Perceptions of the quality of health care in the public and private sectors in Ireland: report to the Centre for Insurance Studies, Graduate School of Business, University College Dublin.

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Report to
The Centre for Insurance Studies,
Graduate Business School,
University College Dublin

Dorothy Watson
James Williams
with a Foreword by
Ray Kinsella

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THE CENTRE FOR INSURANCE STUDIES,
GRADUATE BUSINESS SCHOOL,
UNIVERSITY COLLEGE DUBLIN

DOROTHY WATSON
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Ray Kinsella is Director of the Centre for Insurance Studies, Graduate School of Business, University College Dublin. Professor Kinsella wrote the Foreword.
The paper has been accepted for publication by the ESRI. The views expressed therein are the responsibility of the respective authors.

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Research is always a communal endeavour, and we are very conscious that this report would not have been possible without the contributions of a number of people, to whom we would like to express our thanks.

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The results presented here, their interpretation, and any remaining errors or omissions, are the responsibility of the authors.

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FOREWORD

Since the mid-1990s, the annual Centre for Insurance Studies Private Health Insurance (PHI) Conference has brought together the key stakeholders in the acute system, together with leading domestic and international experts, to examine, evaluate and reflect on the present state, and prospective future development, of the system. The idea of surveying the wider population regarding their experiences and perceptions of the acute health system was a direct outcome of the Conference.

The objective of inviting the ESRI to undertake a national survey of the population was to continue the process initiated in the Conference by providing a research resource: one which would help inform public discussion, policy-making, strategic development and reform. In this sense, the survey takes the issues which have been discussed within the Conference back where, ultimately, they belong: into the crucible of the public's experiences of the system and of their views regarding whether, and if so what kind of, reform is required. This is the logical starting point for a reform process.

For all of these reasons, therefore, this survey and the presentation of the results by Dr Watson and Professor Williams comes at a crucial point in the development of the acute health system in Ireland. The Government's present reform process is the latest in a series of initiatives going back to the Commission on Health Funding. Total Government spending has doubled, to some £5 billion, since 1997. At the same time, the strains within the system have become increasingly more evident both to the public and to those working within the system. Fundamental reform – encompassing both the public and private components of the system – is inevitable and, it would appear, increasingly pressing.

The Government's present (2001) strategic review is, therefore, a central element in an *even wider* process of soul-searching about the status of (Acute) Health Care in Ireland and an evaluation of the public's perception of the relative merits of the Public and Private systems. Such a review is important if one is to deliver outcomes which reflect the needs of Irish society – all the more necessary in light of our new economic status and the opportunities that are latent in new clinical and therapeutic advances.

This need for a strategic assessment is common to most EU countries and is currently underway in many Member States – Germany and the UK being two notable examples. The Irish health care system must not be left behind as the majority of other European countries converge towards a "Best of Worlds" Acute health care system. Unless we move in this direction, the failings within our system – reflected in waiting times, epidemiological outcomes in areas such as oncology and also in support of medical research – will become progressively more evident, not alone to domestic users of the acute system, but also at the European level. *More positively, we have a chance over the next several years to position the Irish acute system at the leading edge of a new revolution in European health care systems and outcomes.*

What it comes down to is vision, strategy and a process of change in the face of uncertainty. That is, a vision of what standard of acute health care we want and can fund on a *sustainable* basis; a rigorous and innovative strategy prepared, where necessary, to think the unthinkable; and a change process that can deliver "buy-in" from all of the key stakeholders. That is what is attainable. Indeed, what is attainable now can be enormously leveraged by taking on board emerging disciplines – which can make a real impact on health care outcomes: that's why, for example, the 2001 PHI Conference in October will focus on Clinical Risk Management in Acute Health Care, since this issue represents both a major challenge and, equally, a major opportunity to enhance the outcomes of the acute system.

Turning from the vision to the process, it is important to highlight the fact that recent Irish economic history demonstrates a capacity to achieve a paradigm shift in economic policy (1960s), Exchange Rate Policy (1978) and, most relevant perhaps, in social policy (1980).

The NESC strategy of 1986 that delivered social partnership provides a template for the kind of strategy and "change process" that is now required in acute health care. The "social-partnership" model generated an internationally respected strategy, based on what was (desperately) needed at that stage in Irish economic development in the bleak 1980s. It broke

new ground. Something on the same scale is required to address the structural deficiencies in the Irish acute system.

It would appear that the Public-Private Acute Hospital system is perceived by large proportions of the public to be inequitable, regressive and skewed against those that are most disadvantaged. In addition, the public perceive the quality of hospital care to be better in the privately financed/private health insurance (PHI) sector, as compared with the public system.

The statistical evidence of the BUPA Ireland/ESRI national survey on these points is compelling:

- Almost 90 per cent of people believe that hospital care can be obtained more quickly in the private system compared with the public system.
- Levels of educational attainment and social groupings are closely correlated to PHI coverage. Nearly 70 per cent of those with Third level education have PHI coverage compared with, for example, 40 per cent of those who have the equivalent of the Junior Certificate. Equally, whereas 75 per cent of those in Professional/Management categories have PHI coverage, less than 40 per cent of skilled manual and 21 per cent of unskilled manual workers are covered.
- In terms of public perceptions of quality of care, only half as many people rate the public system as "very good/good" compared with the percentage rating the private sector as "very good" or "good".

Differences in waiting times between the public and private system have been confirmed by other research[1] which demonstrates that some categories of public patients admitted through outpatient referrals face successive hurdles to actually getting the surgery they require. Privately-financed patients do not, in general, confront these hurdles. That is one reason, of course, why people – even in a 'free' universal system – actually take out PHI cover. But a measure of strain in the current system is that those using the PHI sector are now beginning to experience delays and cancellations.

There are, of course, caveats that need to be made. Acute public hospitals have a more complex "case-mix" and operate under different constraints compared with the private sector. But, in a way, that is precisely the point. The two systems are, in reality, one: except that those who take out PHI cover pay twice over and those who cannot are subject to rationing. The two components are not integrated or aligned.

There are a number of factors that make the case for a radical NESC-type "change-strategy" imperative.

The first is that a continued expansion in public expenditure on the scale of recent years is not sustainable. For example, had the economy grown at the average EU growth rate in the 1990s, while allocating the same percentage of GDP to Health Care as we did, the budgetary allocation in 1999 would have been about £1.5 billion *less* than it was. We have been able to keep the share of GDP spent on health at a relatively low level of 6 per cent, only because of the exceptional growth rates of the economy. We are a small open economy. To ratchet up public expenditure which, by its nature, is inflexible[2] is hardly sensible.

The second reason is that future trends in the *affordability* of PHI are problematic. And not just because of a possible relative deterioration in the economy over the medium term. The survey results, for instance, revealed that:

- Only half of those already covered by PHI regarded their health insurance as providing good value; over one-third felt that it was expensive, and one in seven felt that it was either "very expensive" or "close to unaffordable".
- There is significant, but by no means unanimous, support for the idea of compulsory private health insurance. Just over 60 per cent of respondents believed that it should be compulsory for everyone above a certain income bracket to have private medical insurance, making appropriate exceptions and allowances for

[1] R. Kinsella, "The Waiting List Issue: Analysis, Evaluation and Recommendations", Research Paper, Centre for Insurance Studies, 2001, (based on Harvard Association of Ireland Case Study (with grateful acknowledgement to F. McHale, and D. Berkery)

[2] Over 70 per cent is accounted for by salary-related costs that cannot be cut back on in a less benign economic environment. This would appear to point to the need for market structures (including regulatory arrangements) that gradually encouraged competition and, by extension, both capacity-building and greater cost-control.

those who could not afford it. On the other hand, over half of the non-insured would not be willing or able to pay for health insurance, and only one in five would be willing or able to pay amounts at, or above, the median actually paid at present by those who are insured.

Competition policy has an important role to play with regard to delivering more affordable premia and better value for money.

Looking to the future, the costs of underwriting health care insurance are, because of developments in Medical Cost Inflation, likely to accelerate over the medium term. These trends in the affordability of PHI are important in themselves. They are also important because any major shift in the public system – for example, a major increase in bed capacity – will have knock on effects throughout the system. In a scenario of lower growth and rising PHI premia, a major investment in the public sector delivery capacity – which is, of course, in principle very desirable – could actually have the unintended effect of undermining the stability of the PHI sector.

In a voluntary PHI system, it is important that there are affordable and proportionate responses to such an eventuality. For instance, one scenario might be the introduction of compulsory PHI which would reduce the instability inherent in any voluntary system while also allowing (as in Germany's recent reforms in this area) for competition to promote increased affordability in the face of secular increases in PHI premia. Of course, other possible scenarios could also be envisaged. The full range of policy options needs to be explored in addressing these issues.

The debate is far from over. This reinforces the case, for a vision and for a strategy that cuts deep and takes time. And it provides the context for an examination of the balance in the public/private mix which is at the heart of the Irish acute system. Some would argue that the business of government should be to *fund* a universal public entitlement – but not necessarily to *deliver*[3] it through a system of public hospitals and Health Authorities – except where there is "market failure" when the government has a clear responsibility to step in. Others would argue that the market cannot deliver universal health care on the scale and of the quality that we, as a society, would want. Government responsibility lies in articulating a vision of what we want our acute system to be and developing a rolling sustainable strategy to achieve this.

Health care reform should begin with the "big picture". We need to ensure that the total acute system is integrated and reshaped in a way that is driven by medical need: physician directed and ensuring timely access *for all citizens*.

These issues are essentially structural. They are amenable to solutions based on rigorous analysis and informed by the kind of research material presented by the ESRI in this report. But these issues – important as they are – are interrelated with broader societal issues, arising from recent and prospective advances in biogenetics (including cloning) and their implications for Acute Health Services. The development of objective ethical principles[4] by which to evaluate, and legislate for, these challenges need to be addressed in the development of the Irish Acute Health Care System.

The whole aim of this research report, as the culmination of a five-year partnership with the policy, medical, insurance and other stakeholders, is to provide an independent, rigorous and systematic resource for all of us to begin this process of change and to provide us with some insights into how this might best be accomplished to meet the requirements of the national population.

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[3] This point has been made by Jim Golden in "The Irish Health care System: A Programme for Fundamental Reform", Fifth Annual PHI Conference Proceedings

[4] For example, paper presented by Professor Michael Ryan at the 2000 PHI Health Care Conference, and also R. Kinsella "The Growing Role of Financial Service Providers in the PHI Market: The Importance of Systemic Reform in the Tertiary (Acute Hospital) Sector." Pp 3-12 in *Financial Services Law Journal*, Vol. 1, No. 1, November 2000.

1. INTRODUCTION

This paper provides an outline of some of the main findings from The Economic and Social Research Institute "Survey of Perceptions of the Quality of Health Services in Ireland" (sponsored by BUPA Ireland). The goal of the survey was to investigate perceptions of various aspects of the quality of care in the public and privately funded sectors in Ireland.

1.1 Background

There is a considerable degree of interdependence between the public and private sectors, particularly in the provision of hospital services, in Ireland. The entire population is entitled to a core publicly-funded service, including public hospital in-patient services. Patients have to make an explicit choice between public and private care at the point of delivery of hospital services. The acute public hospital sector consists of about 12,300 beds, with about 2,500 of these designated for use by private patients. In addition, there are in the region of 2,500 private and semi-private beds in private hospitals. Most of the latter are dedicated to elective surgical treatment, maternity care and mental health treatment. The majority of medical consultants are engaged in both public and private practice.

There are two categories of eligibility for health services, and these determine which services an individual can obtain free of charge. "Category one" includes those who are "unable without undue hardship to arrange general practitioner services for themselves and their dependants". Membership of this category is determined by a means test, and the weekly income[5] guidelines in 2000 are £93.50 for a single person living alone, £135 for a married couple, and £168 for a family of two adults and two children. The income limit increases at age 66 and again at age 70 (to £151 and £252, respectively, for a married couple). Category one eligibility entitles the person to free medical care, including general practitioner visits, maintenance and treatment in the public wards of hospitals, specialist out-patient services at public clinics, dental, ophthalmic and aural services, and prescribed medications. About 30 per cent of the population fall into this category.

"Category two" eligibility is available to anyone ordinarily resident in Ireland who does not qualify for full eligibility. These individuals are entitled to maintenance and treatment in public wards of hospitals subject to a specified charge, free specialist services at public outpatient clinics, assistance towards the cost of prescribed medicines, general practitioner maternity and infant care services, and free drugs for certain long-term illnesses. Currently about 70 per cent of the population fall into this category.

Private health insurance generally covers the full or partial cost of treatment and maintenance services provided by private hospitals, medical consultants and private facilities in public hospitals. The number of people who avail of private medical insurance has been increasing steadily over time. The main provider is the Voluntary Health Insurance Board (VHI). Since the deregulation of Health Insurance which was implemented in the Health Insurance Act 1996, BUPA Ireland has been providing health insurance. Other

[5] Income refers to gross income less PRSI contributions.

work-related schemes include St. Paul's Garda Medical Aid Society, the Prison Officers' Medical Aid Society and the ESB Medical Provident Fund.

Approximately 75 per cent of the health services are publicly funded, the major portion coming from Exchequer grants. The remaining 25 per cent is made up of payments made by private health insurers and private spending by households. Approximately one-quarter of the total private health insurance contribution to the health services goes directly to the public hospital system. (Department of Health and Children, 1999, p. 11).

The public-private mix of hospital services in Ireland is generally regarded as having been successful in a number of respects (OECD *Economic Survey of Ireland, 1997*; Department of Health and Children, 1999). The OECD Economic Survey of Ireland 1997 concluded that the operation of private health insurance in Ireland means that a significant number of people stay in the private health system, relieving the cost of hospital care to the public system (OECD, 1997). The White Paper on Private Health Insurance Notes:

"The principal advantages of the public and private mix of hospital services are:

- It helps to ensure that medical and other professional and technical staff of the highest calibre continue to be attracted into, and retained in, the public system;
- It promotes more efficient use of consultants time by having public and private patients on the same site;
- It facilitates active linkage between the two delivery systems in terms of the dissemination of current medical knowledge and best practice;
- As accident and emergency services are primarily provided by the public hospital system, it enables patients to avail of private health care when admitted to public hospitals on an emergency basis;
- It represents an additional income stream to the public hospital system." (Department of Health and Children, 1999).

On the other hand, there are a number of drawbacks to the particular mix of public and private health services in Ireland. In particular, waiting lists for consultant and hospital services are a phenomenon of the public rather than the private health system. Second, while there is a "common contract" for consultants working in the public system which stipulates the allocation of their time between the public system and their private consultancy, nevertheless the different payment methods for consultants in the two sectors (salary and fee per item), mean that there is an economic incentive for them to devote a greater proportion of their time to private patients. Third, the absence of economic charging for the use of public hospital beds reduces the revenue which might be available to the State from that source, and may give rise to some distortion in the market for hospital services.

In a recent study of private health care in public hospitals, Nolan and Wiley (2000) examined the extent of the subsidy to the private health sector arising from the absence of economic charging for the use of private beds in public hospitals. About one-fifth of all bed-days in public hospitals in 1997 were accounted for by private patients (Nolan and Wiley, 2000, p.19). A detailed analysis of case-mix data from the Hospital Inpatient Inquiry (HIPE) allowed the authors to compare the costs involved in treating General Medical Service (GMS) and non-GMS patients in public hospitals. It was not possible with these data to further disaggregate the non-GMS patients into those treated as public or as private patients.[6] They found that GMS patients tend to be older and to have more health problems than non-GMS patients (including the insured and non-insured). As a result, they tend to have longer

[6] Data from two large hospitals indicated that about half of the non-GMS patients were treated as public patients and half as private patients, but that there were not any pronounced differences in case-mix between these two groups.

stays. However, because non-GMS patients are more likely to have surgical procedures (rather than medical treatment) during their hospital stay, the estimated cost per bed-day is slightly higher for this group (£246 compared to £230). Aggregating these estimates suggested that private patients accounted for about £120 million in expenditure on direct provision of care[7] in 1996, about twice the income from charges for private accommodation in that year.

1.2 Objectives of the Present Study

The purpose of the present study is to investigate public perceptions of the quality of care available in the public and private systems in Ireland. While perceptions in themselves may bear a loose relationship to the actual experience of patients and the actual treatment they receive – particularly since only about one person in eight is hospitalised in any given year – perceptions are crucial in determining the demand for health insurance, on the one hand, and the peace of mind of those who cannot afford it, on the other. The key issues addressed in this report, then, are:

- What do people believe about the quality of care available to public and private patients in Ireland, in terms of the care itself and the length of wait for it?
- Do these perceptions vary between groups in the population, particularly according to health status, health coverage, social group and experience of hospitalisation?
- What are people's main reasons for taking out health insurance and, crucially, do priorities in this respect differ between those with and those without health insurance?
- Has the perceived affordability of health insurance changed, even in the short period between 1999 and 2000 when the major health insurance provider (VHI) increased premia by 9 per cent on average?
- What level of support is there for government action to improve the quality of the public health system, and how do people who advocate such action believe it should be funded?

1.3 Data and Methodology

FIELDWORK AND RESPONSE RATES

The ESRI carries out a monthly survey on consumer confidence indicators for the European Commission. A total of approximately 1,250 questionnaires is completed in this survey each month. The survey is essentially conducted on the phone with a very small personally administered component. A supplement is often appended to this survey. The current report is based on an additional module added to the survey in the months of July and August 2000. In addition to those two monthly rounds of the consumer confidence survey we augmented the sample for the survey on perceptions of the health system with a dedicated telephone component in early September 2000. These three components left us with a total of 3,000 completed questionnaires for analysis and it is these which form the basis of this report. As discussed below, the data from these three random samples were combined and were statistically adjusted or re-weighted prior to analysis to ensure that they were representative of the population of adults living in private households.

The overall sample for the health survey was selected using a total of 112 randomly selected sampling points throughout the country. A set of 100 random telephone numbers was generated in each sampling point and these are used to generate a targeted 30 completed questionnaires from each cluster point.

[7] This includes direct costs only, and does not include indirect costs

Table 1.1: Response Outcomes from Health Services Survey

	Supplement to Consumer Confidence Survey	Per Cent	Dedicated Component to Health Survey	Per Cent	Total Number of Completed Questionnaires	Per Cent
Completed	2,119	60	881	65	3,000	61
Refused	1,068	30	307	22	1,375	28
Other	346	10	172	13	518	11
Total Valid Calls	*3,533*	*100*	*1,360*	*100*	*4,893*	*100*
No Reply	1,743	–	746	–	2,489	–
Business Number	825	–	302	–	1,127	–
Non-Existent	683	–	370	–	1,053	–
Total	3,251	–	1,418	–	4,669	–

Table 1.1 shows that the 3,000 successfully completed questionnaires were generated from 4,893 phone calls to private households. This gives a response rate of 61 per cent. In a further 28 per cent of households the interview was refused while in the remaining 11 per cent there was some other form of response outcome.

The reader can see that not all calls made were to private households. Because the telephone numbers were randomly selected within each cluster we did not know in advance whether or not the random number which was generated was a valid number for a private household. In many cases it was, for example, the number of a business, fax etc. The lower section of Table 1.1 shows that an additional 4,669 calls were made in the course of the survey. A total of 2,489 of these simply rang without any answer; 1,127 were identified as business numbers and 1,053 were not valid numbers. All three categories are obviously not valid elements of the population of private households and, accordingly, must be excluded from the calculation of response rates.

THE QUESTIONNAIRE

The questionnaire, a copy of which is included in Appendix B, is divided into a number of sections, as follows:

- Health status (self-rated health and presence of a chronic physical or mental health problem, illness or disability).
- Health Coverage: GMS membership, Private Health Insurance (including what is covered and how much respondent pays for it), Membership of Critical Illness or Hospital Cash Plan.
- Perceptions of the quality of care and waiting times in the public and private health sectors in Ireland.
- For those with health Insurance: reasons for having insurance, affordability, concerns if health insurance were to be given up.
- For those without health insurance: reasons for not having insurance, whether would like to have it and whether respondent has ever seriously considered taking out insurance, the maximum amount respondent would be able and willing to pay for health insurance.
- Health service usage in the previous twelve months: GP visits, hospital stays, day surgery, outpatient visits, use of casualty department;
- Views on whether public health service should be put on a par with the private health service and how this should be funded.
- Background characteristics of the respondent (age, sex, marital status, level of education, household size, number of dependent children, broad social group).

SAMPLE WEIGHTS

The purpose of sample weighting is to compensate for any biases in the distribution of characteristics in the completed survey sample compared to the population of interest, whether such biases occur because of sampling error, from the nature of the sampling frame used or to differential response rates.

Whatever the source of the discrepancy between the sample and population distributions, we would like to adjust the distributional characteristics of the sample in terms of factors such as age, sex, economic status and so on to match that of the population. This was done by comparing sample characteristics to external population figures, primarily from the Quarterly National Household Survey (QNHS). The QNHS is based on interviews conducted in over 33,000 households in each quarter. The most recently-available data come from the Fourth Quarter of 1999. Other sources were used to check the number of adults covered by the General Medical Scheme and those covered by Private Insurance Schemes.[8]

The variables used in the weighting scheme were:

- Number of adults in the household (6 categories).
- Location (Dublin, elsewhere in Ireland).
- Age by sex by marital status (18 categories).
- Sex by Principal Economic Status (6 economic status groups).
- Age group (2 categories) by sex by education (4 categories).
- Health coverage (GMS membership, Private Health coverage).

The weighting procedure involved constructing weights so that the distribution of each of the characteristics for the responding individuals was equal to the distribution of these characteristics for the population. The Gross program written by Johanna Gomulka was used. This program uses a minimum distance algorithm to adjust an initial weight so that the distribution of characteristics in a sample matches that of a set of control totals.

Appendix Table A shows the complete list of population control totals, the distribution of characteristics in the unweighted sample data and their distribution in the weighted sample. Prior to weighting, the sample tended to slightly under-represent households with fewer adults, households outside Dublin, young single adults, those with lower levels of education, the uninsured and medical card holders. The sample weights correct the sample distribution with respect to these characteristics and provide a very close match to the population.

1.4 Structure of Report

The remainder of the report is organised into the following sections:

- Chapter 2: Health characteristics of the population (Presence of a health problem, nature of health problem, self-rated health status).
- Chapter 3: Health care coverage (GMS, Insurance, Demographic, Socio-economic and Health Profiles by Type – VHI, BUPA, Other)
- Chapter 4: Usage of Health Services in Past Year (GP visits, hospital – public and private; outpatient, casualty, day surgery; Waiting times by health coverage; personal knowledge of someone waiting for different lengths of time).
- Chapter 5: Perceptions of the quality of care in the public and private systems: quality of medical care, waiting times, facilities, efficiency of management.
- Chapter 6: Perceptions of Health Insurance – reasons for having/not having insurance; affordability issues.
- Chapter 7: Views on funding of the health services: whether government should increase funding; how funding should be raised;

[8] Unpublished estimates from 2000 were provided by The GMS Board, VHI and BUPA.

views on whether health insurance should be compulsory for those above a certain income threshold.

- Chapter 8: Summary of the main findings of the report.

2. CHARACTERISTICS OF THE POPULATION

The purpose of this chapter is to paint a picture of the structure of the Irish adult population in terms of the main classificatory variables used throughout the report and to introduce the health story by outlining the self-defined health status of the population according to these classificatory variables. The section should provide a context for interpretation of the rest of the report.

The analyses reported here are based on the weighted data. Weighting, as described in the first chapter, ensures that the sample is representative of the population in terms of age group, sex, marital status and level of education.

2.1 Characteristics of the Sample: Health Status

Table 2.1 shows respondent's health self-rating (from "very good" to "very bad") classified by whether they have an ongoing health condition or problem. The self-rating item asked: "In general, how good would you say your health is? Would you say it is ...". The response options are as shown in Table 2.1. The item on health problems asked respondents to "Please specify the nature of any chronic physical or mental health problem, illness or disability which you may have. Please specify as fully as possible." Up to three types of health condition were coded according to the major body system affected.

About 15 per cent of the respondents had some health problem or condition at the time of the survey. The respondent's self-rating of their health is strongly associated with the presence of a health problem: over 90 per cent of those with no health problem rate their health as "very good" or "good", compared to only 26 per cent of those with a health problem. Nevertheless, it is interesting to note that very few respondents rate their health as "bad" or "very bad" – only four per cent overall. Even among those with a health problem only one in five rates their health as "bad" or very "bad".

Table 2.1: Self-Rating of Health by Presence of Health Problem

	No Health Problem	Health Problem	Total
		Column %	
Very Good	53	3	46
Good	38	23	36
Adequate	8	54	15
Bad	0	16	3
Very Bad	0	4	1
Total (Row Percentage)	85	15	100

This reluctance to rate one's health negatively is a feature of the Irish population. Comparisons of a similar item for 11 European countries in 1994[9]

[9] The countries are Belgium, Denmark, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain and the United Kingdom. The data come from the 1994 European Community Household Panel.

shows that, on average, 65 per cent of Europeans rated their health as "very good" or "good", compared to 80 per cent in Ireland. On the other hand, 10 per cent rated their health as "bad" or "very bad", compared to only 4 per cent in Ireland. (Department of Health and Children, 2000, p. 48).

The most common health problems, as can be seen from Table 2.2, were those affecting the circulatory system (such as heart conditions, high blood pressure, varicose veins) the musculo-skeletal system (e.g. arthritis, rheumatism), the respiratory system (asthma, emphysema) and the endocrine system (diabetes, thyroid conditions).

Table 2.2: Type of Health Problem, for Those Adults Affected

Nature of Health Problem	Total (Column %)
Circulatory System	30
Musculo-Skeletal System	23
Respiratory System	13
Endocrine System	10
Digestive System	5
Neoplasms (Cancer)	3
Nervous System	6
Genito-Urinary System	4
Back Problems	3
Accident	5
Mental Health	4
Other/Unspecified	8

Note: Base = those reporting health problem. Up to three health conditions were coded.

Table 2.3 shows the demographic characteristics of the sample and the way in which these are associated with the presence of a health condition. The final column of the table shows the distribution of the demographic characteristics in the sample. Thus, for instance, 14 per cent of males reported a health problem, and males constitute 49 per cent of the sample.

Table 2.3: Presence of Health Problems by Demographic Characteristics of the Sample

	Presence of Health Problem (Row Percentages)		Total
	No Health Problem	Health Problem	(Column %)
Total	85	15	100
Male	86	14	49
Female	84	16	51
Under 30	96	4	31
Age 30-49	88	12	33
Age 50-64	76	24	21
Age 65+	68	32	15
Dublin City/County	87	13	30
Elsewhere in Ireland	84	16	70
Married/Cohabiting	84	16	50
Divorced/Separated	86	14	3
Widowed	64	36	7
Never Married	90	10	40
No Children	83	17	67
One Child	88	12	13
Two Children	89	11	12
Three or More Children	90	10	9

The incidence of health problems is only slightly higher among females (16 per cent) than males (14 per cent), but increases dramatically with age. Only 4 per cent of those under age 30 report a health problem, compared to 32 per cent of those over age 65.

The incidence of health problems is slightly lower (13 per cent) in Dublin than in other parts of Ireland (16 per cent).

The higher incidence of health problems among widow(er)s than those with another marital status undoubtedly reflects the concentration of this group in the older age ranges. Age is also likely to be a factor in the higher incidence of health problems among those with no dependent children, many of whom will have children who have grown up and left home.

Table 2.4 shows the self-rated health of respondents by the same set of demographic characteristics. There is, again, a strong association with age, particularly in the fall in the percentage rating their health as "very good" or "good" as age increases – from over 90 per cent of those under 30 to two-thirds of those over 65. There is also an increase with age in the proportion who regard their health as "very bad" or "bad" (from 1 to 6 per cent), but the main shift is from the positive to the "adequate rating", with 28 per cent of the over 65s rating their health as "adequate" compared to 8 per cent of the under 30s. As before, there is a clear reluctance to rate one's health negatively.

The difference between men and women and between Dublin and other parts of the country are small. The widowed and those with no children (including those whose children have grown up) tend to rate their health more negatively, again due to the age composition of these groups.

Table 2.4: Self-Rated Health by Demographic Characteristics of the Sample

(Row Percentages)	Good or Very Good	Adequate	Bad or Very Bad
Total	82	15	3
Male	83	14	3
Female	81	15	3
Under 30	91	8	1
Age 30-49	87	10	4
Age 50-64	72	23	5
Age 65+	66	28	6
Dublin City/County	82	14	4
Elsewhere in Ireland	82	15	3
Married/Cohabiting	82	15	4
Divorced/Separated	75	19	6
Widowed	59	32	9
Never Married	86	12	2
No Children	79	17	4
One Child	85	11	3
Two Children	86	10	4
Three or More Children	90	10	0

Tables 2.5 and 2.6 examine the relationship between socio-economic characteristics of the respondents and health status.

There are sizeable differences according to the person's self-defined principal economic status. The lowest incidence of health problems is found among those in full-time education and training (2 per cent), primarily reflecting the youth of this group. Eight per cent of those in full-time employment have a health problem, a figure that is only slightly more than half the average of 15 per cent. Those in part-time employment have a higher incidence of health problems, at 12 per cent, but it is still below the average. Thirty per cent of the unemployed (a small group in 2000) and 31 per cent of the retired have a health problem. The figure is also fairly high for women in home duties (25 per cent), reflecting the fact that these women tend to be in the older age groups.

Almost half of those in the "unable to work because of illness/disability" category have a health problem. One might expect this to be closer to 100

per cent, however the wording of the question probably has an impact on the response: in some cases, the illness or disability leading to inability to work may be seen as temporary in nature, rather than chronic, (such as the "flu or a broken leg"). In other cases, the person may not regard the condition as constituting a "problem", "illness" or "disability". An earlier study, based on data from the Living in Ireland Survey, found a similar "slippage" between the principal economic status "unable to work due to illness or disability" and the presence of a chronic physical or mental health condition that restricted the person's daily activities (Watson, 1996). If all of those who are "unable to work due to illness or disability" were considered to have a health problem, the proportion with a health condition would increase only slightly (from 15 per cent to 16 per cent), since the group is small in magnitude.

Table 2.5: Presence of Health Problems by Socio-Economic Characteristics of the Sample

		No Health Problem	Health Problem	Total (Col %)
		Row Percentages		
	Total	85	15	100
Economic Status	Full-Time Employed	92	8	47
	Part-Time Employed	88	12	8
	Unemployed	70	30	4
	Retired	69	31	9
	Full-Time Training/Education	98	2	10
	Domestic Duties	75	25	20
	Ill/Disabled	52	48	2
Education	Primary Education Only	74	26	32
	Junior Cycle	87	13	23
	Leaving Certificate	92	8	28
	Third Level etc.	94	6	17
Household Net Weekly Income	Under £200	69	31	23
	£200 to £334	86	14	29
	£335 to £449	92	8	25
	£450 and over	93	7	23
Social Group	S/e or farmer	87	13	22
	Professional/Managerial	94	6	18
	Other Non-manual	86	14	15
	Skilled manual	86	14	24
	Unskilled manual	74	26	20

The relationship between highest level of education achieved and the presence of a health problem is also affected by the fact that older people tend to have finished school earlier. One-quarter of those with primary education only have a health problem, falling to 8 per cent of those with a Leaving Certificate and 6 per cent of those who completed Third Level.

There is also an association between both household income and social group[10] and the presence of a health problem. In income terms, almost one-third of those in households with income in the bottom quartile have a health problem, compared to fewer than one in ten of those in households with incomes in the top quartile. Six per cent of those in the professional/ managerial social group have a health problem, compared to one quarter of those in the unskilled manual social group. Adults in the self-employed, farm,

[10] Social group in the present analysis is based on the interviewer's classification of the occupation of the main earner in the household into one of 6 categories: Self-employed (not farmer), farmer (self-employed), Professional/senior managerial, other non-manual worker, skilled manual worker, unskilled manual worker. Where social group was not available (e.g. the main earner had never worked), it was assigned based on the respondent's level of education.

other non-manual and skilled manual social groups occupy an intermediate position in terms of the proportion with health problems (11 to 14 per cent).

As shown in Table 2.6, the relationship between socio-demographic characteristics of the person and self-rated health follows a very similar pattern. Those with higher levels of education, higher household incomes and in the professional/managerial social group are more likely to rate their health as "very good" or "good".

The reluctance to rate one's health negatively is again evident here. The main contrast is between those with positive and those with "adequate" ratings. The unemployed, retired and, to a lesser extent, women engaged on home duties are more likely to rate their health as "adequate" than are the full-time employed, part-time employed and students. Only among those unable to work because of illness or disability do we find a substantial minority (32 per cent) rating their health as "bad" or "very bad".

Table 2.6: Self-Rated Health by Socio-Economic Characteristics of the Sample

	(Row Percentages)	Good or Very Good	Adequate	Bad or Very Bad
	Total	82	15	3
Economic Status	Full-Time Employed	91	8	1
	Part-Time Employed	79	18	3
	Unemployed	69	22	8
	Retired	67	28	5
	Full-Time Training/Education	89	11	0
	Domestic Duties	72	22	6
	Ill/Disabled	47	21	32
Education	Primary Education Only	69	26	6
	Junior Cycle	83	13	4
	Leaving Certificate	90	9	2
	Third Level etc.	92	7	1
Household Net Weekly Income	Under £200	65	27	8
	£200 to £334	83	14	3
	£335 to £449	89	9	2
	£450 and Over	89	10	1
Social Group	S/e or Farmer	84	14	2
	Professional/Managerial	91	8	1
	Other Non-manual	84	11	5
	Skilled Manual	82	14	4
	Unskilled Manual	69	25	6

2.2 Age, Other Factors and Health Problems

In this section we attempt to disentangle the effects of age, social group, education and other characteristics of the respondents on the presence of a health condition. We saw earlier that the incidence of health problems increases markedly with age. To what extent is the observed difference between men and women, between Dublin and other parts of the country, between those with different levels of education due to the fact that these groups differ in age structure? Women tend to be older, on average, as do those with primary education only, while residents of the Dublin area tend to be slightly younger, on average, than those in other parts of Ireland.

Table 2.7 shows the percentage of people with a health problem according to sex, location, economic status, level of education, household income and social group – *within each age group*. Turning first to the differences between men and women, we see that the differences are small for those under 50, but with a slightly higher proportion of women reporting a health problem. Between the ages of 50 and 64, men are more likely to report a health problem. Over age 65 the gender gap widens, with women reporting health problems more often than men. This is because women in

this age group are older than men – more of them are over 70, over 80 and so on. This suggests that the differences between men and women are largely, but not entirely, due to differences in their distribution across age groups.

We saw earlier that those living outside Dublin were slightly more likely than Dubliners to report a health problem. The fact that these differences, although relatively small in size, persist in the 30 to 49 age group and in the 50 to 64 age group suggest that the Dublin/non-Dublin health gap is not due to age differences in the populations.

Table 2.7: Presence of Health Condition by Characteristics of Adults within Age Group (Per Cent with Health Problem)

		Under 30	Age 30-49	Age 50-64	Age 65+
		Percentage with Health Problem			
	Total	4	12	24	32
Sex	Male	3	11	27	25
	Female	5	12	20	37
Region	Dublin City/County	6	9	19	30
	Elsewhere in Ireland	3	12	26	32
Economic Status	Full-Time Employed	5	7	13	15
	Part-Time Employed	0	13	17	0
	Unemployed	13	26	56	—
	Retired	—	39	42	29
	Full-Time Training/Education	2	—	—	—
	Domestic Duties	9	13	23	41
	Ill/Disabled	—	42	—	—
Education	Primary Education Only	—	10	27	32
	Junior Cycle	4	15	26	32
	Leaving Certificate	3	11	16	21
	Third Level etc.	4	7	14	32
Household Net Weekly Income	Under £200	6	21	38	35
	£200 to £334	5	12	22	31
	£335 to £449	4	10	12	23
	£450 and Over	3	7	17	2
Social Group	S/e or farmer	1	11	23	22
	Professional/Managerial	2	7	12	29
	Other Non-manual	1	13	28	37
	Skilled Manual	3	14	23	31
	Unskilled Manual	19	11	30	38

Note: "—" indicates too few cases to provide estimate.

The next panel of Table 2.7 shows that even within age group, the part-time employed, the unemployed, the retired and those engaged on home duties are more likely than those who are full-time employed to experience health problems. The same is true, as we might expect, of those who are unable to work because of illness or disability – though it is only in the 30-49 age group that there were enough cases to analyse these results. Differences in health status by the person's main economic activity, then, are not just reflecting age differences between the groups.

In terms of level of education, the differences in the incidence of health problems become more evident for older adults. However, the relationship is not a smooth or linear one. Among those under 30, there is little difference in health status by level of education. In the 30-49 age group, the clearest contrast is between those with Leaving Certificate or lower education, and those with Third Level education, with the latter being less likely to experience health problems. There is only a small number of cases in this age group with primary education only, so the apparently better health of this

group compared to those with Junior cycle education must be treated with caution. In the 50 to 64 age group, the sharpest contrast is between those with Junior Cycle or lower education and those with Leaving Certificate or higher. In the over 65 age group the contrast is between those with Leaving Certificate or higher and those with less than Leaving Certificate education. In this age group the number of persons with Third Level education is small, so the decline in health status between those with Leaving Certificate and those with Third Level education may be a function of the small number of cases in the sample.

The relationship between health status and household income persists in all age groups. Those in higher-income households are less likely to have a health problem, no matter what age group they belong to.

Finally, when it comes to social group, the clearest pattern within age groups is that those in the professional/managerial social group are least likely to have health problems while those in the unskilled manual social group are most likely to have health problems.

2.3 Summary

In this section we examined the health status of the adult population using two different indicators: whether the person had a chronic health problem, and self-rated health. The two indicators are somewhat different, capturing slightly different aspects of health status. In particular, it is clear that very few people rate their health as bad or very bad, even if they have a long-term health problem.

There is a clear deterioration in the average health self-rating with age, and an increase in the incidence of health problems. When age is controlled,

- there is little difference between men and women in the incidence of health problems;
- there is a regional difference, with Dubliners reporting health problems less frequently than residents of other parts of the country;
- those who are unemployed, retired, engaged on home duties and, to a lesser extent, the part-time employed report health problems more often than the full-time employed;
- differences in the incidence of health problems by level of education are less clear, but those with Leaving Certificate or higher report health problems less often than those with Junior cycle or lower levels of education;
- clear differences in the incidence of health problems by level of household income remain, with the incidence of health problems falling as income rises;
- in terms of social group, those in the professional/managerial social group tend to experience health problems least often, while those in the unskilled manual social group experience health problems most often.

3. HEALTH CARE COVERAGE

In this chapter we consider several aspects of the incidence of various health care coverage options. In Section 3.1 we begin by focusing on the general incidence of coverage among the population as a whole and consider how this varies according to basic socio-demographic characteristics; and health status. In Section 3.2 we consider the incidence of cover under the main types of insurance and variations therein according to socio-demographic and related characteristics. Finally, in Section 3.3 we provide a brief summary of our findings.

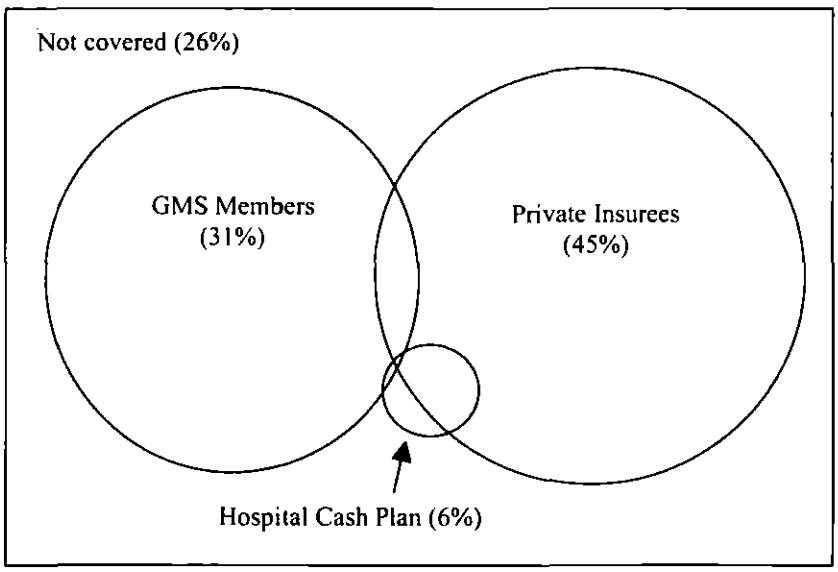
3.1 Incidence of Health Care Coverage in Ireland

3.1.1 GENERAL COVERAGE

Figure 3.1 provides a graphical representation of the health care coverage situation of Irish adults in 2000. The diagram classifies adults into one of four categories in terms of their health care coverage status. These are: (i) those covered by a Medical Card (either as holders of their own card or named on someone else's card) under the General Medical Scheme; (ii) those who hold some form of private health insurance cover such as that provided by the VHI or BUPA-Ireland as well as occupation-related schemes such as the Garda Medical Aid Society; the Prison Officers Medical Aid Society; the ESB Medical Provident Fund etc; (iii) those covered under a hospital cash plan. This latter type of insurance scheme principally covers the insured for accommodation in hospital as well as providing some compensation for loss of earnings during their illness; (iv) those not covered under any of the other three coverage schemes. From this diagram one can see that, in aggregate, just under one-third of all adults have medical card coverage (i.e. GMS members); 45 per cent are covered by private medical insurance or a workplace health plan; 6 per cent have a hospital cash plan and approximately 26 per cent have no medical coverage at all.

There is some overlap between the different types of coverage. A small percentage of the population (approximately 4 per cent) have both private and medical card coverage. In general, this subgroup with dual cover tends to be made up of either young adults or retirees who are eligible for a medical card on the grounds of low current incomes but who are also covered under someone else's private health insurance (for example a parent in the case of young persons) or continue to be covered by an occupation linked health scheme. Approximately two-thirds of those covered by a hospital cash plan are also covered by private health insurance. This implies that only a tiny proportion of the population (approximately 2 per cent) have a hospital cash plan as their only form of health cover. The overlap between medical card cover and cover under a hospital cash plan is very small, accounting for less than 1 per cent of the population.

Figure 3.1: Graphical Representation of Health Coverage of Adults



Note: Scale is approximate. Numbers do not sum to 100 because some people have more than one form of coverage.

Of all persons covered by a medical card over 90 per cent have a card in their own name. The remaining 10 per cent are usually on the card of a parent or spouse.

Variations in Health Coverage by Demographic Characteristics

Table 3.1 presents details on health cover among adults according to their principal demographic characteristics. The figures in Panel A of Table 3.1 provide a breakdown according to the demographics in question. For example, they show the percentage of males who are covered by a Medical Card, by Private Medical Insurance (PMI) and so on. In contrast, the figures in Panel B of the table provide the breakdown of adults in each of the four coverage categories according to their demographic characteristics. For example, 26 per cent of adult men are covered by a medical card; but 41 per cent of those covered by a medical card are men. Both sets of figures are equally valid and provide complimentary interpretations of the same topic.

Variation by Gender

Women are more likely than men to have medical card coverage (36 per cent compared to 26 per cent), but men are slightly more likely to have private insurance or a hospital cash plan. However, men are also more likely to have no health coverage (29 per cent, compared to 24 per cent of women). The figures in Panel B of Table 3.1 provide details on the breakdown of the various coverage regimes according to demographic profile of those covered.

Table 3.1: Type of Health Coverage by Demographic Characteristics of Adults

	A. Type of Health Cover (Per Cent of Group with cover)				B. Profile of those Covered (Column Per cent)				Total (Col %)
	GMS	Private Insurance	Cash Plan	No Cover	GMS	Private Insurance	Cash Plan	No Cover	
Total	31	45	6	26	100	100	100	100	100
Male	26	46	7	29	41	51	62	54	49
Female	36	44	4	24	59	49	38	46	51
Under 30	18	46	5	38	18	32	27	45	31
Age 30-49	22	52	10	25	23	38	57	31	33
Age 50-64	33	46	4	22	23	22	15	18	21
Age 65+	73	25	0	11	35	8	1	6	15
Dublin City/County	25	46	7	31	25	31	38	36	30
Elsewhere in Ireland	33	45	5	24	75	69	62	64	70
Married/Cohabiting	27	51	7	24	43	56	60	45	50
Divorced/Separated	44	35	17	23	5	3	10	3	3
Widowed	81	18	0	7	18	3	0	2	7
Never Married	26	44	4	34	34	38	31	51	40
No Children	35	42	4	27	76	62	48	68	67
One Child	23	52	9	27	9	14	21	13	13
Two Children	17	56	9	27	6	14	18	12	12
Three or More Children	28	47	8	23	8	9	13	8	9

Note: Row percentages in first panel need not add to 100 since a small proportion of adults are covered by more than one scheme.

One can clearly see that females account for a much higher percentage of those covered, by a Medical Card than do males (59 per cent and 41 per cent respectively). In contrast males represent substantially higher proportions of those who are either covered under a Hospital cash plan or who have no coverage (62 per cent and 54 per cent respectively).

Variations by Age

As one might expect there is clearly a strong relationship between coverage and age. Nearly three-quarters of all persons aged 65 years and over are covered under the GMS. This compares with only 18 per cent for those aged under 30 years; 22 per cent for those aged 30-49 years and so on. It is clear that the probability of having no cover is very strongly linked to age, falling from 38 per cent of those under 30 years to only 11 per cent of those aged 65 years and over.

Private insurance cover is highest among the middle age cohorts of 30-49 years (52 per cent), falling to 46 per cent for each of the under 30 year and 50-64 year cohorts while dropping substantially to only 25 per cent for the cohort which is 65 years and over.

The strong relationship between age and coverage status is also clearly apparent from the figures in Panel B of Table 3.1. This is particularly so in respect of those who have no cover. One can see that 45 per cent of those with no cover are less than 30 years of age; 31 per cent are aged 30-49 years; 18 per cent are aged 50-64 per cent and only 6 per cent are aged 65 years or more. A comparison of this within the breakdown of the total population according to age cohort (shown in the final column in Table 3.1) clearly illustrates the degree of over and under-representation of the four age groups in each of the coverage status categories. For example, those in the under 30 age category account for 31 per cent of adults, but for 45 per cent of adults with no cover. Those age 65 and over account for 15 per cent of adults, but for only 6 per cent of those with no cover.

The figures indicate that there are some regional variations in coverage figures as between Dublin city and county[11] and the rest of the country. One can see that there is an 8 point difference in Medical Card coverage between Dublin and the rest of the county with only 25 per cent of adults in Dublin being covered compared with 33 per cent of adults resident in other parts of the county. There are only marginal differences in the percentages covered by private insurance or hospital cash plans as between the two regions.

Regional trends in coverage are also underlined by the figures in Panel B of the table. One can see that only 25 per cent of those covered by a Medical Card are in the Greater Dublin Area compared with approximately 30 per cent of the adult population. This means that those covered by a Medical Card are under-represented in Dublin City & County by approximately 17 per cent as compared with the distribution of all adults as a whole. In contrast, those with Cash Plan or no cover are over-represented in Dublin in the order of 27 per cent and 20 per cent respectively.

Variations by Marital Status and Number of Children

Table 3.1 also shows the relationship between Medical Card coverage on the one hand and marital status and number of dependent children on the other. The trends apparent within this set of variables are substantially (though not exclusively) driven by the age profile of the groups in question. For example, one can see that 81 per cent of those who are widowed are covered by a Medical Card. This high incidence rate is largely a re-expression of those in the oldest age cohort as outline above. The medical card as a secondary benefit of some categories is also apparent from the figures (e.g. Divorced/Separated with a coverage rate of 44 per cent).

3.1.2 HEALTH COVERAGE BY SOCIO-ECONOMIC CHARACTERISTICS

Table 3.2 outlines incidence levels in the four main coverage categories according to a number of socio-economic characteristics: principal economic status, level of educational attainment, broad household income category, and socio-economic group.

Principal Economic Status

If one first considers principal economic status one can see that Medical Card coverage is lowest among those in full-time employment (10 per cent) rising to almost 70 per cent for the unemployed and those who are retired. This clearly reflects the extent to which the Medical Card is a secondary benefit for persons in these categories.

Private Medical Insurance cover is highest among those in full-time employment and Training/Education (54 per cent and 60 per cent respectively). Those in the latter group are largely covered on someone else's card – usually a parent.

The incidence of Hospital Cash Plan is highest among the employed (9 per cent among the full-time employed and 4 per cent among their part-time counterparts) and those who are classified as Ill/Disabled (8 per cent).

The level of non-coverage is highest among the full-time employed (35 per cent). This, in part, is a mirror image of the lower levels of GMS coverage among this group. The lowest incidence of non-coverage is apparent among those who are retired (10 per cent). This is clearly in line with the trends observed in our discussion of age in Table 3.1 above.

Panel B of Table 3.2 presents details on these trends from a slightly different perspective. From this panel of the table one can see, for example,

[11] In Dublin city is defined as the Dublin County Borough or Dublin Corporation Area. Dublin County includes Fingal, Dun Laoghaire/Rathdown and Belgard.

that those who are in full-time employment constitute 47 per cent of all persons but represent only 16 per cent of those with Medical Card coverage. Similarly, the level of over-representation of the unemployed under the GMS and their under-representation in the Private Medical Insurance sector is also clear from the table. Although the unemployed represent 4 per cent of all adults they constitute 9 per cent of those covered by a Medical Card and only 1 per cent of those with Private Insurance or Hospital Cash Plan cover.

It is clear that variations in coverage status are very strongly linked to level of educational attainment. The incidence of Medical Card cover falls directly with increases in attainment levels with trends in private insurance cover going in the opposite direction. Thus, one can see from Panel A of Table 3.2 that, for example, 57 per cent of adults who have left full-time education at the primary level have Medical Card cover; the comparable figure for those who left on completion of Junior Cycle was 28 per cent; 17 per cent for those with a Leaving Certificate and 8 per cent for those who left with third level or equivalent. The relationship between educational attainment and Private Medical Insurance cover is equally strong – though in the opposite direction. For example, only 28 per cent of those who leave education with after the Primary level have private insurance. This compares with a figure of 69 per cent among those who leave on completion of Third Level or equivalent.

Table 3.2: Type of Health Coverage by Socio-Economic Characteristics of Adults

	A. Type of Health Cover (Row Per Cent)				B. Profile of those Covered (Column Per Cent)				Total
	GMS	Private Insurance	Cash Plan	No Cover	GMS	Private Insurance	Cash Plan	No Cover	(Col %)
Total	31	45	6	26	100	100	100	100	100
Full-Time Employed	10	54	9	35	16	56	73	62	47
Part-Time Employed	38	37	4	27	10	7	6	8	8
Unemployed	68	14	1	20	9	1	1	3	4
Retired	69	30	1	10	20	6	2	3	9
Full-time Training or Education	23	60	1	26	8	14	2	10	10
Domestic Duties	51	34	3	16	33	15	12	12	20
Ill/Disabled	58	29	8	15	5	2	3	1	2
Primary Education Only	57	28	3	20	59	20	19	24	32
Junior Cycle	28	40	7	32	21	21	29	28	23
Leaving Certificate	17	53	6	31	16	33	31	33	28
Third Level etc.	8	69	7	23	4	26	21	15	17
Under £200	74	16	1	14	57	8	6	13	23
£200 to £334	28	37	4	36	26	24	22	40	29
£335 to £449	13	59	9	28	11	33	38	27	25
£450 and Over	8	69	8	24	6	35	34	21	23
S/e or Farmer	25	46	9	28	18	23	34	23	22
Professional/Managerial	11	75	7	19	7	31	24	13	18
Other Non-manual	27	53	4	23	13	18	12	13	15
Skilled Manual	34	36	5	32	27	20	22	30	24
Unskilled Manual	55	21	2	27	36	9	9	21	20

Note: Row percentages in first panel need not add to 100 since a small proportion of adults are covered by more than one scheme.

One can see from the table that the relationship between education and Hospital Plan cover is not as clearly defined. Rates of cover under this option do not vary between the top three attainment categories presented in the table (each being 6-7 per cent) although the level of cover among those who leave the education system on completion of the Junior Certificate is substantially lower at only 3 per cent.

In terms of non-coverage one can see that the lowest levels are among those who leave on completion of the Primary level or third level. This trend is clearly related to the high cover afforded to the former category by the GMS and to the latter group by the Private Insurance sector.

The figures in Panel B of Table 3.2 clearly indicate the under-representation of those with lowest level of educational attainment among the Private Medical Insurance sector and their over-representation in the GMS. Although those who have left full-time education on completion of primary level constitute 32 per cent of the total population of adults they constitute 59 per cent of persons covered by a Medical Card but only 20 per cent of those covered by Private Medical Insurance.

Variations by Income Level

The figures in Panel A of Table 3.2 show a very strong relationship between level of household income and type of health cover. One can see that 74 per cent of persons who are resident in households with an average weekly income of under £200 are covered by a Medical Card. This figure falls to 28 per cent of adults who live in households with a weekly income of £200 – £334; 13 per cent for those in households with a weekly income of £335 – £449 and 8 per cent among those with an average income of £450 or more per week. An equally strong trend (though clearly in the opposite direction) is apparent for Private Medical Insurance cover. Thus we can see from the table, for example, that only 16 per cent of persons in households with an average weekly household income of under £200 are covered by Private Medical Cover. This rises progressively with increases in weekly income to stand at 69 per cent for those who live in households with a weekly income of £450 or more.

It is clear from the figures in Panel A of Table 3.2 that cover under the Hospital Cash Plan option is positively correlated with income level and is largely concentrated in the top two income categories cited in the table.

From Panel B of the table one can see, for example, the very substantial over concentration of GMS cover among those in the lowest income category. In contrast, the over concentration of private medical insurance among persons in households in the highest income group is equally apparent.

Socio-Economic Group

The final segment in Table 3.2 relates to socio-economic classification of the household in which the respondent lives. A five-fold classification is used as follows:

- Self-employed and farmers
- Professional or Managerial
- Other non-manual category
- Skilled manual category
- Unskilled manual category

In general, one can see that trends in GMS cover conform with what one might expect. As socio-economic status increases one sees a fall in the level of GMS cover. Thus, one can see, for example, that 55 per cent of persons from Unskilled Manual backgrounds are covered by the Medical Card; 34 per cent of those from Skilled Manual backgrounds and so on. Only 11 per cent of those from Professional/Managerial backgrounds are covered under the scheme. In stark contrast to this trend, however, one can see that incidence of cover in the PMI sector is very strongly and positively related to socio-economic background. For example, 75 per cent of those from Professional/Managerial backgrounds are covered by PMI compared with only 21 per cent of those in the Unskilled Manual group.

One can see from the figures that the incidence of Hospital Cash Plan schemes are highest among the Self-employed and Farmers (9 per cent) and also the Professional/Managerial group (7 per cent).

Panel B of Table 3.2 highlights the very substantial over-concentration of both the Self-employed/Farmers and also the Professional/Managerial groups among those who are covered under Hospital Cash Plan schemes. For

example, persons in the Self-employed/Farmer category represent 22 per cent of the total adult population whereas they account for 34 per cent of hose covered by a Cash Plan scheme. Similarly, persons in the Professional/ Managerial group account for 24 per cent of those covered by a Cash Plan Scheme compared with 18 per cent of the total adult population.

Variations by Self-Assessed Health Status

In the course of the survey respondents were asked a number of questions relating to their current health status. (See, for example, Questions 1 and 2, Appendix B, and discussion in Chapter 2). The relationship between self-assessed health status and type of health cover is summarised in Table 3.3 below. In interpreting the information in the table, the reader is reminded that we saw in Chapter 2 that there was, as one would expect, a strong and negative relationship between propensity to assess health status as being "Very Good/Good" and age. As age increases one finds a lower percentage of persons who assess their health status as being "Very Good/Good". We also saw in that chapter that although there do not appear to be systematic trends in self-assessed health status with gender or region, we did find that persons in low income and low social group categories had a higher propensity than other groups to express negative views regarding their own health status. In interpreting the figures in Table 3.3, therefore, the reader should bear in mind that the health status variable is correlated with many of the socio-demographic variables contained in Tables 3.1 and 3.2 above.

Panel A of Table 3.3 shows that 62 per cent of those who record that they experience some sort of health problem say that they are covered under the GMS. A further 25 per cent are covered by PMI and 3 per cent by a Hospital Cash Plan. As many as 18 per cent who record that they have a health problem say that they are not covered under any of the health care options.

Table 3.3: Type of Health Coverage by Health Status of Adults

	A. Type of Health Cover (Per Cent of Group With Cover)				B. Profile of those Covered (Column Per Cent)				Total
	GMS	Private Insurance	Cash Plan	No Cover	GMS	Private Insurance	Cash Plan	No Cover	(Col %)
Total	31	45	6	26	100	100	100	100	100
No Health Problem	25	49	6	28	70	92	93	90	85
Health Problem	62	25	3	18	30	8	7	10	15
Very Good Health	18	53	7	30	26	55	56	51	46
Good Health	34	43	6	26	40	34	36	35	36
Adequate Health	52	31	3	22	25	10	7	12	15
Bad or Very Bad Health	76	15	2	11	8	1	1	1	3

Note: Row percentages in first panel need not add to 100 since a small proportion of adults are covered by more than one scheme.

The coverage status of those who record their health status as "Very Good" conforms to a very different picture from that of those who feel that their health is "Bad or Very Bad". One can see that only 18 per cent of those who say that their health status is "Very Good" are covered under the GMS. A total of 53 per cent are covered by Private Insurance; 7 per cent have a Hospital Cash Plan and as many as 30 per cent have no coverage at all. In contrast, three-quarters of those who rate their health as "Bad or Very Bad" are covered by a medical card, only 15 per cent have PMI, 2 per cent are covered by a hospital cash plan and 11 per cent have no cover.

3.2 Incidence of Types of Health Insurance

In this section we focus exclusively on the 45 per cent of the adult population who are covered by Private Medical Insurance. We begin by discussing in detail the socio-demographic characteristics of this subgroup in terms of their gender, age, marital status and whether they have dependent children.

3.2.1 TYPE OF PRIVATE MEDICAL INSURANCE CLASSIFIED BY DEMOGRAPHIC CHARACTERISTIC

Variations by Gender

Table 3.4 presents details on the type of private medical insurance cover held according to the demographic characteristics of those covered. In aggregate, one can see that a total of 85 per cent of adults covered by Private Medical Insurance are covered under the VHI. A further 8 per cent are covered by BUPA-Ireland and the remaining 7 per cent are covered by some other option.

In terms of gender differentials one can see that the principal difference arises in the "Other" category. This option accounts for 9 per cent of males who are covered by PMI compared with only 4 per cent of females. This substantial gender difference clearly reflects the much greater relative importance of occupationally oriented schemes for men than women. The schemes in question include, for example, the Garda Medical Aid Society; the Prison Officer Medical Aid Society and other job-related schemes of this nature. Panel B of Table 3.4 clearly shows that the genders are relatively evenly split in terms of both VHI and BUPA – Ireland. In regard to the "Other" schemes, however, males account for 68 per cent of all adults covered – even though they account for only 49 per cent of all adults in the population.

Variations by Age Cohort

Panel A of Table 3.4 shows that 80 per cent of persons covered by PMI and who are under 30 years of age have a policy with the VHI. This figure increases progressively with age cohort so that 90 per cent of those aged 50 years or more are covered by the VHI. In contrast, the incidence of BUPA-Ireland coverage seems to be negatively related to age. It is at its maximum for the under 30 year age category (13 per cent), falling to 9 per cent for the 30-49 age cohort; 2 per cent for the 50-64 age cohort and 4 per cent for the 65 or more cohort.

These trends in terms of age profile of persons covered by the major companies are shown even more clearly in Panel B of Table 3.4. From this one can see that about half of BUPA-Ireland's members are under 30 years of age; 42 per cent are aged 30-49 years; 6 per cent are aged 50-64 years and only 4 per cent are aged 65 year or more. This largely reflects the relative recency with which BUPA-Ireland has entered the Irish market. The younger age profile reflects the inflow of new clients as they take out private health insurance in their own name for the first time. This effect would, of course, be inflated by the assumed low switching rates from one insurance company to another once a policy has been taken out. If this is, in fact, the case then any new entrant to the market will increase its share primarily by taking on the new, younger clients who are being insured in their own right for the first time.

Marital Status and Number of Dependent Children

From Panel A of Table 3.4 one can see that an above average percentage of BUPA-Ireland clients have never been married. BUPA-Ireland has 11 per cent of all persons who are classified as "Never Married" compared with their 8 per cent share of the total Private Medical Insurance market. The company also has a substantially lower than average level of clients who are classified as "Widowed". A total of 2 per cent of their client-base fall into this category.

Table 3.4: Type of Private Health Insurance by Demographic Characteristics of Adults Covered by Insurance

	A. Type of Health Cover (Row Per Cent)			B. Profile of those Covered (Column Per Cent)		
	VHI	BUPA-Ireland	Other	VHI	BUPA-Ireland	Other
Total	85	8	7	100	100	100
Male	83	9	9	49	50	68
Female	87	8	4	51	50	32
Under 30	80	13	7	30	49	35
Age 30-49	85	9	5	38	42	31
Age 50-64	90	2	8	23	6	27
Age 65+	90	4	6	9	4	8
Married/Cohabiting	85	7	8	57	48	64
Divorced/Separated	91	9	0	3	3	0
Widowed	95	2	3	3	1	1
Never Married	83	11	6	37	49	35
No Children	86	8	6	63	56	58
One Child	82	11	7	14	18	16
Two Children	82	11	7	14	19	16
Three + Children	86	7	7	9	7	10

These trends are even more readily apparent from Panel B of Table 3.4. From this one can see that 49 per cent of BUPA-Ireland clients are classified as "Never Married". This compares with 37 per cent among VHI clients and 35 per cent in the total population. Similarly, only 1 per cent of the BUPA-Ireland client-base compared with 3 per cent of VHI's members are classified "Widowed".

As noted in earlier sections of the report, in interpreting these trends the reader should note that they largely reflect the age profile of the client-base of the two PMI insurers in Ireland. We saw above that the age profile of BUPA-Ireland's clients indicated that they were characterised as being relatively younger than the VHI client-base, arising from the recency with which the Irish PMI market was deregulated. This is subsequently reflected in the marital status categories. The "Never Married" group is largely made up of younger persons while the "Widowed" group is almost entirely made up of persons from older cohorts.

3.2.2 TYPES OF PRIVATE MEDICAL INSURANCE CLASSIFIED BY SOCIO-ECONOMIC STATUS

Table 3.5 provides a breakdown of type of health cover according to the standard socio-economic variables used throughout the report.

Employment Status

From Panel B of Table 3.5 one can see that the principal difference in terms of client profiles between the two main private insurance companies is centred on the higher percentage of BUPA-Ireland's clients who are in employment. A total of 61 per cent of its clients are in full-time employment, a further 12 per cent in part-time employment. Comparable figures for VHI are 54 per cent and 6 per cent respectively. The "Other" private insurance option has 68 per cent of its client base accounted for by those in full-time employment and 4 per cent in part-time employment. Given the occupational nature of the schemes in question this is hardly surprising. It is clear that the 73 per cent of persons covered by both BUPA-Ireland and "Other" insurance schemes who are in full-time or part-time employment is substantially above the 57 per cent of all persons in these economic status categories in the population as a whole.

Level of Educational Attainment

In terms of level of educational attainment among those who are covered by private medical insurance one can see that the lower two educational categories account for a much higher proportion of persons covered by the "Other" schemes than is the case for either the VHI or BUPA-Ireland. Those who leave full-time education with a Junior Certificate or less account for 30 per cent of the BUPA-Ireland clientbase; 41 per cent of the VHI client base and 53 per cent of the client base for "Other" schemes. It is clear from Panel B of Table 3.5 that BUPA-Ireland's clients have substantially higher levels of educational attainment relative to those of the VHI and the "Other" private schemes. As noted above in our discussion of other tables, these differences according to level of educational attainment may reflect the generally younger age profile of BUPA-Ireland's clientbase.

Variations According to Weekly Disposable Household Income

The figures in Panel B of Table 3.5 on the breakdown of clients covered by the three main insurance schemes would suggest that the income profile of persons covered by BUPA-Ireland schemes is *slightly* higher than that of the VHI's clients. For example, a total of 74 per cent of BUPA-Ireland's clientbase come from households in the top two income categories, compared to 67 per cent for VHI.

Table 3.5: Type of Private Health Insurance by Socio-Economic Characteristics of Adults Covered by Insurance

	A. Type of Health Cover (Row Per Cent)			B. Profile of Those Covered (Column Per cent)		
	VHI	BUPA-Ireland	Other	VHI	BUPA-Ireland	Other
Full-Time Employed	83	9	8	54	61	68
Part-Time Employed	81	15	4	6	12	4
Unemployed	77	19	4	1	3	1
Retired	93	5	2	6	4	2
Full-time Training or Education	89	7	5	14	11	10
Domestic Duties	88	5	7	16	9	15
Ill/Disabled	100	0	0	2	0	0
Primary Education Only	89	3	8	21	7	25
Junior Cycle	81	10	9	20	23	28
Leaving Certificate	83	10	7	32	40	33
Third Level etc.	87	9	4	27	30	14
Under £200	91	6	3	9	6	3
£200 to £334	86	7	7	24	20	25
£335 to £449	81	11	8	32	41	39
£450 and Over	86	8	6	35	33	32
S/e or Farmer	91	7	2	24	19	6
Professional/Managerial	89	6	5	32	23	23
Other Non-manual	79	10	11	17	21	31
Skilled Manual	78	11	11	18	26	31
Unskilled Manual	83	10	7	9	11	10

Variations According to Socio-Economic Status

The final segment of Table 3.5 shows variations in type of health insurance cover according to socio-economic group. These figures would seem to suggest that there is not a strong systematic trend in the type of insurance cover according to socio-economic group. The VHI has the highest percentage of "Self-employed persons and farmers" as well as the highest percentage of "Professional/Managerial workers" among the three options. The "Other Non-manual" and "Skilled Manual" categories seem to be over-represented among the "Other" insurance schemes.

3.2.3 TYPE OF PRIVATE MEDICAL INSURANCE COVER CLASSIFIED ACCORDING TO SELF-DEFINED HEALTH STATUS

Finally, in this section we consider variations in type of health insurance cover according to self-defined health status of respondent. From Panel B of Table 3.6 one can see that a slightly higher percentage of the client base captured by both BUPA-Ireland and "Other" private medical schemes record that they have no health problems (96 per cent and 95 per cent respectively). This compares with a figure of 91 per cent for the VHI. In terms of self-assessed health status it would appear that when one aggregates the response categories into a threefold classification of "Very Good/Good"; "Adequate", and "Bad/Very Bad" there is very little difference between the three health insurance options.

Table 3.6: Type of Private Health Insurance by Health Characteristics of Adults Covered by Insurance

	A. Type of Health Cover (Row Per Cent)			B. Profile of those Covered (Column Per cent)		
	VHI	BUPA-Ireland	Other	VHI	BUPA-Ireland	Other
Health Problem?						
No Health Problem	84	9	7	91	96	95
Health Problem	92	4	4	9	4	5
Self-rated Health						
Very Good	83	10	7	53	63	59
Good	88	6	6	36	22	31
Adequate	82	12	7	10	14	10
Bad or Very Bad	93	7	0	1	1	0

3.3 Summary

In this section we have provided a detailed consideration of incidence levels of different coverage statuses along with variations in such statuses according to standard socio-demographic characteristics as well as self-assessed health status.

We saw that 31 per cent of adults were covered under the Medical Card or GMS scheme; 45 per cent by Private Medical Insurance; 6 per cent by a Hospital Cash Plan and 26 per cent were not covered under any scheme. Overlaps in terms of coverage between the schemes would indicate that approximately 4 per cent of the population had both private insurance and Medical Card coverage. These were mostly younger adults or retired persons. The former are often eligible in their own right for a Medical Card due to their low income status while still being named on their parents' insurance scheme. Approximately two-thirds of the 6 per cent covered by a Hospital Cash Plan are also covered by Private Medical Insurance meaning that only about 2 per cent of the adult population have a Cash Plan as their only form of medical insurance.

We found that there were some clearly defined variations in coverage according to gender, age and region. We saw, for example, that there was a much higher incidence of Medical Card cover among females than males. In contrast, however, the incidence of Cash Plan cover was substantially higher among males than females. Males were also slightly more likely not to have any medical coverage than their female counterparts

As one would expect, age was very highly correlated with coverage. In particular, the percentage with no cover was very strongly and negatively related to age. In other words, as age increased the probability of not having any medical coverage feel sharply. For example, 38 per cent of those under 30 years had no medical cover. This fell to only 11 per cent of those over 65 years or more. As a corollary to this trend, we found that as age increased so too did the probability of being covered on a Medical Card – rising from 18 per cent for these aged under 30 years to 73 per cent for those aged 65 or over.

In terms of broad regional variations we found that the incidence of Medical Card cover in Dublin was 7 percentage points lower than in the rest

of the country. The incidence of private insurance and hospital cash plan schemes were largely the same in Dublin and the rest of the country.

We saw that variations in coverage status with socio-economic variables conformed more-or-less with what one might expect *a priori*. For example, GMS cover was lowest among the employed and highest among the unemployed and retired categories. This latter trend reflects the secondary benefit of the Medical Card among the groups in question. In contrast, PMI cover was highest among those in full-time employment and also in education/training (most of whom are still insured on their parents' insurance).

Cover was also strongly correlated with socio-economic status, income and level of educational attainment – all in the direction which might be expected.

In terms of *type* of insurance held, we saw that 85 per cent of those covered were with the VHI; 8 per cent were with BUPA-Ireland; and 7 per cent were with some "Other" scheme. In broad terms, we saw that there were some differences between the socio-demographic profile of those insured by BUPA-Ireland as compared with those covered by other schemes. BUPA-Ireland's clients were slightly younger, better educated, from higher income households, had a higher probability of being in full-time employment and has a lower incidence of having a health problem. These differential client profiles between the main insurers may result from a number of factors. Given the assumed low levels of switching from one insurance company to another, all new entrants to the Irish market must draw nearly all of their clientbase form the inflow of first-time policy holders. This inflow of new clients will disproportionately be made up of younger adults.

4. CONSUMPTION OF HEALTH SERVICES IN THE LAST TWELVE MONTHS

This chapter focuses on health service utilisation over the twelve months preceding the survey and, as in previous sections, considers how this varies according to the demographic and socio-economic variables discussed throughout the report. In Section 4.1 we begin by considering basic utilisation before moving on in Section 4.2 to focus on waiting times and waiting lists. Finally, in Section 4.3 we provide a brief summary of our findings.

4.1 Health Service Utilisation

Using information on their utilisation of health services, respondents were classified into one of seven mutually exclusive health service categories as follows:

- No usage;
- GP only;
- Casualty Department;
- Outpatient;
- Day Surgery;
- Private Hospital.
- Public Hospital;

Respondents were assigned to the relevant category according to their most intensive usage pattern. Thus, for instance, a person who enters the hospital through a visit to the casualty department and is admitted for at least one night is classified as a hospital user.

4.1.1 UTILISATION ACCORDING TO DEMOGRAPHIC CHARACTERISTICS

Table 4.1 presents details on the utilisation profile of adults according to their standard demographic characteristics. From this one can see that one-quarter of adults had not used the health services in the year preceding the survey while a total of 44 per cent had used only the services of their GP. This latter involved either a visit by the GP to the patient or the patient to the offices of the GP.

Table 4.1: Broad Health Service Usage by Demographic Characteristics of Adults

	Row Percentages						
	No Usage	GP Only	Casualty	Outpatient	Day Surgery	Hospital-Private	Hospital-Public
Total	25	44	5	9	3	6	7
Male	31	40	7	7	3	4	7
Female	20	49	3	11	2	7	8
Under 30	29	41	10	5	3	6	6
Age 30-49	29	43	4	10	3	6	5
Age 50-64	21	47	3	12	3	6	9
Age 65+	15	51	2	11	2	5	13
Married/Cohabiting	26	46	3	10	3	6	7
Divorced/Separated	14	46	3	16	6	7	7
Widowed	11	53	2	13	0	7	13
Never Married	28	41	8	7	3	6	7
No Children	25	44	6	9	3	6	8
One Child	29	43	5	8	3	6	6
Two Children	25	46	3	12	4	5	6
Three or More Children	27	44	4	10	2	6	6

A total of 13 per cent of the population had spent one or more nights in hospital in the 12 months preceding the survey – 6 per cent in a private hospital while 7 per cent were hospitalised as public patients. A total of 3 per cent of adults had been treated in a day surgery but had spent no nights in hospital while 9 per cent had presented for specialist outpatient treatment or consultation without hospitalisation. Finally, 5 per cent had visited the Accident & Emergency (Casualty) department of a hospital in the twelve months prior to the survey.

Utilisation by Gender

In general, one can see that females have a substantially higher propensity than males to utilise the health services. A total of 80 per cent of females used some aspect of the health system as set out in Table 4.1. The comparable figure for males is 69 per cent. The only area where usage is greater among males than females appears to be in Casualty which was used by approximately 7 per cent of males and 3 per cent of females.[12]

Utilisation by Age

As one would expect there is a very clear relationship between service utilisation and age. The figures in Table 4.1 show that 70 per cent of those aged less than 50 utilised some aspect of the health services. This compares with 79 per cent of those aged 50–64 and 85 per cent of those aged 65 years or more. There is really no difference between the age cohorts in terms of their level of utilisation of day surgery and private hospital utilisation. The incidence of hospitalisation as a public patient is more strongly influenced by age cohort. This is presumably a reflection of the higher rates of Medical Card coverage among the older cohorts, as noted in the previous chapter. The only area in which usage is greater among young adults is in visits to the Casualty Department with 10 per cent of person in the Under 30 year cohort visiting a

[12] If one focuses only on those who used some aspect of the health services in the period in question one finds that 10 per cent of men who utilised some aspect of the health system visited Casualty Department. The comparable figure for females is 4 per cent.

Casualty Department compared with 2-3 per cent for the rest of the population.

Variation in Utilisation by Marital Status and Number of Dependent Children

In general, there is little variation in utilisation levels according to marital status and number of dependent children. There are only two exceptions to this general observation. The first is the incidence of hospitalisation as a public patient among Widows. This is clearly related to age. The second is in the pattern of utilisation of out-patient and casualty services among those who are classified as Never Married. An above average percentage of this group use the services of Casualty Departments and a below average percentage use outpatient services. This is also a reflection of the age profile of persons in this category. We saw in the previous section that younger persons had a lower propensity to use out patient services and a higher propensity to use Casualty than other age cohorts. This may also reflect the influence of age since, for example, the "Never Married" individuals are relatively young.

4.1.2 UTILISATION ACCORDING TO SOCIO-ECONOMIC CHARACTERISTICS

Table 4.2 outlines patterns in usage according to socio-economic characteristics.

Principal Economic Status

In general, one can see that usage levels are highest among those classified as retired (86 per cent using some aspect of the health services) and on Domestic Duties (85 per cent). Lowest utilisation rates were apparent among the full-time employed. Somewhat surprisingly, perhaps, quite a high percentage of those who were ill/disabled had not used the health services in the 12 months preceding the survey though their overall hospitalisation rates were particularly high.

Level of Educational Attainment

Health service consumption is strongly and negatively related to level of educational attainment. In other words, the lower the level of education the higher is the level of service utilisation. Some of this may, of course, be driven by the relationship between educational attainment and age, as those with lower levels of attainment are generally from older age cohorts.

Income

The influence of income on health service utilisation is apparent from the table. For example, 83 per cent of those from households with a weekly income of under £200 used some aspect of health services in the twelve months preceding the survey. This figure falls progressively with income level to stand at only 70 per cent for those from households with an average weekly income of £450 or more. Public hospital utilisation rates and outpatient usage levels are highest for those in the lowest income bracket (13 per cent of adults in both areas). As one would expect, private hospital utilisation levels increase directly with income level. It is also interesting to note that the use of Casualty or A & E increases quite substantially with income. For example, only 1 per cent of adults from households with a weekly income of under £200 presented to casualty in the twelve months preceding the survey. This increases progressively with income bracket to stand at 9 per cent for those from households with an average weekly

income of £450 or over. This may arise if those from lower-income households who visit the casualty department are more likely to be hospitalised – they would then be classified as hospital users in Table 4.2.

Table 4.2: Broad Health Service Usage by Socio-Economic Characteristics of Adults

	Row Percentages						
	No Usage	GP Only	Casualty	Outpatient	Day Surgery	Hospital-Private	Hospital-Public
Full-Time Employed	32	42	7	7	2	5	5
Part-Time Employed	24	46	4	10	5	5	6
Unemployed	27	42	2	11	1	7	11
Retired	14	51	1	10	3	7	15
Full-time Training or Education	25	46	8	4	6	9	2
Domestic Duties	15	49	2	14	2	6	10
Ill/Disabled	29	22	7	9	0	0	32
Primary Education Only	19	48	3	11	3	4	12
Junior Cycle	26	43	9	9	2	4	7
Leaving Certificate	27	44	4	8	3	9	5
Third Level etc.	32	41	6	7	3	7	4
Under £200	17	49	1	13	2	4	13
£200 to £334	28	45	5	8	2	5	6
£335 to £449	25	45	6	7	4	7	6
£450 and Over	30	38	9	8	3	7	4
S/e or Farmer	28	47	4	6	2	6	7
Professional/Managerial	28	45	5	6	5	8	3
Other Non-manual	25	40	5	10	3	8	9
Skilled Manual	25	42	8	11	3	5	7
Unskilled Manual	21	47	3	11	1	4	12

Socio-economic Status

Utilisation levels are clearly lowest for those Professional/Managerial and Self Employed/Farmer categories (72 per cent) and highest for the unskilled manual group (79 per cent). Use of outpatient services is directly related to economic status, being substantially higher for the three lower status categories than for the Professional/Managerial and Self-employed/Farmer categories.

4.1.3 UTILISATION ACCORDING TO HEALTH STATUS AND COVERAGE

Health Problems and Self-Assessed Health Status

Table 4.3 presents details on utilisation levels according to health status and health coverage. As one would expect, by definition, those with a health problem have much higher utilisation rates than the rest of the population (97 per cent and 71 per cent respectively). Hospitalisation and use of Outpatient Services are much higher among those with a health problem whereas use of GP services *only* (i.e. without any more intensive usage) is more frequent among the rest of the population. A total of 46 per cent of those without a health problem used only GP services in the year preceding the survey compared with 38 per cent of those with a health problem.

Table 4.3: Broad Health Service Usage by Health Status and Health Coverage of Adults

	Row Percentages						
	No Usage	GP Only	Casualty	Outpatient	Day Surgery	Hospital-Private	Hospital-Public
Health Problem?							
No Health Problem	29	46	5	7	3	5	5
Health Problem	3	38	5	22	2	9	22
Self-Rated Health							
Very Good	33	45	6	5	2	5	4
Good	24	47	5	9	3	6	6
Adequate	10	41	4	17	4	8	15
Bad	2	20	5	29	0	10	33
Very Bad	4	3	0	26	0	11	56
Health Coverage							
GMS	16	49	2	13	2	5	14
Private Insurance	28	43	6	7	4	10	2
Not Covered	31	41	7	8	3	1	8

Usage levels according to self-assessed health status are very much in line with expectations. Particularly high levels of hospitalisation and use of outpatient services are apparent among those who assess their health to be "Bad" or "Very Bad".

Health Coverage

Finally, in terms of health coverage we find that health service usage is highest among those covered by the GMS – 84 per cent. The level for those with PMI is 72 per cent while the figure for those with no cover is 69 per cent. Use of outpatient, GP and the public hospital system is highest among Medical Card holders while the private hospital system and Casualty are, relatively speaking, highest among those with PMI.

4.1.4 NUMBER OF GP VISITS AND NIGHTS IN HOSPITAL

An alternative way of interpreting health service consumption is to consider the number of GP visits or nights in hospital in the twelve months preceding the survey. The relevant figures are presented in Tables 4.4 and 4.5.

Table 4.4: Number of General Practitioner Visits in Previous Twelve Months by Health Status and Health Coverage

	Row Percentages					Mean	Median
	None	One	2-5	6-10	Over 10		
Self-Rated Health							
Very Good or Good	33	18	38	7	4	2.4	1.0
Adequate	14	8	32	21	25	7.7	4.0
Very Bad or Bad	3	7	27	19	44	11.0	8.0
Health Problem?							
No Health Problem	33	18	38	7	4	2.4	1.0
Has Health Problem	5	6	27	24	38	9.7	6.0
Health Coverage							
GMS	18	8	39	15	20	5.8	4.0
Private Insurance	33	20	36	8	3	2.2	1.0
Not Covered	35	18	34	7	5	2.7	1.0

Table 4.5: Number of Nights in Hospital in Previous Twelve Months by Health Status and Health Coverage

	Row Percentages				Mean	Median
	None	1-3	4-10	Over 10	(Where > 0)	
Self-Rated Health						
Very Good or Good	90	4	4	2	7.8	4.0
Adequate	77	5	9	9	15.4	8.0
Very Bad or Bad	52	4	11	33	25.0	14.0
Health Problem?						
No Health Problem	90	4	4	2	8.7	5.0
Has Health Problem	69	7	10	14	17.8	10.0
Health Coverage						
GMS	82	4	6	9	16.5	10.0
Private Insurance	88	5	4	3	9.2	5.0
Not Covered	90	4	4	1	6.9	5.0

Note: Mean and median are shown for those individuals spending at least one night in hospital.

Self Assessed Health and Health Problems

Table 4.4 outlines details on GP visits. From this one can see that the number of visits to or from a GP in the reference period increased progressively with deterioration in self-assessed health status. For example, one can see from the table that 44 per cent of those who considered that their health was "Very Bad or Bad" used the services of their GP 10 or more times in the year in question. Only 25 per cent of those who considered their health status to be "Adequate" used the services of their GP with such a high frequency while only 4 per cent of those who rated their health status as "Very Good/Good" did so. The mean and median figures presented in the table clearly illustrate the strength of the relationship between consumption levels and self-assessed health status. It is clear from the table that the presence of a health problem is equally strongly correlated with number of visits.

Table 4.5 presents comparable information on number of nights in hospital in the twelve months preceding the survey. Hospitalisation is also strongly related to both self-assessed health status and presence or otherwise of a health problem. One can see, for example, that for those who assess their health as being "Very Bad" or "Bad" the mean number of nights spent in hospital was 25. The comparable figure for those who assessed their health as "Very Good" or "Good" is just under 8 nights.[13] The same variation is apparent as between those with and without a health problem.

Health Coverage

The extent to which health service consumption is linked to health coverage is illustrated by the figures in Table 4.4. From this one can see that a very substantially higher number of visits to or from the GP are made by those covered under the GMS. A total of 20 per cent of Medical Card holders made or received over 10 such visits in the year preceding the survey. The comparable figure for those with private health insurance is 3 per cent and for those with no cover it is 5 per cent. The mean and median number of visits presented in the table underline these differential usage patterns.

[13] The reader should note, of course, that the average of 8 nights among those who rate their health status as being "Very Good or Good" is based only on the *10 per cent* of this category who did, in fact, spend one or more nights in hospital. The average of 25 nights among those who noted their health status as "Very Bad or Bad" is based on the *48 per cent* of the relevant category who spent at least one night in hospital.

Table 4.5 shows that the median and mean number of nights spent in hospital by those covered by the GMS is substantially, higher than either those with PMI or those with no medical cover of any sort.

4.2 Waiting Times for Health Services

Much popularised coverage of health service provision has focused on length of waiting lists for access to health services, with a particular emphasis being placed on differences in waiting time between the GMS and PMI sectors. In this section we consider the extent of these differences in waiting times according to type of health coverage. The relevant information is presented in Tables 4.6 and 4.7 below.

Table 4.6 provides details on average waiting time for three types of health services for those Adults who received them in the previous twelve months, viz. hospitalisation; day surgery; outpatient services. The information is presented separately for the three types of health coverage.

The first segment of the table relates to hospitalisation. The figures under each health coverage category clearly refer only to those hospitalised. As we saw in Table 4.3 this varies between the three coverage groups. Table 4.3 indicated that a total of 19 per cent of those covered in the GMS were hospitalised in the year in question; 12 per cent of those covered by PMI were hospitalised and 9 per cent of those with no cover were hospitalised. Table 4.6 examines the waiting times among those who received different types of medical care in the last 12 months. From Table 4.6 one can see that of the Medical Card holders who were hospitalised, 59 per cent did not have to wait for hospitalisation.. The comparable figures for those with PMI and No Cover were 54 per cent and 74 per cent respectively.[14]

Of those who had to wait for admission, however, it is clear that the waiting times for those in the PMI sector are substantially shorter than for those in the GMS sector or those with no coverage. A total of 20 per cent of the GMS members and 21 per cent of these with No Cover had to wait more than 1 month for hospitalisation. The comparable figure for those with private insurance was 9 per cent.

Table 4.6: Waiting Time For Different Health Services, by Coverage

		GMS	Private Insurance	Not Covered
Hospital	None	59	54	74
	1-4 weeks	21	37	4
	1-6 months	11	7	17
	6-12 months	5	1	1
	Over 1 year	4	1	3
Mean (including 0 weeks wait)		6	3	6
Day Surgery	None	0	56	0
	1-4	70	16	80
	1-6 months	20	18	15
	6-12 months	0	6	5
	Over 1 year	10	3	0
Mean (including 0 weeks wait)		12	8	6
Outpatient	None	31	24	27
	1-4	43	56	49
	1-6 months	22	16	22
	6-12 months	3	4	0
	Over 1 year	0	0	2
Mean (including 0 weeks wait)		5	4	6

[14] Since GMS members tend to be older and are more likely to have health problems, these no-wait admissions may represent admissions via the Casualty Department.

The mean number of weeks waiting for hospitalisation is also shown in the table. This shows that the average waiting time of three weeks for those with private insurance is only about half that experienced by others who were hospitalised in the period in question.

Details on day surgery are shown in the second segment of the table. These show that as many as 56 per cent of those persons with private medical insurance who availed of this service experienced no waiting time while a further 16 per cent had to wait 1 – 4 weeks. The figures indicate that no-one who was not covered by private insurance had immediate access to day surgery services. The average waiting time for this service was 8 weeks for those with medical insurance. This compares with 6 weeks for those not covered and 12 weeks for those in the GMS.

Finally, the third segment of the table contains details on waiting time for outpatient services. Once again, one can see that those who are privately insured are advantaged in terms of access to the service in question – through not to the same degree as in the case of hospitalisation and day surgery services. The average waiting time for persons with private insurance was 4 weeks. This compared with 5 weeks for those in the GMS and 6 weeks for those who had no cover.

Table 4.7: Percentage Currently on Waiting List for Hospital Bed and Length of Wait by Coverage

		GMS	Private Insurance	Not Covered
Current	% Waiting	7	2	3
Length of Wait	None	4	15	2
	1-4 weeks	19	25	21
	1-6 months	53	53	42
	6-12 months	10	2	12
	Over 1 year	13	4	23
Median, Where >0		16	8	14

Table 4.7 presents details on the percentage of persons currently on a waiting list for a hospital bed or in-patient services. We can see that 7 per cent of those in the GMS say they are on such a list, 2 per cent of those with private insurance and 3 per cent of those who have no cover. Of those who are waiting, the median time waiting so far is 16 weeks for GMS members, 8 weeks for PMI members and 14 weeks for those with no health coverage.

4.3 Summary

In this chapter we considered utilisation levels according to a range of socio-demographic characteristics. We saw that three-quarters of the adult population used some aspect of the health services in the year preceding the survey. The most frequently used services were those of the GP; public hospitals and outpatient services. Consumption levels were higher among women than among men and, as one might expect, were strongly influenced by age. Usage levels also varied according to level of educational attainment, income and socio-economic status. Usage levels fell with increases in each of these three variables. For example, 83 per cent of adults from households with an average weekly income of under £200 used some type of health service. This fell progressively with income category until it stood at 70 per cent for those from households with an average weekly income of £450 or more.

Health Status was clearly a key determinant in the utilisation of services. A total of 97 per cent of those who had a health problem used some form of health service. This compares with 71 per cent of their counterparts who reported having no health difficulties.

Usage levels also varied according to coverage status being highest among Medical Card holders (84 per cent), falling to 69 per cent for those with no health cover.

Direct measures of health care consumption in the form of number of visits to or from a GP or nights spent in hospital confirm all these trends. Thus, for example, persons who were covered by a Medical Card made or received, on average, 5.8 visits to their GP.[15] This compares with 2.7 visits for those not covered by any medical scheme and 2.2 visits for those covered by private medical insurance.

The same trend is clearly apparent in terms of number of nights spent in hospital. Among persons who spent a night in hospital the average number for a medical card holder is 16.5. This compares with an average of 9.2 nights for those with private insurance and 6.9 nights for those with no cover.

Finally, we considered waiting times for access to health services. In general, we found that these were strongly influenced by coverage status. Average waiting times for access to hospital services among those covered by the GMS were twice the level among persons covered by private insurance (6 weeks compared with 3 weeks respectively). Similarly, those with private insurance had shorter waiting times for both Day Surgery and Outpatient Services than their counterparts in the GMS system.

[15] Based only on those who made/received *any* visits from a GP.

5. Perceptions of the Public and Private Health Care Systems in Ireland

This chapter outlines some of the key views and perceptions of the health care system, broken down by the relevant classificatory variables.

5.1 Perceptions of the Quality of Health Care in the Public System

Media reports would suggest a widespread perception that the quality of care available in the public health system is not on a par with that in the private system, particularly with regard to the waiting times necessary for seeing a specialist consultant and for hospital procedures. In this section, we examine perceptions of the quality of care in the public health system, and attempt to pinpoint the areas where that care is perceived to be lacking. We also explore whether there are differences between groups in the population (particularly with respect to health status, health coverage and social group) in perception of the public health system. In other words, is it those most likely to make use of the public health system – people with health problems, those in less advantaged social groups – who are most critical of it?

Respondents were asked their perception of the overall quality of care in the public health system: "In general, how would you describe the total level of care received in the PUBLIC Health system, in Ireland, in terms of QUALITY OF CARE." Response options were "very good", "good", "adequate", "bad" and "very bad".

Overall, as shown in Table 5.1, just over two-fifths rate the quality of care in the public health system as very good or good. Positive ratings increase with age (60 per cent of the over 65s), and are more frequent among those outside of Dublin (47 per cent) than in Dublin city or county (34 per cent). The association between age and a positive perception of the public health system is also evident in the pattern across marital statuses: widows, who tend to be older, are more likely to rate the public health system positively (60 per cent), particularly in contrast to adults who are divorced or separated (32 per cent).

Those in the youngest age group (under 30) are less likely to have a negative perception of the public health system than adults in their middle years: 19 per cent of the under 30s view the quality of care in the public health system as very bad or bad, compared to 29 per cent of those aged 30 to 49 and 24 per cent of those aged 50 to 64. This may be associated with life-cycle stage: single adults and those without children tend to be more positive than those who are married and those who have children.

Table 5.1: Perceptions of Quality of Care in the Public Health Systems by Demographic Characteristics of Adults

	Row Percentages Quality-Public Health		
	Good or Very Good	Adequate	Bad or Very Bad
Total	43	34	23
Male	43	33	23
Female	43	35	22
Under 30	41	40	19
Age 30-49	37	34	29
Age 50-64	44	32	24
Age 65+	60	24	16
Dublin City/County	34	34	32
Elsewhere in Ireland	47	34	19
Married/Cohabiting	40	33	28
Divorced/Separated	32	41	27
Widowed	60	28	12
Never Married	46	36	18
No Children	45	34	21
One Child	39	33	28
Two Children	40	35	25
Three or More Children	44	32	24

There are only minor differences in the perceived quality of the public health system between men and women.

Table 5.2 examines whether there are differences in the perceived quality of the public health system by the socio-economic characteristics of Adults. The association between age and a positive perception of the public health system is again evident in that over half of retired people regard it as good or very good. It is also interesting that two-thirds of those who are ill or disabled view the quality of the public health system as very good or good. In fact, people unable to work due to illness or disability, those in full-time education or training and those engaged in home duties are less likely than persons at work to view the quality of the public health system as bad or very bad.

There is also a clear relationship between level of education and perceptions of the quality of the public health system, with positive ratings declining as level of education increases. A similar pattern is found with respect to total net household income. Here the differences are even more dramatic, with 61 per cent of those with a total household income under £200 a week regarding the quality the public health system as very good or good, falling to only 32 per cent of those with household income of £450 a week or more. The differences according to socio-economic group are less marked. However, those in the Professional and Managerial social group tend to be most critical of the public health system, with only 33 per cent giving a positive rating, in contrast to 48-49 per cent of those in the Skilled and Unskilled Manual social group.

Table 5.2: Perceptions of Quality of Care in the Public Health Systems by Socio-Economic Characteristics of Adults

	Row Percentages		
	Quality-Public Health		
	Good or Very Good	Adequate	Bad or Very Bad
Total	43	34	23
Full-Time Employed	36	39	25
Part-Time Employed	41	28	30
Unemployed	48	23	28
Retired	55	24	21
Full-time Training or Education	43	45	12
Domestic Duties	50	29	21
Ill/Disabled	67	13	19
Primary Education Only	55	26	19
Junior Cycle	40	37	23
Leaving Certificate	37	38	25
Third Level etc.	34	39	27
Under £200	61	26	13
£200 to £334	43	34	23
£335 to £449	37	37	26
£450 and Over	32	40	29
S/e or Farmer	44	35	21
Professional/Managerial	33	40	27
Other Non-manual	39	35	26
Skilled Manual	48	33	19
Unskilled Manual	49	27	23

Table 5.3 looks at perceptions of the quality of care in the public health system by health characteristics of the Adults, including the type of health coverage they have, and whether they have been hospitalised in the previous year. It is clear from this table that those with most exposure to the public health services tend to give a more positive rating to the public health system than those with less exposure to it. This is particularly clear in the contrast between those hospitalised as public patients and those hospitalised as private patients. Six out of every ten people who had been hospitalised as *public* patients in the previous months give a positive rating to the quality of care in the public health system. In this respect, their evaluation of the public health system is considerably more favourable than that of people who had been hospitalised as *private* patients, only 36 per cent of whom rate the public health system positively. Over half of those with a health problem or condition give a positive rating to the public health system, while 58 per cent of those covered by the GMS do so. The differentiation according to the individual's self-rated health status is less clear, particularly since the small group rating their health as very bad or bad are more likely than average (about one-third, compared to under one-quarter on average) to give a negative rating to the public health system.

Table 5.3: Perceptions of Quality of Care in the Public Health Systems by Health Characteristics of Adults

	Row Percentages Quality-Public Health		
	Good or Very Good	Adequate	Bad or Very Bad
Total	43	34	23
No Health Problem	41	36	23
Health Problem	56	24	20
Very Good Health	42	34	24
Good Health	43	35	22
Adequate Health	48	34	19
Bad or Very Bad Health	47	18	36
GMS	58	26	16
Private Insurance	35	37	28
Not Covered	39	38	23
No Hospitalisation	42	35	23
Private Patient	36	33	31
Public Patient	60	22	17

The differences are fairly small between those with private health insurance and those with no health insurance, but the privately insured tend to be more critical.

Some insight into which aspects of the public health care system are viewed negatively can be obtained from the next set of Tables (5.4 to 5.6), which show the percentage in each group rating various aspects of the public health system positively ("good" or "very good"). The question wording was as follows: "I'm going to read out 4 statements about aspects of care in the Public Health system. For each item I would like you to tell me whether you think the Public Health system is Very Good; Good; Adequate; Bad; Very Bad."

a) Quality of medical care received as a Public patient;
b) Length of stay, given your condition, as a Public patient;
c) Quality of the facilities as a Public patient;
d) In general, efficient running or management of medical care in the Public Hospital system.

More than half view the quality of *medical* care in the public health system as good or very good, while 44 per cent view the quality of facilities as good or very good. However, fewer than two-fifths have a positive view of the length of stay and the efficient management of the public health care system.

Older adults, those in the lowest-income households, and GMS members are most positive across all aspects of the public health system with more than half giving positive ratings. In fact, 68 per cent of those aged 65 and over give a positive rating to the quality of medical care in the public health system. The association between age and widowhood and age and retirement mean that widow(er)s and retired persons also rate the public health system positively. Those with a health condition and those who had been hospitalised as public patients are also likely to give a positive rating to the quality of medical care and the quality of facilities, but slightly fewer than half give a positive rating to the length of stay and the efficient management of the public health system.

Table 5.4: Perceptions of Aspects of Care in the Public Health Systems by Demographic Characteristics of Adults

	Quality of Medical Care % (V) Good	Length of Stay % (V) Good	Quality of Facilities % (V) Good	Efficient Management % (V) Good
Total	52	38	44	39
Male	51	37	44	38
Female	52	39	45	41
Under 30	51	36	41	37
Age 30-49	45	32	39	34
Age 50-64	52	39	45	39
Age 65+	68	54	62	56
Dublin City/County	45	32	35	28
Elsewhere in Ireland	55	41	49	44
Married/Cohabiting	46	34	39	34
Divorced/Separated	48	31	51	37
Widowed	69	60	68	60
Never Married	55	40	46	42
No Children	54	39	45	41
One Child	51	39	45	34
Two Children	45	35	37	36
Three or More Children	45	36	46	37

Again, those who spent time in hospital as *private* patients are considerably more critical of the *public* health system, as are those in the professional and managerial social group, and higher income households.

Table 5.5: Perceptions of Aspects of Care in the Public Health Systems by Socio-Economic Characteristics of Adults

	Quality of Medical Care % (V) Good	Length of Stay % (V) Good	Quality of Facilities % (V) Good	Efficient Management % (V) Good
Total	52	38	44	39
Full-Time Employed	45	30	38	33
Part-Time Employed	55	35	44	36
Unemployed	51	38	41	36
Retired	63	51	56	50
Full-time Training or Education	53	46	45	47
Domestic Duties	59	47	53	47
Ill/Disabled	59	57	71	50
No Education beyond Primary	62	48	56	51
Junior Cycle	49	36	43	34
Leaving Certificate	48	32	38	36
Third Level etc.	42	30	35	29
Under £200	70	55	63	55
£200 to £334	49	34	42	39
£335 to £449	46	35	39	32
£450 and Over	41	29	34	31
S/e or Farmer	51	40	47	41
Professional/Managerial	41	32	36	34
Other Non-manual	51	33	38	30
Skilled Manual	56	40	48	41
Unskilled Manual	57	43	51	47

Overall then, perceptions of the quality of care in the public health system are not high. But those who are most likely to have used the public health system have a more positive view of it. This may be due to lack of accurate information on the part of young adults and those in more advantaged social groups, or it may reflect differences with respect to expectations.

Table 5.6: Perceptions of Aspects of Care in the Public Health Systems by Health Characteristics of Adults

	Quality of Care % (V) Good	Length of Stay % (V) Good	Quality of Facilities % (V) Good	Efficient Management % (V) Good
Total	52	38	44	39
No Health Problem	50	37	42	38
Health Problem	59	45	57	47
Very Good Health	51	37	42	38
Good Health	50	38	44	38
Adequate Health	56	41	54	47
Bad or Very Bad Health	56	46	52	35
GMS	67	52	57	50
Private Insurance	42	30	35	32
Not Covered	48	34	44	39
No Hospitalisation	51	37	44	39
Private Patient	45	39	36	30
Public Patient	61	47	57	46

Per cent rating as very good or good.

Table 5.7: Whether Waiting Times for Treatment in Public Hospitals Longer Now than Three Years ago by Demographic Characteristics

	Waiting Times Longer Now Than Three Years Ago?		
	Yes, Longer Now	No	Don't Know
Total	59	13	28
Male	56	14	30
Female	62	12	25
Under 30	52	15	33
Age 30-49	61	11	28
Age 50-64	65	13	21
Age 65+	62	13	25
Dublin City/County	70	9	22
Elsewhere in Ireland	55	15	30
Married/Cohabiting	63	11	26
Divorced/Separated	59	13	28
Widowed	59	17	24
Never Married	54	15	31
No Children	59	13	28
One Child	61	12	28
Two Children	59	15	27
Three or More Children	62	10	28

A key element of the quality of care in the public health system is the length of time people have to wait for treatment. Tables 5.7 to 5.9 examine whether people believe that the waiting times for treatment in a public hospital have increased in the last three years. This is similar to a question

included in the 1999 survey reported in Nolan and Wiley (2000), except that their wording referred to the previous five years. Nolan and Wiley reported that 65 per cent of respondents in that survey felt that waiting times had increased, 28 per cent believed the times had not increased, while the remaining 7 per cent did not know. Table 5.7 presents a slightly more positive picture, albeit one founded on greater uncertainty as to how waiting times may be changing rather than a conviction that they are not getting any worse: 59 per cent of those interviewed in 2000 believed that waiting times had grown longer, 13 per cent believed they had not changed, and 28 per cent did not know.

Table 5.8: Whether Waiting Times for Treatment in Public Hospitals are Longer now than Three Years ago by Socio-Economic Characteristics of Adults

	Waiting Times Longer Now Than 3 Years Ago?		
	Yes, Longer Now	No	Don't Know
Total	59	13	28
Full-Time Employed	58	12	30
Part-Time Employed	64	13	23
Unemployed	62	15	22
Retired	63	13	24
Full-time Training or Education	50	18	31
Domestic Duties	63	13	24
Ill/Disabled	48	16	36
Primary Education Only	61	13	26
Junior Cycle	62	13	25
Leaving Certificate	57	13	30
Third Level etc.	55	13	31
Under £200	61	16	23
£200 to £334	62	11	28
£335 to £449	56	14	29
£450 and Over	58	11	30
S/e or Farmer	59	12	28
Professional/managerial	56	11	33
Other Non-manual	64	8	28
Skilled Manual	58	16	26
Unskilled Manual	61	16	23

Residents of Dublin and those hospitalised as private patients in the previous year are most likely to believe that waiting times have grown longer (70 per cent), while those unable to work because of illness or disability (48 per cent) are least likely to believe that waiting times have worsened. It is interesting that when it comes to how waiting times have changed in recent years, GMS members, older adults and those hospitalised as public patients are slightly more critical than average. This contrasts with their tendency to be more positive than average in their overall rating of the quality of care in the public health system.

Table 5.9: Whether Waiting Times for Treatment in Public Hospitals are Longer Now Than Three Years Ago by Health Characteristics of Adults

	Waiting Times for Public Hospitals Longer Now Than 3 Years Ago?		
	Yes, Longer Now	No	Don't Know
Total	59	13	28
No Health Problem	58	12	30
Health Problem	66	18	16
Very Good Health	56	15	29
Good Health	61	11	28
Adequate Health	65	11	24
Bad or Very Bad Health	64	23	12
GMS	60	16	24
Private Insurance	60	10	30
Not Covered	57	15	28
No Hospitalisation	58	13	29
Private Patient	71	10	19
Public Patient	67	14	18

5.2 Perceptions of the Quality of Health Care in the Private System

There is a considerably more positive view of the quality of care in the private health system, as Tables 5.10 to 5.12 reveal. Over four-fifths of respondents view the quality of care in this sector as "very good" or "good", and fewer than one in twenty view it as "bad" or "very bad".

Table 5.10: Perceptions of Quality of Care in the Private Health Systems by Demographic Characteristics of Adults

	Quality-Private Health		
	Good or Very Good	Adequate	Bad or Very Bad
Total	83	15	3
Male	83	15	3
Female	83	15	2
Under 30	82	17	2
Age 30-49	81	16	3
Age 50-64	85	12	3
Age 65+	85	13	2
Dublin City/County	79	18	4
Elsewhere in Ireland	84	14	2
Married/Cohabiting	82	15	3
Divorced/Separated	81	15	4
Widowed	86	13	1
Never Married	83	15	1
No Children	82	16	2
One Child	85	10	4
Two Children	79	17	4
Three or More Children	87	10	3

The general pattern of differences among groups is similar to that for perceptions of the public health system, although the differences tend to be smaller in magnitude. Again, older persons, those living outside Dublin, those

in lower-income households, GMS members, and those with a health condition tend to give higher than average ratings to the private health system. Dublin residents, those in higher-income households, in the Professional and Managerial social group and those hospitalised as private patients tend to be more critical. However, even among the "critical" groups, over 70 per cent give a positive rating to the private health system.

Table 5.11: Perceptions of Quality of Care in the Private Health Systems by Socio-Economic Characteristics of Adults

	Quality-Private Health		
	Good or Very Good	Adequate	Bad or Very Bad
Total	83	15	3
Full-Time Employed	80	18	2
Part-Time Employed	86	10	3
Unemployed	81	16	3
Retired	86	12	2
Full-time Training/Education	87	12	1
Domestic Duties	86	11	3
Ill/Disabled	69	21	10
Primary Education Only	85	12	3
Junior Cycle	84	14	3
Leaving Certificate	82	16	2
Third Level etc.	77	20	3
Under £200	86	12	2
£200 to £334	86	11	3
£335 to £449	80	17	3
£450 and Over	78	20	2
S/e or Farmer	85	12	3
Professional/Managerial	76	21	3
Other Non-manual	81	17	2
Skilled Manual	87	12	1
Unskilled Manual	82	14	4

Table 5.12: Perceptions of Quality of Care in the Private Health Systems by Health Characteristics of Adults

	Quality-Private Health		
	Good or Very Good	Adequate	Bad or Very Bad
Total	83	15	3
No Health Problem	82	15	2
Health Problem	86	11	3
Very Good Health	81	16	2
Good Health	84	13	2
Adequate Health	84	13	2
Bad or Very Bad Health	74	15	11
GMS	87	11	2
Private Insurance	80	17	3
Not Covered	82	15	3
No Hospitalisation	83	15	2
Private Patient	78	16	6
Public Patient	81	14	5

A more direct comparison between the public and private health sectors is possible by looking at whether the respondents believe that a better quality

of care is received in the public or the private health systems (Tables 5.13 to 5.15). The question was: "Suppose you needed hospital treatment. Do you think that the quality of care received would be better (a) on the private health system (b) on the public health system or (c) it would make no difference to the quality of care received."

Table 5.13: Perceptions of Relative Quality of Hospital Care in the Public and Private Health Systems by Demographic Characteristics of Adults

	Quality of Care		
	Better on Private	Better on Public	No Difference
Total	62	0	38
Male	64	0	36
Female	60	0	39
Under 30	70	0	30
Age 30-49	65	1	34
Age 50-64	56	0	43
Age 65+	46	0	54
Dublin City/County	63	1	37
Elsewhere in Ireland	62	0	38
Married/Cohabiting	61	0	39
Divorced/Separated	65	0	35
Widowed	47	0	53
Never Married	66	0	33
No Children	60	0	40
One Child	69	0	30
Two Children	65	1	35
Three or More Children	63	0	36

Sixty-two per cent believe that the quality of hospital care is better in the private health system, 38 per cent believe there is no difference, with almost no respondents believing that the quality of care is better in the public health system.

Older Adults (54 per cent), GMS members (49 per cent), and those hospitalised as public patients (49 per cent) are most likely to believe that there is *no difference* in the quality of care between the public and private systems. Young adults, those in the professional and managerial social group, those with third level education, those in the higher-income households, the privately insured and those hospitalised as private patients are most likely (69 to 71 per cent) to believe that the quality of hospital care is better in the private system.

Table 5.14: Perceptions of Relative Quality of Hospital Care in the Public and Private Systems by Socio-Economic Characteristics of Adults

	Quality of Care		
	Better on Private	Better on Public	No Difference
Total	62	0	38
Full-Time Employed	68	1	32
Part-Time Employed	59	0	41
Unemployed	64	1	35
Retired	45	0	55
Full-time Training or Education	69	0	31
Domestic Duties	55	0	45
Ill/Disabled	49	0	51
Primary Education Only	48	0	52
Junior Cycle	69	0	31
Leaving Certificate	68	1	31
Third Level etc.	69	1	30
Under £200	47	0	53
£200 to £334	65	0	35
£335 to £449	67	1	33
£450 and Over	69	0	31
S/e or Farmer	61	0	38
Professional/Managerial	69	1	30
Other Non-manual	67	1	32
Skilled Manual	61	0	38
Unskilled Manual	53	0	47

Table 5.15: Perceptions of Relative Quality of Hospital Care in the Public and Private Systems by Health Characteristics of Adults

	Quality of Care		
	Better on Private	Better on Public	No Difference
Total	62	0	38
No Health Problem	63	0	37
Health Problem	56	0	44
Very Good Health	62	1	37
Good Health	63	0	37
Adequate Health	61	0	39
Bad or Very Bad Health	55	0	45
GMS	50	0	49
Private Insurance	71	1	28
Not Covered	61	0	39
No Hospitalisation	62	0	37
Private Patient	71	0	29
Public Patient	52	0	48

Perhaps the most dramatic difference in perceptions of the public and private health systems are found with regard to waiting times (Tables 5.16 to 5.18). The question was: "Suppose you needed hospital treatment. Do you think you could get it more quickly (a) on the private health system (b) the public health system or (c) it would make no difference to the time taken to receive the treatment." Nearly nine out of ten believe that required hospital

care would be obtained more quickly on the private health system than on the public system.

Table 5.16: Perceptions of Relative Waiting Times for Hospital Care in the Public and Private Health Systems by Demographic Characteristics of Adults

	Row Percentages		
	Quicker Hospital Treatment		
	More Quickly on Private	More Quickly on Public	No Difference
Total	88	0	12
Male	87	1	12
Female	88	0	12
Under 30	88	1	12
Age 30-49	92	0	8
Age 50-64	90	1	10
Age 65+	74	0	26
Dublin City/County	94	0	6
Elsewhere in Ireland	85	1	15
Married/Cohabiting	90	1	9
Divorced/Separated	93	1	6
Widowed	74	0	26
Never Married	86	0	14
No Children	86	0	14
One Child	94	1	5
Two Children	87	1	12
Three or More Children	88	0	11

Again, older adults, those in the lowest-income households, GMS members and those hospitalised as public patients were more likely than other groups to believe that there is no difference in waiting times between the public and private health systems, but even here more than three out of four believe that treatment can be obtained more quickly on the private system.

5.3 Summary

There is a clear perception that both the quality of care and the speed with which required treatment can be obtained is better on the private than on the public health system.

However, those most critical are the people least likely to have used the public health system.

Nevertheless, 40 per cent of those hospitalised as public patients in the previous twelve months and 42 per cent of GMS members rate the public health system as adequate or worse.

The strongest criticisms are of the speed with which treatment can be obtained, particularly in comparison with the private health system, the length of hospital stay in the public health system and the efficiency with which the public health system is managed. On the other hand, over half of the respondents rate the quality of medical care in the public health system as very good or good.

Table 5.17: Perceptions of Relative Waiting Times for Hospital Care in the Public and Private Health Systems by Socio-Economic Characteristics of Adults

	Row Percentages		
	Quicker Hospital Treatment		
	More Quickly on Private	More Quickly on Public	No Difference
Total	88	0	12
Full-Time Employed	92	1	8
Part-Time Employed	91	1	8
Unemployed	89	0	11
Retired	74	0	25
Full-time Training or Education	85	0	15
Domestic Duties	83	1	16
Ill/Disabled	88	0	12
Primary Education Only	80	0	19
Junior Cycle	90	1	10
Leaving Certificate	91	0	9
Third Level etc.	93	0	7
Under £200	76	1	23
£200 to £334	89	0	10
£335 to £449	90	0	10
£450 and Over	94	0	6
S/e or Farmer	88	0	12
Professional/managerial	93	0	7
Other Non-manual	92	0	7
Skilled Manual	85	1	14
Unskilled Manual	81	1	18

Table 5.18: Perceptions of Relative Waiting Times for Hospital Care in the Public and Private Health Systems by Health Characteristics of Adults

	Row Percentages		
	Quicker Hospital Treatment		
	More Quickly on Private	More Quickly on Public	No Difference
Total	88	0	12
No Health Problem	88	0	11
Health Problem	84	0	16
Very Good Health	88	0	12
Good Health	89	1	11
Adequate Health	83	1	16
Bad or Very Bad Health	86	0	14
GMS	79	1	20
Private Insurance	95	0	5
Not Covered	86	0	14
No Hospitalisation	88	0	12
Private Patient	93	0	7
Public Patient	78	0	21

6. VIEWS FOR AND AGAINST HAVING PRIVATE HEALTH INSURANCE

This section will examine arguments for and against having private medical health insurance. In addition, it will examine the extent to which segments of the population who are not currently covered by private insurance would like to be covered and estimates of the maximum amount which they would be willing to pay for such insurance.

6.1 Perceptions of Insurance Among those Insured

We begin in Tables 6.1 to 6.3 by looking at the reasons for having health insurance among those who are insured. This group includes those privately insured through VHI and BUPA-Ireland, as well as the smaller number who have health insurance through a specific occupational scheme (such as St. Paul's Garda Medical Aid Society, the Prison Officers Medical Aid Society and the ESB Medical Provident fund). Those with a hospital cash plan or critical illness cover only, a very small group, as we saw in Chapter 3, are not included. Respondents were presented with a set of reasons for having health insurance, and were asked to rate each reason as "very important", "important", "not very important" and "not at all important". The wording of the items was as follows:

a) Being able to have a private or semi-private room in hospital;
b) Being able to choose your own consultant;
c) Being sure of getting into hospital quickly when you need treatment;
d) Being sure of getting good treatment in hospital;
e) Being able to get a private bed in a hospital;
f) Being sure of getting consultant care;
g) Being able to arrange hospital treatment for when it suits you;
h) Avoid large medical or hospital bills.

The reasons most often cited as very important were "avoiding large bills" (88 per cent) and "being sure of getting into hospital quickly" (85 per cent), followed by "being sure of getting good treatment in hospital" (73 per cent). The ability to arrange the timing of treatment (57 per cent), ensuring consultant care (59 per cent) and the ability to choose a consultant (43 per cent) were also seen as very important by a substantial proportion of respondents. Of lesser importance overall were having a private room (22 per cent "very important") and being sure of a private bed (25 per cent).

Table 6.1: Reasons for having Private Insurance, Among those Insured, by Demographic Characteristics of Adults

	Reasons for Having Insurance							
Total	Private Room	Choose Consultant	Ensure Quick Treatment	Ensure Good Hospital Treatment	Private Bed	Ensure Consultant Care	Arrange Time of Treatment	Avoid Large Bills
Total	22	43	85	73	25	59	57	88
Male	21	41	86	74	24	60	56	88
Female	23	44	84	72	27	58	58	87
Under 30	19	39	82	74	23	59	51	81
Age 30-49	21	44	85	73	24	56	57	88
Age 50-64	20	46	85	69	25	65	61	95
Age 65+	40	46	91	82	41	62	70	92
Dublin City/County	18	38	89	74	19	55	59	87
Elsewhere in Ireland	24	45	82	72	28	61	56	88
Married/Cohabiting	22	44	87	73	25	61	59	91
Divorced/Separated	51	76	91	83	57	78	81	90
Widowed	38	56	88	73	41	66	68	93
Never Married	19	37	80	72	22	55	51	83
No Children	23	42	86	75	25	61	57	89
One Child	21	46	85	70	26	55	55	82
Two Children	22	43	78	67	26	56	54	87
Three or More Children	16	42	86	74	22	61	62	91

Per cent for whom each reason is very important.

This set of items is very similar to those reported in Nolan and Wiley (2000) based on a 1999 survey. Their results also indicated that the reasons most often cited as "very important" were avoiding large bills (89 per cent), ensuring that treatment is available quickly (86 per cent), and "being sure of good treatment in hospital" (77 per cent). Compared to the results reported by Nolan and Wiley, however, our tables suggest a decline in the importance of "choice of consultant" (from 53 per cent citing it as very important in 1999 to 43 per cent in 2000), ensuring consultant care (68 per cent to 59 per cent), arranging the timing of treatment (69 per cent to 57 per cent), and having a private room (28 per cent to 22 per cent).

There are some differences according to characteristics of the respondents in the relative priority attached to the different factors. Not surprisingly, avoiding large bills is relatively less important for those in the top income quartile than for other households, although even among this group 82 per cent see this as a very important reason for having health insurance. Being sure of getting treatment quickly is more important (90 per cent) for those who consider their health to be bad or very bad, but not for those with a health problem. This might occur if those who consider their health bad tend to have conditions which would require more urgent attention.

Table 6.2: Reasons for Having Private Insurance, Among those Insured, by Socio-Economic Characteristics of Adults

	Reasons for Having Insurance							
	Private Room	Choose Consultant	Ensure Quick Treatment	Ensure Good Hospital Treatment	Private Bed	Ensure Consultant Care	Arrange Time of Treatment	Avoid Large Bills
Total	22	43	85	73	25	59	57	88
Full-time Employed	21	42	85	73	24	59	58	89
Part-time Employed	16	46	91	76	23	60	61	93
Unemployed	27	55	92	75	28	68	45	94
Retired	40	47	85	77	37	65	63	88
Full-time Training or Education	18	32	75	73	21	58	52	77
Domestic Duties	24	46	88	71	26	62	58	95
Ill/Disabled	0	75	91	44	48	27	34	52
Primary Education Only	25	42	86	76	30	61	59	93
Junior Cycle	19	42	89	71	26	58	52	89
Leaving Certificate	20	42	83	74	23	60	57	85
Third Level etc.	24	44	82	71	24	59	60	85
Under £200	34	49	82	73	38	61	58	92
£200 to £334	27	41	85	74	30	60	57	92
£335 to £449	18	42	85	72	22	60	61	90
£450 and Over	20	43	85	73	22	57	53	82
S/e or farmer	28	51	89	80	33	67	67	91
Professional/Managerial	20	44	85	71	24	57	56	84
Other Non-manual	20	37	85	72	23	55	58	91
Skilled Manual	17	36	78	73	17	56	49	86
Unskilled Manual	27	42	84	66	32	62	50	89

Per cent for whom each reason is very important.

Being able to choose a consultant is a higher priority than average for those with a health problem and those who consider their health to be bad (52 and 49 per cent compared to 43 per cent on average). Being able to arrange the timing of treatment is relatively more important for those working part-time (61 per cent), those with 3 or more children (62 per cent), and the self-employed and farmers (67 per cent). The "amenity" aspects – having a private room – tend to become more important with age (40 per cent of those over 65 and 38 per cent of those who are widowed), and with bad self-rated health (34 per cent), but are of very little importance (4 per cent citing it as a "very important reason") to those hospitalised as public patients in the previous year.[16]

[16] However, among the insured, number who were hospitalised as public patient in the previous year is very small (46 cases).

Table 6.3: Reasons for having Private Insurance, Among those Insured, by Health Characteristics of Adults

	Reasons for Having Insurance							
	Private Room	Choose Consultant	Ensure Timely Treatment	Ensure Good Hospital Treatment	Private Bed	Ensure Consultant Care	Arrange Time of Treatment	Avoid Large Bills
Total	22	43	85	73	25	59	57	88
No Health Problem	22	42	85	73	25	59	58	87
Health Problem	23	52	83	75	24	59	46	96
Very Good	22	44	85	76	26	61	61	87
Good	23	41	84	68	27	58	54	86
Adequate	15	41	84	72	17	54	47	97
Bad or Very Bad	34	49	90	85	24	60	36	98
No Hospitalisation	22	41	84	72	25	59	57	88
Private Patient	22	52	86	75	30	62	59	85
Public Patient	4	54	88	87	5	57	54	94

Per cent for whom each reason is very important.

The next set of tables are based on a question to those with health insurance: "In making the choice as to whether or not you would give up private health insurance if the premium were increased which one of the following would concern you MOST about having to rely on the public hospital system." This item provides a more direct ranking of health-related reasons for having insurance than Tables 6.1 to 6.3 where, potentially, a respondent could have regarded all of the presented reasons as "very important". All of these reasons relate to the quality of health care, and the reason emerging as most important of all in Tables 6.1 to 6.3 – avoiding large medical bills – was not included. Respondents were offered the option to list another, open-coded reason, but fewer than one per cent did so.

Table 6.4: Factor of Most Concern in Deciding Whether to Give Up Insurance, Among those Insured, by Demographic Characteristics of Adults

	Factor of Most Concern (Row Percentages)			
	Quality of Care	Choice of Consultant	Length of Wait	Non-Medical Amenities
Total	20	5	72	3
Male	21	4	72	3
Female	19	6	72	3
Under 30	28	7	62	3
Age 30-49	18	4	76	1
Age 50-64	14	6	77	3
Age 65+	11	1	80	8
Dublin City/County	19	3	75	2
Elsewhere in Ireland	20	6	71	3
Married/Cohabiting	16	5	76	3
Divorced/Separated	7	2	87	4
Widowed	10	4	86	0
Never Married	26	7	64	3
No Children	20	5	72	3
One Child	15	9	72	5
Two Children	22	4	73	0
Three or More Children	18	5	75	2

The tables clearly show that it is the length of wait for obtaining public hospital care which is of the greatest concern. Almost three-quarters of respondents choose this as the factor which would concern them most. One-fifth cited the quality of care they would receive as public patients, and one in twenty or fewer cite "choice of consultant" or the "non-medical amenities".[17]

It is interesting that "length of wait" is of relatively greater importance to those over 65 (80 per cent), those with a health problem (80 per cent) and those working part-time (90 per cent). The importance of choice of consultant to those who regard their health as bad, seen above in Table 6.3, is again evident here. The non-medical amenities are the most important factor for a substantial minority (21 per cent) of those who regard their health as bad.

Table 6.5: Factor of Most Concern in Deciding Whether to Give Up Insurance, Among those Insured, by Socio-Economic Characteristics of Adults

	Factor of Most Concern (Row Percentages)			
	Quality of Care	Choice of Consultant	Length of Wait	Non-Medical Amenities
Total	20	5	72	3
Full-time Employed	19	4	74	3
Part-time Employed	9	1	90	0
Unemployed	31	8	61	0
Retired	13	3	77	7
Full-Time Training/Education	36	8	53	3
Domestic Duties	16	6	77	2
Ill/Disabled	0	54	46	0
Primary Education Only	18	2	75	5
Junior Cycle	16	9	71	4
Leaving Certificate	23	5	70	2
Third Level etc.	20	4	74	2
Under £200	14	1	78	7
£200 to £334	19	3	76	3
£335 to £449	20	5	73	2
£450 and Over	22	8	68	3
S/e or Farmer	23	4	70	3
Professional/Managerial	20	9	71	1
Other Non-manual	20	3	72	4
Skilled Manual	20	4	73	3
Unskilled Manual	10	5	82	4

[17] "Level of non-medical amenities such as privacy, semi-private room etc."

Table 6.6: Factor of Most Concern in Deciding Whether to Give Up Insurance, Among those Insured, by Health Characteristics of Adults

	Factor of Most Concern (Row Percentages)			
	Quality of Care	Choice of Consultant	Length of Wait	Non-Medical Amenities.
Total	20	5	72	3
No Health Problem	21	5	72	3
Health Problem	10	7	80	4
Very Good	23	4	70	2
Good	17	5	75	2
Adequate	12	8	76	5
Bad or Very Bad	12	16	51	21
No Hospitalisation	19	5	73	3
Private Patient	24	8	63	5
Public Patient	22	4	75	0

Note: Among the insured, the number who were hospitalised as public patients in the previous year is very small (46 cases).

We turn now to the perceived affordability of health insurance among those insured. The wording was: "Given the price of your current health insurance do you regard your health insurance cover as ...", with response options as shown in Tables 6.7 to 6.9. Only 3 per cent regard it as "quite cheap", the biggest group (46 per cent) regard it as "good value", a substantial minority (37 per cent) regard it as "expensive", one in ten regards it as "very expensive" and 4 per cent regard it as "close to unaffordable".

Table 6.7: Perceived Affordability of Health Insurance, Among those Insured, by Demographic Characteristics of Adults

	Perceived Affordability of Private Insurance (Row Percentages)				
	Quite Cheap	Good Value	Expensive	Very Expensive	Close to Un-affordable
Total	3	46	37	10	4
Male	4	48	35	9	4
Female	2	43	40	12	3
Under 30	4	58	30	5	2
Age 30-49	3	42	42	11	2
Age 50-64	2	39	38	15	6
Age 65+	1	42	39	9	9
Dublin City/County	5	49	30	11	6
Elsewhere in Ireland	2	44	41	10	3
Married/Cohabiting	3	40	40	12	5
Divorced/Separated	3	55	26	15	2
Widowed	2	34	40	9	15
Never Married	4	55	34	6	2
No Children	4	48	34	9	4
One Child	2	44	42	11	1
Two Children	2	39	46	10	3
Three or More Children	2	45	35	13	5

Compared to a similar question included in the 1999 survey (Nolan and Wiley, 2000, p.100), the perceived affordability of health insurance has improved. In particular, there has been an increase in the proportion who regard it as "good value" (from 35 to 46 per cent) and a drop in the

proportions regarding it as "expensive" (from 43 to 37 per cent) or "very expensive" (from 18 per cent to 10 per cent). There has been little change in the extremes of the affordability distribution: those regarding it as "quite cheap" or "close to unaffordable".

The average VHI premium increased by 9 per cent in September 1999, and had increased by a similar percentage in the previous year, but plans for an increase in premiums in September 2000 were dropped. Since the interviews for the 2000 survey spanned July to September, the absence of an increase in 2000 can have had an impact on perceived affordability only to the extent that respondents were looking ahead to what they would have to pay next year. It is likely that the confidence inspired by continuing economic growth, together with cuts in taxation in the 1999 Budget, have contributed to more people finding their health insurance to be "good value" in 2000 than in 1999.

Table 6.8: Perceived Affordability of Health Insurance, Among those Insured, by Socio-Economic Characteristics of Adults

	Perceived Affordability of Private Insurance (Row Percentages)				
	Quite Cheap	Good Value	Expensive	Very Expensive	Close to Un-affordable
Total	3	46	37	10	4
Full-time Employed	4	48	36	9	4
Part-time Employed	1	27	50	13	9
Unemployed	1	57	27	11	3
Retired	3	50	31	13	4
Full-time Training or Education	4	62	30	4	0
Domestic Duties	2	35	42	17	4
Ill/Disabled	0	46	48	7	0
Primary Education Only	3	47	32	9	8
Junior Cycle	4	40	43	10	4
Leaving Certificate	3	48	38	9	3
Third Level etc.	3	46	37	12	1
Under £200	0	36	47	12	5
£200 to £334	3	45	33	13	6
£335 to £449	3	44	40	10	3
£450 and Over	4	50	36	8	2
S/e or farmer	2	38	42	12	6
Professional/Managerial	3	46	39	9	3
Other Non-manual	2	49	40	7	2
Skilled Manual	6	50	29	13	2
Unskilled Manual	3	50	33	8	6

There are some differences in perceived affordability according to characteristics of the respondents, particularly in terms of household income: just over one-third of those in the lowest-income households find their health insurance to be good value, compared to over half of those in the highest income households. Men are more likely than women to find health insurance to be good value (48 per cent compared to 43 per cent), as are those under age 30 compared to the over 65s (58 per cent compared to 42 per cent).

Table 6.9: Perceived Affordability of Health Insurance, Among those Insured, by Health Characteristics of Adults

	Perceived Affordability of Private Insurance (Row Percentages)				
	Quite Cheap	Good Value	Expensive	Very Expensive	Close to Unaffordable
Total	3	46	37	10	4
No Health Problem:	3	46	38	10	4
Health Problem	2	49	34	12	3
Very Good	3	50	34	10	3
Good	3	40	42	10	4
Adequate	2	46	35	8	8
Bad	1	23	53	22	1
Very Bad	1	28	52	19	1
No Hospitalisation	3	46	38	10	4
Private Patient	2	45	35	14	3
Public Patient	5	51	30	8	6

Note: Among the insured, number who were hospitalised as public patient in the previous year is very small (46 cases).

Tables 6.10 to 6.12 show the weekly cost to the respondents of their health insurance. Cases where the premium is paid in full, or subsidised, by the employer are excluded. In nearly nine out of ten cases, the insurance is paid for by the insured person (or his/her family). Employers pay the premium in about one case in ten, and subsidise the premium in a further 2 per cent of cases.

Table 6.10: Weekly Cost of Health Insurance, Among those Insured who Pay for it, by Demographic Characteristics of Adults

	Weekly Cost of Health Insurance (Row %)				
	£1-£5	£6-£10	£11-£20	£21-£30	£31+
Total	9	28	46	13	4
Male	9	27	47	14	3
Female	9	29	45	12	5
Under 30	17	39	36	7	1
Age 30-49	6	25	53	12	4
Age 50-64	6	25	44	19	6
Age 65+	17	33	35	9	6
Dublin city/county	12	26	48	12	2
Elsewhere in Ireland	8	29	45	14	5
Married/Cohabiting	6	17	54	17	5
Divorced/Separated	7	38	49	6	0
Widowed	6	59	31	3	0
Never Married	16	52	27	4	2
No Children	11	35	39	11	4
One Child	7	22	51	16	4
Two Children	6	14	64	13	3
Three or More Children	5	15	53	23	5

Note: Excludes cases where insurance is paid for by employer.

Table 6.11: Weekly Cost of Health Insurance, Among those Insured who Pay for it, by Socio-Economic Characteristics of Adults

	Weekly Cost of Health Insurance (Row %)				
	£1-£5	£6-£10	£11-£20	£21-£30	£31+
Total	9	28	46	13	4
Full-time Employed	9	32	42	14	3
Part-time Employed	9	26	48	9	9
Unemployed	27	27	37	9	0
Retired	16	32	38	6	8
Full-time Training or Education	8	4	69	20	0
Domestic Duties	4	18	58	15	5
Ill/Disabled	20	0	60	20	0
Primary Education Only	10	28	50	8	4
Junior Cycle	8	22	51	15	4
Leaving Certificate	9	27	44	14	5
Third Level etc.	9	32	41	15	3
Under £200	16	49	25	5	5
£200 to £334	10	33	49	6	2
£335 to £449	5	22	49	19	5
£450 and Over	10	23	47	16	5
S/e or farmer	5	24	50	16	5
Professional/Managerial	10	22	47	17	4
Other Non-manual	8	34	44	7	6
Skilled Manual	12	29	45	12	2
Unskilled Manual	12	43	37	4	3

Note: Excludes cases where insurance is paid for by employer.

The median amount paid is in the £11 to £20 per week range. About one person in ten pays less than £5 per week, 28 per cent pay £6 to £10 per week, 46 per cent pay £11 to £20 per week, 13 per cent pay £21 to £30 and 4 per cent pay £31 or more.

Table 6.12: Weekly Cost of Health Insurance, Among those Insured who Pay for it, by Health Characteristics of Adults

	Weekly Cost of Health Insurance (Row %)				
	£1-£5	£6-£10	£11-£20	£21-£30	£31+
Total	9	28	46	13	4
No Health Problem	8	28	46	13	4
Health Problem	14	26	45	11	5
Very Good	12	26	46	15	2
Good	5	30	48	11	7
Adequate	9	34	43	12	3
Bad or Very Bad	16	27	41	0	16
No Hospitalisation	9	27	47	13	4
Private Patient	7	35	42	11	4
Public Patient	13	25	37	16	9

Note: Excludes cases where insurance is paid for by employer. Among the insured, number who were hospitalised as public patients in the previous year is very small (46 cases).

The amount paid tends to be higher, as we might expect, for those who are married and for those with dependent children. There are only small differences by level of education or household income, except that households in the bottom quartile are less likely to pay over £10 per week.

Since community-rating is in effect in Ireland, there is little difference between those with and those without a health problem.

6.2 Perceptions of Private Insurance Among Those Not Insured

In this section we turn our attention to those who do not have health insurance. We begin by looking at what they would regard as important reasons for having health insurance. This will allow us to assess whether their priorities differ from the population of those covered by health insurance. In other words, do people choose not to have health insurance because their priorities and preferences differ from those with health insurance, or are they not covered because they cannot afford it?

In Tables 6.13 to 6.15 we show the proportions of those without health insurance rating each reason as "very important". In general, the proportions rating each reason as "very important" are 10 to 20 percentage points lower than among the insured, but the relative importance of the different reasons is very similar. As with the insured, avoiding large medical bills (75 per cent) and ensuring that treatment can be obtained quickly (71 per cent) are cited most often as very important, closely followed by "ensuring good hospital treatment" (61 per cent).

Table 6.13: Reasons for Having Private Insurance, Among those NOT Insured, by Demographic Characteristics of Adults

	Reasons for Having Insurance							
	Private Room	Choose Consultant	Ensure Quick Treatment	Ensure Good Hospital Treatment	Private Bed	Ensure Consultant Care	Arrange Time of Treatment	Avoid Large Bills
Total	8	23	71	61	10	41	39	75
Male	6	18	68	62	9	39	36	75
Female	9	27	73	60	11	43	41	75
Under 30	11	25	73	62	11	40	41	72
Age 30-49	5	23	70	62	11	42	40	78
Age 50-64	7	25	75	64	10	42	39	77
Age 65+	6	18	64	55	7	41	33	72
Dublin City/County	9	27	78	65	15	38	51	70
Elsewhere in Ireland	7	21	68	59	8	42	34	77
Married/Cohabiting	5	23	71	61	9	41	36	79
Divorced/Separated	17	25	78	72	20	57	58	71
Widowed	5	16	64	57	8	42	34	67
Never Married	10	24	71	61	10	40	41	73
No Children	7	22	69	60	9	41	38	73
One Child	11	32	77	68	15	45	37	79
Two Children	6	19	69	59	6	38	38	76
Three or More Children	6	27	76	65	13	45	49	84

Per cent for whom each reason is very important.

Being able to arrange the timing of treatment and ensuring consultant care come next (39 – 41 per cent). Being able to choose a consultant, ensuring a private bed and a private room are regarded as very important by only a minority.

Those not covered by health insurance include GMS members, already entitled to free medical care, and non-GMS members. We might expect them to differ in terms of the reasons they would regard as important, but this is not the case. The two groups are very similar in terms of the proportion regarding each reason as "very important".

Table 6.14: Reasons for Having Private Insurance, Among those NOT Insured, by Socio-Economic Characteristics of Adults

	Reasons for Having Insurance							
	Private Room	Choose Consultant	Ensure Timely Treatment	Ensure Good Hospital Treatment	Private Bed	Ensure Consultant Care	Arrange Time of Treatment	Avoid Large Bills
Total	8	23	71	61	10	41	39	75
Full-time Employed	6	21	71	61	9	39	39	78
Part-time Employed	13	32	74	57	18	42	49	75
Unemployed	7	20	68	56	11	34	36	69
Retired	4	20	67	58	9	46	42	74
Full-time Training or Education	17	30	75	74	11	50	39	77
Domestic Duties	5	23	70	60	8	41	35	74
Ill/Disabled	19	15	76	66	15	42	33	56
Primary Only	6	20	67	59	9	41	37	75
Junior Cycle	7	23	68	58	9	36	33	72
Leaving Certificate	9	26	79	66	12	47	46	77
Third Level etc.	9	28	72	65	11	39	45	78
Under £200	8	21	66	56	8	43	36	74
£200 to £334	8	23	73	64	12	45	42	77
£335 to £449	9	24	71	60	10	35	37	75
£450 and Over	4	26	76	68	9	34	40	72
S/e or farmer	7	19	71	55	7	38	33	79
Professional/Managerial	12	30	74	66	15	39	40	70
Other Non-manual	10	33	78	67	15	46	50	71
Skilled Manual	5	20	69	64	8	40	37	73
Unskilled Manual	8	22	67	58	11	43	40	77

Per cent for whom each reason is very important.

Table 6.15: Reasons for Having Private Insurance, Among those NOT Insured, by Health Characteristics of Adults

	Reasons for Having Insurance							
	Private Room	Choose Consultant	Ensure Timely Treatment	Ensure Good Hospital Treatment	Private Bed	Ensure Consultant Care	Arrange Time of Treatment	Avoid Large Bills
Total	8	23	71	61	10	41	39	75
No Health Problem	7	22	71	62	10	41	39	76
Health Problem	10	25	70	58	12	41	39	70
Very Good	7	21	71	60	9	40	40	76
Good	7	22	70	63	9	43	39	77
Adequate	6	27	68	53	11	40	37	70
Bad or Very Bad	18	26	79	77	20	46	39	67
GMS	9	23	70	60	11	43	38	73
Not Covered	7	23	71	62	9	40	39	77
No Hospitalisation	8	22	70	61	9	41	39	76
Private Patient	7	27	51	51	13	46	32	46
Public Patient	7	27	77	64	14	41	35	76

Per cent for whom each reason is very important. Among the uninsured, number who were hospitalised as private patients in the previous year is very small (36 cases).

Given that the non-insured have a similar ranking of priorities to those covered by health insurance, the next question concerns their reasons for NOT having health insurance. Respondents were presented with three reasons for not having health insurance, and asked to rate the importance of these reasons: "I am going to read out three reasons for not having private medical health insurance. In respect of each could you please tell me whether or not you think it is: Very Important; Quite Important; Neither Important nor Unimportant or Not at all important." The next set of Tables (6.16 to 6.18) shows the percentage ranking each reason as "very important".

The main reason for not having health insurance centres on its cost. Two-thirds of the respondents say that the expense of having health insurance is a very important reason for not being covered; almost one-third rate satisfaction with the public health system as a very important reason, and slightly fewer than one in five cite not being likely to need it as a very important reason.

The cost of health insurance becomes an increasingly important factor with age (77 per cent of those over 65 see this as a very important reason), but so does being satisfied with the public health system: 45 per cent of those over age 65 cite "satisfaction with the public health system" as a very important reason for not being insured, compared to 23 per cent of those under 30. The expense involved is also more important than average for those in lower-income households, those with primary education, those in the unskilled manual social group, GMS members and those with a health problem.

We saw earlier, in Tables 6.7 to 6.9, that nearly half of those with private medical insurance thought it provided 'Good Value'. The figures for the uninsured show, on the other hand, that two-thirds of them point to the cost as a very important reason for *not* having insurance. This is partly due to the fact that those with private medical insurance tend to have higher incomes, on average, than those without it (see Table 3.2). It may also reflect differences in the assessment of the "value for money" provided.

Table 6.16: Reasons for NOT having Private Insurance, Among those Not Insured, by Demographic Characteristics of Adults

	Reasons for Not Having Insurance (Per cent for Whom Each Reason is Very Important)		
	Not Likely to Need	Too Expensive	Satisfied with Public Health
Total	16	67	31
Male	18	63	28
Female	15	70	34
Under 30	22	53	23
Age 30-49	11	70	30
Age 50-64	13	72	31
Age 65+	18	77	45
Dublin City/County	26	72	33
Elsewhere in Ireland	12	65	31
Married/Cohabiting	14	71	31
Divorced/Separated	10	81	34
Widowed	14	72	45
Never Married	19	59	28
No Children	18	64	32
One Child	9	75	23
Two Children	17	70	33
Three or More Children	9	75	34

Per cent for whom each reason is very important.

Being satisfied with the public health system is cited as very important with greatest frequency by those over age 65, as noted above, and by other groups who tend to be older, such as the widowed (45 per cent), the retired (43 per cent), women in home duties (41 per cent). It is also cited more often than average by GMS members and those with a health problem (37 per cent).

In general, few regard "not being likely to need it" as a very important reason for not having health insurance. The highest proportions citing this reason are among those in the highest income households (29 per cent). This suggests that respondents are not just thinking about the need for health care when they give this response, but also, perhaps, about the role of health insurance in meeting health expenses.

Table 6.17: Reasons for NOT Having Private Insurance, Among Those Not Insured, by Socio-Economic Characteristics of Adults

	Reasons for Not Having Insurance (Per Cent for Whom Each Reason is Very Important)		
	Not Likely to Need	Too Expensive	Satisfied with Public Health
Total	16	67	31
Full-time Employed	18	59	22
Part-time Employed	14	71	36
Unemployed	8	77	28
Retired	14	75	43
Full-time Training or Education	22	52	24
Domestic Duties	14	75	41
Ill/Disabled	19	75	32
Primary Education Only	14	74	39
Junior Cycle	19	63	28
Leaving Certificate	14	61	22
Third Level etc.	20	58	27
Under £200	12	76	39
£200 to £334	15	65	30
£335 to £449	15	59	22
£450 and Over	29	55	25
S/e or farmer	15	57	26
Professional/Managerial	23	52	32
Other Non-manual	14	74	29
Skilled Manual	17	63	34
Unskilled Manual	14	79	34

Per cent for whom each reason is very important.

The last set of tables indicated that affordability was a major issue for those without health insurance. We now turn to whether they would actually like to have health insurance and whether they ever seriously considered taking it out. The questions were: "Would you like to be covered by private medical health insurance?" and "Have you ever seriously considered taking out private health insurance?" Tables 6.19 to 6.21 show the percentages in each group responding in the affirmative to each of these items.

Overall, 58 per cent of the non-insured would like health insurance, but only 29 per cent had ever seriously considered taking it out. The proportion who would like health insurance declines with age (to 43 per cent of those over age 65), but increases with number of dependent children (to 75 per cent of those with three or more children). It is only slightly higher than average for those with a health problem (60 per cent), and those who consider their health bad (63 per cent). It is quite high (66 per cent) for those

who had been hospitalised as private patients (and presumably had to pay the cost themselves) in the previous year.

Table 6.18: Reasons for NOT Having Private Insurance, Among those Not Insured, by Health Characteristics of Adults

	Reasons for Not Having Insurance (Per Cent for Whom Each Reason is Very Important)		
	Not Likely to Need	Too Expensive	Satisfied with Public Health
Total	16	67	31
No Health Problem	17	65	30
Health Problem	11	76	37
Very Good	19	59	27
Good	15	71	32
Adequate	12	72	36
Bad or Very Bad	15	78	37
GMS	12	75	37
Not Covered	20	59	26
No Hospitalisation	16	66	30
Private Patient	14	81	31
Public Patient	18	71	38

Per cent for whom each reason is very important. Among the uninsured, number who were hospitalised as private patients in the previous year is very small (36 cases).

Table 6.19: Whether Would Like Private Insurance and Has Ever Considered Taking out Private Insurance, Among those Not Insured, by Demographic Characteristics of Adults

	Whether Would Like/Has Seriously Considered Private Insurance	
	Would Like	Has Seriously Considered
Total	58	29
Male	56	28
Female	60	30
Under 30	56	26
Age 30-49	69	42
Age 50-64	61	34
Age 65+	43	10
Dublin City/County	62	34
Elsewhere in Ireland	56	27
Married/Cohabiting	65	38
Divorced/Separated	66	27
Widowed	35	11
Never Married	55	25
No Children	53	24
One Child	73	42
Two Children	62	36
Three or More Children	75	47

Per cent responding in the affirmative.

Those most likely to have seriously considered health insurance are adults in the 30 to 49 age group (42 per cent), married people (38 per cent), those with dependent children (47 per cent of those with three or more children), the full-time employed (40 per cent), those unable to work because of illness or disability (47 per cent) and those with Third Level education (43 per cent).

Adults with a health problem are also more likely than average to have considered health insurance (35 per cent).

Table 6.20: Whether Would Like Private Insurance and Has Ever Considered Taking out Private Insurance, Among those Not Insured, by Socio-Economic Characteristics of Adults

	Whether Would Like/has Seriously Considered Private Insurance	
	Would Like	Has Seriously Considered
Total	58	29
Full-time Employed	60	40
Part-time Employed	76	34
Unemployed	56	17
Retired	43	13
Full-time Training or Education	65	14
Domestic Duties	53	23
Ill/Disabled	55	47
Primary Education Only	52	22
Junior Cycle	57	33
Leaving Certificate	64	32
Third Level etc.	71	43
Under £200	50	19
£200 to £334	68	38
£335 to £449	56	34
£450 and over	58	30
S/e or farmer	56	30
Professional/Managerial	69	31
Other Non-manual	71	42
Skilled Manual	58	31
Unskilled Manual	50	20

Per cent responding in the affirmative.

Table 6.21: Whether Would Like Private Insurance and Has Ever Considered Taking out Private Insurance, Among those Not Insured, by Health Characteristics of Adults

	Whether Would Like/has Seriously Considered Private Insurance	
	Would Like	Has Seriously Considered
Total	58	29
No Health Problem	57	27
Health Problem	60	35
Very Good	53	26
Good	61	30
Adequate	60	31
Bad or Very Bad	63	35
GMS	52	22
Not Covered	64	36
No Hospitalisation	58	28
Private Patient	66	39
Public Patient	55	33

Per cent responding in the affirmative. Among the uninsured, number who were hospitalised as private patients in the previous year is very small (36 cases).

Those in households with income in the bottom quartile are unlikely to have considered health insurance (19 per cent). However, if anything, the proportion who considered health insurance seems to decline as we move from the second lowest to the highest household income quartile. This may be because those in the higher-income households who really wanted health insurance have already taken it out, since they could more easily afford it. For those at the bottom of the income distribution, the decision may be quickly made as well, since they would have the greatest difficulty in affording it and are more likely to be eligible for cover as GMS members. The decision is most difficult, then, for those with incomes in the intermediate ranges and it is here that we find the highest proportion of the non-insured who claim they seriously considered taking out health insurance.

In the first half of this section we examined the main concerns of the insured in deciding whether to give up insurance. We presented them with a set of four health care items and asked which would be of most concern: the quality of care, the choice of consultant, the possible length of wait for treatment or the non-medical amenities. We presented a parallel set of items to *those without health insurance*, but this time asked which would be the main reason for seriously considering taking out health insurance. The items were presented to all of the uninsured, not just those who said they had seriously considered taking out health insurance.

Table 6.22: Among the Non-Insured, What Would be the Main Reason for Seriously Considering Private Insurance, by Demographic Characteristics of Adults

	Main Reason for Considering Private Insurance (Row %)			
	Quality of Care	Choice of Consultant	Length of Wait	Non-Medical Amenities
Total	19	5	74	2
Male	20	4	75	2
Female	19	6	74	1
Under 30	25	4	69	2
Age 30-49	16	6	76	1
Age 50-64	20	5	74	1
Age 65+	16	3	80	1
Dublin City/County	18	6	73	3
Elsewhere in Ireland	20	4	75	1
Married/Cohabiting	18	6	75	1
Divorced/Separated	25	8	66	1
Widowed	18	2	78	2
Never Married	21	4	73	2
No Children	20	4	75	1
One Child	20	7	71	2
Two Children	15	7	74	4
Three or More Children	21	4	72	2

Table 6.23: Among the Non-Insured, What Would be the Main Reason for Seriously Considering Private Insurance, by Socio-Economic Characteristics of Adults

	Main Reason for Considering Private Insurance (Row %)			
	Quality of Care	Choice of Consultant	Length of Wait	Non-Medical Amenities
Total	19	5	74	2
Full-time Employed	20	5	74	1
Part-time Employed	17	10	73	1
Unemployed	27	3	70	0
Retired	17	3	78	2
Full-time Training/Education	29	1	65	6
Domestic Duties	17	4	77	2
Ill/Disabled	11	5	84	0
Primary Only	16	6	76	1
Junior Cycle	21	3	73	3
Leaving Certificate	23	5	72	1
Third Level etc.	20	3	76	1
Under £200	18	5	76	2
£200 to £334	20	5	74	0
£335 to £449	20	6	73	1
£450 and Over	21	1	73	5
S/e or farmer	22	6	72	0
Professional/Managerial	20	2	75	2
Other Non-manual	17	5	75	3
Skilled Manual	24	4	70	2
Unskilled Manual	14	4	80	2

Table 6.24: Among the Non-Insured, What Would be the Main Reason for Seriously Considering Private Insurance, by Health Characteristics of Adults

	Main Reason for Considering Private Insurance (Row %)			
	Quality of Care	Choice of Consultant	Length of Wait	Non-Medical Amenities
Total	19	5	74	2
No Health Problem	21	5	73	1
Health Problem	14	4	79	3
Very Good	21	4	73	1
Good	20	5	74	1
Adequate	17	5	76	2
Bad or Very Bad	13	5	76	6
GMS	19	3	76	2
Not Covered	20	6	73	1
No Hospitalisation	20	4	74	2
Private Patient	29	5	66	0
Public Patient	15	7	77	1

Among the uninsured, number who were hospitalised as private patients in the previous year is very small (36 cases).

Overall, the responses reflected a very similar pattern of priorities: concerns about the length of wait for treatment were dominant (identified as the main reason by 74 per cent), with the quality of care a distant second (19 per cent). The choice of consultant and non-medical amenities would be the

main reason for considering health insurance by only 5 per cent and 2 per cent respectively.

Again, we find that concerns about waiting times tend to be more salient for older respondents (80 per cent of those over age 65) and those with a health problem (79 per cent). Among the non-insured, however, part-time workers do not stand out as being more concerned than average about length of wait, unlike their insured counterparts.

Given the concern with waiting times, it is worth asking how the uninsured would respond to an increase in waiting times for hospital treatment. This would give a good indication of whether the non-insured have any room to manoeuvre within their current income and other constraints. How likely is it that the uninsured would buy private health insurance if waiting times for treatment in public hospitals got longer, given their current income and the current cost of health insurance? This is the next question we put to the respondents without health insurance: "If waiting times for the public health system were to get longer in the future, do you think that that, of itself, would make you much more likely to buy private health insurance (given your current income and current cost of insurance)?"

Table 6.25: Likelihood of Buying Private Insurance If Waiting Times Got Longer, Given Current Income and Current Cost of Insurance, by Demographic Characteristics of Adults

	If Waiting Times Longer, How Likely Buy Private Insurance? (Row Percentages)			
	Very Likely	Likely	Unlikely	Not At All
Total	14	26	38	22
Male	13	30	37	20
Female	15	23	39	24
Under 30	16	37	34	13
Age 30-49	19	31	34	16
Age 50-64	15	23	41	21
Age 65+	1	7	47	44
Dublin City/County	21	30	29	20
Elsewhere in Ireland	11	25	42	23
Married/Cohabiting	14	27	37	22
Divorced/Separated	28	13	35	24
Widowed	4	7	47	43
Never Married	15	31	37	17
No Children	12	25	38	25
One Child	22	31	36	11
Two Children	12	25	40	23
Three or More Children	22	33	35	11

Table 6.25 shows that 14 per cent would be very likely to take out health insurance, a further 26 per cent would be likely to do so, 33 per cent would be unlikely to take out health insurance and 22 per cent would not be at all likely to do so. In all, 60 per cent would be unlikely to respond by taking out health insurance.

The differences among groups in the likelihood of buying health insurance point to the complexity of the factors behind the decision on whether to buy health insurance. First, we might expect that those most likely to respond by taking out health insurance would be the higher-income groups. From Table 6.26, it is not at all clear that this is the case. Those in the lowest income households would indeed be least likely to take out health insurance, but there is certainly not a linear relationship between household income and the proportion "very likely" to buy insurance. On the other hand,

when we consider those "very likely" and those "likely" to buy insurance together, the pattern approaches the one we would expect to see, although still not in a linear fashion. Combining "very likely" and "likely", we see that those in households in the top two quartiles are more inclined to respond by buying insurance (56-57 per cent), while those in the second-lowest quartile occupy an intermediate position (49 per cent).

Table 6.26: Likelihood of Buying Private Insurance If Waiting Times Got Longer, Given Current Income and Current Cost of Insurance, by Demographic Characteristics of Adults

	If Waiting Times Longer, How Likely Buy Private Insurance? (Row Percentages)			
	Very Likely	Likely	Unlikely	Not At All
Full-time Employed	18	37	33	11
Part-time Employed	22	29	34	15
Unemployed	6	25	42	26
Retired	4	14	44	38
Full-time Training or Education	13	27	35	25
Domestic Duties	9	16	44	31
Ill/Disabled	22	11	39	28
Primary Education Only	9	13	44	34
Junior Cycle	13	37	34	17
Leaving Certificate	16	37	36	11
Third Level etc.	35	33	25	7
Under £200	7	12	44	37
£200 to £334	17	32	39	13
£335 to £449	22	34	29	15
£450 and Over	15	42	33	10
S/e or farmer	11	29	30	30
Professional/managerial	24	30	32	13
Other Non-manual	20	30	35	16
Skilled Manual	16	30	37	18
Unskilled Manual	8	19	48	25

Second, we might expect those with a health problem to be more likely to respond by buying health insurance, but those with no health problem are in fact more likely to do so (42 per cent very likely or likely compared to 32 per cent of those with a health problem).

The complexity of the patterns here point to the importance of a number of different factors: ability to afford insurance (itself influenced not only by income but by number of dependants), and perceived need for it (affected by health status, perceptions of the relative quality of care in the public and private systems, and whether the person already has GMS coverage). These complexities can only be adequately captured in a multivariate analysis, which is beyond the scope of the present report.

The final set of tables in this section asks what is the maximum weekly amount that the non-insured would be willing and able to pay for health insurance. The most striking finding in these tables is that the majority (58 per cent) of the uninsured are unwilling or unable to pay anything for health insurance. This increases to three-quarters of those in the lowest income quartile and GMS members, and over 80 per cent of those over age 65.

Table 6.27: Likelihood of Buying Private Insurance If Waiting Times Got Longer, Given Current Income and Current Cost of Insurance, by Demographic Characteristics of Adults

	If Waiting Times Longer, How Likely Buy Private Insurance? (Row Percentages)			
	Very Likely	Likely	Unlikely	Not At All
No Health Problem	14	28	38	20
Health Problem	12	20	38	30
Very Good	15	33	37	14
Good	13	22	38	27
Adequate	12	23	41	24
Bad or Very Bad	16	18	33	33
GMS	8	17	46	29
Not Covered	19	35	31	15
No Hospitalisation	13	26	39	22
Private Patient	17	13	51	19
Public Patient	17	28	32	23

Note: Among the uninsured, number who were hospitalised as private patients in the previous year is very small (36 cases).

Table 6.28: Among the Non-Insured, Maximum Weekly Amount Willing and Able to Pay for Private Insurance, by Demographic Characteristics of Adults

	Maximum Weekly Amount Willing and Able to Pay for Private Insurance (Row Percentages)				
	£0	£1-£5	£6-£10	£11-£20	£21+
Total	58	12	12	5	13
Male	57	11	13	6	14
Female	58	13	12	4	12
Under 30	46	15	18	5	16
Age 30-49	49	11	16	9	15
Age 50-64	58	17	11	3	11
Age 65+	85	4	2	0	9
Dublin City/County	49	20	15	6	10
Elsewhere in Ireland	61	9	11	5	14
Married/Cohabiting	54	11	14	6	15
Divorced/Separated	57	12	14	6	11
Widowed	83	5	3	0	9
Never Married	55	15	13	4	12
No Children	60	13	11	3	13
One Child	47	13	18	7	15
Two Children	54	10	15	7	14
Three or more Children	51	6	10	18	15

One in eight is willing and able to pay between £1 and £5 per week, with a similar proportion willing and able to pay £6 to £10 per week. Five per cent would pay £11 to £20 per week, the median amount for those currently insured. Just over one in eight would pay £21 or more per week. One fifth of those with Third Level education would pay over £20 per week, but only 13 per cent of those in the highest household income quartile would do so.

Table 6.29: Among the Non-Insured, Maximum Weekly Amount Willing and Able to Pay for Private Insurance, by Socio-Economic Characteristics of Adults

	Maximum Weekly Amount Willing and Able to Pay for Private Insurance (Row Percentages)				
	£0	£1-£5	£6-£10	£11-£20	£21+
Total	58	12	12	5	13
Full-time Employed	38	16	21	8	17
Part-time Employed	52	15	14	3	16
Unemployed	74	7	5	4	11
Retired	78	8	4	1	9
Full-time Training or Education	72	4	9	6	9
Domestic Duties	72	8	6	2	11
Ill/Disabled	67	23	7	3	0
Primary Education Only	74	8	7	1	10
Junior Cycle	51	16	12	7	14
Leaving Certificate	46	14	18	7	15
Third Level etc.	32	15	23	10	20
Under £200	77	8	5	1	9
£200 to £334	50	12	16	5	16
£335 to £449	46	10	18	10	16
£450 and Over	38	26	17	6	13
S/e or farmer	57	11	14	5	13
Professional/managerial	49	12	17	7	14
Other Non-manual	45	22	15	7	11
Skilled Manual	54	12	14	6	14
Unskilled Manual	70	9	7	1	13

Table 6.30: Among the Non-Insured, Maximum Weekly Amount Willing and Able to Pay for Private Insurance, by Health Characteristics of Adults

	Maximum Weekly Amount Willing and Able to Pay for Private Insurance (Row Percentages)				
	£0	£1-£5	£6-£10	£11-£20	£21+
Total	58	12	12	5	13
No Health Problem	56	11	14	5	14
Health Problem	65	16	7	4	8
Very Good	47	15	14	6	17
Good	64	8	14	4	10
Adequate	61	14	9	5	11
Bad or Very Bad	72	16	6	0	5
GMS	75	9	5	2	8
Not Covered	41	15	19	7	17
No Hospitalisation	57	11	13	5	14
Private Patient	74	13	4	1	8
Public Patient	56	18	13	4	9

Note: Among the uninsured, number who were hospitalised as private patients in the previous year is very small (36 cases).

In fact, nearly 40 per cent of those in the top household income quartile would not be willing to pay for health insurance. For this group, it is not a matter of being able to afford health insurance, but of perceiving it to be bad value for money, or not needed: we saw earlier that over half felt it was too

expensive and nearly 30 per cent felt they were not likely to need it (Table 6.17). While the avoidance of large medical bills is rated as a very important reason for having health insurance by a majority of this group (Table 6.14), concern about the ability to meet such bills is likely to be less pressing for those in the highest income households.

6.3 Summary

In this section, we examined in detail the views for and against having private health insurance on the part of both the insured and the uninsured. We found that both groups were very similar in terms of their priorities and concerns: avoiding large medical bills and ensuring timely treatment were the most important reason for having health insurance. Among the health-related reasons for having insurance, concerns about the length of wait for treatment in the public health system emerged as the main factor over twice as often as concerns about the quality of care available in that sector per se.

Among the non-insured, the cost of health insurance emerged as a very important reason for not having insurance for about two thirds of respondents, while just under one third were satisfied with the public health system. Perceptions that health insurance is "too expensive" are likely to be linked to notions of "value for money" as well as to affordability per se. This is evident in the fact that over half of the non-insured in the highest income quartile regard insurance as too expensive.

Altogether, over half of the non-insured would not be willing or able to pay for health insurance. Only one in five would be willing or able to pay amounts at or above the median amount actually paid at present by those who are insured. Nearly two out of five of the non-insured in the highest income quartile are unwilling to pay for health insurance, and only about one fifth are willing and able to pay more than $10 per week. This group can better afford the financial risk of illness: they are in a better position than those with fewer resources to pay directly for private health care if they should need it. Their willingness to buy private health insurance, then, is likely to be strongly influenced by the perceived "value for money" that it provides. It is not that they have a more positive view of the public health system than their insured counterparts: separate breakdowns showed that while 33 per cent of those with insurance in the top income category rated the public health system positively ("very good or good"), 28 per cent of the noninsured in the same income category did no.

Although length of wait was the health-related factor of greatest concern, most of the non-insured would be unlikely to buy health insurance even if the length of wait for public hospital treatment were to grow longer. For many of them, the main issue is likely to centre on the affordability of health insurance.

7. IMPROVING AND FUNDING THE PUBLIC HEALTH SYSTEM

This chapter examines views on funding improvements in the Public Health system, in particular to put its waiting lists in line with those of the Private Health system.

7.1 Views on Funding Improvements in Public Health

There is a high degree of support for increased funding to improve the quality of the public health system in Ireland. Overall, as shown in Table 7.1, 96 per cent of respondents say they would be in favour of the government taking steps to put the waiting lists for public hospital beds in line with those for private beds, and 95 per cent favour substantially increasing the amount it spends on the public health system to reduce waiting times and improve service. There are only small differences between groups in this respect: the large majority across all categories favours increased Government spending in order to improve the quality of the public health system.

Table 7.1: Whether (1) it is Important for Government to Reduce Public Waiting Lists and (2) Spend More to Improve Public Health, by Demographic Characteristics of Adults

	Should the Government . . .	
	Put Public Waiting Lists in Line with Private	Spend more on Public Health to Reduce Wait and Improve Service
Total	96	95
Male	96	94
Female	96	95
Under 30	94	95
Age 30-49	97	96
Age 50-64	98	96
Age 65+	95	92
Dublin City/County	97	95
Elsewhere in Ireland	96	95
Married/cohabiting	97	96
Divorced/separated	97	93
Widowed	95	92
Never married	94	94
No children	95	94
One child	99	97
Two children	97	97
Three or more children	98	97

Table 7.2: Whether (1) it is Important for Government to Reduce Public Waiting Lists and (2) Spend More to Improve Public Health, by Socio-Economic Characteristics of Adults

	Should the Government . . .	
	Put Public Waiting Lists in Line with Private	Spend More on Public Health to Reduce Wait and Improve Service
Full-Time Employed	96	95
Part-Time Employed	94	97
Unemployed	98	94
Retired	94	92
Full-time Training or Education	93	93
Domestic Duties	97	96
Ill/Disabled	100	89
Primary Education Only	96	93
Junior Cycle	96	97
Leaving Certificate	96	94
Third Level etc.	96	96
Under £200	97	95
£200 to £334	96	96
£335 to £449	95	95
£450 and over	96	94
S/e or farmer	95	94
Professional/Managerial	95	95
Other Non-manual	97	96
Skilled Manual	98	95
Unskilled Manual	94	93

Table 7.3: Whether (1) it is Important for Government to Reduce Public Waiting Lists and (2) Spend More to Improve Public Health, by Health Characteristics of Adults .

	Should the Government . . .	
	Put Public Waiting Lists in Line with Private	Spend More on Public Health to Reduce Wait and Improve Service
No Health problem	96	95
Health problem	98	96
Very good	95	95
Good	96	95
Adequate	97	95
Bad or very bad	98	99
GMS	97	94
Private Insurance	96	95
Not covered	96	95
No hospitalisation	96	95
Private patient	94	95
Public patient	97	96

There is a good deal less unanimity when it comes to how such increased spending should be funded (Tables 7.4 to 7.6). The items are not mutually exclusive, since respondents had the option of saying "yes" to any or all of them.

The question wording was:

"How do you think that this increase in expenditure should be funded?

Increases in income taxes;

Reduction in Government spending in infrastructure, roads etc.;

Reduction in Government spending in areas of social support such as education, social welfare etc.;

Compulsory private medical insurance for those over a certain income;

Other (specify)".

Table 7.4: Views on How Improvements in Public Health Should be Funded by Demographic Characteristics of Adults

	Increase Taxes	Reduce Infra-Structure	Reduce Social Support	Compulsory Private Medical Insurance	Other
Total	24	20	9	52	38
Male	25	17	9	52	38
Female	23	24	10	51	37
Under 30	26	26	11	49	33
Age 30-49	23	20	8	52	42
Age 50-64	23	19	9	52	40
Age 65+	22	12	8	58	33
Dublin City/County	29	25	12	53	36
Elsewhere in Ireland	21	18	8	51	38
Married/cohabiting	21	19	8	54	43
Divorced/separated	35	24	5	41	36
Widowed	22	15	6	50	25
Never married	27	23	11	50	32
No children	24	20	9	52	35
One child	23	24	8	53	45
Two children	22	20	8	48	43
Three or more children	22	21	10	54	41

About a quarter would favour an increase in taxes while a fifth would favour a reduction in government spending on infrastructure. Fewer than one in ten would favour a reduction in government spending in areas of social support such as education and social welfare. About half would favour raising money for the public health system by the introduction of compulsory private medical insurance for those over certain income. Over a third would favour funding through some other mechanism. Differences among the groups in terms of the proportion in favour of each strategy are relatively small.

Table 7.5: Views on How Improvements in Public Health Should be Funded by Socio-Economic Characteristics of Adults

	Increase Taxes	Reduce Infra-Structure	Reduce Social Support	Compulsory Private Medical Insurance	Other
Full-Time Employed	24	18	9	49	40
Part-Time Employed	27	27	9	48	40
Unemployed	35	24	6	60	37
Retired	21	14	8	51	40
Full-time Training or Education	30	32	13	50	23
Domestic Duties	18	20	7	56	37
Ill/Disabled	36	13	23	67	31
Primary Education Only	21	19	8	55	34
Junior Cycle	26	21	7	52	41
Leaving Certificate	24	23	10	51	37
Third Level etc.	25	18	12	46	40
Under £200	22	20	7	53	33
£200 to £334	24	22	9	56	38
£335 to £449	22	19	10	44	36
£450 and over	27	20	11	53	43
S/e or farmer	26	16	8	50	42
Professional/Managerial	24	22	10	50	40
Other Non-manual	25	22	12	47	39
Skilled Manual	21	21	8	57	30
Unskilled Manual	24	21	9	53	39

Table 7.6: Views on How Improvements in Public Health Should be Funded by Health Characteristics of Adults

	Increase Taxes	Reduce Infra-structure	Reduce Social Support	Compulsory Private Medical Insurance	Other
No Health problem	23	21	10	50	36
Health problem	28	19	6	60	45
Very good	22	19	10	48	36
Good	24	23	9	54	40
Adequate	28	19	6	56	38
Bad or very bad	34	24	18	61	35
GMS	24	23	9	54	34
Private Insurance	24	17	10	49	40
Not covered	24	23	8	53	37
No hospitalisation	24	19	8	52	38
Private patient	25	28	14	51	31
Public patient	23	28	13	54	43

Per cent in favour of measure.

As Table 7.7 shows, the most common among these "other" mechanisms are suggestions that improvements be funded by means of the present government surplus, by using funds from the National Lottery, by improvements in the efficiency with which government funds are used and distributed or by reducing TD salaries and expenses.

Table 7.7: Breakdown of "Other" Views on Funding Improvements in Public Health Services

	Total Column %
From Government surplus	26
Lottery funding	18
Improved government efficiency	11
Reduce TD salaries	10
From existing government funds	8
Increase health service efficiency	4
Special taxes (e.g. alcohol)	3
Reduce spending on tribunals	3
Reduce funding for sport	1
Other source	8
Unspecified	9

Note: Per cent of those who suggest some other method of funding.

Tables 7.8 to 7.10 are based on a slightly different question: "In general, do you think that it should be compulsory for everyone above a certain income bracket to have private medical insurance making appropriate exceptions and allowances for those who could not afford it?". This item is asked of all respondents, whether or not they are in favour of increased government spending on the public health system. It also differs from the earlier item in that it mentions making appropriate exceptions and allowances for those who could not afford it.

About three-fifths of respondents overall would be in favour of compulsory private medical insurance under these conditions. There are some differences among the groups in terms of the level of support, mainly related to social group, with the lowest level of support among the professional and managerial social group (49 per cent) and the highest level of support among those in the skilled and unskilled manual social groups (68 to 70 per cent). It is particularly interesting that the level of support for compulsory medical insurance for those above a certain income is slightly higher among those with *no health coverage* than among the *privately insured* (63 per cent and 58 per cent, respectively). This may be related to differences between these two groups in household income: the level of support for compulsory private insurance drops from 67 to 55-56 per cent between the two lowest and the two highest income groups. In none of the groups however, does the level of support fall much below one-half.

Table 7.8: Whether Private Health Insurance Should be Compulsory for those on Higher Incomes by Demographic Characteristics of Adults

	Compulsory Pvt. Insurance, General
Total	62
Male	63
Female	61
Under 30	57
Age 30-49	62
Age 50-64	64
Age 65+	67
Dublin City/County	57
Elsewhere in Ireland	64
Married/cohabiting	63
Divorced/separated	63
Widowed	66
Never married	59
No children	62
One child	57
Two children	64
Three or more children	66

Per cent in favour of measure.

Table 7.9: Whether Private Health Insurance Should be Compulsory for those on Higher Incomes by Socio-Economic Characteristics of Adults

	Compulsory Pvt. Insurance, General
Full-Time Employed	60
Part-Time Employed	68
Unemployed	65
Retired	63
Full-time Training or Education	53
Domestic Duties	67
Ill/Disabled	59
Primary Education Only	67
Junior Cycle	64
Leaving Certificate	59
Third Level etc.	53
Under £200	67
£200 to £334	67
£335 to £449	55
£450 and over	56
S/e or farmer	62
Professional/Managerial	49
Other Non-manual	56
Skilled Manual	70
Unskilled Manual	68

Per cent in favour of measure.

Table 7.10: Whether Private Health Insurance Should be Compulsory for those on Higher Incomes by Health Characteristics of Adults

	Compulsory Pvt. Insurance, General
No Health problem	60
Health problem	72
Very good	59
Good	62
Adequate	67
Bad or very bad	73
GMS	65
Private Insurance	58
Not covered	63
No hospitalisation	61
Private patient	65
Public patient	69

Per cent in favour of measure.

The idea of compulsory medical insurance, then, does have considerable, although by no means unanimous, support in the population. However, the ten percentage point difference between the percentages in favour in Tables 7.4 and 7.8, suggest that (a) there may be some reservations as to whether the income from such insurance should be used to improve the public health system, and/or (b) the level of support for such a proposal would be increased to the extent that adequate allowances could be made for those who might have difficulty in paying for it.

8. SUMMARY

This report has focused on perceptions: perceptions of the relative quality of care available in the public and private systems in Ireland and perceptions of the advantages of health insurance. While, as noted in the first chapter, perceptions do not necessarily provide an accurate reflection of reality, they are important in their own right for two reasons. First, perceptions of the quality of care in the public system are likely to be a central determinant of the demand for private health insurance. Second, those same perceptions have important implications for the peace of mind of those who cannot afford private medical insurance, particularly as they grow older and where they develop health problems.

In this final chapter we draw together the main findings in order to provide an overview of perceptions of public and private health care in Ireland.

8.1 Health Status

In Chapter 2 we examined the health status of the adult population. There is a clear deterioration in the average health self-rating with age, and an increase in the incidence of health problems. When age is controlled,

- there is little difference between men and women in the incidence of health problems;
- there is a regional difference, with Dubliners reporting health problems less frequently than residents of other parts of the country;
- those who are unemployed, retired, engaged on home duties and, to a lesser extent, the part-time employed report health problems more often than the full-time employed;
- differences in the incidence of health problems by level of education are less clear, but those with Leaving Certificate or higher report health problems less often than those with Junior Cycle or lower levels of education;
- clear differences remain in the incidence of health problems by level of household income, with the incidence of health problems falling as income rises;
- in terms of social group, those in the Professional/Managerial social group tend to experience health problems least often, while those in the Unskilled Manual social group experience health problems most often.

8.2 Health Coverage

- Just under one-third of adults are GMS members, 45 per cent are covered by private medical insurance or a workplace health plan, 6 per cent have a hospital cash plan, and about one in four have no medical coverage. There is some overlap between the types of coverage: a small proportion of the population (about 4 per cent) have both private and Medical Card coverage, and two-thirds of those with a hospital cash plan also have private medical insurance.
- GMS members tend to be older and are more likely to have health problems than non-GMS members.

- Those with no coverage are concentrated in the under 30 age group, and are slightly more likely than those with private medical insurance to have a health problem.
- The analysis by type of private health insurance showed that 85 per cent of those covered are VHI members, 8 per cent are covered by BUPA-Ireland and 7 per cent are covered by other, mainly-work-based, schemes.
- Differences in the client-base of VHI and BUPA-Ireland reflect the relatively recent entry of BUPA-Ireland into the market, and the fact that people are slow to change health coverage. Members of BUPA-Ireland tend to be younger (nearly half are under age 30). As a consequence, BUPA members are somewhat less likely than VHI members to have health problems and a higher percentage (63 compared to 53 per cent) rate their health as "very good". Members of the other schemes (typically work-based schemes) fall in between VHI and BUPA members in terms of age distribution and health status.

8.3 Consumption of Health Services

- About one adult in eight had spent at least one night in hospital in the previous twelve months. Over half of these had been hospitalised as public patients.
- Hospitalisation was more common among older adults (nearly one in five of those over 65), and particularly among those with a health problem (just under one-third).
- As we might expect, because they tend to be older and more likely to have health problems, GMS members were more likely to have visited a general practitioner in the previous year, and to have a higher number of visits than those covered by PMI or the uninsured.
- GMS members were also more likely than others to have been hospitalised (18 per cent compared to 12 per cent of those with private insurance and 10 per cent of those not covered). Of those hospitalised, GMS members were likely to have had longer stays (a mean of 16.5 nights and a median of 10 nights, compared to 9.2 and 5, respectively, for the PMI group).
- Among those who had been hospitalised in the previous year, 9 per cent of GMS members had to wait 6 months or more, compared to 2 per cent of PMI members and 4 per cent of those not covered by insurance. However, since a small number of the uninsured had very long waits, the average wait was the same (6 weeks) for GMS members and those with no health coverage, while the average was 4 weeks for the privately insured.
- The average wait for day surgery and outpatient treatment was also longer for GMS patients than for those with private insurance. Two per cent of those with no health coverage had waiting times of over one year for outpatient treatment.
- Seven per cent of GMS members were currently waiting for a hospital bed, compared to 2 and 3 per cent, respectively, of the privately insured and those with no health-coverage. The median length of time for those waiting was 16 weeks for GMS members, compared to 14 weeks for those with no cover and 8 weeks for those with private insurance.

8.4 Perceptions of Public and Private Health Systems

- There is considerable criticism of the overall quality of care in the public health system, with fewer than half of respondents giving it a positive rating.
- However, the strongest criticism comes from those least likely to have direct experience of the public health system: those in the Professional and Managerial social group and those with private health insurance. It is

unclear whether this reflects lack of information or differences in expectations. The fact that older respondents and those with health problems also give a higher rating to the quality of care in the private health system suggests that differences in expectations play at least some role.

- Nevertheless, two out of every five persons hospitalised as public patients in the previous twelve months rate the overall quality of care in the public system as no more than "adequate".
- The particular aspects of quality of care which are viewed most critically tend to be the waiting times for treatment (particularly in contrast to the private health system), length of stay as a public patient and the efficiency with which the public health system is run. The quality of medical care in the public system is viewed more favourably, receiving a positive rating from more than half of the respondents.
- Perceptions of the private health system are consistently more positive. Four out of five respondents give a positive rating to the overall quality of care in the private health system, and nearly two-thirds believe that the quality of care is better on the private than on the public system. Almost nine out of ten believe that hospital treatment can be obtained more quickly as a private patient.

8.5 Perceptions of Insurance

- The insured and the non-insured were very similar in terms of their priorities and concerns: avoiding large medical bills and ensuring timely treatment were the most important reason for having health insurance. Among the health-related reasons for having insurance, concerns about the length of wait for treatment in the public health system, rather than the quality of care available, emerged as the dominant factor.
- Among the non-insured, two-thirds pointed to the cost of health insurance as a very important reason for not having insurance, while just under one-third identified satisfaction with the public health system as a very important reason. Perceptions that health insurance is "too expensive" are likely to be linked to notions of "value for money" as well as to affordability *per se*. This is evident in the fact that over half of the uninsured in the highest income quartile regard insurance as "too expensive".
- Altogether, over half of the non-insured would not be willing or able to pay for health insurance. Only one in five would be willing or able to pay amounts at or above the median amount actually paid at present by those who are insured. Nearly two out of five of the non-insured in the highest income quartile are unwilling to pay for health insurance, and only about one fifth are willing and able to pay more than $10 per week. This group can better afford the financial risk of illness: they are in a better position than those with fewer resources to pay directly for private health care if they should need it. Their willingness to buy private health insurance, then, is likely to be strongly influenced by the perceived "value for money" that it provides.
- Although length of wait was the health-related factor of greatest concern, most of the non-insured would be unlikely to buy health insurance even if the length of wait for public hospital treatment were to grow longer. For many of them, the main issue is likely to centre on affordability of health insurance.

8.6 Views on Funding Improvements in Public Health

- The overwhelming majority of respondents would favour increased government spending to reduce waiting times and improve the quality of the service provided in the public health system.
- Slightly more than half of those in favour of increased funding would support the introduction of compulsory private medical insurance for those over a certain income as a means of financing improvements in the public system. About one-quarter would support a tax increase and one-fifth would favour a reduction in spending on infrastructure. Fewer than one in ten would favour a reduction in government spending on social support as a means of increasing funding for the health services.
- There are indications that support for compulsory private insurance would be greater (by about 10 percentage points) if "appropriate exceptions and allowances" were made for those who could not afford it. A separate item on the introduction of compulsory private health insurance for those above a certain income bracket (not explicitly linked to funding for public health) suggested that three out of five of the respondents would be in favour of it, in principle.

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Appendix A

Sample Weights

APPENDIX A: SAMPLE WEIGHTS

Appendix Table A: Population and Sample Distribution of Key Characteristics and Effect of Sample Weights

	A	B	C	D	E	F	G	H
	Population	Pop. %	Unweighted Sample	Sample %	D-B	Weighted Sample	Sample %	G-B
Number adults								
One	356,799	12%	495	17%		362,710	13%	0.2%
Two	1,265,570	44%	1,460	49%		1,266,001	44%	0.0%
Three	585,999	20%	556	19%		584,925	20%	0.0%
Four	381,784	13%	309	10%		380,458	13%	0.0%
Five	153,010	5%	111	4%		152,350	5%	0.0%
Six or more	139,538	5%	66	2%		136,256	5%	-0.1%
Location								
Dublin	872,968	30%	1,053	35%		875,751	30%	0.1%
Elsewhere	2,009,732	70%	1,944	65%		2,006,949	70%	-0.1%
Women								
Married, <30	52,900	2%	61	2%		52,664	2%	0.0%
Single, <30	390,900	14%	204	7%		386,446	13%	-0.2%
Married, 30-64	582,300	20%	877	29%		580,336	20%	-0.1%
Single, 30-64	112,000	4%	126	4%		111,604	4%	0.0%
Widowed, <65	33,400	1%	67	2%		33,506	1%	0.0%
Married, 65+	84,900	3%	89	3%		87,637	3%	0.1%
Single, 65+	32,800	1%	35	1%		33,585	1%	0.0%
Widowed, 65+	120,300	4%	163	5%		124,940	4%	0.2%
Separated /Divorced, all ages	58,500	2%	61	2%		58,525	2%	0.0%
Men								
Married, <30	31,000	1%	38	1%		30,862	1%	0.0%
Single, <30	424,400	15%	219	7%		422,506	15%	-0.1%
Married, 30-64	579,300	20%	616	21%		576,715	20%	-0.1%
Single, 30-64	154,700	5%	170	6%		154,010	5%	0.0%
Widowed, <65	12,000	0%	17	1%		11,946	0%	0.0%
Married, 65+	113,800	4%	128	4%		116,155	4%	0.1%
Single,65+	36,200	1%	30	1%		36,329	1%	0.0%
Widowed,65+	28,800	1%	56	2%		30,006	1%	0.0%
Separated /Divorced, all ages	34,500	1%	40	1%		34,929	1%	0.0%

Appendix Table A (Continued)

	A	B	C	D	E	F	G	H
	Population	Pop. %	Unweighted Sample	Sample %	D-B	Weighted Sample	Sample %	G-B
Women								
At work	625,612	22%	710	24%		623,143	22%	-0.1%
Unemployed	35,626	1%	49	2%		35,618	1%	0.0%
In Education	156,162	5%	76	3%		155,465	5%	0.0%
Home Duties	565,499	20%	636	21%		565,145	20%	0.0%
Retired	61,618	2%	205	7%		69,203	2%	0.3%
Ill/Disabled	23,483	1%	7	0%		20,669	1%	-0.1%
Men								
At work	951,811	33%	861	29%		948,011	33%	-0.1%
Unemployed	80,724	3%	72	2%		80,411	3%	0.0%
In Education	139,393	5%	89	3%		138,771	5%	0.0%
Home Duties	8,835	0%	6	0%		8,796	0%	0.0%
Retired	184,439	6%	272	9%		188,192	7%	0.1%
Ill/Disabled	49,498	2%	14	0%		49,277	2%	0.0%
Women-Education								
Primary, <65	244,484	8%	171	6%		243,393	8%	0%
Junior Cycle, <65	277,323	10%	279	9%		273,376	9%	0%
Leaving Cert,<65	447,887	16%	378	13%		448,644	16%	0%
Third Level,<65	255,659	9%	563	19%		255,557	9%	0%
Primary, 65+	236,788	8%	137	5%		232,976	8%	0%
Junior Cycle, 65+	1,884	0%	50	2%		4,797	0%	0%
Leaving Cert, 65+	2,516	0%	52	2%		5,424	0%	0%
Third Level,65+	1,459	0%	53	2%		5,076	0%	0%
Men-Education								
Primary, <65	273,544	9%	150	5%		272,323	9%	0%
Junior Cycle, <65	380,392	13%	228	8%		378,695	13%	0%
Leaving Cert,<65	346,463	12%	340	11%		349,774	12%	0%
Third Level,<65	230,534	8%	375	13%		229,505	8%	0%
Primary, 65+	178,522	6%	117	4%		172,868	6%	0%
Junior Cycle, 65+	1,985	0%	36	1%		3,574	0%	0%
Leaving Cert, 65+	1,836	0%	25	1%		2,600	0%	0%
Third Level,65+	1,424	0%	43	1%		4,118	0%	0%
Health Cover								
GMS Member	884,100	31%	840	28%		887,125	31%	0.1%
VHI, BUPA	1,259,664	44%	1,611	54%		1,298,733	45%	1.4%

Note: Population figures are estimates of number of adults covered by VHI and BUPA in 2000. Sample figures include all insured (including other work-based schemes). The numbers on health insurance were not explicitly included as a control total in the weighting procedure.

Appendix B

Questionnaire

SURVEY ON PERCEPTIONS OF THE HEALTH SERVICES

– Supplement to Consumer Survey, August 2000

Area Code ☐☐☐ **Respondent Code**_____ **Interviewer Number**_____

I would now like to ask you some questions about your health, about how you feel, and so on.

S.1 **In general, how good would you say your health is?: Would you say it is:**

Very good ..... ❑1 Good ..... ❑2 Fair ..... ❑3 Bad ..... ❑4 Very bad ..... ❑5

S.2 **Please specify the nature of any chronic, physical or mental health problem, illness or disability which you may have? Please describe as fully as possible.** None ..... ❑0 _____

_____

S.3 **Are you currently covered by a medical card, either in your own name or covered on someone else's card?**

Card in own name ..... ❑1 Covered on someone else's card ..... ❑2 Not covered ..... ❑3

S.4 On whose card? Spouse ..... ❑1 Parents ..... ❑2 Other ..... ❑3 (specify) _____

S.5 **In general, how would you describe the total level of care received in the PUBLIC Health system, in Ireland, in terms of QUALITY OF CARE. Would you say it is:**

Very good ..... ❑1 Good ..... ❑2 Adequate ..... ❑3 Bad ..... ❑4 Very bad ..... ❑5

S.6 **In general, how would you describe the total level of care received in the PRIVATE Health system in terms of QUALITY OF CARE. Would you say it is:**

Very good ..... ❑1 Good ..... ❑2 Adequate ..... ❑3 Bad ..... ❑4 Very bad ..... ❑5

S.7 **I'm going to read out 4 statements about aspects of care in the PUBLIC Health system. For each item I would like you to tell me whether you think the PUBLIC Health system is Very Good; Good; Adequate; Bad; Very Bad.**

	Very Good	*Good*	*Adequate*	*Bad*	*Very Bad*
a) Quality of medical care received as a Public patient	❑1	❑2	❑3	❑4	❑5
b) Length of stay, given your condition, as a Public patient	❑1	❑2	❑3	❑4	❑5
c) Quality of the facilities as a Public patient	❑1	❑2	❑3	❑4	❑5
d) In general, efficient running or management of medical care in the Public Hospital system	❑1	❑2	❑3	❑4	❑5

S.8 **Would you say that the Public Health system in Ireland, in general, is better, the same or worse than that in other Mainland European Countries like France, Germany, UK, Spain etc.**

Irish system is better ..... ❑1 Same ..... ❑2 Irish system is Worse ..... ❑3

S.9 **Do you have private health insurance cover through VHI, BUPA Ireland or through some other health insurance scheme? (e.g. occupational scheme, the Gardaí, Prison Officers, etc.)**

Yes ... ❑1 No ..... ❑2 → **Go to S.16**

S.10 **Are you covered by (i) VHI, (ii) BUPA Ireland or through some (iii) Other Scheme?** [Int: Tick 'Yes' or 'No' for each one in Col. S.10 of Table below]

S.11 [If Yes] **Which plan are you on?** [Int: Specify in Col. S.11 of Table below]

S.12 [If Yes] **Are you covered for: (i) hospitalisation; (ii) consultant's fees; (iii) GP visits; (iv) dental care; (v) eye exam and/or lenses.** [Int: Tick 'Yes' or 'No' in table below for each type of cover]

	(S.10)		(S.11) Plan	(S.12) Covered for:									
			Please specify	*(i) Hospitalisation*		*(ii) Consultant*		*(iii) GP Visits*		*(iv) Dental*		*(v) Eyes*	
	NO	*YES*		*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
(i) BUPA	❑2	❑1→		❑1	❑2	❑1	❑2	❑1	❑2	❑1	❑2	❑1	❑2
(ii) VHI	❑2	❑1→		❑1	❑2	❑1	❑2	❑1	❑2	❑1	❑2	❑1	❑2
(iii) Other (specify)	❑2	❑1→		❑1	❑2	❑1	❑2	❑1	❑2	❑1	❑2	❑1	❑2

S.13 **Is this private health insurance paid for (i) by you, your spouse, family etc. or (ii) by your employer?**

By resp./resp's family etc ..... ❑1 by employer ..... ❑2

S.14a What does your health insurance cost per week, per month etc. IR£ _____ per _____ (period)
[Int. Specify an amount and a reference period]

S.14b Who is covered on this insurance? [Int: Tick all that apply]

Self..... ❑1 Spouse..... ❑2 Children..... ❑3→How many _____ Other ..... ❑4 (specify) _____

S.15 Please describe your main reasons for having private medical insurance? [Int. Probe as fully as possible]

_____

S.16 Are you (also) covered under any Critical Illness or Hospital Cash Plan scheme. This would be in addition to or instead of BUPA/VHI etc. and would provide you with a cash amount for any days spent in hospital as well as cover for the cost of the hospital stay itself.

Covered under Critical Illness Cash Plan Scheme ..... ❑1

Not covered under critical illness/ Cash Plan Scheme ..... ❑2→**Go to S.24**

S.17 Is this instead of or in addition to BUPA Ireland/VHI?

Instead of ..... ❑1 In addition to ..... ❑2

S.18 Why did you decide to take out the critical illness/hospital cash plan scheme. Describe as fully as possible.

_____

_____

S.19 Do you feel this hospital cash plan or critical illness scheme gives: (a) better quality of care; (b) better choice of care; (c) better value of money than insurance under VHI and/or BUPA Ireland?

(a) better quality of care	Yes..... ❑1	No..... ❑2
(b) better choice of care	Yes..... ❑1	No..... ❑2
(c) better value for money	Yes..... ❑1	No..... ❑2

S.20 What is the premium per week/month/year for this Hospital Cash Plan cover? IR£ _____ per _____ (period)
[Int. Specify an amount AND a reference period]

S.21 Who is covered on this insurance:?: [Int: Tick all that apply]

Self..... ❑1 Spouse..... ❑2 Children..... ❑3→How many _____ Other ..... ❑4 (specify) _____

S.22 How many days in hospital are you covered for under this scheme? _____ days in hospital.

S.23 Please describe your main reasons for having cover under a Critical Illness or Hospital Cash Plan scheme [Int. Probe as fully as possible]

_____

_____

S.24 I'm going to read out a number of reasons for having private health insurance cover either BUPA Ireland, VHI, or with Critical illness cover. In respect of each could you please tell me whether or not you think each is: Very Important; Quite Important Neither Important nor Unimportant or Not At All Important as a reason for having private medical insurance.

	Very Important	*Quite Important*	*Neither Important Nor Unimportant*	*Not At All Important*
a) **Being able to have a private or semi-private room in hospital**	❑1	❑2	❑3	❑4
b) **Being able to choose your own consultant**	❑1	❑2	❑3	❑4
c) **Being sure of getting into hospital quickly when you need treatment**	❑1	❑2	❑3	❑4
d) **Being sure of getting good treatment in hospital**	❑1	❑2	❑3	❑4
e) **Being able to get a private bed in a hospital**	❑1	❑2	❑3	❑4
f) **Being sure of getting consultant care**	❑1	❑2	❑3	❑4
g) **Being able to arrange hospital treatment for when it suits you**	❑1	❑2	❑3	❑4
h) **Avoid large medical or hospital bills**	❑1	❑2	❑3	❑4
i) **Other (specify)** _____	❑1	❑2	❑3	❑4

S.24a Int: Transfer code from S.9 on page 1 to here: 1 (Yes at S.9)→ Go to S.25
2 (No at S.9) → Go to S.27

S.25 Given the price of your current health insurance do you regard your health insurance cover as

Quite Cheap..... ❑1 Good Value..... ❑2 Expensive..... ❑3 Very Expensive..... ❑4 Close to Unaffordable..... ❑5

S.26 **In making the choice as to whether or not you would give up private health insurance if the premium were increased which one of the following would concern you MOST about having to rely on the public hospital system.** [Int. Tick ONE only. Which would concern respondent *MOST*].

Quality of care ..... ❑1	Choice of Consultant ..... ❑2	Possible length of time waiting for treatment ..... ❑3	Level of non medical amenities such as privacy, semi-private room etc..... ❑4

NOW GO TO S.34

S.27 **Please describe your main reasons for not having private medical health insurance?** [Int. Please probe as fully as possible] _____

_____

S.28 **I am going to read out 3 reasons for not having private medical health insurance. In respect of each could you please tell me whether or not you think it is: Very Important; Quite Important; Neither Important nor Unimportant or Not at all important.**

	Very Important	*Quite Important*	*Neither Important Nor Unimportant*	*Not at all Important*
a) I'm not likely to need it	❑1	❑2	❑3	❑4
b) It's too expensive	❑1	❑2	❑3	❑4
c) I'm satisfied with the healthcare I receive as a public patient	❑1	❑2	❑3	❑4

S.29 **Would you like to be covered by private medical health insurance?** Yes..... ❑1 No..... ❑2

S.30 **Have you ever seriously considered taking out private health insurance?** Yes..... ❑1 No..... ❑2

S.31 **What would be your MAIN reason for seriously considering taking out private health insurance.**
[Int Tick ONE only]

Quality of care ..... ❑1	Choice of Consultant ..... ❑2	Possible length of time waiting for treatment ..... ❑3	Level of non medical amenities such as privacy semi-private room etc..... ❑4

S.32 **What would be the maximum amount per week you could afford and would be willing to pay for private health insurance?**

Nothing/Zero..... ❑0 Other Amount per week (specify) IR£ _____ per week

S.33 **If waiting times for the public health system were to get longer in the future, do you think that that, of itself, would make you much more likely to buy private health insurance (given your current income and current cost of insurance)?**

Very likely ..... ❑1 Likely ..... ❑2 Unlikely ..... ❑3 Not at all..... ❑4

[INT: ALL RESPONDENTS FROM HERE]

S.34 **Do you yourself personally know any family, friends or neighbours who have recently had to wait more than 3 months; 6 months; 1 years for important hospital treatment?**

(a) 3 Months wait Yes .... ❑1 No ..... ❑2 **(b) 6 Months wait** Yes.... ❑1 No..... ❑2 **(c) 1 yrs wait** Yes .... ❑1 No...

S.35 **Do you think waiting times for treatment in public hospitals are longer now than 3 years ago?**

Yes, longer now ..... ❑1 No..... ❑2 Don't know ..... ❑3

S.36 **Suppose you needed hospital treatment. Do you think you could get it MORE QUICKLY (a) on the private health system (b) the public health system or (c) it would make no difference to the time taken to received the treatment.**

More quickly if on private health system..... ❑1
More quickly on public health system..... ❑2
No difference..... ❑3

S.37 **Again, suppose you needed hospital treatment. Do you think that the QUALITY OF CARE received would be better (a) on the private health system (b) on the public health system or (c) it would make no difference to the quality of care received.**

Better on private health system..... ❑1
Better on a public health system..... ❑2
No difference..... ❑3

S.38 **How many nights have you spent in hospital during the last 12 months on your own behalf (include all hospitals, - general, geriatric, psychiatric).**

_____ nights None ..... ❑$_0$ → Go to S.42

S.39 **How many separate admissions did this cover?** _____ admissions

S.40 **How many of these nights were as a private patient?** _____nights

How many of these nights were in a Health Board or Voluntary Hospital in a:

Private room (1 bed) _____nights **Public ward (5+ beds)** _____nights

Semi-private room (2-4 beds) _____nights **TOTAL** _____ nights
[Int. Check this adds to number of nights at S.40]

S.41 **How long did you have to wait for admission for stays in hospital in the last 12 months. If admitted on more than one occasion please give the average of periods spent waiting for admission. Exclude any admissions related to previous treatment.**

_____weeks

S.42 **Are you currently on a waiting list for in-patient treatment?** Yes .... ❑$_1$ → **For how long?** _____weeks No ..... ❑$_2$

S.43 **How many visits to the casualty department of a hospital have you made on your own behalf in the last 12 months?**

None..... ❑$_0$ _____visits

S.44 **How many visits have you made on your own behalf in the last 12 months to an outpatient clinic?**

None..... ❑$_0$ → Go to S.46 _____visits

S.45 **How long did you have to wait to get this outpatient treatment? Please include time spent before you actually saw the consultant.**

_____weeks or _____months or _____years

S.46 **How many visits to a hospital have you made on your own behalf in the last 12 months for day surgery?**

None..... ❑$_0$ _____visits

S.47 **Did you have to go on a waiting list to get this day surgery?**

Yes ..... ❑$_1$ **For how long?** _____ weeks No..... ❑$_2$

S.48 **Approximately how many visits on your own behalf have you made to your GP or has your GP made to you in your home during the last 12 months?**

None..... ❑$_0$ _____visits

S.49 **In principle, do you think that it would be important for the government to develop the Public Health System to put its waiting lists in line with the Private Hospital System.**

Yes ..... ❑$_1$ No..... ❑$_2$

S.50 **Suppose the Government planned to substantially increase the amount it spends on the Public Health System to reduce waiting times and improve the service it provides. Would you be in favour of such a scheme?**

Yes, in favour..... ❑$_1$ No, not in favour..... ❑$_2$

S.51 **How do you think that this increase in expenditure should be funded?**	Yes	No	
Increases in income taxes	❑$_1$	❑$_2$	
Reduction in Government spending in infrastructure, roads etc	❑$_1$	❑$_2$	If yes: in which areas? _____
Reduction in Government spending in areas of social support such as education, social welfare etc	❑$_1$	❑$_2$	If yes: in which areas? _____
Compulsory private medical insurance for those over a certain income	❑$_1$	❑$_2$	
Other (specify)_____	❑$_1$	❑$_2$	

S.52 **In general, do you think that it should be compulsory for everyone above a certain income bracket to have private medical insurance making appropriate exceptions and allowances for those who could not afford it?**

Yes ..... ❑$_1$ No..... ❑$_2$

S.53 **Finally, perhaps you could tell me whether or not either you or a member of your family for whom you are responsible has been in hospital in the last year for :**

(a) Psychiatric care/treatment Yes ❑$_1$ No ❑$_2$
(b) Mental handicap Yes ❑$_1$ No ❑$_2$

Finally, I would like to ask you a few short questions about yourself.

S.54 Sex of respondent Male..... ❑1 Female ..... ❑2

S.55 Respondent's Age Group:

16 – 19 yrs	❑1	50 – 59 yrs	❑5
20 – 29 yrs	❑2	60 – 64 yrs	❑6
30 – 39 yrs	❑3	65+	❑7
40 – 49 yrs	❑4	Don't Know	❑8

S.56 Size of Household: (Include the respondent. Exclude children living permanently outside the household.)
Number of household members:

Aged under 18 _____ b) Aged 18 or more _____

S.57 Which of the following best describes your marital status?

Married	❑1	Living with Partner	❑4
Separated	❑2	Widowed	❑5
Divorced	❑3	Never Married	❑6

S.58 Employment status. Are you .....

full-time employed	❑1	in full-time training/education	❑5
part-time employed	❑2	domestic duties/housewife	❑6
unemployed	❑3	Other	❑7
retired – living on pension/investment income	❑4		

S.59 Occupation of Respondent. What is your main occupation? If housewife, retired or unemployed, give previous occupation. If studying or training, state future occupation. If never worked write 'NEVER WORKED' (Write full title and tick appropriate box below)

_____

_____

Full-time employed (not farmer)	❑1	unskilled manual worker	❑6
Farmer (self-employed)	❑2	Never worked	❑7
Professional/Senior Managerial	❑3	Other	❑8
Other non-manual worker	❑4	Don't know	❑9
Skilled manual worker	❑5		

S.60 Are you the main earner in this household?

Yes ..... ❑1 ⇨go to S.62 No ..... ❑2 ⇨go to S.61

S.61 Occupation of Main Earner. What is the occupation of the main earner in the household? If retired or unemployed give previous occupation. If never worked write 'NEVER WORKED' (Write full title and tick appropriate box below)

_____

_____

Full-time employed (not farmer)	❑1	unskilled manual worker	❑6
Farmer (self-employed)	❑2	Never worked	❑7
Professional/Senior Managerial	❑3	Other	❑8
Other non-manual worker	❑4	Don't know	❑9
Skilled manual worker	❑5		

S.62 What is the highest level of education which you have completed?

Primary level..... □1
Group, Inter, Junior Cert..... □2
Leaving Cert or equivalent .....□3

Other Second Level

(nursing, agricultural, commercial college etc.) ..... □4

Third level

University, college of Technology, art college, teacher training, professional qualifications etc. ..... □5

S.63 How many dependent children do you have under the age of 18 years who are currently living with you?

_____ dependent children

S.64 Finally could I ask about the approximate level of net household income? This means the total income, after tax, PRSI and other statutory deductions, of all members of the household. It includes all types of income: income from employment, social welfare payments, rents, interest, pensions etc. We would just like to know which of four broad groups the total income of your household falls into. Perhaps you'd tell me into which of the four groups (A,B,C,D) your household falls. I'd like to assure you once again that all information you give me is entirely confidential. [Int: circle A,B, C or D as appropriate]

	Per week	Per Month	Per Year	
A.	Under £130	Under £559	Under £6,750	□1 Go to S.65A
B.	£130 - £219	£560 - £950	£6,751 - £11,380	□2 Go to S.65B
C.	£220 - £359	£951 - £1,555	£11,381 - £18,649	□3 Go to S.65C
D.	£360 or more	£1,556 or more	£18,650 or more	□4 Go to S:65D

S.65A If under £130 per week: Could you tell me whether or not this was approximately in the range of:

Under £50 per week ..... □1 £50-£74 per week..... □2 £75-£99 per week .....□3 £100-£129 per week.. □4

S.65B If £130-£219 per week: Could you tell me whether or not this was approximately in the range of:

Under £149 per week ..... □1 £150-£174 per week.. □2 £175-£199 per week ..□3 £200-£219 per week.. □4

S.65C If £220-£359 per week: Could you tell me whether or not this was approximately in the range of:

Under £254 per week ..... □1 £255-£299 per week.. □2 £300-£334 per week ..□3 £335-£359 per week.. □4

S.65D If £360+ per week: Could you tell me whether or not this was approximately in the range of:

Under £449 per week ..... □1 £450-£549 per week.. □2 £550-£649 per week .... □3 £650+ per week ..... □4

THANK-YOU VERY MUCH FOR HAVING PARTICIPATED IN THIS SURVEY

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