

# Equity in the use of physician visits in Norway. Changing patterns over time?

by

Astrid Grasdal and Karin Monstad

University of Bergen, Dept. of Economics, Hermann Foss gt.14,  
N-5007 Bergen, Norway.

Email addresses: [astrid.grasdal@econ.uib.no](mailto:astrid.grasdal@econ.uib.no), [karin.monstad@econ.uib.no](mailto:karin.monstad@econ.uib.no)

(Preliminary version! Please do not quote without permission from the authors)

## Abstract

We analyse and compare inequity in use of physician visits (GP and specialists) in Norway based on data from the Surveys of Living Conditions for the years 1998, 2002 and 2005. Within this period the Norwegian public health care system underwent two major reforms, both aimed at ensuring equitable access to health care services for the entire population. A list patient system was introduced in the primary health care sector in 2001, and in 2002 the ownership of hospitals was moved from the regional to the state level. At both care levels a real increase in public expenditures followed in the wake of the reforms. We apply the indirect standardization approach and estimate the relationship between health care use, need and other control variables by linear and nonlinear regression. We measure need standardized horizontal inequity in physician visits by concentration indexes and describe changes in inequity over time by decomposing the concentration indexes into the contribution of its determinants. Preliminary results show clear differences between use of GP and specialist services regarding both inequality and inequity. The distribution of GP visits shows little change over time. They are concentrated among the poor in all three years and the inequality is statistically highly significant. When we take into account the fact that need-predicted use vary by income, the index of horizontal inequity becomes close to zero and statistically insignificant. For specialist services pro-poor inequity in the probability of seeing a specialist in 1998 turns into statistically significant pro-rich inequity in 2002 and 2005.

## 1. Introduction

A growing number of empirical analyses, most of them comparative (van Doorslaer, Koolman and Puffer (2002), van Doorslaer, Koolman and Jones (2004), van Doorslaer et al (2004) , Bago d’Uva, Jones and van Doorslaer (2007)), but also some single country studies (Sutton (2002), etc), show that countries subscribing to a principle of equitable distribution of health care tend to succeed quite well at the primary health care level. However, when it comes to utilisation of specialist medical care, inequity in favour of the well-off tends to be more of a rule rather than the exception. Even countries with universal coverage of the populations through public insurance schemes ensuring access to high quality services at low or no financial cost, like Sweden and Norway, tends to exhibit pro-rich inequity in specialised medical services.

Several explanations have been offered for why, given need, rich are more likely to seek and utilize specialist help than the poor. **TBA**

While comparative analyses can exploit variation across countries in financing and delivery systems to explain differences in estimated equity indices, such analyses are often limited to the set of comparable variables available for all countries in the study. For single countries access to richer data sets usually allows for more precise estimates and additional explanations of the patterns observed. This paper presents an analysis of inequity in the use of GP and specialist care in Norway, when taking advantage of three years of cross-sectional data from the Norwegian Survey of Living Conditions (SLC). In the OECD-analyses conducted by van Doorslaer et al (2004), Norway appeared with equity in general practitioner (GP) visits but statistically significant pro-rich inequity in the probability of a specialist visit based on SLC-data from year 2000. Our aim here is i) to provide a more detailed analysis of income related inequity in doctor utilisation when exploiting a broader set of need variables in the regression of health care use, and ii) to examine changes in patterns of inequity over time by comparing estimates of equity indices across years. With highly comparable data for the years 1998, 2002 and 2005 we can study the presence and development of need standardised inequalities health care services during a period when two major reforms were implemented in the health care sector to improve accessibility to services. In the primary health care sector a list patient system was established in June 2001 in order to improve GP accessibility, strengthen the stability of the patient-doctor relationship and thus, facilitating equity in the use of health care services. In the sector for

specialised medical care a major reform of ownership and organisation of hospitals was implemented in January 2002. In both sectors activity and expenditures increased considerable in the years after the reforms.

Our analysis cannot be seen as an impact evaluation of the effect on equity of any of the two reforms. Both the close timing of the implementation of the reforms and the fact that in addition, a market for private health insurance has been established and rapidly growing during the period of our study, prevent isolation of the impact each of these changes has had on the development of equity in the use of health care services.

In what follows we first present a brief review of literature contributing to the understanding of the patient-doctor relationship and the demand for health services in section 2. In section 3 we describe the Norwegian health care system. Section 4 presents the data underlying our analysis. The analysis and the results are presented in section 5, while a summary and a discussion of main results in section 6 concludes the paper.

## **2. Demand for physician services**

**TBA**

## **3. The Norwegian health care system**

The Norwegian health care system is characterised by tax-financed public provision and universal coverage. The system aims to serve the population with high quality health services independently of whether they live in urban areas or in the more remote and thinly settled parts of the country.<sup>1</sup>

The responsibility of the provision of health services is since 2002 divided between the central government and the local municipalities. The central government, represented by the Ministry of Health, is in charge of the overall regulation, administration, and supervision of health care activities. As owner of the vast majority of central and regional hospitals, the central government is also responsible for the delivery of hospital services and treatment. Before 2002, the public hospitals were owned by the 19 regional counties. The funding was three-tiered with i) the county councils providing the bulk of financing by local tax proceeds and block grants from the central government with a proportion of the block grant being activity based,<sup>2</sup> ii) reimbursement from the National Insurance System for ambulatory (outpatient) care and from the education authority for teaching services and iii) earmarked grants provided by the central government targeted at specific activities. When the state took over ownership of public hospitals in 2002, five Regional Health Enterprises (RHE) were established, each reporting to the Ministry of health and responsible for delivering health services in their regions.<sup>3</sup> The RHEs own the local “health trusts” and are responsible for monitoring their costs and quality of services. The central Government decided to keep the main principles of the reimbursement system, with block grants from the central government, an increasing part of this being activity based, and additional reimbursements from the NIA and the educational authority as before. The state is not obliged to balance the RHE-budgets ex post, but the Minister of Health stand surety for the hospitals in the event of bankruptcy.

---

<sup>1</sup> A description of the organization and performance of the Norwegian health care sector is presented OECD Economic Surveys: Norway, OECD 2005.

<sup>2</sup> Activity/DRG based funding of hospital services was introduced in 1997.

<sup>3</sup> Hagen and Kaarboe present a detailed description of the reform.

In the wake of the 2002-reform most health trusts centralise administrative functions and many specialize in specific treatments, though with some scope of competition as health trust can compete with each other for patients which in principle are free in their choice of provider. Kjerstad (2003) shows that activity based funding has led to increased activity both in terms of number of patients treated and production of Diagnosis Related Group (DRG) points, though DEA-analysis by Biorn et al (2003) reveal that this has not been cost efficient. Hagen and Kaarboe (2006) report that that the waiting lists were shortened considerably and waiting times reduced by 20% during the first two years after the reform in 2002.

Primary health care is the responsibility of the municipalities. Most general practitioners (GPs) are self-employed on a fee-for-service basis. The fees are partly paid by patients themselves (co-payment), partly by the National Insurance Scheme and by the municipality. Before the Regular General Practitioner (RGP) Scheme was introduced in June 2001 the contribution from the municipality used to be a practice allowance depending on the number of auxiliaries, but with the reform this was replaced by a capitation component depending on list size. Approximately 30% of the income earned by GPs is expected to come from capitation and the rest from the fee-for-service. Some small municipalities have employed rather than contracted GPs, while some of the large municipalities also have GPs in private practices outside the patient list system. Both prior to and after the RGP-scheme was introduced GPs serve as gatekeepers in the sense that patients must see a GP in order to be referred to a specialist or to elective hospital treatment. Specialist health care services are provided by the public hospitals, in-patient or out-patient, and by private, self employed medical specialists or clinics serving the regional RHEs based on contracted agreements about provision and funding of services.

As pointed out by van Doorslaer et al (2004), private health insurance may be an important contributor to inequities in health care utilisation. They find pro-rich contribution of private health insurance, in particular for specialist health care utilisation in France, Ireland, and the Unites States. In 1998 private health insurance was virtually non-existent in Norway. Since then, a growing number of private insurance companies are offering supplementary private health insurance that guarantees specialist examination and treatment shortly after referral from a GP. From 2002 to 2005 the number of insured increased from...

#### 4. Data

The data we use are from the Norwegian Surveys of Living Conditions (SLC). Since 1996, but except 1999, Statistics Norway (SN) has conducted annual, theme rotating cross sectional surveys. The main sample for the SLC is 5000 persons aged 16 + drawn according to SN's general sampling plan (institutionalised are excluded). In some years additional, externally funded samples are drawn. Data regarding working and housing conditions, health, leisure, living conditions in general, and the theme rotating topics are collected through a combination of personal interviews and postal questionnaires. In addition, data is merged with administrative records with information regarding income, social insurance benefits, education and additional demographics.

In 1998, 2002 and 2005 health and use of health care services was given particular attention in the SLCs. In all three years respondents were asked about the number of times they had consulted a GP/medical specialist. The questions used are two-fold; i) Have you, during the past 12 months, due to your own health condition, consulted a GP? And, if so, ii) how many times during the last 12 months have you consulted a GP? For medical specialists there are separate questions for poly-clinical consultations in hospital/out-patient clinic and consultations with private specialist/clinic. Regrettably, in 1998 information about the number of specialist consultations is incomplete as one only asked if, and not for the number of specialist consultations in hospital poly-clinic/out-patient clinic. Our chosen outcome variables available for all three years are therefore 1) the dichotomous for having consulted a GP, 2) the continuous number of GP-visits and 3) the dichotomous for having consulted a medical specialist. (In 2002 and 2005 we can also analyse inequity in number of consultations with a medical specialist (TBA)).

For the need standardisation of utilisation we include, in addition to age and gender dummies, measures of health based on responses to the question on self-assessed health status as either very good, good, neither good nor bad, poor or very poor, and responses to two questions regarding presence of any chronic physical or mental health condition and, if so, the degree of limitation in daily activities due to this. We also include a variable counting the number of conditions respondents report that they have when presented with a list of 50 different diseases and health problems. In addition to this we follow van Doorslaer et al (2004) and include variables not directly related to need or health status, but

still relevant for the utilisation of health care services. Here educational level, marital status and country of origin are expected to affect efficiency of health production and the propensity to seek care, while activity status and region of residence are expected to affect the time price of health care use. In the Norwegian setting, region of residence is also assumed to capture differences in access to medical services, as many medical specialist services are located in urban areas and in the capitol and surrounding areas in particular.

The response rate in the SLC's main samples is stable at around 70 percent, with the main reason for non-response being refusal to participate. After excluding observations with missing data on one or more variables except educational level, we are left with 3310 observations in 1998, 3358 in 2002 and 3369 in 2005. As immigrants typically are overrepresented among respondents with missing data on education we decided to keep these observations in the sample and control for this in the regression analyses by including a dummy for missing data on education. Means and standard deviations for dependent variables and covariates in all three samples/years are listed in Table 1. For utilisation of physician services we see that 70-74 percent of the respondents have consulted a GP at least once during the last 12 months, whereas the corresponding number for specialist has decreased from 36 percent in 1998 to 32 percent in 2005. The average number of consultation with a GP has increased from 2.51 in 1998 to 2.88 in 2002 and 2.85 in 2005. Comparison of sample proportions for the need- and non-need variables across years confirms that the three different samples are comparable with regard to observable characteristics. This supports our assumption that changing inequity indices over time reflect real changes in patterns of behaviour rather than differences in sampling or collection of data.

5. Analysis

6. Discussion



## References

Biorn, E., Hagen, T.P., Iversen, T and J. Magnussen: The effect of activity based financing on hospital efficiency: a panel data analysis of DEA-efficiency scores 1992-2000. *Health Care Management Science*, 2003, 6, 271-73.

*Evaluering av fastlegereformen 2001-2005*. English summary, Norges Forskningsråd, 2005.

Hagen, T.P. and O.Kaarboe: The Norwegian hospital reform of 2002: central Government takes over ownership of public hospitals. *Health Policy*, 2006, 76 (3), 320-333.

Kjerstad, E.: Prospective funding of General Hospitals in Norway – Incentives for Higher Production? *International Journal for Health Care Finance and Economics*, 2003, 3, 231-251.

Nerland, S.M. and T.P.Hagen: Forbruk av spesialisthelsetjenester. *Tidsskrift for Samfunnsforskning*, 2008, 49 (1), 37-71.

O'Donnell, O., van Doorslaer, E., Wagstaff, A., and M. Lindelow: *Analyzing Health Equity Using Household Survey Data. A guide to Techniques and their Implementation*. The World Bank, Washington DC, 2008.

OECD Economic Surveys: Norway: The performance of the Norwegian Health care sector. OECD, 2005.

van Doorslaer, E., Koolman, X. and A.M. Jones: Explaining income-related inequalities in doctor utilization in Europe. *Health Economics*, 2004, 13, 629-647.

van Doorslaer, E., C. Masseria, and the OECD Health Equity Research Group, 2004: "Income-Related Inequality in the use of Medical Care in 21 OECD-countries." *In Towards High-Performing Health Systems: Policy Studies*, ed. OECD Health Project, 109-66, Paris: OECD.

## 1. Means of dependent variables and covariates

Variable	1998 (n=3310)		2002 (n=3358)		2005 (n=3369)	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Number of GP visits	2.506	3.894	2.876	4.166	2.847	4.468
Probability of GP visit	0.711	0.453	0.742	0.437	0.710	0.454
Probability of specialist visit	0.359	0.480	0.342	0.474	0.321	0.467
log of household income, 2005 value	12.130	0.775	12.271	0.516	12.328	0.634
<i>Dummy variables:</i>						
sah very good	0.367	0.482	0.337	0.473	0.379	0.485
sah good	0.443	0.497	0.477	0.500	0.442	0.497
sah neither good nor bad	0.129	0.335	0.125	0.331	0.119	0.324
sah bad	0.051	0.220	0.051	0.220	0.050	0.218
sah very bad	0.010	0.098	0.010	0.099	0.011	0.103
no chronic disease	0.624	0.484	0.621	0.485	0.634	0.482
chronic disease, no limitations	0.035	0.185	0.051	0.220	0.044	0.205
chronic disease, some limitations	0.250	0.433	0.240	0.427	0.231	0.421
chronic disease, severe limitations	0.091	0.287	0.088	0.283	0.091	0.288
>0 of 50 specific diagnosis	0.662	1.136	0.562	1.150	0.555	1.134
overweight	0.076	0.265	0.090	0.287	0.101	0.301
male, age 16-29	0.117	0.321	0.108	0.311	0.116	0.320
male, age 30-44	0.147	0.354	0.144	0.352	0.144	0.351
male, age 45-59	0.123	0.328	0.143	0.350	0.133	0.340
male, age 60-69	0.050	0.218	0.054	0.227	0.060	0.237
female, age 70 and above	0.049	0.216	0.051	0.219	0.054	0.226
female, age 16-29	0.119	0.324	0.110	0.313	0.110	0.313
female, age 30-44	0.156	0.363	0.141	0.348	0.141	0.348
female, age 45-59	0.124	0.329	0.124	0.330	0.127	0.333
female, age 60-69	0.049	0.216	0.058	0.234	0.062	0.241
female, age 70 and above	0.066	0.249	0.065	0.246	0.054	0.227
highest education is primary	0.209	0.407	0.160	0.367	0.151	0.358
highest education is <3 years secondary	0.231	0.422	0.295	0.456	0.273	0.446
highest education is 3 years secondary	0.385	0.487	0.274	0.446	0.280	0.449
highest education is above secondary	0.121	0.326	0.257	0.437	0.256	0.437
missing data on education	0.054	0.227	0.014	0.119	0.039	0.193
region 1 (capitol and surroundings))	0.205	0.404	0.211	0.408	0.218	0.413
region 2(eastern except capitol area)	0.274	0.446	0.267	0.442	0.280	0.449
region 3 (south-west)	0.141	0.348	0.149	0.356	0.129	0.335
region 4 (west)	0.182	0.386	0.171	0.377	0.182	0.386
region 5 (middle)	0.095	0.294	0.099	0.299	0.088	0.283
region 6 (north)	0.102	0.302	0.103	0.304	0.103	0.304
single	0.215	0.411	0.208	0.406	0.238	0.426
married	0.516	0.500	0.518	0.500	0.473	0.499
cohabitating	0.147	0.354	0.154	0.361	0.165	0.372
divorced	0.058	0.234	0.064	0.245	0.067	0.251
widow_er	0.064	0.245	0.056	0.230	0.056	0.230

working  $\geq 30$  hours a week                      0.501    0.500    0.516    0.500    0.492    0.500

---

Table 1. Means of dependent variables and covariates, cont.

	Mean	Std. Dev.	Mean	Mean	Std. Dev.	Mean
disabled	0.057	0.232	0.075	0.264	0.079	0.269
student	0.090	0.286	0.122	0.328	0.140	0.347
doing military service	0.007	0.085	0.004	0.062	0.002	0.042
parttime	0.113	0.316	0.088	0.283	0.088	0.284
retired	0.060	0.238	0.149	0.356	0.146	0.353
inactive	0.172	0.377	0.045	0.207	0.053	0.224
student or doing military service	0.097	0.296	0.126	0.332	0.142	0.349
country of origin is Norway	0.945	0.228	0.939	0.239	0.923	0.267
country of origin is Europe except Norway	0.035	0.183	0.035	0.183	0.045	0.208
country of origin is outside of Europe	0.020	0.141	0.026	0.159	0.032	0.177

## 2. Inequality and inequity in the use of doctor services

	No. of visits to GP			Prob. of GP visit			Prob. of specialist visit		
	Inequality	Inequity		Inequality	Inequity		Inequality	Inequity	
		ols	count		ols	probit		ols	probit
1998 (n=3310)	0.0342	0.0036	-0.0055	0.0191	0.0054	0.0057	-0.0096	<b>-0.0245</b>	<b>-0.0247</b>
<i>t-value</i>	2.42	0.28	-0.41	2.96	0.88	0.92	-0.71	-1.89	-1.91
2002 (n=3358)	-0.0545	0.0094	0.0189	-0.0210	0.0011	0.0020	-0.0035	<b>0.0304</b>	<b>0.0312</b>
<i>t-value</i>	-3.78	0.74	1.47	-3.49	0.20	0.35	-0.25	2.31	2.37
2005 (n=3369)	-0.0553	-0.0002	0.0078	-0.0112	0.0047	0.0053	-0.0088	<b>0.0250</b>	<b>0.0251</b>
<i>t-value</i>	-3.35	-0.02	0.50	-1.74	0.78	0.88	-0.62	1.88	1.89

The table shows, for each year and outcome, concentration indices for use of health services, with t-values below. Inequality is measured by the unstandardized concentration index. Inequity is measured by the need-standardized index, where "need" is defined by age, gender and several health indicators, while also controlling for non-need variables. Standard errors are adjusted for autocorrelation and heteroscedasticity. The count data model used is negbin II. Statistically significant HI indices in bold (P<0.10).

## 3. Robustness: Inequity in the use of doctor services

	No. of visits to GP			Prob. of GP visit			Prob. of specialist visit		
	OLS	Negbin II		OLS	Probit		OLS	Probit	
		at mean	at median		at mean	at median		at mean	at median
1998 (n=3310)	0.0036	0.0007	0.0150	0.0054	0.0037	-0.0006	-0.0245	0.0253	-0.0245
2002 (n=3358)	0.0094	0.0226	-0.0056	0.0011	0.0013	0.0086	0.0304	0.0327	0.0270
2005 (n=3369)	0.0002	0.0106	-0.0266	0.0047	0.0056	0.0118	0.0250	0.0270	0.0139

The table shows need-standardized concentration indices from decomposition. For non-linear models, indices are based on partial effects that are estimated at mean or median values of the covariates, respectively. "Need" is defined by age, gender and several health indicators. Horizontal inequity index estimated by OLS is shown for comparison.

#### 4. Probability of specialist visit - partial effects after probit

	1998			2002			2005		
	dF/dx	P> z	x-bar	dF/dx	P> z	x-bar	dF/dx	P> z	x-bar
sah2	0.038	0.058	0.443	0.049	0.015	0.477	0.103	0.000	0.442
sah3	0.077	0.013	0.129	0.164	0.000	0.125	0.176	0.000	0.119
sah45	0.155	0.001	0.061	0.178	0.000	0.061	0.243	0.000	0.061
limit1	0.132	0.006	0.035	0.074	0.062	0.051	0.155	0.000	0.044
limit2	0.185	0.000	0.250	0.166	0.000	0.240	0.167	0.000	0.231
limit3	0.226	0.000	0.091	0.204	0.000	0.088	0.246	0.000	0.091
kort1	0.037	0.000	0.662	0.038	0.000	0.562	0.032	0.000	0.555
m30_44	-0.002	0.967	0.147	-0.035	0.355	0.144	0.019	0.613	0.144
m45_59	-0.022	0.593	0.123	0.009	0.832	0.143	0.039	0.349	0.133
m60_69	0.049	0.363	0.050	0.080	0.124	0.054	0.042	0.405	0.060
m70	0.083	0.176	0.049	0.008	0.907	0.051	0.110	0.091	0.054
f29	0.153	0.000	0.119	-0.009	0.813	0.110	0.059	0.115	0.110
f30_44	0.132	0.001	0.156	-0.009	0.823	0.141	0.080	0.044	0.141
f45_59	0.142	0.001	0.124	0.066	0.136	0.124	0.104	0.017	0.127
f60_69	0.015	0.784	0.049	0.095	0.077	0.058	0.136	0.011	0.062
f70	0.032	0.588	0.066	0.002	0.980	0.065	0.095	0.160	0.054
disabled	-0.042	0.270	0.057	-0.003	0.929	0.075	0.036	0.327	0.079
studmil	0.001	0.967	0.097	0.026	0.428	0.126	-0.006	0.848	0.142
parttime	-0.052	0.073	0.113	0.049	0.137	0.088	0.015	0.630	0.088
retired	-0.002	0.969	0.060	0.078	0.087	0.149	0.042	0.325	0.146
inactive	-0.034	0.283	0.172	-0.043	0.325	0.045	0.016	0.674	0.053
second1	-0.003	0.905	0.231	0.025	0.350	0.295	0.030	0.276	0.273
second2	-0.020	0.410	0.385	0.086	0.004	0.274	0.055	0.060	0.280
highedu	-0.039	0.217	0.121	0.073	0.016	0.257	0.060	0.047	0.256
edumiss	-0.062	0.152	0.054	-0.013	0.875	0.014	0.059	0.277	0.039
r2	-0.082	0.001	0.274	-0.047	0.054	0.267	0.014	0.565	0.280
r3	-0.079	0.006	0.141	-0.066	0.018	0.149	-0.027	0.349	0.129
r4	-0.090	0.001	0.182	-0.010	0.713	0.171	0.024	0.365	0.182
r5	-0.047	0.149	0.095	-0.085	0.007	0.099	-0.026	0.431	0.088
r6	-0.082	0.009	0.102	-0.076	0.014	0.103	-0.026	0.401	0.103
married	0.088	0.003	0.516	0.055	0.059	0.518	-0.010	0.704	0.473
cohab	0.073	0.024	0.147	0.035	0.257	0.154	0.025	0.392	0.165
divorced	0.038	0.403	0.058	0.043	0.325	0.064	0.014	0.714	0.067
widow_er	0.009	0.861	0.064	0.017	0.734	0.056	-0.080	0.077	0.056
b_europe	0.062	0.205	0.035	0.163	0.001	0.035	0.034	0.389	0.045
b_other	0.112	0.068	0.020	0.026	0.633	0.026	0.072	0.147	0.032
log of income	-0.008	0.471	12.130	0.030	0.119	12.271	0.009	0.547	12.328
obs. P			0.35861			0.341572			0.32087
pred. P (at x-bar)			0.348989			0.330946			0.30649
n			3310			3358			3369
Pseudo R2			0.0706			0.077			0.0907

## 5. Inequality in use of specialist services decomposed

Probability of specialist visit, inequality contributions of regressors

Covariates	1998			2002			2005		
	elasticity	CI	% Contr	elasticity	CI	% Contr	elasticity	CI	% Contr
sah2	0.047	-0.025	12.4	0.068	-0.003	5.8	0.142	-0.017	28.2
sah3	0.028	0.069	-20.0	0.060	-0.147	251.2	0.065	-0.093	69.2
sah45	0.026	0.122	-33.5	0.032	-0.308	279.8	0.046	-0.243	127.0
limit1	0.013	0.056	-7.7	0.011	0.040	-12.6	0.021	0.074	-17.9
limit2	0.129	0.045	-60.0	0.116	-0.066	219.4	0.120	-0.033	45.4
limit3	0.057	0.061	-36.3	0.052	-0.213	320.2	0.070	-0.144	114.5
kort1	0.068	0.073	-51.5	0.062	-0.083	147.7	0.056	-0.084	53.2
m30_44	-0.001	-0.093	-0.6	-0.015	0.095	40.6	0.009	0.063	-6.2
m45_59	-0.008	-0.015	-1.2	0.004	0.223	-23.1	0.016	0.238	-43.6
m60_69	0.007	0.129	-9.2	0.013	0.157	-57.7	0.008	0.176	-15.8
m70	0.011	0.161	-19.1	0.001	-0.313	10.1	0.018	-0.203	42.6
f29	0.051	0.015	-7.8	-0.003	-0.188	-15.4	0.020	-0.233	54.0
f30_44	0.057	-0.168	100.4	-0.004	0.018	1.9	0.035	-0.003	1.3
f45_59	0.049	0.021	-10.5	0.024	0.199	-136.1	0.041	0.216	-101.0
f60_69	0.002	0.188	-4.1	0.016	-0.002	0.9	0.026	0.049	-14.5
f70	0.006	0.250	-15.6	0.000	-0.476	4.2	0.016	-0.389	71.3
Disabled	-0.007	-0.336	-23.5	-0.001	-0.151	-3.2	0.009	-0.121	12.2
Studmil	0.000	-0.090	0.4	0.009	-0.255	69.2	-0.003	-0.328	-9.9
Parttime	-0.016	-0.043	-7.4	0.013	-0.058	20.9	0.004	0.016	-0.8
Retired	0.000	-0.212	-0.7	0.034	-0.350	340.2	0.019	-0.298	65.7
Inactive	-0.016	0.291	50.0	-0.006	-0.177	-28.8	0.003	-0.040	1.3
second1	-0.002	-0.038	-0.8	0.022	-0.049	30.9	0.026	-0.070	20.6
second2	-0.021	0.067	14.7	0.069	-0.004	7.6	0.048	0.013	-7.0
Higgedu	-0.013	0.251	34.5	0.055	0.248	-392.5	0.048	0.243	-133.4
Edumiss	-0.009	0.040	4.0	-0.001	-0.318	-4.8	0.007	-0.189	15.4
r2	-0.063	-0.020	-13.2	-0.037	-0.004	-4.6	0.012	-0.014	2.0
r3	-0.031	0.007	2.2	-0.029	-0.023	-18.6	-0.011	0.049	6.2
r4	-0.046	-0.025	-11.7	-0.005	-0.090	-13.0	0.014	-0.062	9.7
r5	-0.013	-0.022	-3.0	-0.025	-0.057	-40.6	-0.007	-0.086	-7.0
r6	-0.023	0.054	13.2	-0.023	-0.031	-20.4	-0.008	-0.068	-6.4
Married	0.126	-0.099	130.0	0.083	0.112	-265.3	-0.015	0.150	26.1
Cohab	0.030	-0.028	8.6	0.016	0.050	-22.8	0.013	0.075	-11.0
Divorced	0.006	0.270	-17.2	0.008	-0.164	38.3	0.003	-0.171	5.9
widow_er	0.002	0.385	-6.3	0.003	-0.390	31.0	-0.014	-0.365	-57.9
b_europe	0.006	-0.011	0.7	0.017	0.024	-11.4	0.005	-0.019	1.0
b_other	0.006	-0.254	16.7	0.002	-0.345	19.6	0.007	-0.215	17.8
log of income	-0.288	0.033	99.7	1.065	0.020	-618.2	0.329	0.023	-85.6
Residual			-26.6			-50.3			-172.7
			100.0			100.0			100.0
CI, unstandardized			-0.0096			-0.0035			-0.0088
Need-standardized CI			-0.0253			0.0327			0.0270