Combat Poverty Agency
working for the prevention and elimination of poverty

POLICY SUBMISSION

Submission to the Medical Card Review Group

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1. Introduction

The Combat Poverty Agency has a statutory responsibility to provide policy advice to the Minister for Social, Community and Family Affairs and other relevant bodies on all aspects of social and economic planning in relation to poverty. The Agency welcomes the review of the medical card[1] being undertaken by the chief executive officers of the health boards and the Eastern Regional Health Authority and the opportunity it presents to consider important issues relating to poverty and ill-health. The review is of particular relevance in the context of the National Anti-Poverty Strategy, the government policy initiative to prioritise the needs of the poor and the social excluded. Indeed, in the current revision of the strategy, health has been included as a key policy issue in tackling poverty.[2] Also framing the review is the government's new health strategy.

The review of the medical card arises from the *Programme for Prosperity and Fairness*, which states that

> *health board CEOs are examining the operation of the Medical Card Scheme and will consult with the Social Partners by the end of 2000. Particular emphasis will be placed on the needs of families with children and on removing anomalies and barriers to take up, including information deficits*.

The terms of reference for the review are as follows:

- to contribute to an enhanced and modern interpretation of medical card procedures;
- to put forward a number of recommendations relating to the processes through which decisions are made;
- to draw attention to anomalies in the medical card system;
- *to propose an interpretation of the governing legislation which reflects modern living and working conditions.*

Along with this submission, the Agency has had a formal involvement in the review through its membership of a consultative group advising on the review. In addition, the Agency has provided considerable technical assistance with the research element of the review and has hosted, with the Society of St Vincent de Paul, a roundtable discussion on the review involving a wide range of social policy organisations.[3]

This submission is informed by a number of Agency research and policy reports on the relationship between poverty and ill-health.[4] These present evidence that those who are less well off have higher mortality rates, higher levels of ill health and fewer opportunities or resources to adopt healthier lifestyles. Yet, those most in need of services are least likely to get them, a phenomenon known as the 'inverse care law'.[5]

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[1] The medical card is an instrument the General Medical Scheme (GMS), a primary healthcare intervention which confers free general practitioner care and prescribed drugs. It is a discretionary benefit administered by health boards and eligibility is usually assessed on the basis of a means test.

[2] The National Anti-Poverty Strategy is currently be reviewed, with new targets being considered in relation to child poverty, women's poverty, health, older people and housing/accommodation.

[3] A report on this event was prepared as an input to the review and is available from the Agency.

[4] See Lee & Gibney (1989) *Patterns of Food and Nutrient Intake in a Suburb of Dublin with Chronically High Unemployment* and O'Neill (1992), *Telling it like it is*. The Agency has also made submissions to the NAPS Working Group on Health and the new National Health Strategy. It has also commissioned a on-going study of the health needs of low-incomes families with children.

[5] Developed by Tudor Hart in the seventies.

The existence of a two-tier healthcare system has led to considerable difficulties, particularly for those who are disadvantaged. The Agency believes that we need to move away from this system to one which guarantees a right of access to adequate and appropriate health care services for all, regardless of ability to pay. Access to primary health care is particularly important, given its role in achieving health gain in a cost-efficient manner through prevention, health promotion and early intervention. For low-income families, the medical card is the policy instrument for accessing primary care. Hence, the importance of this review.

However, the review cannot encompass consideration of wider questions about access to healthcare, which the Agency has proposed in its submissions on the National Health Strategy and the National Anti-Poverty Strategy Working Group on Health. Here, then, we focus on identifying short-term recommendations for reform of the medical card in the context of greater access for all to primary health care. The policy priorities are then to provide medical cards to all adults and children on low-incomes and, second, to ensure that the level and quality of service provided is enhanced.[6]

The submission begins by highlighting the links between poverty and ill-health. It then identifies the key problems associated with medical card provision. The submission concludes by drawing together key recommendations for consideration in the review.

2. Links between poverty and health status

The link between poverty and health status has been well established since the publication of the seminal UK Black report in the eighties. While there is some debate about the exact causal pathways between poverty and health outcomes, it is clear that:

- poor people get sick more often and die younger than those who are better off[7]
- poverty contributes to poor health both directly e.g., damp or poor accommodation, more dangerous surroundings, and indirectly e.g., poorer diet and stress
- being poor makes it difficult to access adequate or appropriate health care where or when needed[8]
- poverty can reduce the opportunity or the motivation to adopt healthy life styles.

There are also links between income inequality and health. Research suggests that the most unhealthy societies are not necessarily those that are poorest, but those where the gap between rich and poor is greatest.[9] It is also widely accepted that the higher up the social class or income ladder you go, the better the health status you are likely to have.

Action is required to provide equitable access to adequate and appropriate health care and service regardless of ability to pay, and to target specific initiatives and

[6] Up to and including FIS

[7] For example see: Nolan, B., Socio-Economic Health Inequalities in Ireland, Paper for Southern Health Board Seminar on Health Inequalities, May 2000; *Inequalities in Health, The Black Report* edited by Peter Townsend and Nick Davidson and *The Health Divide* by Margaret Whitehead (published together in a single volume) Pelican books 1988; Mary Shaw et al*, The Widening Gap; Health Inequalities and Policy in Britain*, The Policy Press 1999.

[8] Health Inequalities and Poverty, Society of St Vincent de Paul, April 2001

[9] Wilkinson R., *Unhealthy Societies; The Affliction of Inequality*, Routledge, 1996.

investments at vulnerable groups experiencing particular problems. The fact that health inequalities reflect wider inequalities in society means that the policy response requires not just health service improvements, but a broader redistribution of income.

3. Operation of the medical card

The operation of the medical card can be assessed at two levels: eligibility and service provision.

3.1 Eligibility

3.1.1 Declining coverage

There has been a fall in recent years in the percentage of the population covered by the medical card, from 36 per cent in 1995 to 31 per cent of population in 2000. This is significantly lower than the figure identified under a 1989 agreement between the doctors and the Department of Health which stated that the GMS could be expanded to cover up to 40 per cent of the population. The key question is has this decline come about because of rising incomes and less generous income thresholds.

The 31 percent population coverage corresponds closely to the percentage of people living in households below 60 percent of average incomes. Furthermore, the percentage of the population below this line has also fallen in the 1990s, from 33.7 per cent in 1994 to 30 per cent in 1998.[10] However, this only tells one side of the story.

A second factor behind the fall in the proportion of the population covered by the GMS is because the income eligibility thresholds have not kept pace with rising incomes. For the period 1991 to 2001, the income threshold for a single person increased from £77 to £100, a 30 per cent rise. Over the same period, the allowances per dependent child under 16 increased from £13 to £18 (a rise of 28 per cent). These increases are less than income growth and are also less than changes in welfare payments over this period.

Another factor is the income disregard for adult and child dependants. For couples under 66 years, the income threshold is £144.50 compared with a threshold of £100 for a single person. This represents an equivalence scale of .44 for a couple, which is significantly less that the social welfare equivalence measure of between .6 and 7. For children, the equivalence scale is only .18, which is almost half of that operated by the social welfare system (when child benefit and child dependant allowances are combined). The medical card income thresholds thus penalise families with children.

3.1.2 Regional variation

There are some notable differences in the proportion of medical cards awarded across the health boards, with the North Western Health Board having the highest proportion of medical cards holders in 2000 (46 per cent). The smallest proportion of medical cards were awarded in the Eastern and Mid-Western Health Boards, at 26 per cent and 30 per cent respectively. The percentage of medical cards awarded in each health board has fluctuated greatly over the period from 1990 and 2000, with the North Western Health Board having a consistently high record of awards. In the absence of any objective rationale for such variation, it could be suggested that it is due to the discretionary nature of the GMS.

- GMS delivery has developed in a piecemeal manner and anomalies in the interpretation and operation of the scheme have arisen.

[10] R Layte et al (2001), *Monitoring poverty trends and exploring poverty dynamics in Ireland*, Dublin: Economic and Social Research Institute

3.1.3 Poverty Traps

The means tested nature of the GMS contributes to unemployment and poverty traps. Means tested schemes can act as a disincentive to employment, training or education when an increase in income may result in the loss of benefits. This is particularly acute with medical cards because of the sudden withdrawal of all entitlement (ie there is no tapering mechanism). Thus, for some families, an increased income due to employment may not be sufficient to off-set the loss of the medical card. This effect is highlighted in a recent review by Goodbody[11] of the disincentive effects of secondary benefits. In particular, it noted inconsistencies across health boards in regard to:

- the application of the provisions regarding retention of the medical card
- the duration of entitlement to the medical card for those taking up employment after a period in subsidised employment
- the treatment of those who take-up part-time work while retaining a partial long-term Unemployment Assistance payment.

3.1.4 Take-up

There is evidence to suggest that a significant proportion of the population do not avail of the full range of secondary benefits to which they are entitled.[12] This is explained by a number of factors, including the existence of multiple means testing. The requirement that a person be means tested for eligibility to a number of schemes acts as a deterrent against the take-up of some services. Added to this is the stigma associated with means tested schemes, especially where there are clear divisions between services for the rich and services for the poor.

The level of take-up of the service may also be affected by poor awareness of entitlements. The GMS has been strongly criticised for failing to draw attention to the full range of entitlements, as well as eligibility, retention and application criteria[13]. This has led to numerous calls to develop an active GMS promotion campaign for the public.

3.2 Service provision

3.2.1 A service for the sick

A key criticisms of the GMS is that it is concentrated on sickness rather than on achieving health gains for people who are poor. This has resulted in a narrowly focussed service which is centred around GPs rather than around the range of health care needs for medical card holders. This is reflected in the limited nature of provision where a range of important services are currently outside the scope of the GMS, including psychotherapy, counselling and other mental health interventions. In particular, certain preventative services are not available free of charge to medical card holders, e.g. cervical smear tests. This has particular consequences for women on low incomes who may not be able to afford the additional costs associated with this service[14].

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[11] See Goodbody Report to the Department of Social, Community and Family Affairs (September 1998) *The Disincentive Effects of Secondary Benefits.* Unpublished.

[12] See Cousins, M. & B. Charleton (1991) *Benefit Take-Up*. Dublin: Free Legal Advice Centres

[13] See Goodbody report to the Department of Social, Community and Family Affairs (September 1998) *The Disincentive Effects of Secondary Benefits.* Unpublished. p. 68

[14] See the Institute of Public Health (2001) *Equity of Access to Health Services: Some relevant issues in an Irish context*. Dublin: the Institute of Public Health p. 15

3.2.2 Uneven distribution of GP services

Research shows that there is a poor distribution of GP services in disadvantaged urban and rural areas.[15] It also highlights problems in relation to the quality of GP services in disadvantaged areas as well as limited access to pharmacy services. Arising from these problems, those most in need of services are generally least likely to get them.

3.2.3 Difficulties accessing services

A medical card cannot solve the problems that exist with accessing certain health services. This is because eligibility for a medical card does not mean the same as access. This is evidenced by data on waiting lists and waiting times for some medical card holders which show that in some cases people wait months or even years when seeking admission to hospital as a public patient.[16] On this issue, Mr. Kevin Callinan, IMPACT National Secretary, recently criticised the quality of health care in Ireland, describing the medical card as 'a passport to a hospital queue'.[17]

Ensuring that eligibility to a medical card implies access to healthcare requires increased investment in a primary health care infrastructure and a radical restructuring of primary health care in Ireland. As discussed above, it also requires an extension of the treatments available and the inclusion of health promotion and prevention work in the GMS.

4. Recommendations

The Agency makes a number of recommendations for reform of the medical card. These are premised on a fundamental restructuring of the primary healthcare service.

4.1 Primary healthcare services

- Develop a comprehensive community-based primary health care service, with the GMS providing access as of right for those whose needs are not being met.

In addition, the Agency proposes a number of improvements regarding eligibility, administration, service provision and future development.

4.2 Eligibility

- Put entitlement to the medical card on a statutory basis;
- Guarantee those on welfare-to-work schemes retain the medical card for three years;
- Develop clear eligibility criteria based on an official adequacy standard, with an annual uprating mechanism which reflects changes in living standards [18]
- Introduce a tapered withdrawal of the medical card for people who are slightly above the eligibility criteria;
- Introduce a transitional period of 1 year for people who exceed the eligibility criteria.

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[15] Sinclair H, Bradley, F, Murphy AW, Kelly A. *The Inverse Care Law: A Rubicon yet to be crossed? Paper presented at the Association of University Departments of General Practice* 26th Annual Scientific meeting 16-18 July 1997, Trinity College Dublin. Also, work in progress at SAHRU, Department of Community Health, Trinity College

[16] See the Institute of Public Health (2001) *Equity of Access to Health Services: Some relevant issues in an Irish context*. Dublin: the Institute of Public Health p. 11

[17] *Medical Cards for all not practical says Martin* in Irish Times 15/5/01

[18] See the Agency's submission to the adequacy benchmarking and indexation working group entitled *'How much is enough? Setting an inclusive minimum income standard*'.

4.3 General administration of the GMS

- Administer the GMS on a national basis, with locally delivery by the health boards overseen by an independent national body;
- Establish an independent appeals procedure for medical card applicants, linked to the social welfare appeals system;
- Develop an active information campaign on the GMS;
- Make resources available for the effective delivery and assessment of the GMS.

4.4 Service provision

- Restructure the content of the GMS to ensure a focus on prevention as well cure
- Broaden the scope of the GMS to include primary health care services, cervical smears, psychotherapy, counselling and other mental health interventions
- Guarantee a broader range and better choice of doctors for all medical card holders

4.5 Monitoring and development of the GMS

- Develop a programme of research to assess the impact of the GMS on the health of medical card holders, with a strong client input;
- Put in place mechanisms to monitor and evaluate the GMS on an ongoing basis.