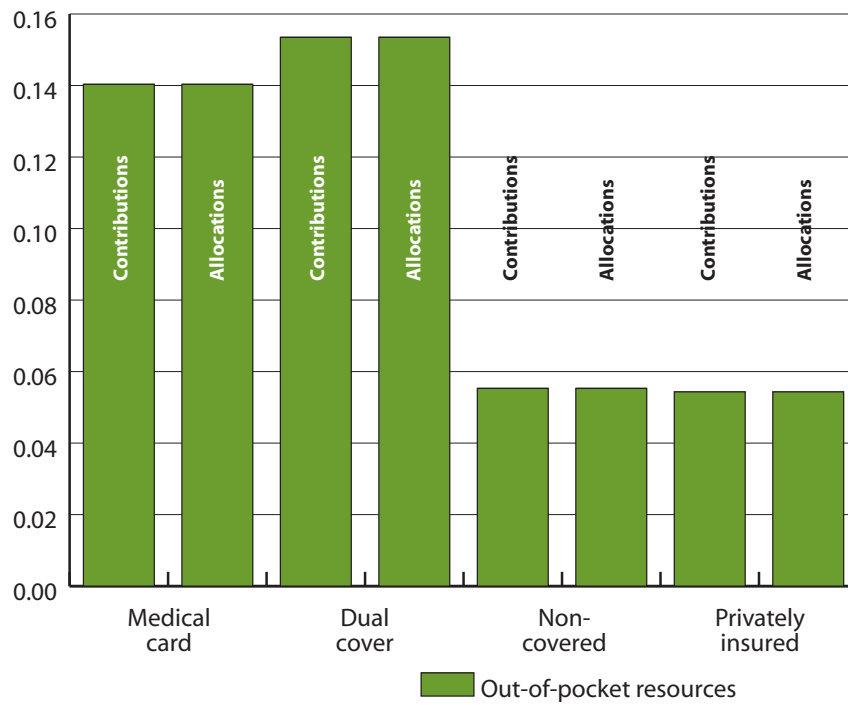


Figure 2.10 Mean contributions and allocations of non-prescription medicine resources for each entitlement group, 2004 (€000)



2.7.3 SUBSIDISATION BY SPECIFIC RESOURCE FLOWS

Resource flows for specific items of expenditure highlight potential patterns of cross subsidisation in the opposite direction to the aggregate picture.

Tax relief on private insurance premiums (Figure 2.11) is contributed to by all entitlement categories, and benefits only the dual cover and privately insured groups.

Figure 2.11 Mean contributions and allocations of private health insurance tax relief resources for each entitlement group, 2004 (€000)

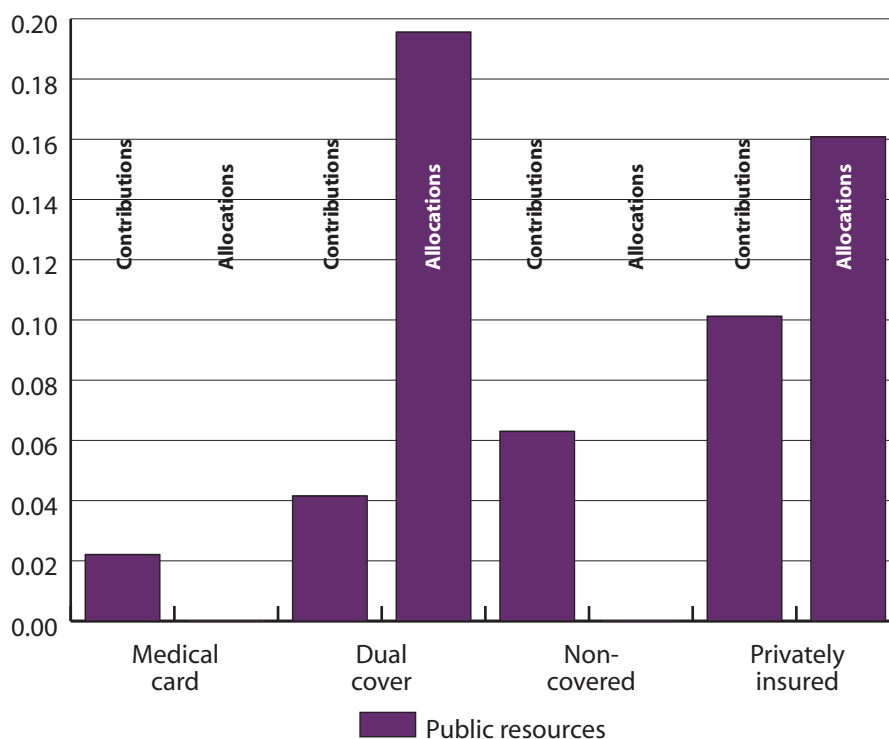
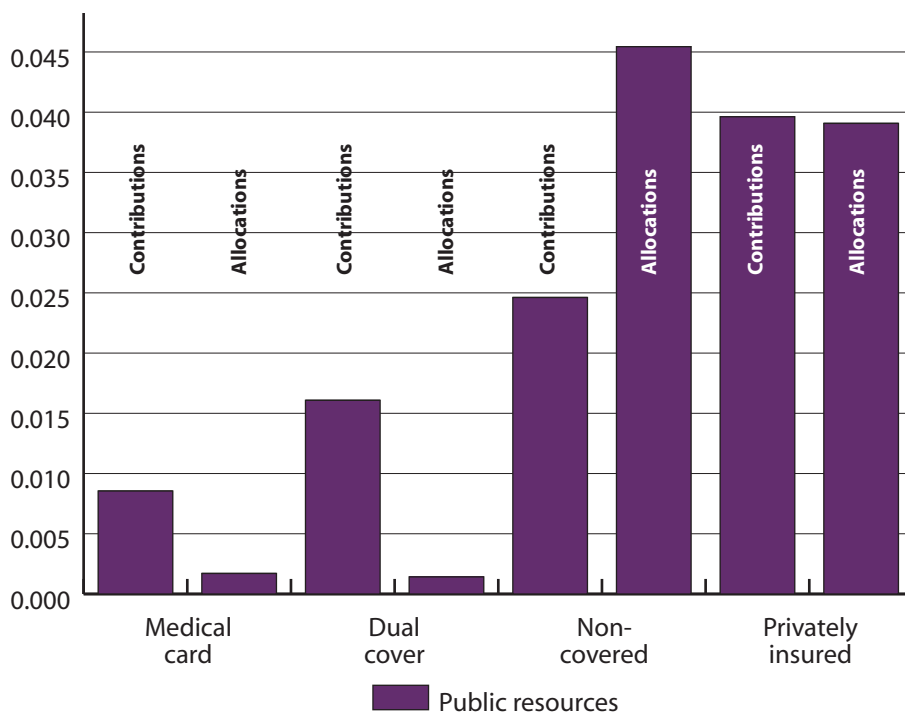


Figure 2.12 Mean contributions and allocations of health expenses tax relief resources for each entitlement group, 2004 (€000)



All entitlement groups contribute to, and benefit from, tax relief on health expenses (Figure 2.12). Mean allocations are lower than contributions for the medical card and dual cover groups. Mean allocations are greater than contributions for the non-covered group. For the privately insured group, mean allocations and contributions are almost equal.

Figure 2.13 outlines mean contributions and allocations for the National Treatment Purchase Fund (NTPF). The NTPF secures private surgical treatment for public patients who have waited extended periods of time on the public waiting list. The private treatment is received either in participant private hospitals in Ireland (95% of cases) or abroad (NTPF, 2006). All entitlement groups contribute to the Fund while only the medical card and non-covered groups are seen to benefit from it. Mean allocations are greater than mean contributions in the medical card group. For the non-covered group, the gap between mean contributions and allocations are almost equal.

Resources to the Drugs Payment Scheme are contributed to by all groups (Figure 2.14) but benefit only the non-covered and privately insured groups. Mean allocations are greater than contributions for the non-covered and marginally so for the privately insured group.

Figure 2.13 Mean contributions and allocations of NTPF resources for each entitlement group, 2004 (€000)

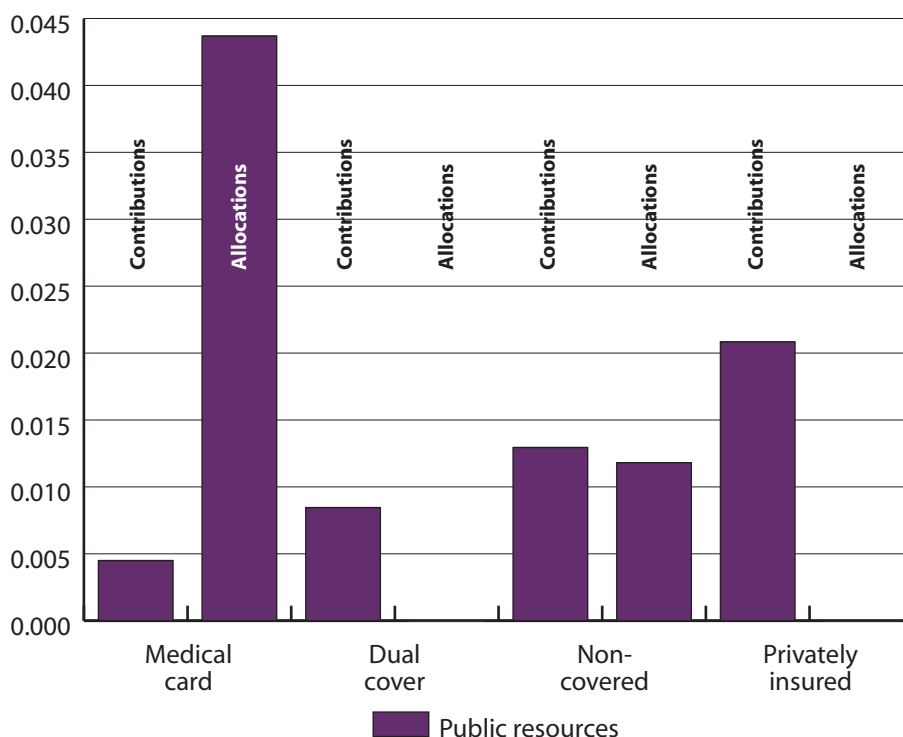
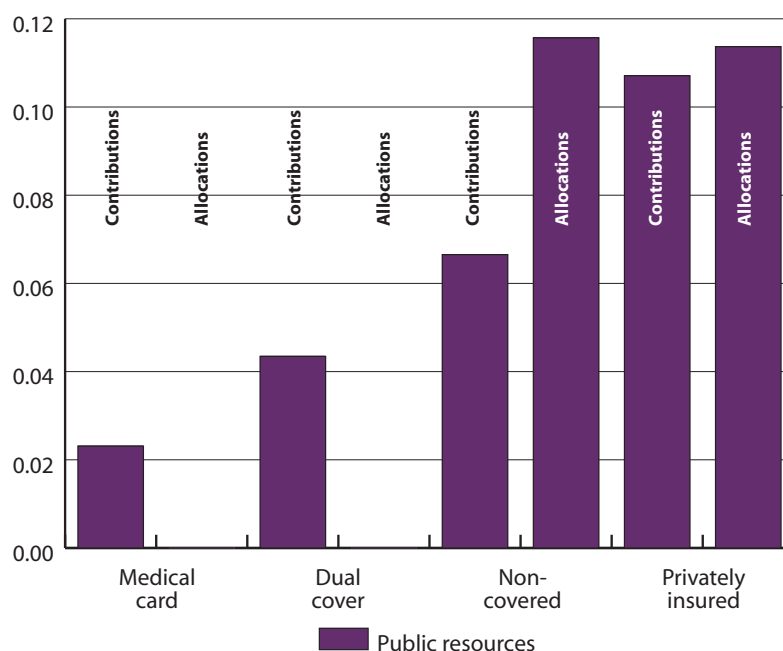


Figure 2.14 Mean contributions and allocations of Drugs Payment resources for each entitlement group, 2004 (€000)



Eligibility for public resources is restricted. The above diagrams illustrate that these restrictions vary and are not always determined on the basis of need or socio-economic status. This gives rise to potential cross subsidisation effects from poorer to richer individuals that are not picked up in aggregate trends. The fact that all entitlement groups contribute to public funding even if they are not entitled to benefit from those resources is not new. What is important here is that this pattern does not change even when the public resources are not always allocated to the poorest or sickest in the population.

2.8 LESSONS FROM THE FLOW OF FUNDS

The flow of funds analysis makes a number of contributions to analysing equity in the Irish health care financing system.

First, the analysis points to a central contradiction around private financing in the Irish system. Private sources of financing account for a relatively small proportion of total health care resources, but their role in the system is not marginal. In the literature, the need to interpret progressivity in private sources differently from public sources has been given little/no attention in the European context where private sources are assumed to represent a marginal, supplementary source of financing. The breakdown of the resource flow by health care provider shows that in Ireland, private sources represent an important source of financing for specific health services. In particular, out-of-pocket resources account for a large proportion of GP and prescription medicine allocations.

Analysis by entitlement status highlights uneven patterns in resource flows that are not revealed in summary index measures. Measurement of progressivity across the income distribution gives a general picture of the overall pattern of payments, but does not show that uneven patterns within the distribution are clustered into specific groups, defined by entitlement. In particular, the burden of out-of-pocket resources (shown to be regressive in progressivity analysis) falls unevenly across the population. Out-of-pocket payments represent a much larger proportion of total health care funding for the non-covered group relative to the other entitlement groups in the population.

Potentially inequitable patterns of cross subsidisation have been identified. While all entitlement groups contribute to public

resources, not all of these resources are available for allocation across the population as a whole. Analysis of specific resource flows (e.g. tax relief, NTPF) illustrates that the eligibility restrictions are not always determined on the basis of health/socio-economic status. All individuals in the tax net contribute to the cost of public tax relief on private health insurance which in turn benefits only those who can afford to purchase health insurance.

Restrictions in entitlement to public resource allocations give rise to further interactions at different levels in the system that can lead to some unusual resource flows. Tax relief on health expenses is one example of an expenditure flow that arises because of restrictions elsewhere in the financing system. Cross subsidisation for this expenditure is not necessarily in the direction of rich to poor (indicated above). As stated in policy, this form of tax relief is specifically aimed at those who are not protected by a medical card or private insurance. This relief accounts for a relatively small proportion of health financing but is important in terms of the inequity that it highlights. The policy justification for the relief explicitly acknowledges that some individuals require assistance in meeting out-of-pocket health care payments. The tax relief itself has a regressive structure and offers a relatively higher benefit to those on higher incomes (the relief is granted at the individual's marginal tax rate) so that even against its own objectives the relief is not optimally designed. Yet the need for the relief, in any form, could be avoided if exposure to direct out-of-pocket payments did not fall so heavily on one particular group in the population. The opportunity cost of the tax relief expenditure can therefore be questioned against an alternative of adjusting the fundamental entitlement structures to reduce cost sharing burdens on non medical card populations.

The expenditure flow under the NTPF exists because of problems created by the incentives that favour the treatment of private patients over public patients in the public hospital system. The NTPF addresses the subsequent problem of long waiting lists for public patients. As with the tax relief on health expenses, the resource flow for the NTPF gives rise to cross subsidisation that is not necessarily in the direction of rich to poor. The NTPF creates a complicated resource flow whereby some of the contributions made by individuals to public resources are allocated to purchasing health care in the private sector, at private sector rates, for public patients through the NTPF. The

importance of the NTPF to this discussion is not because it involves a large amount of money (<1% of total public expenditure), but because of its existence and what it says about the rest of the system. The NTPF is a symptom of the wider problems in the system caused by complex supply and demand side incentives that operate to favour the treatment of private patients over public patients within the public hospital system, regardless of health care need or socio-economic status.

These examples indicate that inequitable patterns of cross subsidisation can occur because of second best solutions to problems elsewhere in the system, as in the case of tax relief on health expenses and the NTPF. However, they can also arise because of specific government policy goals, such as the explicit use of tax relief on private health insurance premiums as a means of encouraging consumption of private health insurance. Although small in magnitude relative to total health care resources, these complex resource flows can represent large proportions of funding for specific groups/services,²⁵ and are important signals for wider inconsistencies in the rest of the financing system.

Moreover, a complex, but relatively small, flow of resources might in time become much more disruptive to a system if it is used to channel a larger flow of resources. The inconsistencies associated with the NTPF would be much more visible if its budget were multiplied. Nolan made a similar point in a discussion on private health insurance. The problems associated with the privately insured gaining preferential access to the public health system were in existence prior to the rise in the number of insured individuals, but there is no doubt that the rapid increase in the insured population has exacerbated the problem and made it more visible (Nolan, 2004). The complex systems perspective can serve as an 'early warning system' by highlighting seemingly insignificant, but potentially disruptive, complexities in the system. This has lessons not just for the Irish system, but for other international systems. For example, the interaction of supplementary private insurance with the public health care system in the UK may be similar to the Irish experience but is too small to identify.²⁶

2.9 CONCLUSION TO PART II

Existing measures of equity in Irish health care financing have focused on the progressivity patterns in the main financing sources. Total public sources are progressive and account for the largest proportion of total health resources. This can give a relatively benign picture of equity in health care financing. However, these measures do not pick up on the complexities in the health care resource flows. In Part II of this brief, flow of funds analysis has demonstrated that behind these broad patterns of progressivity there are a wide range of complications and interactions that give rise to less equitable patterns. A central message from the analysis is that in order to understand equity in the Irish health care system, the devil really is in the detail.

²⁵ For example, tax relief on private health insurance premiums accounts for approx. 20% of total expenditure on premiums.

²⁶ Less than 11% of the UK population are estimated to hold private health insurance, based on data from the late 1990s (European Observatory, 1999).

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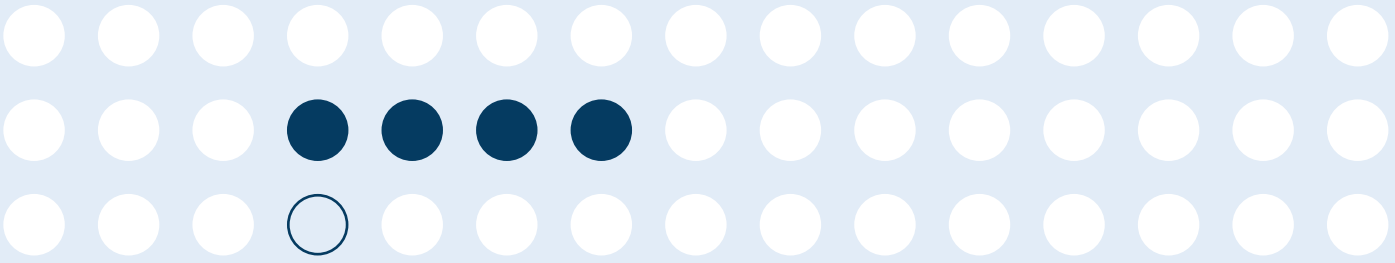
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