

Medical Card Eligibility: Profiling People Living in Poverty without a Medical Card using EU-SILC 2006

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Abstract

In 2006, almost 22 per cent of people living in consistent poverty and 30 per cent of people 'at risk of poverty' did not have a medical card. The medical card is a means - tested benefit designed to assist people on a low income with the cost of primary care. The research seeks to understand why a substantial number of people living in poverty are not qualifying or taking up the medical card by compiling a profile of their key socio-demographic characteristics.

Two key findings emerged from this research. Firstly, people living in poverty without a medical card were, for the majority, living in working poor households. Evidence suggests that these people may be just above the income threshold and therefore do not qualify or they assume they will not be eligible so therefore they have never applied. Secondly, medical card cover was spread across all income deciles, indicating that eligibility is not solely aligned with income. This, along with the finding that health status was the strongest predictor of medical card take-up, illustrates the extent to which the discretion of the community welfare officer in assessing cases of 'undue hardship' is exercised. Overall the main recommendation that emerged from these findings is that all people living in poverty and low-income groups should have free access to primary care as it has been highlighted as a key policy solution to reducing health inequalities. The study suggests that this can be achieved by: increasing income thresholds of the medical card above the poverty line, equivalised in-line with other social benefits; developing a programme of benefit uptake aimed in particular at the 'working poor'; and making the current medical card system more transparent, with clear eligibility criteria.

Key words: health and inequality, medical cards, primary care

Disclaimer

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Abbreviations

CSO: Central Statistics Office

DOHC: Department of Health and Children

ESRI: Economic and Social Research Institute

EU-SILC: European Survey of Income and Living Conditions

FIS: Family Income Supplement

Combat Poverty Agency (2008b). *Combat Poverty Advice for Government: Budget 2009*. Dublin: Combat Poverty Agency .

GMPB: General Medical Payments Board

GMS: General Medical Services

G.P: General Practitioner

HSE: Health Service Executive

IMO: Irish Medical Organisation

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Chapter 1: Introduction and Background

1.1 Introduction

In 2005, almost 16 per cent of people living in consistent poverty and 30 per cent of people 'at risk of poverty'¹ did not have a medical card (Combat Poverty Agency 2007, Layte, Nolan and Nolan, 2007). Using data from the 2006 European Social and Living Condition Survey (EU-SILC), this study profiles people living in poverty and 'at risk of poverty' without a medical card, in terms of their demographic characteristics, health, and economic status. The analysis will focus in particular on the income thresholds and eligibility criteria for the medical card. The core aim is to understand why a substantial number of those living in poverty do not have a medical card. In this chapter the background to this study is presented. The policy context and previous studies that have looked at the relationship between health and inequality, access to primary care, medical card eligibility and barriers to medical card take-up are discussed. The review of the literature and policy is used to identify the aims of the current study. An outline of the methodology used in the study is also presented.

¹ A person is considered to be 'at risk of poverty' if his/her income is below 60 per cent of the equalised median income (in 2006 this was equivalent to 202 euro a week). A person is considered to be living in consistent poverty if he/she has an income below the 60 per cent poverty line and is suffering two or more forms of deprivation (See section 1.7 of this chapter for a more detailed discussion).

1.2 Health and Inequality

The relationship between health and inequality has been highlighted by a number of studies, and it is now accepted that poverty and poor health are closely linked (Layte et al 2007, Farrell et al 2008, Combat Poverty Agency 2007, Balanda and Wilde 2001 and WHO 2004). Poor people are more likely to die younger than wealthier people and more likely to suffer from ill-health (Balanda and Wilde 2001, Farrell et al 2008, Battel-Kirk and Purdy 2007). Indeed people's health is highly determined by social and economic conditions and these conditions are often termed 'social determinants of health' (WHO 2004, Farrell et al 2008). According to the World Health Organisation (2004), the social conditions in which people live and work can help create or destroy their health. Lack of income, inappropriate housing, unsafe workplaces and lack of access to the health care system are some of the social determinants of health leading to inequalities.

Poverty and social condition can have a significant impact of a person's health. Conversely, people suffering from an illness or disability are more likely to fall into poverty than people in good health, or have debt problems due to health-care costs (Combat Poverty 2007, NDA 2005, O'Reilly et al 2006).

Recent studies using health and poverty statistics have demonstrated that the lower an individual's social class, educational qualifications and income, the worse that individual's health will be (Layte et al 2007, Wilkinson and Marmot 2003). Indeed as income, social class and education level rise, there is a simultaneous improvement in the person's health status. In 2005, according to EU-SILC, over a third of those at risk of poverty (38 per cent) and half of those living in consistent poverty reported having a chronic illness, compared to only a quarter (23 per cent) of the general population (Combat Poverty 2007, 2008a).

Living in poverty can have a profound impact on mental health, where stress and financial worries can lead to deterioration in mental health (OPEN 2007, McDaid 2004). The link between poverty and mental health was highlighted as an issue of

concern in the National Action Plan for Social Inclusion 2007-2016, where poverty was linked to an increased use of mental health services. This was also clearly recognised in the mental health strategy *A Vision for Change*, where it was recommended that deprivation be taken into account in the allocation of resources to mental health services.

The gendered nature of poverty and ill-health is well established (WHC 2004). A recent study carried out by the Women's Health Council and the Money Advice and Budgeting Services (MABS) found that women who were experiencing over-indebtedness are likely to have significant health concerns, particularly in the area of mental health.

Ethnicity, poverty and health inequality demonstrate significant links. People from the Traveller community in particular are more likely than the general population to suffer from poor health. Travellers have a much lower life expectancy and higher incidence of infant mortality (Barry et al 1987). The 2002² census found that the accidental death ratio was significantly higher for the Traveller community, mostly occurring on roadside camps. Data are also indicative of a higher incidence of children with a disability and mental health problems. Indeed a 2004 study of Traveller health found a high incidence of mental health problems where one-third of Travellers said their family had been affected by depression (Traveller Health Unit 2004). This study also found that 73 per cent of Traveller men did not consult a doctor when the needed to do so, and that 13 per cent of all Travellers had experienced difficulties with registering with a GP. Many of these health outcomes have been linked to poor living

² This is the most recent census information relating to accidental death for Travellers.

conditions, lack of health promotion and discrimination (Pavee Point 2004, Traveller Health Unit 2004). In 2002, a Traveller Health Strategy was introduced to tackle this trend and these issues were also subsequently addressed within the HSE Intercultural Strategy.

Asylum seekers and other ethnic minority groups suffer poorer health. Research indicates that asylum seekers and low-income migrant workers face discrimination and difficulties in accessing services. They have a high incidence of deprivation and poverty which impacts on their health (CSO 2006, Migrant Rights Centre 2007, Manandhar et al 2006, Pieper 2006). Homeless people also report serious health problems due to poor living conditions (Simon Community 2007).

Children born into poverty are more likely to suffer poor health (Nolan 2000, Layte et al 2006). Poor health in childhood may affect education achievements and work chances and therefore may reproduce a cycle of inequality and poor health (Farrell et al 2008). Children living in poverty are more likely to suffer from poor oral health, behavioural problems and poor diet (DHSSPS 2002). Within the National Children's Strategy a number of targets has been set by the Government to reduce health inequalities among children.

Policy in recent years has acknowledged the social determinants of health, i.e. that people's social and economic conditions influence health outcomes. The first National Anti-Poverty Strategy 1997 and the National Action Plan for Social Inclusion 2007-2016 have specific targets to tackle health inequalities by increasing access to primary care, with a focus on the needs of medical card holders (Farrell et al 2008). The current health care strategy *Quality and Fairness: A Health System for You* (DOHC 2001) also focuses on equity in access, in particular to primary care. According to Farrell et al (2008), addressing poverty and inequality in Ireland is fundamental to the reduction in health inequalities. The challenge of health inequalities requires the combination of three approaches: focusing on and targeting the most disadvantaged, narrowing the health gap between rich and poor and

reducing the social gradient, whereby health is not dependent on income or socio-economic status (Farrell et al 2008, Whitehead and Dahlgreen 2006). In 2005, Ireland spent approximately 8.8 per cent of GDP on health care and this is one of the lowest levels of health expenditure in the OECD (Farrell et al 2008).

1.3: Primary Health Care in Ireland

Primary health care is defined as a range of services that keep people healthy and fit by providing health promotion, screening and assessment at the first point of contact (*Primary Care: A New Direction* 2001). Primary care in Ireland is primarily provided by general practitioners but also includes other services such as nursing, counselling, speech and language therapy, occupational therapists and dentists. In the current primary health care strategy *Primary Care: A New Direction* (2001) the Government acknowledges that the primary health care system is inadequate because services are fragmented (Combat Poverty 2007).

As the previous section conveyed, poor people are more likely to suffer from poor health. Therefore they may have a greater need for health care encompassing health promotion, screening and acute health services (Burke 2007). Primary health care is central to any health care system as it is the first point of contact for someone who is sick (WHO 2004). According to a number of studies, health status is significantly linked to access to primary care (Burke 2007, WHC 2004). People with financial difficulties can be deterred from accessing primary care because of the costs (Kelleher et al 2003, Layte et al 2007). Research indicates that if access to primary care was improved the current strains on A&E could be relieved (Combat Poverty 2007a, Burke 2007).

In the 2008 WHO Commission on Social Determinants of Health report *Closing the Gap in a Generation* a number of key points were made regarding the importance of primary care. Countries that focus on primary care experience: better health outcomes, improvements in population health because more primary care physicians

are available, and improvements in general health due to preventative measures which are facilitated by better primary care (WHO 2008).

The medical card is one benefit introduced by the Government as a mechanism for improving access to primary care for people on low incomes. Medical card cover is discussed in detail in the next section.

1.4: Medical Card Cover in Ireland

1.4.1: What Does it Entitle you to and Who is Entitled?

In Ireland, a medical card provides people with free access to primary care including: GP, oral, opticians and aural services, medicines and prescriptions, in-patient and out-patient services, medical appliances (hearing aids, artificial limbs etc.) and maternity care. The medical card also entitles the holder to other secondary benefits such as exemption from health contributions, free transport to school (for children who are three or more miles from school), exemption from secondary school exam fees and assistance with the cost of school books (but dependent on the arrangements within the school) (HSE 2007).

Medical cards are a means-tested benefit, i.e. eligibility is dependent on income. In some cases people who are just above the income threshold but suffer from a health condition are deemed eligible. This situation is considered as 'undue hardship' caused by not having a medical card (HSE 2007). Similarly, in most cases if people's incomes are derived solely from social welfare payment such as Job Seekers Allowance (JSA), One-Parent Family Payment (OFP), Disability allowance or the

Non-Contributory Old Age pension they may be automatically eligible for the medical card, as they have already satisfied a means test.³ Those who have some of their income from social welfare will have this income disregarded (HSE 2007:16).

Although the HSE states that 'Entitlement is based on legislation, regulation and administrative guidelines', it is unclear whether social welfare recipients have the legal entitlements to the medical card (HSE 2007:3 and Comhairle 2004).

From 2001 to 2008, all people aged over 70⁴ are automatically eligible regardless of income. Table 1.1 displays the current income limits for medical cards. They have remained the same since an increase of 7.5 per cent in 2005 (Department of Health and Children 2005).

Table 1.1: Weekly Income Thresholds for the Medical Card 2006-2009

	Aged: 16-65	66-69
Single person living alone	€184	€201.50
Single person living with family	€164	€173.50
Married couple/Lone-parent with children	€266.50	€298

³ Job seekers allowance/benefit is a payment for those who are currently unemployed and not in full-time education. In 2006 the maximum payment for a single person was €165.80. The One Parent Family payment, paid to the head of a one parent family was also €165.80 for someone aged under 66 in 2006. The non-contributory old age pensions was set at €182 for someone under the age of 80.

⁴ In the Budget for 2009 it was announced that means testing for over-70s would be reintroduced. The **gross** income limits are €700 per week for a single person and €1,400 per week for a married couple. There will be no standard deductions allowable (for example, for income tax). However, if a person has high medical bills or pays for a nursing home he/she may be assessed under 'undue hardship' similar to those under 70. Pensions, investments, all income and capital are assessed in the means test (www.citizensinformation.ie).

Allowance for 1 st two children under 16	€38	€38
Allowance for 3 rd and subsequent children under 16	€41	€41
Allowance for 1 st two children over 16 (with no income)	€39	€39
Allowance for 3 rd and subsequent children over 16 (no income)	€42.50	€42.50
Dependents over 16 in full-time, non grant 3 rd level education	€78	€65

Based on these income thresholds, a person living alone cannot qualify for a medical care if he/she earns over €184.00 a week, or a family of 2 adults with 2 children under 16 could not earn over €342.50 a week. All means-tested benefits, including the medical card, are equivalised based on the type of household, i.e. the number of people in the household and the proportion of householders who are financially dependent, e.g. children. Significantly, different systems of equivalisation are used in assessing different means-tested benefits. The income thresholds for the medical card in relation to dependent adult and child are lower than most other social welfare benefits and are well below the recommended target for children of 33-35 per cent of a qualified adult (Combat Poverty 2008c).

Comparing the medical card limits to the limits for the JSA, a dependent adult is equivalised to .66⁵ of the qualified adult. A couple applying for the medical card can earn up to €266.50 compared to €184 for a single adult; therefore a dependent adult

⁵ Weekly income threshold for dependent adult/weekly income threshold of qualified adult for Jobseekers allowance is $131.30/197.80 = .66$

is equivalised to .45.⁶ Similarly children are equivalised to .2⁷ for the medical card compared to .32 for JSA (allowance of €24 plus child benefit of 40 = 64/197.8). If the medical card thresholds were equivalised to the same standards as other social welfare payments, income thresholds would be more generous and would make more people eligible for the medical card.

At the current rate the medical card income thresholds can be considered to excessively penalise families with children (Combat Poverty 2001).

1.4.2: Trends in Medical Card Coverage

Over the last number of years the percentage of the population covered by the medical card has been declining. In 1989 an agreement was reached between the Department of Health and Children and the Irish Medical Organisation that medical card cover should be extended to 40 per cent of the population (IMO 2005). A commitment was also made under the 2001 Health Strategy to increase the number of people covered by the medical card. In February 2008 approximately 28.9 per cent⁸ of the population or 1,281,091 people were covered by the medical card (www.dohc.ie). Table 1.2 illustrates how the percentage of population covered by the medical card has declined in recent years. In 1983, 38 per cent of the population had a medical card; this declined to 29 per cent in 2002 (GMPB 2008, Burke 2007). In 2001 the numbers covered by the medical card rose by 50,000; this was followed by a decrease of 30,000 the following year. The absolute number of people covered by

⁶ Weekly income threshold of dependent adult/weekly income threshold of qualified adult for the medical card is $82.50/184 = .45$

⁷ Weekly income threshold for first child/weekly income threshold for qualified adult is $38/184 = .2$

⁸ Based on population estimate for 2008 of 4,429,554

the medical card continued to decline until 2006 when it began to rise again. As a percentage of the population, it has remained between 28 per cent and 29 per cent between 2005 and the most recently available figures for 2008.⁹

Table 1.2: Numbers and Percentages of Population Covered by the Medical Card 1997-2008 (IMO 2005:1 and the Department of Health and Children 2008: www.dohc.ie)

	Number Covered	per cent of Population
December 1997	1,219,852	33.64 per cent
December 1998	1,183,554 -	31.95 per cent
December 1999	1,164,187 -	31.09 per cent
December 2000	1,148,055 -	31.24 per cent
December 2001	1,199,454 +	31.24 per cent
December 2002	1,168,745 -	29.84 per cent
December 2003	1,158,143 -	29.57 per cent
December 2004	1,148,914 -	29.33 per cent
January 2005	1,145,083	29.22 per cent
January 2006	1,156,965	27.3 per cent
January 2007	1,221,603	28.2 per cent
March 2008	1,280,510	28.92 per cent

The income thresholds and the means testing of the medical card were introduced in the 1970s as a means of standardising the eligibility criteria for the medical card

⁹ Percentages are based on population estimates for each given year by the population calculator at www.cso.ie using the 2006 census. The estimations for 1997-2005 are taken from the IMO 2005 publication and are estimated using the 2002 census.

(Comhairle 2004). Initially, like other social welfare benefits, thresholds were indexed to the Consumer Price Index (CPI). In recent years the medical card thresholds have fallen behind this, while other social welfare benefits have increased faster than CPI. Coupled with the fact that wages have increase substantially over the last number of years, it is not surprising that the percentage of the population who are eligible for the medical card has declined (Comhairle 2004:9).

1.4.3: The Policy Response

The Government has introduced a number of measures to increase the number of people covered by the medical card, most notably the introduction of the over-70s medical card in 2001 and an increase in the income thresholds in 2005. Recently, people moving from welfare to work are allowed to retain their medical card for up to three years provided they have been in receipt of certain benefits (i.e. JSA, OFP, DA) for more than twelve months. This has removed some of the poverty traps associated with the medical card (OPEN 2006).

Another measure was introduced in 2005 to help with the cost of primary care. The GP visit card was introduced to help lower income groups who were not eligible for a full medical card. The GP visit card covers the cost of visiting the GP only, with all additional costs such as prescriptions or other primary care services being borne by the individual. The income thresholds are 50 per cent greater than the medical card (Income threshold for a single person in 2008 was €270 and €230 in 2006). When it was announced in 2004 a commitment was made to provide 200,000 GP visit cards. In February 2008, 76,094 people had a GP visit card, representing just 1.7 per cent of the population (www.dohc.ie). Although the introduction of the GP visit card was welcomed, the Irish Medical Association felt that it is of limited value to low-income groups compared to the medical card, particularly with the rising cost of medicine (IMO 2005).

As the medical card is a means-tested benefit and targets those most in need, it is reasonable to expect that the majority of people who are the most disadvantaged and

with the lowest income would have a medical card. According to EU-SILC 2005, approximately 16 per cent of people who live in consistent poverty and 30 per cent of people 'at risk of poverty' did not have a medical card (Combat Poverty 2007). This is equivalent to approximately 220,000 people at risk of poverty and 47,000 people in consistent poverty.¹⁰ The purpose of this study is to understand why these people are not taking up or qualifying for the medical card. The aims of the study are outlined in more detail section 1.8. First it is important to give an overview of other research that has explored the current medical card system.

1.5 Barriers to Taking up a Medical Card and Medical Card Eligibility

The previous section highlighted that despite recent efforts by the Government to increase the number of people with a medical card there has been a continued decline in the proportion of the population covered. Of particular concern is the significant number of people living in consistent poverty and 'at risk of poverty' without a medical card. This suggests that there may be a number of barriers to accessing a medical card or that the eligibility criteria are inappropriate.

1.5.1: Income Thresholds

The previous section highlighted that the income thresholds for the medical card were increased in 2005 but that the equivalence scales are considerably lower than other social welfare payments. Many studies have reported that the current income thresholds are too low and that people who are just above the income threshold are less likely to visit a GP as the cost would be a considerable portion of their income (Layte et al 2007, Comhairle 2004, WHC 2007, Combat Poverty 2008a, O'Reilly et al

¹⁰ Based on population estimates for 2005

2006). It has been argued that the income thresholds should be indexed to other social welfare payments (most prominently the Family Income Supplement) and equalised in a similar manner as they are more generous and would target those most in need (Combat Poverty 2007, 2008a, 2008b, 2001; Comhairle 2004). Others argue that medical care income thresholds should be indexed to minimum wage (IMO 2005). It is widely agreed that the income thresholds should be in line with rising costs of living (Vincentian Partnership for Social Justice 2008). Comhairle (2004:4) recommended that income should be objectively assessed, taking into account the amount required by low-income groups to meet GP and related bills. At present this is only carried for those who have significant health problems and are above the income thresholds (HSE 2007).

1.5.2: The Discretionary Nature of the System

A key criticism of the current medical card system is that it lacks transparency, and that eligibility in many cases is left to the discretion of the Community Welfare Officer or the HSE (Comhairle 2004, Combat Poverty 2008a). According to a study carried out by Comhairle¹¹ (2004), the eligibility criteria are unclear and inconsistent, and the discretion used by the Health Boards is not sufficiently published. In 2007 the HSE set out to try and clarify the guidelines Community Welfare Officers should adhere to when assessing cases of those just above the income guidelines. The deciding officer should take into consideration the applicant's ability to meet daily living costs such as housing, childcare, heating, nutrition, clothing and medical costs. In essence

¹¹ Study based on medical card related queries to Comhairle in 2002. Of their health-related queries over 50 per cent related to the medical card.

the assessment of 'undue hardship' must take into account the 'personal, medical or social circumstances of the applicant and/or their family' (HSE 2007:23).

As well as assessing medical circumstances that may cause financial strain, the deciding officer may also take into account addiction problems, poor money management and social deprivation. Although discretion and flexibility can be useful in allocation there is no indication of how or when discretion is used and to what extent these guidelines are enforced.

A number of costs to families can be taken into account when applying for the medical card including: transport¹² (distance to and from work), childcare and mortgage costs. Although transport costs are laid out specifically, there is no definitive numerical statement on what constitutes reasonable expense for childcare and mortgage/rent repayments (HSE 2007:12). The lack of clarity over what constitutes 'reasonable childcare and mortgage/rent costs' could mean that this aspect is also left to the discretion of the welfare officer (Combat Poverty 2008a).

Another issue is that in recent years social welfare payments are higher than the income thresholds for the medical card, so technically one could be unemployed but not eligible. Although some evidence suggests that people who have satisfied one means test are automatically eligible for the medical card, research has found that people have lost their medical card as their social welfare payment increased beyond

¹² Takes into account the cost of public transport or 18c per km/30c per mile to cover running costs of a car. They all take into account those who car pool.

the medical card threshold, whilst other social welfare recipients have been refused a medical card because their payment is above the threshold limit (Comhairle 2004).

The discretionary nature and lack of clarity over entitlement to the medical card was also highlighted by a consultation with the Building Health Communities Programme carried out by Combat Poverty in 2008.¹³ People felt that they did not know what they were entitled to or who would be deemed eligible. People who had been refused a medical card were not sure why this was the case and felt that the system lacked transparency. It has been argued that there is a need for an independent appeals bodies to keep the system in check (Combat Poverty 2008a, Comhairle 2004).

1.5.3: Information: Language and Literacy Barriers

Lack of information on the eligibility criteria to the medical card has been identified as an issue in accessing a medical card (Combat Poverty 2008a). Lack of availability on the type of medical cards, who is entitled and what people are entitled to, leads to a situation where people do not apply as they assume they will not be eligible. This is particularly true for people who are in paid employment (Comhairle 2004, Combat Poverty 2008a). These issues are compounded by the fact that people most in need may have literacy and language problems, or English language difficulties, and have greater difficulty accessing and understanding information on the medical card

¹³ Combat Poverty was invited to carry out a consultation with the Building Healthy Communities Projects in 2008 by the Department of Health and Children's Medical Card Eligibility Committee. The Building Healthy Community Programme was set up in 2003 to help the work of community development projects who work specifically with people experiencing health inequalities. Questionnaires were sent to the people participating in the projects and the project workers. A discussion paper on the key findings can be found at www.combatpoverty.ie/publications.

(Galway Refugee Support Group 2007, National Ethnic Minority Health Forum 2007). Indeed for people with literacy difficulties and English language difficulties, the entire application process can be intimidating, and can often deter people from applying for the medical card. Although the application form has been proofed by the National Adult Literacy Association, many people still find the form intimidating as it contains a lot of detail, and requires numeracy as well as literacy capabilities (Combat Poverty 2008a).

1.5.4: Administrative Issues

The application form for the medical card asks claimants questions on their personal details, spouse details, statements of all income, statement of outgoing expenses, GP details including a letter of consent. The application form can be downloaded off the internet or is available from an applicant's local health centre, where a list of GMS doctors can also be found.

A number of administrative issues affecting the efficiency and delivery of the medical card service have been highlighted. In 2001 there was a major overhaul of the GMS system as it was discovered that a number of people on the list were deceased. Therefore medical card renewal forms are now sent out more frequently and have to be returned within 21 days. This study highlighted how problematic such a procedure was for homeless people in particular.

This policy change can be seen in the number covered by a medical card in Table 2.1, where there was a decrease of almost 50,000 people covered by the medical card between 2001 and 2002. According to O'Carroll et al (2008) the policy change had a profound impact, most notably on patients with limited literacy or transient living circumstances and an overall negative effect on the health care of vulnerable groups. According to this study, 1,489 people were removed from the GMS list over a 2-and-a-half year period because they did not return their renewal form. Forty of these people were interviewed, where over 60 per cent said they had not received a medical card renewal form. During this period without medical card cover, 11 per

cent did not get a medical consultation when they needed to do so and 26 per cent had to pay out of their own pocket, even though they felt they were eligible.

According to the Combat Poverty study the renewal form was a particular problem for transient people, in particular Travellers, asylum seekers living in direct provision and people living in private rented accommodation. In many cases renewal forms were sent to an address people no longer lived at and were therefore left without a medical card and access to health care (Combat Poverty 2008a).

Research indicates that the application process is lengthy, with people waiting for a significant period of time without a medical card/care (OPEN 2006, Combat Poverty 2008a). In some instances people's applications had been misplaced by the HSE and therefore they had to reapply (Combat Poverty 2008a).

1.5.5: Access to GP and GP Utilisation

Accessing a GP is a major issue for medical card holders. In order for a medical card application to be approved the potential recipient must be accepted by a General Medical Services (GMS) GP. The individual is tasked with sourcing a GP to take on his/her care. This is difficult for many low-income and disadvantaged groups.

Evidence suggests that Travellers, asylum seekers, people living in disadvantaged areas and people with drug problems have the greatest difficulty registering with a GP (Combat Poverty 2008a, Burke 2007). At the time of writing, over a quarter of GP's list are closed due to national shortages of GPs (Burke 2007). In recent months the number of dentist taking GMS patients has also declined. The task of finding a GP and/or dentist has become increasingly difficult for people who need it most (Combat Poverty 2008a).

According to Layte et al (2007) medical card holders visit the GP more often, even when all health and economic characteristics are controlled for. On average, medical card holders visit the GP 5.8 times a year. The national average is 3.3 visits a year. In Northern Ireland this is 3.8 times (Burke 2007). GP utilisation falls dramatically for

those just above the income thresholds. This was true for all income groups, i.e. the costs of a visit to a GP are a major deterrent to utilising the service, regardless of income. These results suggest that medical card holders may overuse GP services, but forthcoming research indicates that due to a number of regulations medical card holders have to visit the doctor more often (O'Carroll 2008). For example, medical card holders are only given three-month prescriptions as opposed to six and need to return to the GP more frequently to renew prescriptions irrespective of the nature of medication. Therefore the high level of utilisation among medical card holders may be over-estimated and does not take into account the different regulations for this group. In Northern Ireland, where visiting a GP is universally free for all, the average number of visits for the population is only slightly above (3.8) the average for Ireland (3.3) where 70 per cent of the population have to pay (Burke 2007).

1.5.6: Importance of the Medical Card to Low-Income Groups

Many studies have highlighted the importance of medical cards for people on a low income (VPSJ 2008, Combat Poverty 2008a, Comhairle 2004). Having a medical card can be supportive of healthy behaviours for people on a low income because barriers to accessing primary care are removed; as such it is a pro-poor measure (Layte et al. 2007, Burke 2007). Importantly the medical card also acts as a marker for other secondary benefits such as the School Books scheme and the waiver on waste charges in some local authorities (VPSJ 2008, Combat Poverty 2008a). Low-income families with young children have been highlighted as a group with the greatest need for a medical card. Evidence suggests that parents, and in particular mothers, may neglect their health by putting off going to the GP when they need to do so (Comhairle 2004, Vincent de Paul 2003). In most cases the medical card is of great psychological value as opposed to monetary value because of the security it offers (Comhairle 2004). It has been suggested that targeting this group could be achieved by linking medical card eligibility to the Family Income Supplement (Comhairle 2004).

Estimates carried out in 2004 stated that the medical card could be worth a possible €3,000 to a family annually (Comhairle 2004). This is based on the average cost of a medical card in 2004 of €700. In 2008 this was estimated to have risen to between €1,000 to €1,600 (*Irish Times*, Health Supplement, 16 September). Therefore the value of a medical card to a family with 2 children and 2 parents could be in the region of €4,000 annually. Obviously this is dependent on the needs of the holder and his/her health status.

1.6: Summary

- There is a clear relationship between health and inequality; poor people die younger and suffer poorer health.
- Social conditions such as poor housing, low education, low income and difficulties in accessing services all can have a negative impact on people's health.
- Primary care is an essential component of any health care system as it is the first point of contact for the individual.
- Access to primary care is particularly important for people living in poverty as they have poorer health.
- The Irish primary care system is fragmented and inadequate. At present 70 per cent of the population pay for primary care; the remaining 30 per cent are medical card holders who have free access to primary care.
- The medical card is a means-tested benefit aimed at people who are on a low income or living in poverty.
- Eligibility is based on income, where people below a certain income threshold are entitled; in some cases where people are above the threshold their social, economic and health status will be taken into account.
- Since 2000 the proportion of the population covered by the medical card has been declining, primarily due to the fact that wages, CPI and other social welfare payments have risen faster than the income thresholds for the medical card.
- The medical card is seen as a pro-poor measure as it is a targeted benefit aimed at those who are the least well-off in society; therefore it is surprising to find that

in 2005 16 per cent of people living in consistent poverty and 30 per cent of people at risk of poverty did not have a medical card.

- Empirical and anecdotal evidence suggests that there are a number of difficulties with the current system that make it difficult for people who need it most to access the medical card. Such difficulties include the income thresholds, entitlement to the medical card not being clear, the system being to a large extent discretionary and the lack of transparency. Information on entitlement and the eligibility criteria is not clearly disseminated. This is an issue of particular concern for people with literacy or English language difficulties. Administrative barriers to access exist, particularly in relation to the renewal forms. People also encounter difficulties when trying to access GPs and dentists.
- The value and importance of the medical card to low-income groups and the need to extend this benefit to vulnerable families was highlighted.

1.6.1: Aims of Study

Following on from this review of literature and policy, the main aim of this study is to understand why a considerable number of people who should have a medical card do not. Or in other words why do 16 per cent of people living in consistent poverty and 30 per cent of people at risk of poverty not have a medical card?

To meet this aim, the study objectives are to

- Update existing statistics on the relationship between health and poverty
- Profile people living in poverty and at risk of poverty without a medical card, in terms of their social, economic and health status
- Use this evidence to corroborate previous research on why people are not taking up and/or not qualifying for the medical card.

These aims will be achieved by means of quantitative analysis of EU-SILC 2006. The focus will be on eligibility criteria such as income, economic status and health status.

Chapter 2: Methodology

2.1: European Survey of Income and Living Conditions 2006

A quantitative analysis of the 2006 European Survey of Income and Living Conditions was undertaken to meet the aims and objectives of the study.

EU-SILC is an annual survey of basic income and living conditions of the general population. It also measures poverty and deprivation levels. All national indicators of poverty are derived from this Survey.¹⁴ In 2006 the sample was made up of 14,634 people and 5,845 households.

The survey has two main measures of poverty; the 'at risk of poverty' measure and the 'consistent poverty' measure. The most commonly accepted marker of 'income poverty' or relative poverty is below 60 per cent of the median equivalised income¹⁵ (CSO 2006). People living below the 60 per cent line are considered to be 'at risk of poverty' in Ireland. The term 'at risk of poverty' has largely replaced the term 'relative poverty'. In 2006 this meant living on €202.49 or less a week. The consistent poverty measure is the nationally accepted marker of poverty under the National Anti-Poverty Strategy. A person is considered to be living in consistent poverty if his/her income is

¹⁴ Before EU-SILC came into use in 2003 the Living in Ireland survey was used as the main source of deprivation and poverty indicators. EU-SILC has now replaced this.

¹⁵ The median instead of the mean is used as it eliminates the sensitivity that the mean may have to extreme high or low incomes. Disposable household income is equivalised based on 1, .66 and .33 for a child.

below 60 per cent of the median income and he/she is suffering from two or more of the following forms of deprivation:

- No substantial meal for at least one day in the past two weeks due to lack of money
- Without heating at some stage in the past year due to lack of money
- Experienced debt problems arising from ordinary living expenses
- Unable to afford two pairs of strong shoes
- Unable to afford a roast once a week
- Unable to afford a meal with meat, chicken or fish (of vegetarian equivalent) every second day
- Unable to afford new (not second-hand) clothes
- Unable to afford a warm, waterproof coat.

This index has been revised to include the following new indicators: inability to replace worn-out furniture, inability to have a night out for entertainment in last two weeks due to lack of money and unable to have friends or relatives over for dinner or drinks due to lack of money. This new index replaced the old index in 2007.

In 2006 6.9 per cent of the population was living in consistent poverty and 17 per cent was at risk of poverty or living below the 60 per cent poverty line.

EU-SILC also has a number of self reported health measures:

- Do you suffer from a chronic illness? Yes/No

- Do you have a health condition that limits or strongly limits you activities? Yes strongly limits/Yes limits/No.
- How would you rate your health in general? Very Good/Good/Fair/Bad/Very Bad

Although these measures are basic, they do have a value for predicting mortality (Layte et al 2007). Respondents are also asked a number of questions on their health service use, including number of free GP visits, prescriptions,¹⁶ number of nights spent in a public/private hospital, and whether they needed to consult a doctor over the last 12 months but did not and why they did not. Respondents are also asked if they have a medical card (Yes/No) and/or private health insurance (Yes in Family name/Yes in own name/No).

2.2: Overview of Analysis

- The aim of this study is to profile those living in poverty and at risk of poverty without a medical card, in terms of their socio-demographic and health characteristics. Within the sample, 995 people were defined as consistently poor and 2,442 people were 'at risk of poverty' or living below the 60 per cent threshold.
- The analysis prioritised analysis of those at risk of poverty, i.e. living below the 60 per cent poverty line, comparing those with a medical card to those without. There are three reasons for this:
- Firstly, people living in consistent poverty are a subset of people at risk of poverty

¹⁶ This question was only asked of those with a medical cover. Therefore the researchers were unable to make comparisons based on GP utilisation of medical card holders vs. non medical card holders.

- Secondly, the results for consistently poor are similar to the results for those 'at risk of poverty', but the sample size is much smaller so statistically it is difficult to make conclusions from the results
- Finally, medical card eligibility is means-tested according to income and therefore it is more important to compare income levels and poverty lines as opposed to level of deprivation. A number of comparisons are made at the 40 per cent, 50 per cent and 70 per cent poverty line.
- The results for people living in consistent poverty are summarised in Appendix A.

2.3: Methodological Issues: Removing Bias in the Sample

For the purpose of the analysis of the key demographic factors a number of adjustments had to be made to remove a number of biases within the sample. These adjustments only apply to the findings presented in Chapter 4. The findings presented in Chapter 3 represent the entire population unless otherwise stated.

2.3.1: Private Health Insurance

Initial analysis found that a number of people 'at risk of poverty' and living in consistent poverty also had private health insurance. The people who are covered by private insurance were kept in the analysis because the medical card and private health insurance are inherently different in terms of what they can provide in relation to access to health services. The medical card provides free access to primary health care whereas private health insurance entitles some customers to quicker access to secondary care. Private health insurance does not entitle the holder to free primary care which would remain an extra cost for those without a medical card.

Recommendations for further research are presented in Chapter 5.

2.3.2: Students

When initial analysis was first run, individuals who classed their principal economic status (PES) as a 'student' and households with three or more adults were less likely to have a medical card than other groups. On closer examination the average age of those in the 'Student' category was 18 years. From this there were two distinct groups: those completing secondary school and those currently completing a degree.

The decision was made to remove those who were currently completing a degree¹⁷ as they may be classed as living in poverty but may still be financially dependent on their parents. Additionally, students completing third level education have free access to some forms of primary care (GP, Health Screening, etc). Those who are completing a second level education (aged 16-25) remained in the analysis as it is assumed that they are still dependent on their parents or they are adults returning to education. Certificate and diploma students remained in the analysis as they had a higher percentage reporting having a child dependent than other education groups. Over 11 per cent of those completing a cert or diploma had a dependent child; this is compared to 2 per cent of those at secondary level and 1 per cent at third level.

2.3.3: Over 70

As all those over 70 are entitled to a medical card regardless of income, all people aged 70 and older were removed from this part of the analysis. This would remove any bias in the results as over-70s do not have the same process to go through in order to get a medical card. Children were also removed as many of the variables did not apply to those aged 15 or younger (work, income and health related questions not asked of those under 15)

2.4: Limitations

There are a number of factors that limit the potential of this research. EU-SILC at present does not ask respondents if they have a GP visit card. This would be useful as it would help assess the uptake of this new benefit and who is taking it up. Also

¹⁷ Respondents who said they were currently completing a degree, higher diploma, masters, professional degree or a PhD were suppressed during the analysis.

some of the people who do not have a medical card may have a GP card. This could be an indicator of people who were above the income thresholds for a medical card and were therefore granted a GP visit card. As EU-SILC is not a health-related survey there are a number of limitations with this. Firstly, the health measures are to a large extent self-reported and therefore subjective. Secondly, a key question that would have added to this study is whether people had even applied for a medical card, and if so, whether they had been deemed eligible or not.

The 'at risk of poverty' indicator has been criticised as a robust measure of poverty. It takes no account of overall living standards and fails to reflect the fact that the 60 per cent median income threshold increased by 98 per cent, from €102.44 in 1997 to €202.49 in 2006. Over the same period (1997–2006), prices (CPI) increased by just 35.8 per cent, average industrial earnings increased by 61.8 per cent and basic social welfare payments increased by 99.7 per cent.

Despite this, EU-SILC is the most robust and up-to-date data on social and living conditions in Ireland and has the potential to provide valuable statistical evidence to the medical card eligibility related policy and discourse.

2.5: Structure of Report

Chapter 3 presents an overview of the health status of those living in poverty as well as trends in medical card cover and private health insurance cover over the last four years, using EU-SILC 2006. Chapter 4 presents the socio-economic characteristics of people 'at risk of poverty' without a medical card in order to ascertain whether these factors are related to medical card take-up/eligibility. A model of medical card take-up by analysing which socio-economic factors influence whether someone has a medical card or not is also presented. Chapter 5 offers some conclusions and recommendations based on these findings.

Chapter 3: Health Status, Poverty and Medical Card Cover

3.1: Introduction

Chapter 1 highlighted the relationship between poverty and poor health and issues relating to accessing a medical card and medical card eligibility. This chapter updates existing statistics on the relationship between health and poverty. Trends between 2003 and 2006 are presented.¹⁸ The numbers covered by the medical card and the numbers with private health insurance at different income deciles and poverty lines are also examined.

3.2: Health Status

Over the last number of years the relationship between poverty and poor health has been widely documented (Layte et al 2007, Balanda and Wilde 2001). The previous chapter highlighted the phenomenon of poor people experiencing more ill-health. Conversely those suffering from poorer health or a disability are more likely to experience poverty and deprivation. EU-SILC has documented this relationship over the past three years with three measures of health.¹⁹

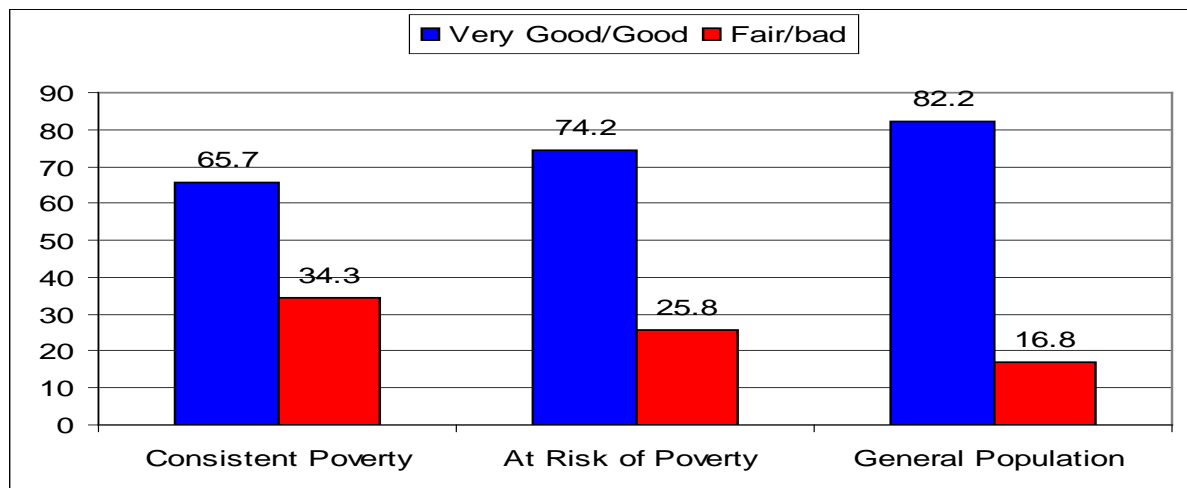
Figure 3.1 illustrates the proportion of people in consistent poverty and 'at risk of poverty' who report 'fair, bad or very bad health'. Over a third of those consistently

¹⁸ The first round of EU-SILC was released in 2003. At the time of writing 2006 was the most up-to-date dataset available.

¹⁹ EU-SILC has three questions on health status; the first asks respondents to rate their health from good to bad on a five point scale, the second asks if they suffer from chronic illness and the third asks if they have a health conditions that limits their activities.

poor and a quarter of those who are 'at risk of poverty' describe their health as 'very bad, bad or fair'. This is compared to 17 per cent of the general population.

Figure 3.1 Health Status by Consistent Poverty and 'At Risk of Poverty' (EU-SILC 2006)

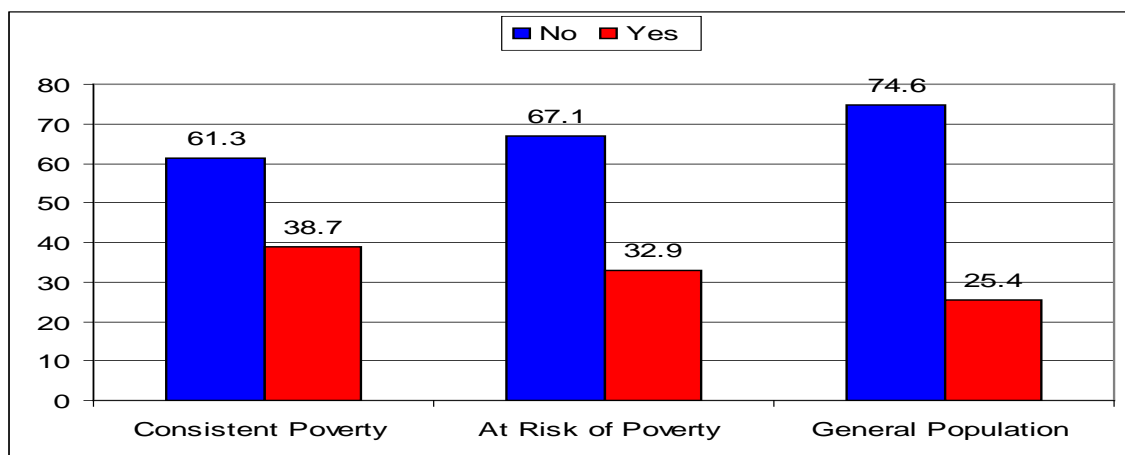


Similarly the incidence of suffering from a chronic illness is also related to whether someone is living in poverty or 'at risk of poverty'. Almost 40 per cent of consistently poor people and over a third of those 'at risk of poverty' reported suffering from a chronic illness compared to 25 per cent of the general population (See Figure 3.2).

Measures of disability, including whether respondents had a health condition that limited or strongly limited their activities, were also examined in terms of the relationship with poverty measures. Once more those living in consistent poverty had the highest incidence of health problems limiting or strongly limiting their activities (37 per cent). Of those 'at risk of poverty', 28 per cent said that they had a health condition that limited or strongly limited their activities; this is compared to 19 per cent of the general population.

Poverty exhibited a consistent relationship with the three measures of health status, with those living in consistent poverty and those 'at risk of poverty' reporting poorer health. These findings are consistent with other studies (See Layte et al 2007).

Figure 3.2 Incidence of Chronic Illness by Consistent Poverty and 'At Risk of Poverty' (EU-SILC 2006)



Gender and age significantly influence the relationship between health and poverty. Women and older people are more likely to report poor health (Layte et al 2007). Forty-five per cent of people aged over 65 'at risk of poverty' rated their health as 'fair, bad or very bad', compared to 23 per cent of those under 65 'at risk of poverty'. Similar results were found for those in consistent poverty where people over 65 rated their health worse than those under 65 (60 per cent compared to 32 per cent). No differences were found for gender. The relationship between poor health and poverty remain even when age and gender are controlled for.

3.3: Medical Card Coverage

In 2006, according to EU-SILC, 32 per cent of the population had a medical card, approximately 1,137,000 people.²⁰ This includes approximately 308,000 children, representing 32 per cent of all children.²¹ Over the last number of years there has been an increase in the number of people covered by the medical card. According to the EU-SILC figures, 31 per cent were covered in 2005 and 30.5 per cent in 2004. This is slightly higher than the percentages covered by the medical card according to the Department of Health's figure (see Table 1.2). For 2006 the Department of Health and Children had a figure of 28 per cent.

3.2.1: Consistent Poverty

In 2006, 2.2 per cent of people without a medical card were living in consistent poverty, or conversely 22 per cent of people living in consistent poverty were not covered by a medical card, comprising approximately 64,000 people. Approximately 14,500 of these people were children, representing 14 per cent of children who were living in consistent poverty. When all those over 70 are removed from the analysis, nearly 23 per cent of people living in consistent poverty did not have a medical card.

3.2.2: At Risk of Poverty

People are considered to be at risk of poverty if they are living below 60 per cent of the median equivalised income. At present the income threshold for a single person is €184 and the 60 per cent poverty line or the 'at risk' line for 2006 is set at €202 a week. Almost 8 per cent of those without a medical card are at risk of poverty. Thirty

²⁰ Based on the percentage of the population estimate for 2006 and the census from CSO

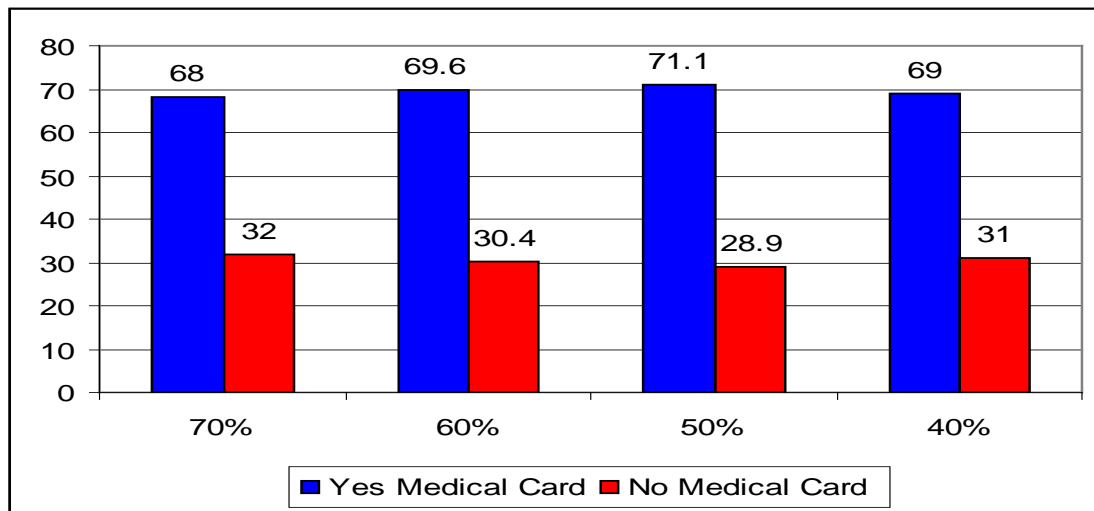
²¹ Children defined as those aged 15 or younger

per cent of people at risk of poverty do not have a medical card. This represents approximately 219,000 people, including 45,000 children. Almost 18 per cent of people under the age of 69²² not at risk of poverty have a medical card.

The 60 per cent of the median of equivalised income is broadly accepted as the primary poverty line (CSO 2007). Figure 3.5 shows the percentage of people not covered by a medical card at 40 per cent, 50 per cent, 60 per cent and 70 per cent poverty lines. The percentage of people below each poverty line without a medical card is an average of 30 per cent. It drops to 28 per cent at the 50 per cent line but rises again to 31 per cent at the 40 per cent line. This is useful as it conveys that at a number of different poverty lines the proportion of people without a medical card does not differ significantly. The 60 per cent line is taken as the reference point for the majority of this study but comparisons are also made at the 50 per cent line.

Figure 3.3: Medical Card Cover at 70 per cent, 60 per cent, 50 per cent and 40 per cent Poverty Line including Over-70s (EU-SILC 2006)

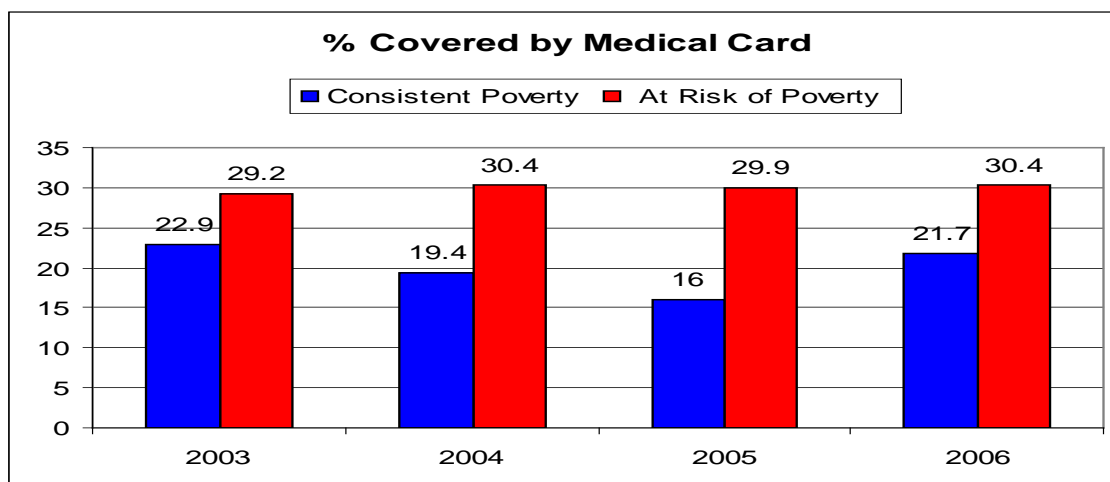
²² In 2006 all people aged over 70 are automatically entitled to the medical card.



3.2.3: Trends in Medical Card Coverage 2003-2006

Figure 2.6 displays the proportion living in poverty without a medical card over the four years from 2003 to 2006. There was little change in the numbers living in poverty without a medical card although there is a small dip in 2005. This could be explained by policy changes in 2005 such as the introduction of the GP only cards and the increase in the income thresholds.

Figure 3.4: Trends in Percentage of People At Risk of Poverty and Consistently Poor without Medical Card (2003-2006)



3.2.4: Medical Card Coverage for Over-70s

Since 2001 all people aged over 70 are automatically entitled to a medical card regardless of income.²³ Only 2.8 per cent of people aged over 70 do not have a medical card compared to 70 per cent of those aged under 70. This tells us that the over-70s account for 0.1 per cent of people without a medical card.

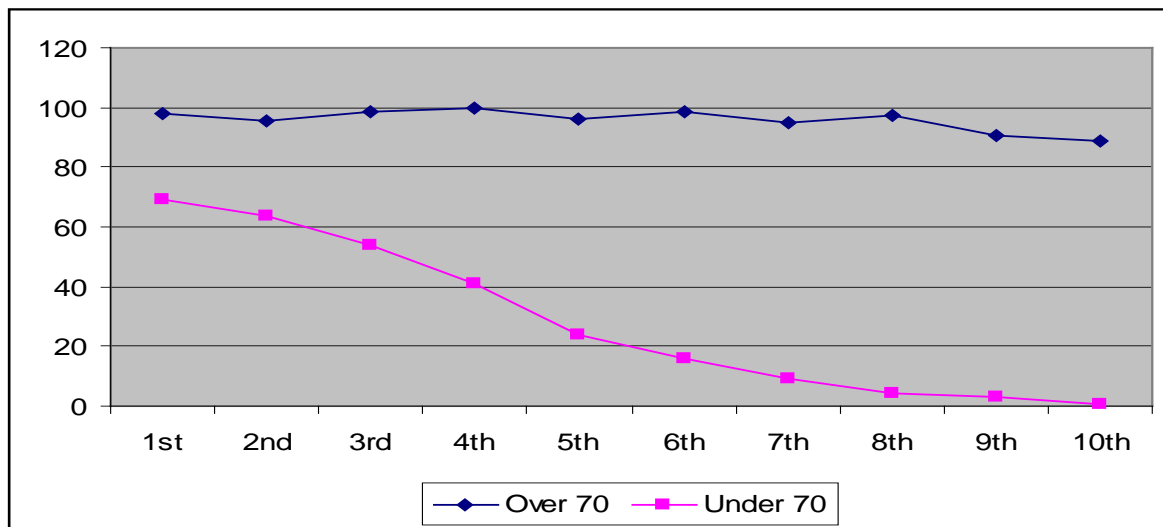
²³ In October 2008, it was announced that the means testing of Over-70s would be reintroduced.

3.2.5: Income Deciles

Medical cards are a means-tested benefit where eligibility is determined by income. Therefore it is important to look at the numbers of people covered by a medical card in each income decile (see Figure 2.8).²⁴

²⁴ Based on individual equivalised income, those in the lowest income decile have a net weekly equivalised disposable income of €184.28; before social transfers total direct income for those in lowest decile group is €16.78. The percentage is based on number of people with a medical card in each income decile.

Figure 3.5 Percentage of People with a Medical Card in Each Income Decile (Under-70s and over-70s) (EU-SILC 2006)



This shows the relationship between medical card cover and income for population aged 69 or younger. As expected those with a lower income were more likely to have a medical card. Almost 70 per cent of people in the lowest income decile have a medical card (weekly disposable income of €184.28). The poverty line is taken as below the bottom two deciles. Surprisingly, a significant number of people have a medical card in the income deciles above this point. For example, 24 per cent of people in the fifth income decile (weekly income disposable income of €333.38) and 16 per cent of people in the sixth income decile (weekly disposable income of €389.60) had a medical card. This falls to 9 per cent in the seventh income decile and 4 per cent in the eighth. In the tenth income decile 0.6 per cent (approximately 2,000 people) have a medical card.

Although this illustrates that the lower your income the more likely you are to have a medical card, almost 48 per cent of people under 70 who have a medical card have an income above the 60 per cent poverty line and the medical card threshold, representing 10 per cent of the population. This illustrates that eligibility is not strongly allied to income in many cases and the extent to which discretion relating to 'undue hardship' may be exercised.

Looking at the trend for those over 70, it is obvious that medical card cover is not affected by income except for those in the highest income decile, where almost 11 per cent of people over 70 in this income bracket do not have a medical card. This displays the high uptake of medical cards for people over 70.

3.5: Private Health Insurance

In 2006 48.2 per cent of the population had private health insurance. Of these 4.3 per cent were at risk of poverty and 0.8 per cent were living in consistent poverty. This equates to 12 per cent of those 'at risk of poverty' and 5.7 per cent of those in consistent poverty with private medical insurance in 2006. It also has a relationship with income where people with a higher income are more likely to have private health insurance.

3.6: Summary

- People living in poverty are more likely to suffer from a chronic illness or disability and have poor health in general, even when controlling for age and gender
- A significant number of people, including children 'at risk of poverty' and living in consistent poverty do not have a medical card. Just over 30 per cent of people 'at risk of poverty' do not have a medical card and 25 per cent of people living in consistent poverty do not have a medical card.
- Medical card cover is directly related to income where the lower people's income the more likely there are to have a medical card
- But the evidence suggest that a large number of people under the age of 69 above the poverty line and income threshold for the medical card have been allocated medical cards, starting at almost 20 per cent of people in the fifth income decile and slowly decreasing to 1 per cent in the top income decile. Forty-eight per cent of people who have a medical card have a weekly income above the income thresholds for the medical card

- People over 70, who automatically have access to a medical card regardless of income, have almost 100 per cent cover. Only 3 per cent of over-70s do not have a medical card and these older people tend to be in the highest income decile
- Almost 50 per cent of the population are covered by private health insurance. This is also related to income, with those in higher income deciles more likely to have private insurance
- Almost 6 per cent of people in consistent poverty and 12 per cent of those at risk of poverty have private insurance.

Chapter 4: Socio-Demographic Characteristics of People at Risk of Poverty without a Medical Card

4.1: Introduction

This chapter looks at the socio-demographic characteristics of people who are 'at risk of poverty' without a medical card. The first section compares people at risk of poverty with a medical card to people at risk of poverty without a medical on demographic factors, health status, economic and income conditions. The second section summarises these factors within a model of medical card take-up to see which factors significantly influence whether a person has a medical card or not. The results for people who are living in consistent poverty without a medical card are presented in Appendix A.

4.1.2: Final Sample

In summary the following analysis represents the socio-demographic characteristics of all adults '**at risk of poverty**', aged between 16 and 69, excluding full time third level students. The necessary adjustments that were outlined in Chapter 2 have been applied. The sample includes only those who are 'at risk of poverty'. Key socio-demographic characteristics are analysed in relation to whether respondents have a medical card or not. Any reference to students in the following section refers to those over 16 completing secondary school or those completing certificates or diplomas.

Therefore in 2006, 33 per cent (or approximately 174,000 people) of adults aged 16-69 'at risk of poverty' and 25 per cent (44,000 people) of adults aged 16-69 who are living in consistent poverty did not have a medical card.²⁵

4.2 Overview of Demographic Characteristics of People at Risk of Poverty with and without a Medical Card

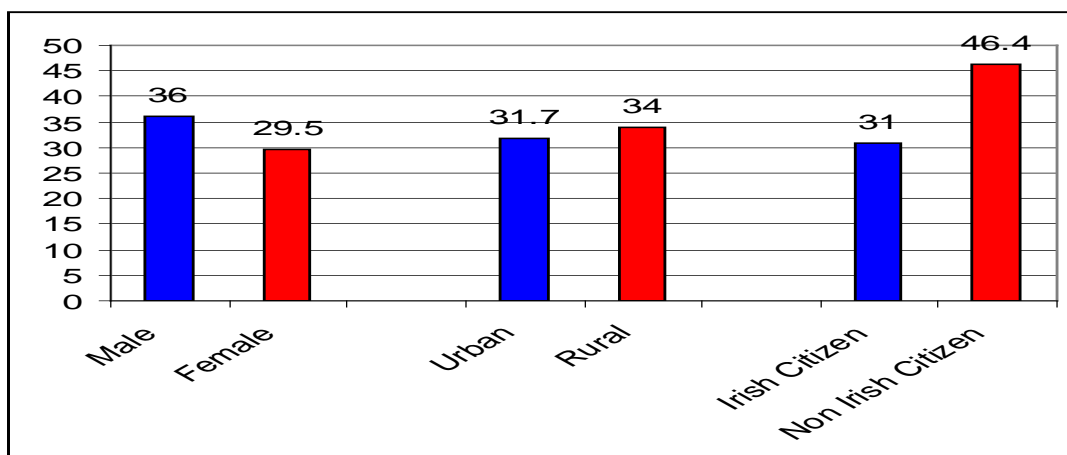
4.2.1 Demographics

Key socio-demographic characteristics analysed in this section of those 'at risk of poverty' or below the 60 per cent poverty line with and without a medical card are age, gender, geographical location, income and employment variables. These variables were examined in the context of health and health service variables and work patterns. The intention here is to understand why there are a number of people living below the poverty line without a medical card.

Figure 4.1 displays the percentage of those 'at risk of poverty' without a medical card by gender, type of area people live in, and nationality. The analysis showed that a higher percentage of men 'at risk of poverty' did not have a medical card compared to women. Almost 36 per cent of men 'at risk of poverty' did not have a medical card, compared to 30 per cent of women.

Figure 4.1: Percentage of People 'At Risk of Poverty' without a Medical Card by Gender, Area and Nationality (EU-SILC 2006)

²⁵ Therefore the corresponding sample size is 1,431 for those at risk of poverty and 524 for those living in consistent poverty.



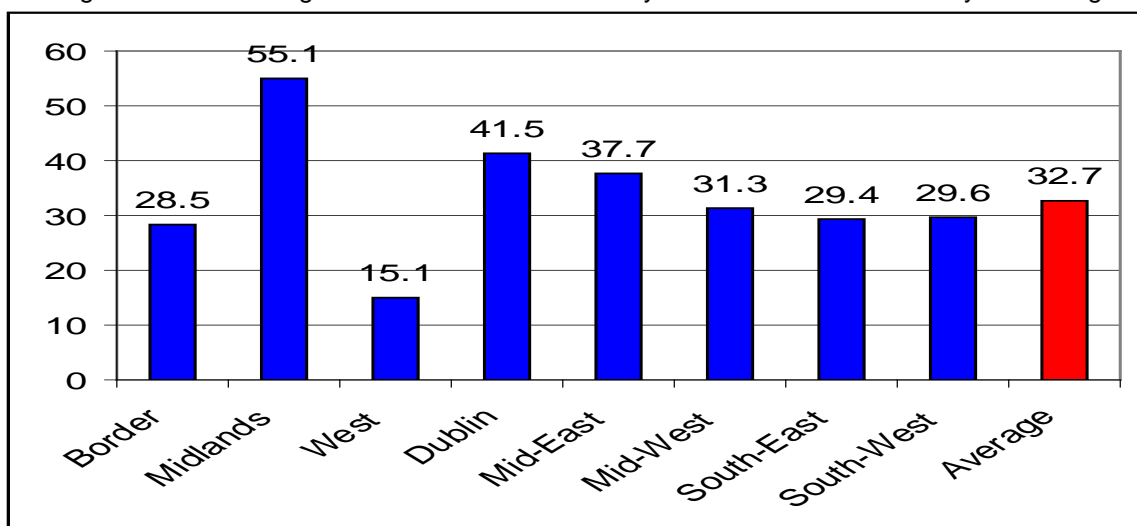
There was little difference between people living in urban areas versus people living in rural areas. Almost 34 per cent of those 'at risk of poverty' living in a rural area did not have a medical card; this is compared to 32 per cent of those living in an urban area.

Conceptualising nationality has become an increasingly difficult task for the Central Statistics Office over the last number of years due to growing multiculturalism in Ireland.²⁶ In total 46 per cent of the 'non-Irish citizens' at risk of poverty do not have a medical card compared to 31 per cent of Irish people. A limitation of this is that there is no indication of whether language is a barrier to non-nationals taking up a medical card. English could be the first language of many people as this category would also include those from the United Kingdom. Based on qualitative research highlighted in Chapter 1 language barriers are a factor in medical card take-up.

²⁶ See page 54 of the background notes of *EU-SILC 2006* published by the CSO in 2007 for discussion on defining nationality.

Figure 4.2 displays the regional difference of those 'at risk of poverty' without a medical card as a percentage of all those in each region 'at risk of poverty'. This illustrates the large variance in medical card take-up between the different regions. In the Midlands 55 per cent of people 'at risk of poverty' did not have a medical card. The West and Border regions have a below-average rate of non-medical card cover. In the west 15 per cent of all those 'at risk of poverty' did not have a medical card and in the Border region 28 per cent of people 'at risk of poverty' did not have a medical card. Dublin (42 per cent) and the Mid-East (38 per cent) also have above-average numbers of people at risk of poverty without a medical card. The Mid-West, South East and South West have similar numbers. Almost 31 per cent of people 'at risk of poverty' in these regions did not have a medical card. A number of factors may be at play when looking at regional differences. For example, there are more older people living in western areas than other regions of the country and this may therefore explain why the majority are covered by a medical card. This will be explored further in the next section.

Figure 4.2: Percentage of those 'At Risk of Poverty' without a Medical Card by NUTS region



The income thresholds for eligibility for the medical card take into account the number of adult and child dependents living in the household. Figure 4.3 displays medical card cover based on household composition. The majority of people 'at risk of poverty' living in one adult households and households with one adult with children have a medical card at 82 per cent and 96 per cent respectively. Households described as 'one adult with children' are used as a marker of lone parent households. It is unsurprising to find that the majority of people in lone parent household have a medical card. Lone parents have one of the highest rates of consistent poverty in 2006, at approximately 33 per cent (CSO 2007). Lone parents are also assessed for a medical card on the income thresholds for a married couple so therefore have a higher income disregard.

Almost 37 per cent of households with two adults with 1 to 2 children 'at risk of poverty' do not have a medical card; 46.5 per cent of people living in households with three or more adults and no children do not have a medical card. As household composition does not necessarily mean family structure, people living in households with '3 adults and no children' may not be related to each other and each may be assessed as a single person for the medical card. Another issue with this category of household composition is that this may be a household with two or one adult with a young person aged 16 or 17.

Figure 4.3: Household Composition of those 'At Risk of Poverty' by Medical Card Cover (EU-SILC 2006)

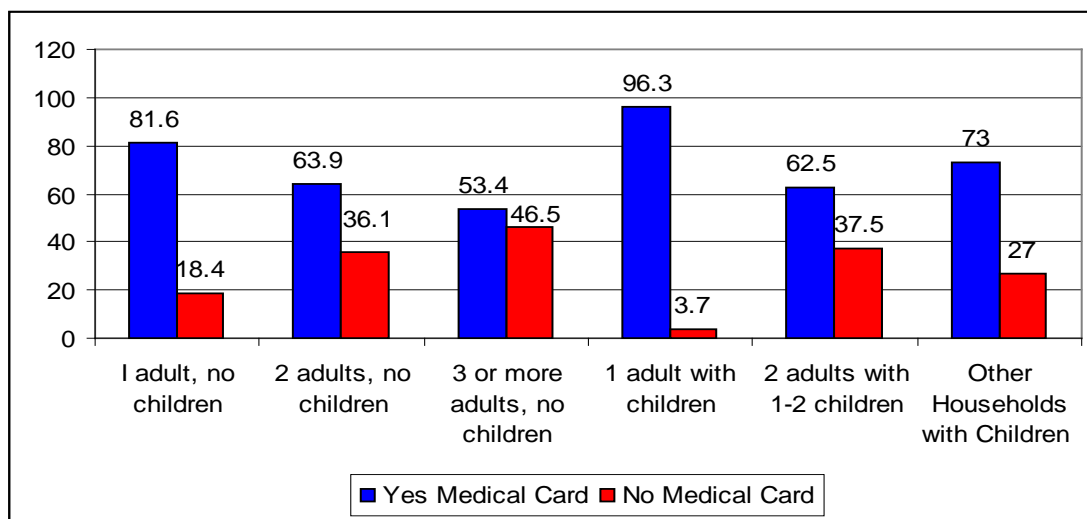
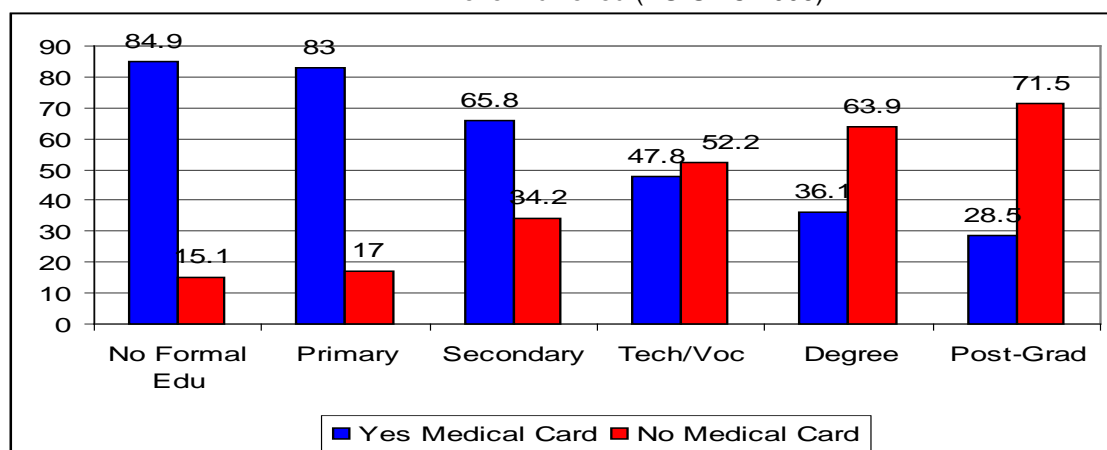


Figure 4.4 looks at 'highest level of education achieved' and medical card cover. The lower the education level the more likely one is to have a medical card. Those who have completed post-leaving cert education are less likely to have a medical card. This may be related to principal economic status as those with a higher level of education may have better paid jobs and higher incomes and therefore be above the limit for medical card eligibility. These issues will be explored in the next section.

Figure 4.4: Medical Card Cover as a Percentage of those 'At Risk of Poverty' by Highest Education Level Achieved (EU-SILC 2006)



Almost 45 per cent of those living in private rented accommodation do not have a medical card compared to 40 per cent of those living in owner occupied housing. The majority of people living in local authority housing or rent free have a medical card, with only 10 per cent reporting no medical card cover.

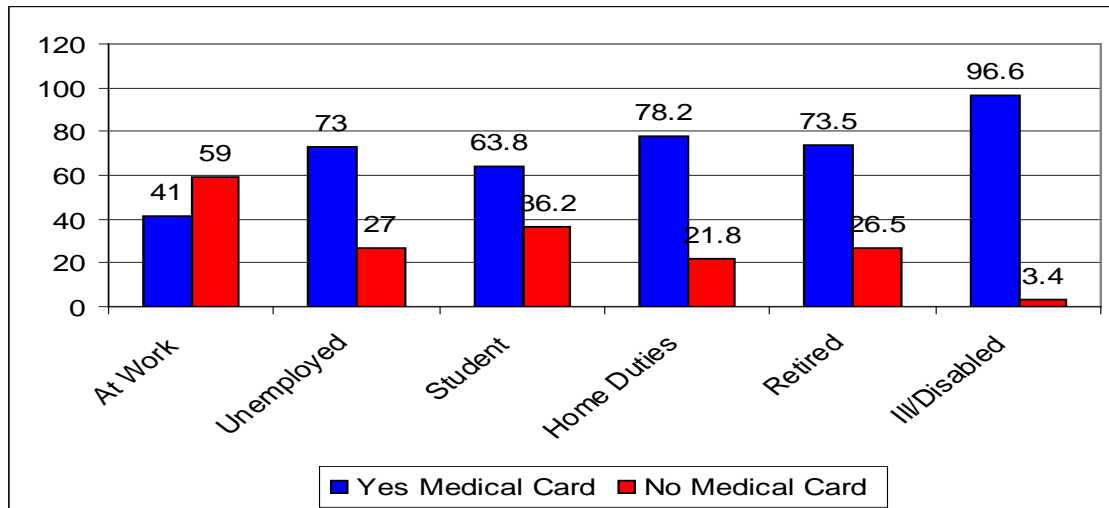
4.2.2: Economic Status and Work

Figure 4.5 displays the principal economic status of people 'at risk of poverty' with and without a medical card. People who are not working by virtue of illness or disability are the most likely to have a medical card, with almost 97 per cent cover. However, it must be noted that almost 3.5 per cent of those 'at risk of poverty' who are ill or disabled do not have a medical card. In Chapter 1 it was highlighted that under current conditions people in receipt of the maximum social welfare payment (JSA, OFP or non-contributory old age pension) may be automatically entitled to a medical card.

Figure 4.6 shows that over 70 per cent of people whose principal economic status is 'Unemployed' have a medical card. Just over a quarter of those whose principal economic status is unemployed do not have a medical card. This may be because they are working part time and not claiming the maximum benefit or they may not have applied for the medical card due to lack of information or having no perceived need for this secondary benefit, an issue highlighted in Chapter 1 (See CPA 2008).

The majority of people 'at work' do not have a medical card (60 per cent), maybe because they have an income above the income thresholds. However, evidence suggests that people who are working, even low-income workers, assume they would not qualify so never go through the application process (Combat Poverty 2008a). Students, excluding those studying for a degree, had an above-average incidence of non-medical card cover, at 36 per cent. This category includes those studying for their leaving certificate and those completing a certificate or diploma.

Figure 4.6: Medical Card Cover of People 'At Risk of Poverty' by Principal Economic Status (EU-SILC 2006)



It is important to remember that this is the principal economic status of each individual; many people may be the dependants of those who are working. Looking at the household level and splitting household into working²⁷ and non-working, working households have a rate of 52 per cent of no medical card cover compared to 17 per cent of those in non-working households.

Analysis based on the household reference person or 'head of household' finds that 53.8 per cent of people at risk of poverty living in households headed by someone at work do not have a medical card compared to people in households with a medical

²⁷ Working household is defined as a household where the principal economic status of one or more people is 'at work'

card. 46.5 per cent of people 'at risk of poverty' living in households headed by students do not have a medical card. Almost 29 per cent of people living in households headed by an unemployed person do not have a medical card and 20 per cent of households headed by an economically inactive person (including ill/disabled, retired or engaged in home duties) do not have a medical card.

Table 4.1: Principal Economic Status of People 'At Risk of Poverty' by Medical Card Cover (EU-SILC 2006)

	At Work	Unemployed	Student	Inactive
Yes Medical Card	46.2 per cent	71.2 per cent	53.6 per cent	79.7 per cent
No Medical Card	53.8 per cent	28.8 per cent	46.4 per cent	20.3 per cent

Figure 4.7 illustrates that the more people at work in a household "at risk of poverty" the less likely it is that a householder will hold a medical card. As the number of unemployed householders increases so does the likelihood of having a medical card. Almost 90 per cent of households with 3 or more people at work do not have a medical card. Similarly 0 per cent of households with four people unemployed do not have a medical card.

Figure 4.7: Percentage of People 'At Risk of Poverty' at Work/Unemployed in Household without a Medical Card (EU-SILC 2006)



Further analysis indicates that people 'at risk of poverty' without a medical card are more likely to have a permanent contract²⁸ and be working full time. Almost 70 per cent of people working full time and at risk poverty do not have a medical card; this is compared to 42 per cent of people working part time. There is only a small difference between people in a supervisory role without a medical card (35 per cent) and those in a non-supervisory role without a medical card (34 per cent).

4.2.3: Income

Income is considered the most important factor determining medical card eligibility. This analysis compares the income of people 'at risk of poverty' with a medical card to those at risk of poverty without a medical card. Table 4.2 compares the pre-social transfers and post social transfers²⁹ equivalised income of those with a medical card

²⁸ * denotes small sample size, although a high number of people who had occasional work did not have a medical card, the sample size was too small to make any estimations or assumptions.

²⁹ Social transfers include: Jobseekers, old age pensions, family/children allowances, housing allowances, disability, survivors, sickness benefits and education allowances (CSO:2006).

to people without one. People with a medical card are more reliant of social transfers than those without. People without a medical card have an annual equivalised income of €3,160 before social transfers; this is equivalent to €60 a week. People with a medical card have an equivalised income of €14 a week pre-social transfers. Social transfers account for over 90 per cent of those at risk of poverty with a medical card, compared to 58 per cent of those without a medical card.

Post-social transfers, there is little difference between the income of people 'at risk of poverty' with a medical card (€165 per week) to people 'at risk of poverty' without a medical card (€166 per week). This suggests that, in practice, medical card eligibility may not solely be based on assessment of income. Considering that the medical card is a means-tested benefit it is surprising to find that there is no difference based on equivalised disposable income for people 'at risk of poverty' with a medical card compared to people 'at risk of poverty' without a medical card. A limitation of this study is that there is no means of ascertaining whether people have applied for a medical card and been refused or have not applied.

Table 4.2: Equivalised Income Pre and Post Social Transfers of People 'At Risk of Poverty' with and without a Medical Card (EU-SILC 2006)

		Annual income Pre Social Transfers (Gross)	Annual income Post Social Transfers (Net)	per cent of income from Social Transfers
60 per cent income threshold	Yes Medical Card	€739	€8629	91.4 per cent
	No Medical Card	€3160	€8631	58.7 per cent
50 per cent Income threshold	Yes Medical card	€0	€7655	100 per cent
	No Medical card	€5009	€7308	29.8 per cent

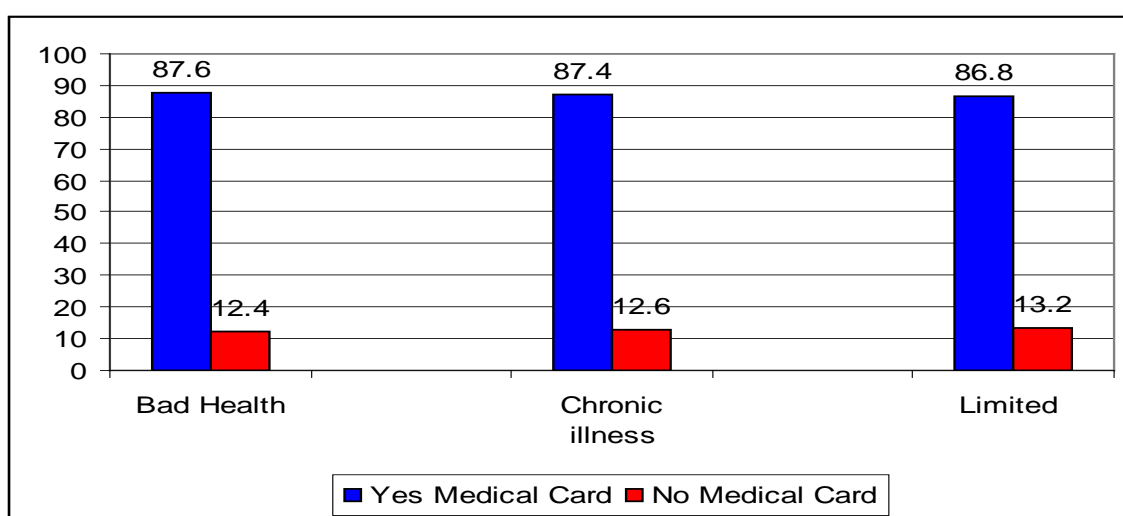
40 per cent Income threshold	Yes Medical Card	€0	€6077	100 per cent
	No Medical card	€4698	€6019	21.9 per cent

At the 50 per cent poverty line those with no medical card actually have a lower income than those with a medical card after social transfers.

4.2.4: Medical Card Coverage and Health Status

The previous chapter showed that people living in poverty were more likely to suffer from poorer health, and that people suffering from a chronic illness or disability are more likely to have low incomes or suffer from deprivation. Figure 3.14 shows clearly that people with a medical card are much more likely to suffer from a health condition or chronic illness and generally have worse health than those without a medical card. In all cases, almost 88 per cent of those with poor health, a chronic illness or limited activities due to a health problem have a medical card. People with an economic status reported as ill and disabled account for many of those at risk of poverty with a medical card. When people with an illness or disability are removed from the analysis, almost 20 per cent of people suffering from chronic illness, in poor health or who are limited in their activities do not have a medical card.

Figure 4.9: Health Status of People 'At Risk of Poverty' by Medical Card Cover (EU-SILC 2006)



As EU-SILC only asked respondents with a medical card how many times they had visited the GP, it was not possible to analyse GP utilisation of medical card holders compared to non medical card holders. However, a comparison of these groups based on the reasons why people did not go to the doctor when they need to do so was conducted. In total 5.6 per cent of people without a medical card and 3 per cent of people with a medical card needed a medical examination in the previous twelve months but did not receive it. Almost 91 per cent of people without a medical card said that the main reason they did not get a medical consultation when they needed it was because they could not afford it. Interestingly 8 per cent of people with a medical card said they could not afford it. This is surprising considering people with medical cards should not have cost as a barrier to medical care. A possible explanation may be that 'medical consultation' could also mean services not covered by the medical card such as certain types of specialist. 'Other' in this instance refers to unable to find childcare, no transport or fear of doctors. Care must be taken when interpreting these results as the sample size is very small but it is still important to note this finding.

Figure 4.10: Private Health Insurance by Medical Card Cover

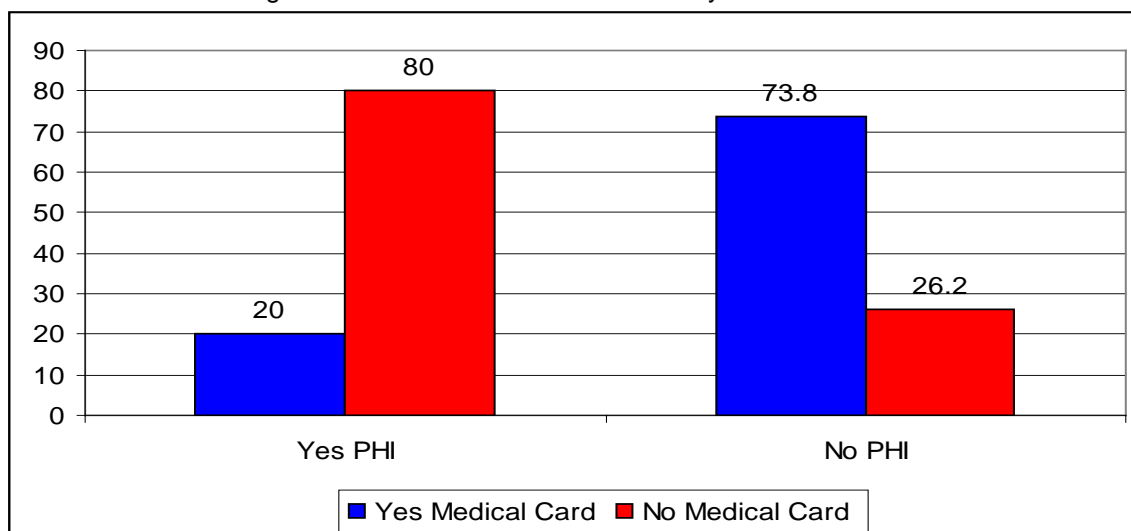


Figure 4.10 illustrates the number of people 'at risk of poverty' with private health insurance and medical card cover. Eighty per cent of people with private health insurance do not have a medical card, 20 per cent have both a medical card and private health insurance. Similarly 73 per cent of people without private health insurance have a medical card and 26 per cent do not. Taken as a percentage of people without a medical card, people with private health insurance equate to 29 per cent of all those without a medical card. This is compared to 3.6 per cent of people with a medical card.

It is difficult to understand why people on low incomes or at risk of poverty take out private health insurance without looking at type of need. It is not within the scope of this paper to answer this, but a number of explanations could be offered. For example, people who suffer from specific types of illness may require secondary care that is not covered by the medical card so therefore it is necessary to take out private insurance. Some analysis was carried out on those at risk of poverty with private health insurance. This group was predominantly at work so it could be possible that they may not know they could be eligible for the medical card and therefore never applied but took out private health insurance.

4.3: Factors influencing Medical Card Take-Up for People at Risk of Poverty

In this section, a model of medical card take-up for people 'at risk of poverty' will be presented using logistic regression. The analysis examines which of the characteristics presented in the previous section are the most important in determining medical card cover for people 'at risk of poverty'. A model of take-up at the 50 per cent poverty line is also presented as it is useful to examine whether the same characteristics are significant in medical card take-up at a lower poverty line. The variables included in this analysis are:

Key demographic characteristics – age, sex, region, urban/rural, nationality and education.

Socio-economic characteristics – equivalised income after social transfers, principal economic status of the head of household and number of people at work

Only one predictor of health was chosen (suffering from a chronic illness) as all health variables exhibited similar relationships with socio-economic characteristics in earlier analysis and because the other two were viewed as more subjective than this variable.

Income pre-social transfers, tenure status and number of people at work in the household were not included as it appeared there may be overlap with some of the other variables in the model, i.e. they may be measuring the same thing, for example income.

The advantage of analysis like this is that it gives a clear outline of what influences people 'at risk of poverty' taking up a medical card when all other factors are controlled for. For example, the higher rate of medical card cover for women found in the previous section may be due to the fact that women have high levels of poverty, or for example more people in western regions have a medical card because there is a higher level of unemployment and poverty. Multiple regression indicates there is a relationship between medical card take-up for people at risk of poverty while suppressing all other possible interactions that may be affecting the result.

Table 4.3 displays the results of the logistic regression and the odds ratios for not having a medical card,³⁰ e.g. you are 2.3 more likely to have a medical card if you are living in a rural area. If the result for an odds ratio is more than one, it means that

³⁰ The reference category for this model is 'Yes covered by a medical card' (No=0 and Yes=1) as it was more difficult to read if the figure was below one; for example you would be reporting if men were less likely not to have a medical card. The p value is set at .05

an increase in the predictor will increase the likelihood of someone having a medical card. If the value is less than one the likelihood decreases, i.e. one is less likely to have a medical card and more likely not to have a medical card. For continuous variables such as age, if the odds ratio is over 1, and if there is an increase in age, the likelihood increases that the person will have a medical card.

Table 4.1: Model of Medical Card Cover at 60 per cent and 50 per cent Poverty Line

		60 per cent poverty line 'at risk'		50 per cent poverty line	
Factor	Categories	P value	Odds Ratio	P value	Odds Ratio
Sex*	Male Female	.004	1.521	.040	1.48 9
Region *	South West (Reference category)				
	Border	.000	2.150	.006	2.78 1
	Midlands	n/s	n/s	n/s	n/s
	West	.013	2.110	n/s	n/s
	Dublin	.001	.410	.018	.436
	Mid- east	n/s	n/s	n/s	n/s
	Mid- West	n/s	n/s	n/s	n/s
	South-east	n/s	n/s	n/s	n.s
Location*	Urban Rural	.011	.661	n/s	n/s
Education*	Leaving Cert Above Leaving Cert	.000	.399	.004	.448
Household Comp*	1 adult, no children	.000	.315	.005	.384
	2 adults no children	.000	.185	.000	.179

	3 adults no children	.n/s	n/s	n/s	n/s
	1 adult with children	n/s	n/s	n/s	n/s
	2 adults with children 1-3	.009	.502	n/s	n/s
	Other households with children (Ref cat)				
Chronic Illness*	Yes	.000	.256	.000	.259
	No				
PES*	At work	n/s	n/s	n/s	n/s
	Unemployed	n/s	n/s	n/s	n/s
	Student	.000	.183	n/s	n/s
	Inactive (Ref cat)				
Income *	Numeric: Units one euro	.000	1.0002	.000	1.00 02
Number at work	0 (Ref cat)				
	1	.000	.146	.000	.149
	2	.000	.054	.000	.081
	3 or more	.000	.011	.000	.028

Table 4.3 illustrates that when controlling for all other factors the following influences whether someone 'at risk of poverty' has a medical card:

gender

location

region

principal economic status of household reference person
income
chronic illness
household composition
education and
number of people at work in the household.

Non-significant results were found for nationality and age.³¹

The r-squared result for the final model was .411, indicating that 40 per cent of the variance in the dependent variable (medical card status) can be explained by the model. Below is a brief discussion of each factor included in the model.

4.3.1: Demographics

No significant results were found for age, i.e. age does not influence whether someone has a medical card or not. As all children and people over 70 are removed, this tells us that there was no significant difference between people 'at risk of poverty' with a medical card and people 'at risk of poverty' without a medical card in the age between 16 and 69. Age was also not significant at the 50 per cent line.

Nationality was also found to be non-significant, i.e. nationality does not influence whether a person 'at risk of poverty' has a medical card when all other factors are controlled for. This is surprising as one of the key barriers cited in previous research to taking up a medical card is English language and literacy difficulties (Combat Poverty 2008a). The non-significant result may be explained by a number of factors.

³¹ Sample only includes people at risk of poverty aged between 16 and 69

Firstly, there is the crude definition of nationality into Irish/ non-Irish. Secondly, people who are disadvantaged with English language difficulties could be underrepresented in a survey of this nature as they are less likely to take part in such research. Therefore their difficulties would not be captured sufficiently. Nationality also was not significant at the 50 per cent line.

A significant result was found for gender, i.e. when controlling for all other factors gender determines whether someone 'at risk of poverty' has a medical card or not. In this case women are 1.521 time more likely to have a medical card. Therefore men 'at risk of poverty' are less likely to have a medical card. Similar results were found at the 50 per cent poverty line where women were 1.489 times more likely to have a medical card.

Looking at location, if you live in a rural area you are 0.66 times less likely to have a medical card than people living in an urban area. Therefore people at risk of poverty living in a rural area are less likely to have a medical card when controlling for all other factors. This may be related to difficulties in access to services for people living in rural areas. For example, people living in rural areas may have difficulties in finding a GMS GP or GP services in general. They may also have limited access to information on the medical card if they are not in contact with a community welfare officer, etc. These issues, in particular accessing a GP, were highlighted by the Combat Poverty Study on access to the medical card. This was not significant for those living below the 50 per cent poverty line.

This may be closely linked to regional difference in medical card cover. As the previous chapter highlighted, medical card cover among those 'at risk of poverty' across the region varied enormously, with the Midlands having a particularly low level of medical card cover and the West have a particularly high level. When all other factors are controlled for, region can significantly influence whether a person at risk of poverty has a medical card or not.

For the purpose of logistic regression it is necessary to make a reference category when a variable has more than two categories. In this case the South-West was chosen as it was the closest to the national average of non medical card cover at 30 per cent. Therefore it was possible to make comparisons with the South-West and the other regions. Looking at Table 4.1, people at risk of poverty living in the border counties are 2.150 times more likely to have a medical card than people living in the South-West. Similarly people living in the West are 2.11 times more likely to have a medical card than people in the South-West. People living in the Dublin area are .41 times less likely to have a medical card than people living in the South-West. The previously chapter showed that people living in the Midlands had a low level of medical card cover, but once all other factors are controlled for these difference are no longer significant. Non-significant results were also found for the Mid-East, Mid-West and South-East as all these have a rate of medical card near the average of 33 per cent.

Therefore if you live in Dublin you are less likely to have a medical card but if you live in the West and Border Area you are more likely to have a medical card. This may be due to different administration of medical cards in different regions or that people are more likely to apply/not apply in certain regions. These differences were also evident at the 50 per cent poverty line, where people living in the Border region were more likely to have a medical card and people living in Dublin were less likely; no differences were found for the West.

Education also significantly influences medical card take-up. In this instance if people have an education level above leaving certificate they are .399 times less likely to have a medical card. Therefore the lower people's education level the more likely they are to have a medical card, when all other factors are controlled for. It must be noted that people who are currently studying for a degree or higher are not included in this analysis. Education was also significant at the 50 per cent line where people who were above leaving certificate were .448 less likely to have a medical card

4.3.2: Economic Status and Work

Only the Principal Economic Status of the household reference person was included in the model as there would be cross-correlation if the PES of the individual was also chosen. The PES of the household reference person was chosen as income and economic status of a household usually follows from the PES of the head of the household. In Table 4.1 the reference category is economically inactive people, including ill/disabled, retired and people engaged in home duties. When all other factors are controlled for, households headed by people 'at risk of poverty' and at work do not differ from households headed by economically inactive people on the likelihood of having a medical card. Similarly there was no significant difference observed for households headed by unemployed people. Households headed by a student were found to be .183 less likely to have a medical card compared to someone in a household headed by an inactive person. Therefore people living in households headed by a student are less likely to have a medical card. Student in this instance refers to anyone studying for a Junior or Leaving certificate, higher certificate or diploma. No differences were observed at the 50 per cent line in relation to Principal Economic Status. Therefore the differences observed in the previous chapter for Principal Economic Status could be attributed to another factor such as income.

Although 'at work' was not significant, the most powerful predictor of medical card take-up was how many people were at work in the house. In this case the reference category is 0 people at work in the household. If there was one person working in the household people were .146 less likely to have a medical card. If there were two people at work in the household they were .054 time less likely to have a medical card and if there were three or more people at work in the household people are .011 less likely to have a medical card. This suggests that the more people at work in the household the less likely they are to have a medical card. Number of people unemployed in the household was not included in the model because it is not mutually exclusive from number of people at work. Similar results were found at the 50 per cent line.

4.3.3: Income

Equivalised income influences whether someone 'at risk of poverty' has a medical card or not as the p value is less than .001. The odds ratio for income is 1. This tells us that there is very little difference based on income. Taking into account the decimal places, this becomes 1.0002. This tells us that as a person's income increases the likelihood of have a medical card increases, but this is only a tiny effect. The units used in this case are €1, so as income increases by €1 the likelihood of having a medical card increases by 1.0002. This could be underestimating the differences based on income; therefore the income variable was recoded in €100 brackets. This only saw a slight increase in the odds ratio to 1.024. What is important here is that as income increases the likelihood of having a medical card increases. Therefore for people at risk of poverty the higher their income the more likely they are to have a medical card.

4.3.4: Health

It was decided that only one measure of health was necessary in order to eliminate any cross-correlation. Looking at chronic illness Table 4.3 confirms earlier findings that if people do not have a chronic illness they are .256 times less likely to have a medical card. Therefore people with worse health are more likely to have a medical card, even when people with illness and disabilities are removed. This may be interpreted as medical card take-up being based on health needs, where people with a health condition are more likely to get a medical card because they have a greater need.

4.3.5: Household Composition

Household composition was also a significant factor in medical card take-up. The reference category for this variable is households with children. People living on their own or people living in households with 2 adults with no children are .315 and .185 times less likely to have a medical card, compared to other households with children. No significant results were found for households with 3 adults or more and 1 adult with children when all other factors were controlled for. Households with 2 adults with

1-3 children were .502 times less likely to have a medical card than other households with children.

4.4: Summary

- The majority of people at risk of poverty and who are unemployed or live in a house headed by an unemployed person had a medical card, but 27 per cent of unemployed people did not have a medical card. Almost 29 per cent people living in households headed by an unemployed person did not have a medical card.
- Sixty per cent of people 'at work' did not have a medical card; 58 per cent of people at risk of poverty living in a household headed by someone at work did not have a medical card.
- The most distinguishing feature of people 'at risk of poverty' without a medical card is that they are living in working poor households, where two or more people are at work.
- Ninety per cent of people 'at risk of poverty' lived in households with three or more people at work did not have a medical card.
- Over 12 per cent (or 20 per cent when people with disability are removed from the analysis) of people at risk of poverty and suffering from a chronic illness did not have a medical card.
- Ninety-eight per cent of people 'at risk of poverty' with a disability had a medical card, but 3.5 per cent of people 'at risk of poverty' who report having a disability did not have a medical card.
- Forty-five per cent of people 'at risk of poverty' living in private rented accommodation did not have a medical card. This is compared to 10 per cent of people 'at risk of poverty' living in local authority housing.
- People 'at risk of poverty' with a medical card are for the majority completely reliant on social transfers as their main source of income.
- Post-social transfer there is little difference in income between people 'at risk of poverty' without a medical card and those with a medical card.
- Many people who do not have a medical card had private health insurance.

- Using Multivariate analysis people 'at risk of poverty' without a medical card were more likely to be
 - male
 - living in a rural area
 - living in the Dublin region
 - have a higher level of education
 - living in a household headed by a student
 - living in a household where one or more people are at work
 - living in a household with 2 or more adults or a household with 2 adults with 1-3 children
 - have a marginally lower income and
 - have better health.

Age and nationality were not significant factors in predicting whether someone 'at risk of poverty' had a medical card or not in analysis of a sample that excluded children and people over 70.

- Women 'at risk of poverty' were more likely to have a medical card than men 'at risk of poverty' even when all other variables such as health status and income are controlled for.
- People 'at risk of poverty' living in rural areas were less likely to have a medical card than people 'at risk of poverty' living in an urban area.
- There are significant differences in medical card cover on a regional basis. People 'at risk of poverty' in the West and Border regions were more likely to have a medical card than people 'at risk of poverty' living in the South West (reference category that was closest to the national average). People living in Dublin were less likely to have a medical card than people 'at risk of poverty' living in the South West.
- The higher the level of education for people 'at risk of poverty' the less likely they are to have a medical card.
- There was no significant difference in medical card coverage among households headed by someone at work or someone who is unemployed compared to an economically inactive person. People 'at risk of poverty' living in households

headed by a student were less likely to have a medical card compared to households headed by an economically inactive person 'at risk of poverty'.

- As the number of people 'at risk of poverty' and at work in a household increased, the likelihood of having a medical card decreased.
- People 'at risk of poverty' and living on their own, households with two adults, and households with two adults and children were less likely to have a medical card than other at risk households with children.
- Equalised income was found to have a negligible impact on whether someone 'at risk of poverty' had a medical card or not. Surprisingly, this marginal effect was in the direction that the higher a person's income the more likely he/she was to have a medical card.
- People 'at risk of poverty' with poorer health were more likely to have a medical card than people 'at risk of poverty' with good health. Health was the strongest predictor of medical card cover.
- Similar results were found on almost all factors at the 50 per cent poverty line.

Chapter 5: Key Findings, Conclusions and Recommendations

5.1: Key Findings

This study's key findings contribute to the evidence available on some of the difficulties with the current medical card system. However, it could not directly examine from the existing data whether people living in poverty did not have a medical card because they were refused or because they did not apply. The main findings are outlined below.

5.1.1: Health, Poverty and Medical Card Cover

- The relationship between poverty and poor health was highly significant. People living in consistent poverty and people 'at risk of poverty' reported a higher incidence of chronic illness, limited activity due to health problems and bad or very bad health.
- These differences remained even when age and gender variations were controlled for.
- Between 2005 and 2006 the percentage of people living in consistent poverty without a medical card rose from 16 per cent to 22 per cent. This is equivalent to 63,000 people, including 14,000 children.
- In 2006, 30 per cent of people 'at risk of poverty' did not have a medical card. This is equivalent to 220,000 people, including 45,000 children.
- Two per cent of people aged over 70 do not have a medical card. The majority of these are located in the top income deciles.
- Almost 50 per cent of the population have private health insurance. Thirteen per cent of people at risk of poverty and 7 per cent of people living in consistent poverty have private health insurance.

5.2.2: The Socio-Demographic Characteristics of People at Risk of Poverty without a Medical Card

Gender

A higher percentage of women 'at risk of poverty' had medical cards compared to men 'at risk of poverty'. These differences remained when all other factors were controlled for such as differences between men and women's economic status, poverty levels and income.

Nationality

Although initial analysis suggested that non-Irish citizens were less likely to have a medical card than Irish people, this was proven non-significant in multiple regression. The non-significant result for nationality is surprising considering that ethnic minority groups report considerable problems accessing medical cards in previous studies. The definition of nationality and the probable under-representation of this group in the EU-SILC survey sample may be contributing to this finding.

Geographical Factors

People living in rural areas were significantly less likely to have a medical card than people living in urban areas when all other factors were controlled for.

- Regional location was also found to be a factor influencing medical card take-up. People living in the West and Border regions were almost 2.5 times more likely to have a medical card, whereas people living in the Dublin region are less likely to have a medical card.

Tenure Status

- Forty-five per cent of people 'at risk of poverty' living in private rented accommodation did not have a medical card. This is compared to 10 per cent of people 'at risk of poverty' living in local authority housing

Income

- As income rises, the proportion of people covered by the medical card decreases. However, a substantial number of people above the bottom two income deciles (which roughly equates to those below the 60 per cent poverty line or those at risk of poverty) have a medical card. For example, almost 20 per cent of people in the

fifth income decile have a medical card. People in this income decile have an equivalised income of almost €350 a week. In total 48 per cent of people with a medical card are above the 'at risk' poverty line

- Little difference was found between people 'at risk of poverty' with a medical card and 'people at risk of poverty' without a medical card in relation to income post-social transfers.
- In a multivariate analysis, income was found to have a negligible impact on whether someone 'at risk of poverty' had a medical card or not. Surprisingly, this marginal effect was in the direction that the higher a person's income the more likely he/she was to have a medical card.

Economic Status

- Seventeen per cent of people at risk of poverty living in households at work had a medical card. This is compared to 57 per cent of people 'at risk of poverty' living in economically inactive households. But when all other factors are controlled for no difference was observed between people in households at work and economically inactive households
- Sixty per cent of people at work did not have a medical card.
Twenty-seven per cent of unemployed people did not have a medical card.
Almost 29 per cent people living in households headed by an unemployed person did not have a medical card.
People at risk of poverty living in households with two or more people at work were significantly less likely to have a medical card than people with zero people at work in a household. This was one of the strongest predictors of non medical card take-up.

Health Status

- Ninety-eight per cent of people 'at risk of poverty' with a disability had a medical card.

- People 'at risk of poverty' with poorer health were more likely to have a medical card than people 'at risk of poverty' with good health. Health status was one of the strongest predictors of medical card cover

5.2: Conclusions

Based on these findings a number of conclusions can be made in relation to the current medical card system, medical card eligibility, and profile of people currently availing of it.

5.2.1: The Discretionary Nature of the System

Much of the empirical research highlighted in Chapter 1 illustrated that current medical card system is based on discretion as opposed to the predefined criteria of eligibility (Comhairle 2004, Combat Poverty 2008a). Evidence suggested that the system can lack transparency and the eligibility criteria are not clear. This study also highlighted the discretionary nature of the system. These conclusions are based on three main findings:

Firstly the medical card is intended to be a means-tested benefit aimed at the people on the lowest income with greatest financial need. However, this analysis shows that incomes of medical card holders were not significantly different to incomes of non-medical card holders. Furthermore, analysis of income deciles shows that a significant number of people in the middle and higher income deciles have a medical card, even when people over 70 are removed from the analysis. A multivariate analysis of factors significantly associated with having a medical card showed that as people's income increased, the more likely they were to have a medical card. This shows that, in practice, income is not being used as the core criterion for allocation of a medical card and confirms previous concerns over the discretionary nature of the system.

Secondly, this study suggests that there is a significant level of discretion awarded to the Health Service Executive and Community Welfare Officers when awarding medical cards. There were significant regional differences in the number covered by

the medical card. Even when all other factors or variations (including gender, income etc) were controlled for, people in the West and Border regions were significantly more likely to have a medical card than people living in other regions. People living in Dublin were significantly less likely to have a medical card than other regions. This illustrates that the discretion used across the country may be a factor in compounding socio-economic and geographic inequalities in access to primary health care services.

Thirdly, it would seem that within the discretionary system currently in operation, a high level of medical card coverage has been achieved among people with ill-health, chronic illness and disability. Health status was one of the strongest predictors of medical card take-up. People at risk of poverty with poorer health or with a disability were significantly more likely to have a medical card than those people with better health. This indicates the extent to which the 'undue hardship clause' is being utilised.

Nonetheless, in terms of optimising population health and reducing inequalities in health it is still important that, at the very least, all people at risk of poverty should have a medical card, even when they are not currently in ill-health or disabled. Prioritising access to primary health care among lower socio-economic groups has an important role to play not just in the prompt treatment of illness, but in optimising health and wellbeing and the prevention of a number of poor health outcomes.

Efforts to increase the transparency of the system and improve the consistency and application of eligibility criteria are needed to ensure that those who most need medical cards receive them. This would help to counteract discretionary effects in the current system that appear to have an inordinate impact on whether someone gets a medical card or not.

5.2.2: Working Poor and Income Thresholds

Much of the research that was highlighted in Chapter 1 advocated that the income thresholds for the medical card should be updated annually and take into account rising wages and cost of living (Combat Poverty 2007, 2008a, 2008b; Comhairle 2004, VPSJ 2008, IMO 2005, Layte et al 2007). The analysis presented here supports this proposal. Working poor households and households with one or more people at work were less likely to have a medical card. It is not within the scope of this research to answer whether people are not qualifying or not applying for the medical card but the fact that over a third of people living below the poverty line at 60 per cent, 50 per cent and 40 per cent do not have a medical card suggests that the income thresholds are too low.

Almost 29 per cent of households headed by an unemployed person did not have a medical card. This corroborates evidence from previous research that if a person is in receipt of a social welfare payment he/she may not be eligible for the medical card (Comhairle 2004). It also indicates that medical card thresholds should be in line with other social welfare payments in order to ensure that all people in receipt of social welfare are eligible for the medical card.

5.2.2: Targeting

Due to the apparent discretionary nature of the system, many people who have the greatest need for a medical card are not applying or not qualifying for it. This analysis has highlighted a number of groups that should be targeted, most prominently low-income working families. Low-income families with 2 adults and 2 or more children are less likely to have a medical card, particularly when there is one or more people at work in the household. As Chapter 1 highlighted, the medical card is of huge value to low-income families (VPSJ 2008, Comhairle 2004).

5.2.3: Information

Language and literacy barriers were cited as a key issue for people applying for medical cards (Combat Poverty 2008a). This study illustrated that people from outside Ireland were more likely not to have a medical card compared to people from

Ireland/full Irish citizens; these differences disappeared when other factors were taken into account. This variable is problematic, as it does not adequately capture English language difficulties. Indeed EU-SILC does not adequately capture the most vulnerable or disadvantaged including: Travellers, asylum seekers and homeless people. But based on the empirical evidence, accessing information on the medical card and the application process is especially difficult for these groups (Combat Poverty 2008a).

Men were also highlighted in this study as being less likely to have a medical card. This is probably related to the fact the men are less likely to seek medical help when they need to do so. They may be less likely to apply for a medical card or less likely to know that they are eligible. People who are working are also less likely to apply for the medical card as they may assume they are not eligible. Many people who are moving from welfare to work are not aware that they may retain their medical card for up to three years (Murphy et al 2008).

5.3: Recommendations

The overall recommendation that has emerged from this study is that there is a need to give all those 'at risk of poverty' and on low incomes easier access to primary care in order to reduce inequalities in health outcomes. The best means of achieving this is to increase medical card coverage in Ireland so that all those living below the poverty line can access free primary care. A number of suggested ways of achieving this are outlined in this section.

5.3.1: Transparency in the System

- Clarify the legal entitlement to the medical card, making explicit who is automatically entitled (people below a certain income, people dependent on social welfare, people with health conditions and illnesses).
- If an applicant is refused or deemed ineligible the reasons for this are made clear and a course for appeal is clearly outlined to the applicant.
- Make the system more transparent, i.e. who is qualifying and on what grounds, and who is not qualifying and on what grounds.

- This could also be achieved by setting up an independent appeals body or an independent audit of sample medical card applications that have been received to examine the reasons given for people being granted and people being refused.
- Although some discretion is needed when looking at particular cases (i.e. someone is just above the income threshold but has a health condition) the 'undue hardship' clause needs to be clarified and made more explicit.
- Numerical clarification is needed on what constitutes reasonable childcare and rent/mortgage costs.

5.3.2: Income Thresholds

Increasing eligibility limits to the equivalent of the higher welfare payment (currently €223 per week for the state pension), plus an earnings disregard of a further 20 percent of this figure (€46 per week). The eligibility limits for a couple or lone parent would be €372 per week and €78 for each additional child.

- Give legal entitlement to the medical card for people in receipt of the maximum social welfare payment.
- In order to increase the take-up of the medical card among low-income families, particularly those who have people at work, a number of recommendations can be made:
 - Link eligibility for Family Income Supplements to medical card eligibility, i.e. if you are eligible for FIS you should be automatically eligible for the medical card
 - Raise income thresholds so that they take into account the cost of primary care for low-income families
 - Equivalise thresholds in line with other social welfare payments so that it does not penalise families with children.

5.3.3: Information

- Information and application form to be made more accessible for people with English language and literacy difficulties and/or numeracy difficulties. Information

should also be available in Irish Sign Language format for people with hearing difficulties.

- Information on the medical card to be targeted at men and people who are at work and people who are thinking of moving from welfare to work. This could be achieved by an active programme of benefits uptake supported by the HSE and citizens advice bureau. It would also be helpful to link this to workplace health promotion and workplace initiatives with low-income workers – service industry, farming and fisheries, manual labour type employment, etc.

5.3.4: Further Research

The following topics could usefully be explored:

- Research why and how people living in poverty are taking out private insurance and the cost of this for people on a low income.
- Conduct independent examinations of medical card applications, focusing on reasons for applications being granted and reasons for an application being refused.
- Analyse the cost of primary care for low-income groups using possibly the Household Budget Survey.

Inclusion of a question on whether a person had applied for a medical card and whether his/her application had been granted or denied within the EU-SILC survey would broaden the scope for further investigation of this topic. Also the inclusion of information on GP only cards would be very beneficial.

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Appendix A: Socio-Demographic Characteristics of People Living in Consistent Poverty without a Medical Card

Below is an overview of the results for people in consistent poverty without a medical card. The first column displays the frequencies, where the highest category or no medical cover is * and marked in red, and the second column displays whether the variable was a significant factor in medical card take-up. The odds ratios for significant results are also displayed. Care must be taken when interpreting results as sample size was small, in particular for some regional categories, work related questions (full time/part time) and the question on reasons why people had not consulted the doctor.

Table a: Summary of Results for Medical Card Cover of Consistently Poor

	per cent No Medical Card	Sig/Not Sig	Odds Ratio
Household Composition		P=.004	
	I adult no children: 11.9 per	.012	.279

	cent		
	2 adults no children: 37.2 per cent	.003	.107
	3 or more adults no children: 49.7 per cent	.024	.388
	1 adult with children: 3.6 per cent	Not significant	n/s
	2 adults with 1-3 children: 18.7 per cent	Not significant	n/s
	Other households with children: 17.2 per cent		Ref category
Income	Medical Card: 8648 No Medical Card: 8124	.001	1.003
Number at work		P=.000	
	0: 13 per cent		Ref cat
	1: 43.4 per cent	.000	.116
	2 or more: 80.7 per cent	.000	.028
Chronic illness	Yes: 10 per cent/ No: 35.2 per cent		

Summary

- Similar to the results for at risk of poverty there was a higher incidence of non-medical card cover among men, non-Irish nationals, people living in owned or private rented accommodation, people with higher levels of education, people at work or students, people living in households with 3 or more adults and people

living in households with 2 or more people at work, people working full time and people living in the Midlands and Mid-East.

- The only aspect that differed from the 'at risk' group was that there was a slightly higher number of people not covered by a medical card in urban areas compared to rural areas. These differences disappeared when all other aspects were controlled for.
- The following factors were seen as significant in relation to medical card take-up for people living in consistent poverty: region, household composition, number of people at work in the household and income.
- The regional differences tell us that people living in the West are more likely to have a medical card, when all other factors are controlled for. The odds ratios tell us that there is large difference in the West compared to the South-West but due to small sample size the confidence intervals are very wide; the real value was between 1.614 and 88.631.
- If people live in a household that has one person at work they are .166 less likely to have a medical card than someone living in a household with no people at work. Similarly people living in a household with 2 or more people at work are .023 less likely to have a medical card.
- Income was also significant but this was only marginal as the odds ratio was close to 1. The effect it did have showed that as a person's income increases the more likely he/she was to have a medical card.
- People living in households with 1 adult no children, 2 adults no children and 3 adults no children were less likely to have a medical card than people in a household with children.