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HOUSING TENURE, HEALTH AND PUBLIC HEALTHCARE COVERAGE IN IRELAND

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ABBREVIATIONS

AROP	At risk of poverty
DHLGH	Department of Housing, Local Government and Heritage
ESRI	Economic and Social Research Institute
EU-SILC	EU Survey on Income and Living Conditions
HAP	Housing Assistance Payment
HSE	Health Service Executive
RPZ	Rent Pressure Zones
SHCEP	Social Housing Current Expenditure Programme
WHO	World Health Organization

ABSTRACT

Housing and health are regarded as pressing concerns for the general public and policymakers in Ireland, but little information exists regarding their relationship. This study utilises data from the EU Survey on Income and Living Conditions (EU-SILC) to examine the correlations between housing tenure (homeowners, private renters or supported renters), health and healthcare coverage in Ireland. Furthermore, the research examines the evolution of these relationships over time and analyses the differences in self-reported health, chronic illness and medical card coverage across key socio-economic dimensions. We find significant variations in health and healthcare coverage across tenure groups. In general, supported renters have the poorest health outcomes, particularly those who are older and unemployed. These groups also have the highest levels of public healthcare coverage. However, a significant proportion of supported renters – especially those who are young and employed – do not hold a medical card. These individuals are at high risk of poverty and have low enough incomes to qualify for public housing assistance, yet may be left with a large financial burden in the event of a health emergency due to a lack of public healthcare coverage. Low medical card coverage rates were also found among private renters, including those who are unemployed or have a chronic illness, putting many private renters at a high financial risk in the event of a health emergency. This study discusses policies to improve equity of access to the public healthcare system through the medical card system, especially for those groups which are most vulnerable in the event of a health emergency. In particular, we discuss the expansion of universal healthcare envisioned by the 2017 Sláintecare report and potential changes to medical card eligibility thresholds.

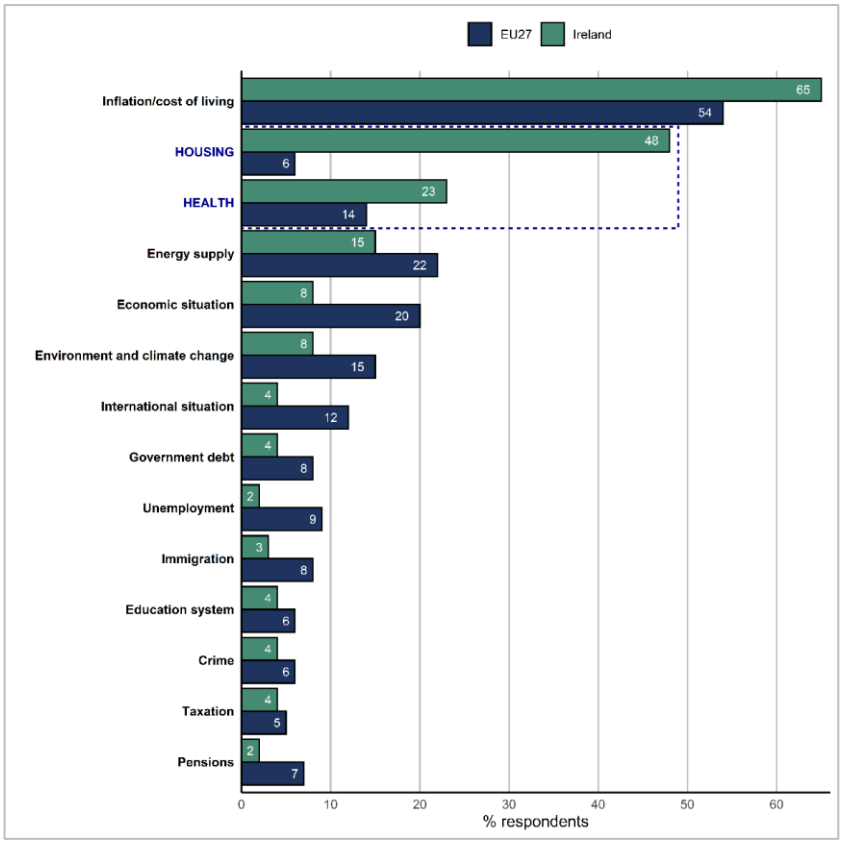
SECTION 1

Introduction

1.1 IMPORTANCE OF HOUSING AND HEALTH

Research into the relationship between housing and health is particularly pertinent in light of the salience of both housing and health in the national discourse. The most recent Eurobarometer survey highlights housing and health as second and third respectively in rankings of public concerns, behind the current cost of living crisis (Figure 1.1). Compared to our European peers, the issues of housing and health are considered much more pressing in the public consciousness in Ireland. This has consistently been the case in recent years and in recent election cycles.

FIGURE 1.1 'WHAT DO YOU THINK ARE THE TWO MOST IMPORTANT ISSUES FACING OUR COUNTRY AT THE MOMENT?'



Source: Standard Eurobarometer 97, summer 2022, Ireland country factsheet, https://europa.eu/eurobarometer/surveys/detail/2693.

Despite the importance of housing and health to the general public in Ireland, and the fact that international evidence suggests a relationship between tenure type and health, to date there has been relatively little research into the influence of housing tenure on health outcomes in Ireland. Similarly, due to the lack of universal healthcare in Ireland, unique in a European context (Wren and Connolly, 2019), a

relationship is also likely to exist between tenure and public healthcare coverage, and by extension, accessibility of healthcare services. Therefore, in this study we: examine the relationships between housing tenure, health and public healthcare coverage in Ireland; analyse the evolution of these relationships over time; and assess variation in health outcomes and coverage across socio-economic groups. Employing data from the EU Survey on Income and Living Conditions (EU-SILC) for the period 2007–2021, we find large variations in health outcomes and healthcare coverage across tenure groups, as well as across a number of other socio-economic dimensions such as age and employment status.

1.2 INTERNATIONAL EVIDENCE ON HOUSING AND HEALTH

The World Health Organization (WHO) lists 'housing, basic amenities and the environment' as key social determinants of health.[1] In support of this, a significant body of international evidence has documented a relationship between housing and health outcomes. The literature typically examines three primary channels through which this relationship transpires:

1. The physical condition of housing ('housing quality') (Rolfe et al., 2020);
2. Neighbourhood characteristics (Meyer et al., 2014; Kivimäki et al., 2021); and
3. Security of tenure (Bentley et al., 2016).

Of the latter channel, homeownership has been shown to increase individuals' sense of security and self-esteem, reduce stress and anxiety, and improve overall mental and psychological wellbeing (Rohe et al., 2013). Evidence also points to homeownership improving physical health. Exploiting variation in house-purchase subsidies in the 'Right to Buy' scheme in England, which incentivised homeownership for former local authority renters, Munford et al. (2020) find that homeownership increases individuals' subjective health ratings and reduces the average number of reported health conditions by 0.65. On the other hand, high homeownerships levels may also reduce mobility and employment rates in the long run for some (Ringo, 2021), thereby indirectly worsening health.

Insecurity of tenure (e.g., in private market rental accommodation) and anxieties around rent and mortgage payments have also been shown to negatively impact mental and physical health (Chung et al., 2020; Arundel et al., 2022). Programmes to improve security of tenure and/or relieve the cost burden of housing act to combat this. Welfare programmes in the United States (US) that reduced households' rent burden to less than 30 per cent of income have been shown to decrease reported psychological distress and poor physical health (Fenelon et al., 2017; Denary et al., 2021). Previous research has found that, in general, there is no evidence of universal housing affordability difficulties in the Irish market (Corrigan

[1] See https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

et al., 2019). However, certain groups, especially households renting in the private rental sector, have been found to face housing affordability challenges, with housing payment-to-income ratios in excess of 30 per cent.

Many of these findings within the international literature are of consequence to housing and health policymakers in Ireland. However, a cross-country comparative study of housing as a social determinant of health found that contextual factors such as population composition, the composition of the housing market (e.g., market-based vs. welfare-based supply), political ideologies and decision-making and data systems, all of which differ across countries, impact housing policies and the health and wellbeing of populations (Mwoka et al., 2021). Therefore, provision of evidence on health and housing in Ireland is important to policymakers here in order to make informed decisions about the direction of future policy.

SECTION 2

Housing and health in Ireland

The relationship between housing and health in Ireland may manifest itself in a number of ways. First, similar to international evidence, poor quality housing is linked with worse health outcomes. Issues such as dampness, mould, indoor pollution and the presence of harmful substances such as lead or asbestos can all contribute towards illness (Krieger and Higgins, 2002; Bonnefoy 2007), particularly respiratory infections, asthma and lead poisoning (Krieger and Higgins, 2002; Orr et al., 2016; Gibney et al., 2018; Laurence et al., 2023).

Second, factors such as overcrowding, housing deprivation and tenure precarity also carry deleterious impacts for mental and physical health. In Ireland, these issues have been shown to more commonly affect groups with lower socio-economic status (Grotti et al., 2018). Such groups have also been shown to live disproportionately within private rental accommodation (Grotti et al., 2018) where, despite new regulatory policies designed to protect tenants, they are often subject to precarious rental agreements and increasing rental costs.

Third, given that public housing and healthcare supports are both arms of the social welfare system, it may be expected that there is some degree of synchronicity between them. However, typically these two domains are regarded as separate matters, despite any potential connections between them. Table 2.1 lists the income limit thresholds that exist for social housing in Ireland, inclusive of the €5,000 increase made to all social housing income eligibility thresholds in January 2023. Income thresholds for housing supports vary by, and are distributed at, the local level by local authorities (i.e., county and city councils).

By contrast, public healthcare supports are dealt with at a national level by the Health Service Executive (HSE) and the Department of Health. Consequently, some discrepancies may arise in terms of eligibility for each arm of state assistance. For example, income limits for social housing and the Housing Assistance Payment (HAP) vary across local authorities, while income limits for medical cards are fixed at a national level (as discussed further in Section 3). While a low-income household may be eligible for housing supports in some localities, they may not always be eligible for a medical card due to the fixed national income threshold.

TABLE 2.1 ANNUAL (WEEKLY) INCOME LIMITS FOR SOCIAL HOUSING ASSESSMENT

BAND 1	SINGLE PERSON	3 ADULT & 4 CHILD FAMILY
Cork City, Dublin City, Dún Laoghaire Rathdown, Fingal, Galway City, Meath, South Dublin, Kildare	€40,000 (€769)	€48,000 (€923)
BAND 2		
Carlow, Clare, Cork County, Galway County, Kerry, Kilkenny, Laois, Limerick City & County, Louth, Wexford, Waterford City & County, Westmeath	€35,000 (€673)	€42,000 (€808)
BAND 3		
Cavan, Donegal, Leitrim, Longford, Mayo, Monaghan, Offaly, Roscommon, Sligo, Tipperary	€30,000 (€577)	€36,000 (€692)

Source: Department of Housing, Local Government and Heritage.
Note: There is no maximum allowance for additional children. Approximate weekly limits included in brackets.

Previous ESRI research has shown that local authorities also differ in terms of the type of income used in their social housing assessments, with some including income from social welfare such as Child Benefit and Carer's Allowance, while others exclude such income (Doolan et al., 2022). This often results in families with the same income being eligible for social housing in one local authority, but being ineligible in another.

Given the complexities that often exist in accessing public supports, it is important to elucidate more clearly the interaction between tenure and healthcare coverage. In particular, low- and middle-income individuals and households are disproportionately impacted by some of the factors outlined above. Similarly, many households in the private rental market, which are more likely to be low and middle income, are being further disadvantaged by the fact that they pay increasingly higher rents while also being vulnerable to further erosion of their disposable incomes in the case of a healthcare cost shock. This carries potentially large ramifications for welfare, both in terms of household disposable income and long-term health outcomes.

SECTION 3

Healthcare coverage in Ireland

Ireland has a mixture of both public and private healthcare coverage. Public healthcare coverage is largely based on eligibility for medical cards and GP visit cards, with some supplementary schemes – such as the Drugs Payment Scheme – also seeking to lower the cost of healthcare provision. Private healthcare coverage, by contrast, is a voluntary insurance-based system, with a range of private health insurance plans being offered by three major providers.[2] Private health insurance typically entitles the holder to a range of benefits not available to those with public coverage, such as private rooms in hospitals or more expeditious access to elective care (Kapur, 2019).

Medical cards are issued by the HSE and entitle the holder (and usually their spouse and dependants) to free healthcare services, including: GP visits; inpatient/outpatient treatment in public hospitals; certain dental, optical and aural services; maternity and infant care services; and reduced prescription charges. Medical card eligibility is primarily based upon a household-level income-means test, with the lowest-income households eligible for a card. The basic and additional income limits are outlined in Table 3.1, with a full description of eligibility terms outlined in Keane et al. (2021). Medical cards may also be granted to those above the income threshold in certain discretionary cases when the cost of healthcare would place 'undue financial burden' on a household, usually as a result of a longstanding and care-intensive illness.

[2] These are Vhi Healthcare, Laya Healthcare and Irish Life Health.

TABLE 3.1 BASIC AND ADDITIONAL WEEKLY INCOME LIMITS FOR MEDICAL CARD ELIGIBILITY

BASIC RATES	AGED UNDER 66	AGED 66-69	AGED OVER 70
Single person living alone	€184.00	€201.50	€550.00
Single person living with family	€164.00	€173.50	€550.00
Couple, married/cohabiting/civil partners, or single parent with dependents	€266.50	€298	€1,050
ADDITIONAL RATES			
Allowance for each of 2 children aged under 16	€38.00	€38.00	€38.00
Allowance for 3rd and each subsequent child under 16	€41.00	€41.00	€41.00
Allowance for each of 2 children aged over 16 (with no income)	€39.00	€39.00	€39.00
Allowance for 3rd and each subsequent child over 16 (with no income)	€42.50	€42.50	€42.50
Allowance for each dependant over 16 in full-time third-level education	€78.00	€78.00	€78.00

Source: Health Service Executive.

For individuals who are ineligible for a medical card, the HSE issue GP visit cards, which entitle the holder to free general practice visits. Eligibility for the GP visit card is again based on a means test, with income thresholds set around 50 per cent higher than for a medical card. Those aged under 6 and over 70 years of age are automatically entitled to a GP visit card, with further expansion of the programme to all those earning below the median income announced in Budget 2023.[3] As of January 2023, approximately 31 per cent of the population (equivalent to over 1.5 million people) hold a medical card, and a further 11 per cent hold a GP visit card.[4]

Medical cards and GP visit cards are primarily used to subside healthcare costs faced by households and are thus an important arm of the social welfare system. There is limited evidence that medical cards or GP visit cards necessarily improve health outcomes (similar to international evidence on public health insurance), but research at the ESRI has found that removal of co-payments for GP care reduces stress by decreasing the financial barriers to accessing healthcare (Ma et al., 2020). Moreover, medical cards are shown to considerably reduce out-of-pocket healthcare costs (Keane et al., 2021), especially for those with multimorbidity (Larkin et al., 2022). For healthcare services that require a GP referral, particularly community care and mental healthcare (Counselling in Primary Care), medical cards also increase accessibility.

The majority of the population without public healthcare coverage (medical card/GP visit card) purchase private health insurance.[5] However, around one-fifth

3 This is equivalent to roughly 400,000 additional people being granted free GP care.

4 In January 2023 there were 1,568,379 medical card holders and 535,741 GP visit card holders out of a total population of 5,073,197 in the 2022 Census. See https://www.sspcrs.ie/analytics/saw.dll?PortalPages.

5 Walsh et al. (2021) estimate 43.5 per cent of the Irish population have private health insurance, with 8 per cent having both private health insurance and a medical card/GP visit card ('dual coverage').

of the population have no public or private coverage, a proportion that increases to over one-third among younger working-age adults (Walsh et al., 2021). This lack of coverage is in itself a public policy concern, in that approximately a million people are potentially vulnerable in the case of a healthcare cost shock.

Households that derive all of their income from social welfare are automatically entitled to a medical card. However, some low- and middle-income working households often end up having income that is higher than the medical card income threshold. Indeed, the stagnancy of medical card income thresholds since 2005, coupled with increasing income levels, have contributed to a fall in medical card coverage rates, particularly during the period of economic growth in the past decade.

In this study, we examine rates of medical card coverage across tenure groups, with particular focus on the differential impacts across different socio-economic groups, such as those in employment.

SECTION 4

Data and methods

4.1 DATA

Using data from EU-SILC for the period 2007–2021, we examine variations in self-reported health, objective health and public healthcare coverage across tenure types for adults (18+).[6] We disaggregate the data according to tenure type, age group and employment status. Survey weights are used throughout.

4.2 HOUSING TENURE

Throughout this study, we partition tenure type into three distinct categories[7]:

1. Ownership (including outright ownership and owned via mortgage),
2. Private rental market, and
3. Supported rental market.

The supported rental market group includes those who receive direct social housing provision by a local authority or non-profit approved housing body, or indirect provision in the form of rent supports distributed by the State, such as the Housing Assistance Payment (HAP) and the Rental Accommodation Scheme. Direct supports house tenants in accommodation owned by the State or a non-profit approved housing body ('social housing'),[8] whereas indirect supports are intended to offer housing cost relief to those renting in the private rental sector. In the case of indirect provision, the tenant pays a proportion of their income towards the overall rental cost depending on their ability to pay, with the State subsidising the remainder.

Those households who report being in a Rent Pressure Zone (RPZ), and thus have their annual rent increases capped at 2 per cent, are included in the private rental category as opposed to the public rental category, as it is considered that RPZs are not a form of public housing support but rather act as a price ceiling in the private rental market.

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6 We restrict the analysis to adults because if a parent is a medical card/GP visit card holder, their children will typically also be covered.

7 'Housing for All – a new housing plan for Ireland' was established in 2021. This policy promotes a mix across four tenures – affordable, social, private rental and private ownership – to ensure that the needs of all sectors of society are met. Evidence-based targets are set out for each of these social, affordable and market delivery tenures, which are aligned with the National Planning Framework and agreed with local authorities. The SILC data used in this analysis predated Housing for All.

8 One exception is the Social Housing Current Expenditure Programme (SHCEP), through which a local authority or approved housing body provides housing to those on the social housing waiting list that is not socially owned but leased from the private sector.

4.3 HEALTH OUTCOMES

We examine both a subjective and an objective measure of health. Self-reported health is based upon responses to the question: 'How is your health in general?'. Five options were available on a Likert-type scale: 'very good', 'good', 'fair', 'bad' and 'very bad'. A binary variable was constructed with a value of one for individuals reporting 'very good' or 'good health', and zero otherwise, in line with recent ESRI research (Walsh and Doorley, 2022). Given potential biases in self-reported health (Baker et al., 2004), we also seek to construct a more objective measure of health: specifically, whether or not an individual suffers from one or more chronic (longstanding) illness or condition. This is again reported as a binary variable.

4.4 HEALTHCARE COVERAGE

While individuals in Ireland can have either public or private healthcare coverage (or indeed a mixture of the two), in this study we concentrate on the main public healthcare coverage available: medical cards. Although GP visit card coverage rates have expanded in recent years, particularly with the extension of automatic entitlement to under 6s and over 70s, the degree of coverage offered by GP visit cards is significantly lower. Particularly for older people and those suffering with chronic conditions or sudden illness/injury, the benefits offered by GP visit cards may be insufficient, as many will require more specialist treatment in acute and community settings that a GP visit card does not cover.

To produce the most up-to-date results, our primary reference year is 2021, though we also estimate trends across the period 2007–2021 to present a fuller understanding of variation in public healthcare coverage over time. Furthermore, this time period offers a good insight into the operation of the medical card system, as it captures the dynamics of how changes in income impact upon public healthcare coverage. With data from 2007–2021, we can account for the rising incomes at the tail end of the Celtic Tiger, the subsequent economic downturn, and a return to economic fortunes from around 2014 onwards. Given that medical cards are means-tested entitlements, rising incomes produce fewer eligible people, while falling incomes increase eligibility.

For each year, we disaggregate mean medical card coverage rates by tenure type. Results are further disaggregated by other socio-economic features on the basis of past evidence and policy interest. For example, research has shown a link between employment status and medical cards (Keane et al., 2021). Therefore, we also consider how employment status (employed vs. unemployed and full-time vs. part-time employment) interacts with medical card coverage. These analyses on employment status are limited to survey respondents of working age (18-64 years).

SECTION 5

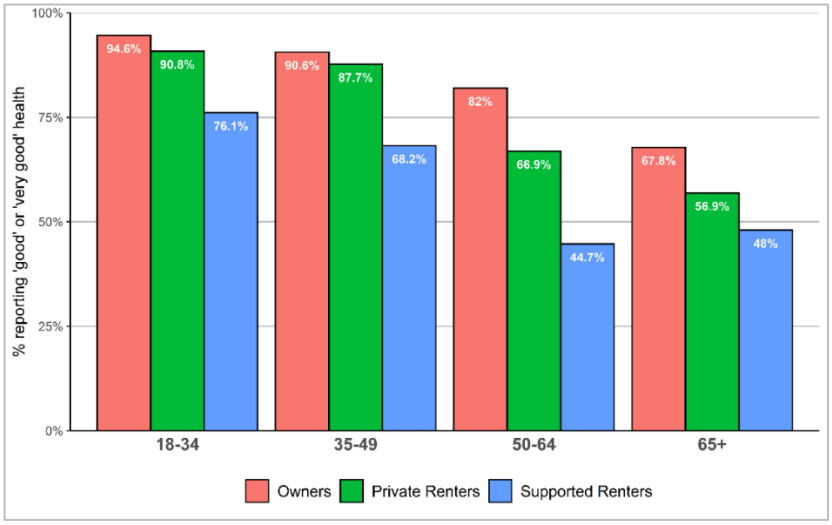
Housing tenure, health and public healthcare coverage in Ireland

5.1 TENURE AND HEALTH OUTCOMES

Figure 5.1 and Figure 5.2 illustrate the percentage of adults in each tenure type and age group with good or very good self-reported health and with a chronic illness, respectively. The results illustrate clear differences in self-reported and objective health across tenure type. In general, those in the supported rental market have the worst health outcomes. Within the supported renters group aged 50 years and older, less than half report good or very good health, while two-thirds report suffering from a chronic illness. This is largely congruent with the international literature (Wiggers et al., 2001; Digenis-Bury et al.; 2008, Kandt et al., 2016).

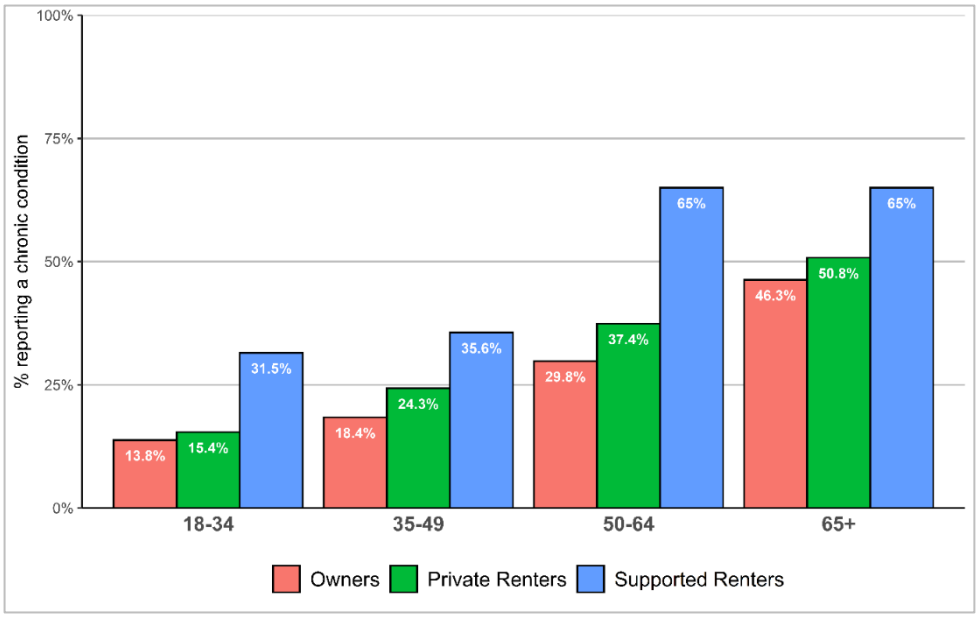
Younger renters in the private rental market predominantly report good or very good health, as well as a low incidence of chronic illnesses. However, the relatively higher rates of good health quickly taper off when considering those aged 50+ living in private rental accommodation. Moreover, across all age groups, private renters on average report worse health and greater incidence of chronic illnesses compared to individuals in the homeowners group. Even in the oldest age bracket of 65 years and over, over two-thirds of individuals in the homeowners group report good or very good health. That being said, nearly half suffer from a chronic illness.

FIGURE 5.1 PERCENTAGE OF INDIVIDUALS WITH GOOD OR VERY GOOD SELF-REPORTED HEALTH BY TENURE TYPE AND AGE GROUP, 2021 (AGED 18+)



Source: Authors' calculations using EU-SILC 2021 data.

FIGURE 5.2 PERCENTAGE OF INDIVIDUALS WITH A REPORTED CHRONIC ILLNESS OR CONDITION BY TENURE TYPE AND AGE GROUP, 2021 (AGED 18+)



Source: Authors' calculations using EU-SILC 2021 data.

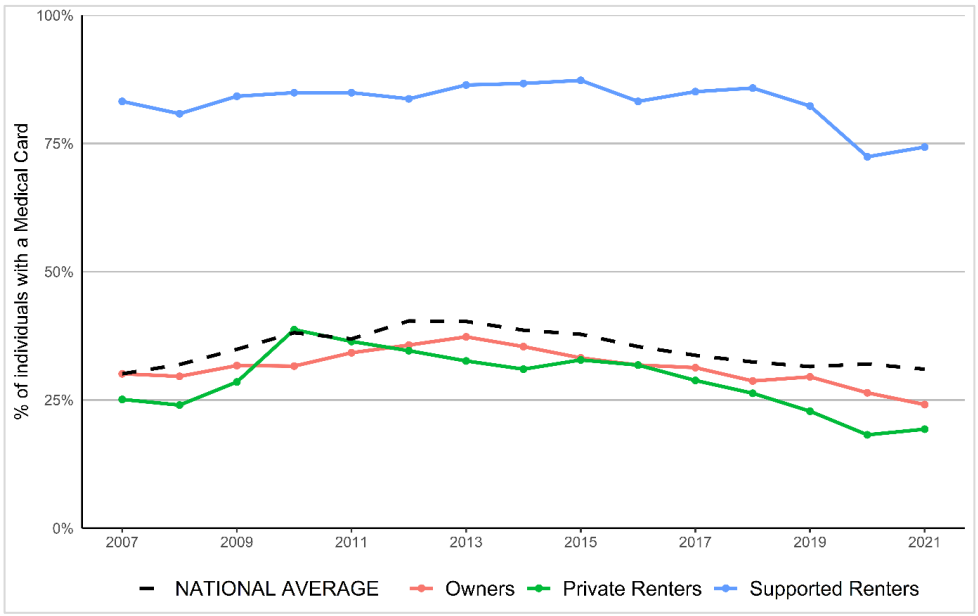
5.2 TENURE AND PUBLIC HEALTHCARE COVERAGE

Figure 5.3 illustrates medical card coverage rates across tenure type (and the national average for adults) for the years 2007–2021 inclusive. Across all years, supported renters have much higher coverage rates compared to the other tenure types. These higher rates are due predominantly to supported renters having lower household income. Furthermore, all individuals who receive all their income from social welfare (which accounts for a large percentage of supported renters) are automatically entitled to a medical card. Private renters and individuals in the homeowners group have similar medical card rates across the period, though in recent years a slight divergence has materialised.

Focusing on the more recent period from 2015 to 2021, there has been a marked decline in medical card coverage across all three tenure types. Coverage has fallen from 33 per cent to 24 per cent among individuals living in owner-occupied households, from 33 per cent to 19 per cent among private renters, and from 87 per cent to 74 per cent among supported renters during the period. This is due in part to rising incomes in the post-recession period. As incomes have risen while medical card income thresholds remained unchanged, fewer households now satisfy the medical card thresholds. However, another more nuanced explanation may also underpin the reductions in medical card coverage for supported renters. Due to the rollout and expansion of HAP there has been a change in the composition of renters, with many lower-income private renters exiting this market to enter the supported rental sector (Doolan et al., 2022). Similarly, as shown by Roantree et al. (2022), from 2007 to 2021 there has been growth in the supported rental sector, particularly for those in the poorest households. During

this period, the share of individuals within the lowest income quintile (poorest 20 per cent) in the supported rental sector increased from 21 per cent to 34 per cent. Even within the third income quintile, the share of individuals within the supported rental sector increased from 6 per cent in 2007 to 12 per cent in 2021. The expansion of public housing supports in recent years has not been matched by similar changes in public healthcare coverage, and thus a larger proportion of households are eligible for the former yet not the latter.

FIGURE 5.3 PERCENTAGE OF INDIVIDUALS WITH A MEDICAL CARD BY TENURE TYPE, 2007–2021 (AGED 18+)



Source: Authors' calculations using EU-SILC 2007–2021 data.

Figure 5.4 illustrates medical card rates across tenure type by employment status (working or not) in 2021.[9] Among the unemployed, medical card coverage is highest for supported renters, with almost 80 per cent holding a card. This is to be expected, given that eligibility is automatic when the sole source of income is social welfare. Medical card rates for unemployed private renters and individuals in the homeowners group remains low (21 per cent and 29 per cent respectively). This is likely due to combined household incomes for these individuals exceeding income thresholds. While we do not observe unemployment duration in this study, some of the lower medical card coverage rates among the unemployed may be due to those who, experiencing a short unemployment spell, do not apply for a medical card. Furthermore, the usual duration of keeping a medical card is three years, including for those who return to employment if they were receiving social welfare (e.g., Jobseeker's Benefit, One-Parent Family Payment) for at least 12 months.[10]

9 The working-age population (aged 18-64) is included in analyses partitioned by employment status. This partially attenuates the coverage rates as medical card coverage rates are highest among those aged 65+.

10 See https://www.citizensinformation.ie/en/employment/starting-work-and-changing-job/training-and-looking-for-work/return-to-work/.

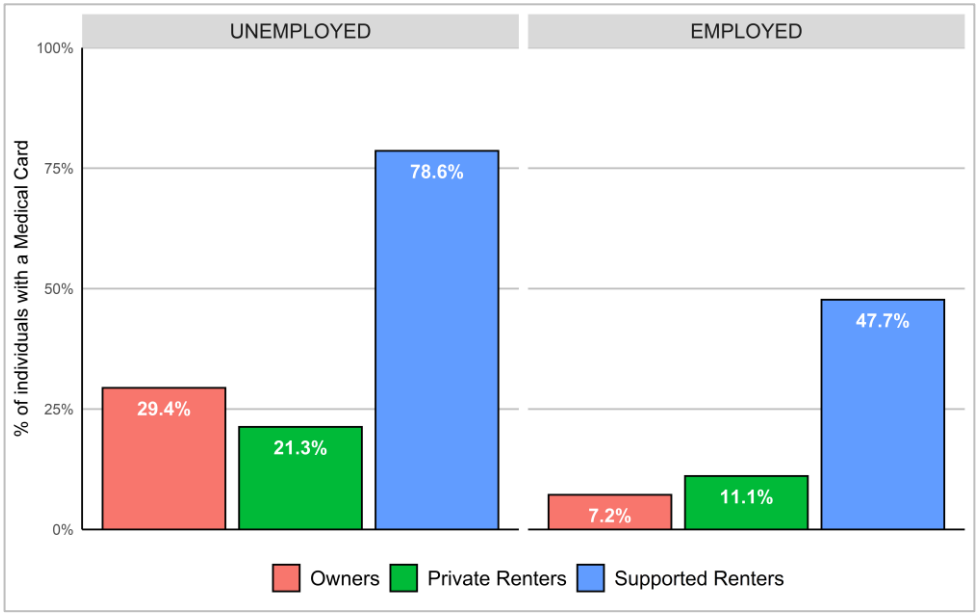
This may explain some of the relatively high medical card coverage rates for supported renters who are employed.

Medical card rates across all tenure types are much lower for those who are employed. Among employed supported renters, less than half hold a medical card. Interestingly, medical card coverage rates among employed individuals in the homeowners and private renters groups are also much lower, with only 7 per cent of employed individuals in the homeowners group and 11 per cent of employed private renters having a medical card. These results show the clear link between employment and medical cards in Ireland. Even for workers living in supported accommodation, their higher income from employment often exceeds medical card income thresholds.

This evidence does suggest some lack of alignment between two arms of social welfare – despite receiving supports for housing, some working households are not necessarily entitled to healthcare supports. Increasing employment participation and hours of work among supported renters may partly explain the decline in medical card coverage for that group, as illustrated in Figure 5.3.

Note, Figure A1 in the appendix also presents results from analyses undertaken partitioning employment by full-time (32+ hours) and part-time (<32 hours). While medical card rates were higher among part-time employees, rates were significantly below those who were unemployed, especially in the supported renters group.

FIGURE 5.4 PERCENTAGE OF INDIVIDUALS WITH A MEDICAL CARD BY TENURE TYPE AND EMPLOYMENT STATUS, 2021 (AGED 18-64)

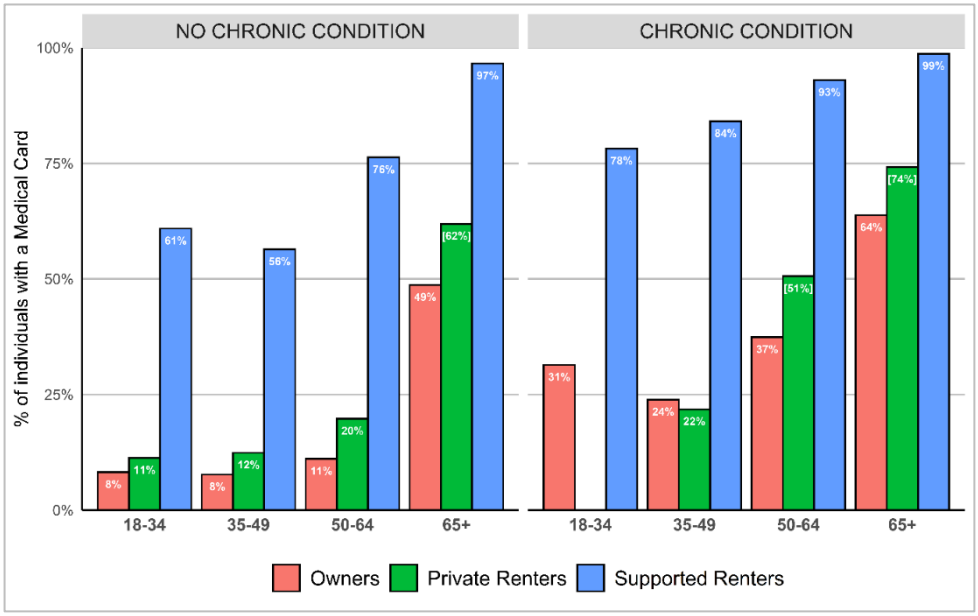


Source: Authors' calculations using EU-SILC 2021 data.

Figure 5.5 provides results on the relationship between chronic illness rates and medical card rates across tenure types and age groups. It is clear from previous

research that medical cards have the largest effect in terms of reducing the financial burden on those with high levels of illness (Larkin et al., 2022). In some cases, individuals with high healthcare need, but whose household income exceeds the income threshold, may access a discretionary medical card.[11] Figure 5.5 results in general highlight much higher medical card rates among those with a chronic illness.

FIGURE 5.5 PERCENTAGE OF INDIVIDUALS WITH A MEDICAL CARD BY TENURE TYPE, AGE GROUP AND CHRONIC CONDITION STATUS, 2021 (AGED 18+)



Source: Authors' calculations using EU-SILC 2021 data.
Notes: No estimate is provided for private renters with a chronic illness in the 18-34 age group, as there is an insufficient number of observations in EU-SILC from which to estimate a meaningful value. Values in square brackets indicate that, due to a small number of observations, estimates are liable to be imprecise.

Figure 5.5 shows that among those with a chronic illness, across all tenure types, medical card coverage increases with age. Within the 65+ age group, almost all supported renters hold a medical card, while coverage rates for supported renters are higher than 50 per cent in all age groups. Among younger individuals in the private renters and owners in younger age groups, coverage rates are low (between 8 per cent and 20 per cent).

Among those with a chronic illness, large variation across tenure type is once again observed, with medical card rates highest among supported renters. Within the 65+ age group, almost all supported renters hold a medical card, while within the youngest age group, 78 per cent hold a medical card. However, a large minority of supported renters with a chronic illness do not hold a medical card. Similarly, a large percentage in the homeowners and private renters groups with a chronic

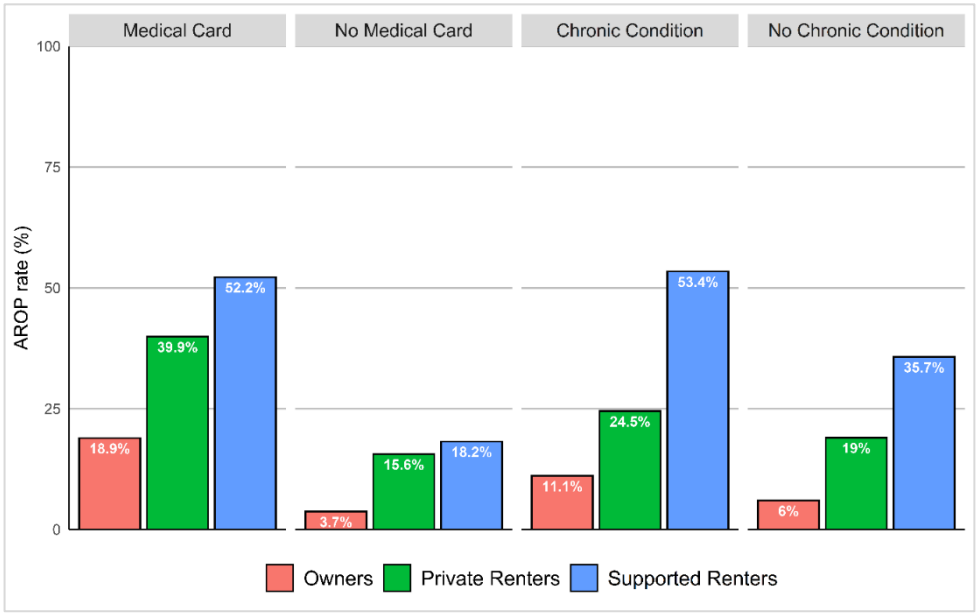
[11] Discretionary medical cards can be issued to those who have long-term, ongoing health issues. Of particular note, lifetime medical cards are now issued to some terminal cancer patients and survivors of childhood or adolescent cancers. However, there is no list of specific illnesses or conditions that automatically entitle an individual to a medical card. As a result, income is still the primary metric against which eligibility is assessed.

illness do not hold a medical card. This is particularly pronounced in the younger age groups, with only approximately 20–30 per cent of private renters with a chronic illness holding a medical card.

Those with chronic illnesses are already a subpopulation with high at risk of poverty (AROP) rates, as demonstrated by Figure 5.6. For example, around one-quarter of private renters with a chronic condition are considered AROP after deducting housing costs, and yet a majority do not hold a medical card. Roantree et al. (2022) also find that a sizeable proportion of the population who report living in a household where someone has a disability experience material deprivation (even if not strictly classed as being AROP), with many of these living on less than €100 per week (in equivalised terms) above the poverty line.

A lack of public healthcare coverage for those with a chronic condition risks exacerbating the risk of poverty or material deprivation that they already face, with the combined costs of housing and healthcare inducing significant financial vulnerability. This suggests that a medical card system based predominantly on healthcare need as opposed to income may offer greater protection, particularly for those with a chronic condition who fall just beyond the income threshold.

FIGURE 5.6 PERCENTAGE OF INDIVIDUALS AT RISK OF POVERTY (AROP) AFTER DEDUCTING HOUSING COSTS, 2021 (AGED 18+).



Source: Authors' calculations using EU-SILC 2021 data.
Notes: AROP is defined as the share of people with an equivalised disposable income (net of taxes and social transfers) below 60 per cent of the after-housing cost median equivalised disposable income. For those in the homeowners group, housing costs only include mortgage interest repayments, whereas for both categories of renter, housing costs refer to the rent paid on the property. A full description of costs included in the AROP measure can be found in Roantree et al. (2022).

SECTION 6

Policy implications and conclusions

This study highlights large variations in health and healthcare coverage across tenure groups in Ireland. As may be expected, supported renters, especially older supported renters, those not in employment and those with a chronic illness have high rates of medical card coverage.

These results have important implications for housing and health planning in Ireland. First, it is clear that supported renters have poorer health outcomes and thus greater healthcare needs. Allied with high rates of medical card coverage, this means that, in general, supported renters will have high demand for healthcare. This is an important factor that will need to be accounted for when developing healthcare supply in a region. Those regions and local housing developments with high rates of social housing and indirect housing supports will require more healthcare services on average than regions and local developments where private renters and homeowners make up the majority of the population. Furthermore, a large percentage of these services will be required to be public, or publicly funded, as opposed to private healthcare services, which rely to a greater extent on private health insurance.

Second, this study finds that a large minority of supported renters, particularly younger and employed individuals, do not have a medical card. These individuals remain at high risk of poverty and have income low enough to warrant public housing support. However, a health shock may result in a large financial healthcare burden for an individual, with no medical card available to offset some of that burden. Some recent policy decisions surrounding sick leave and public hospital costs may reduce the out-of-pocket healthcare risk faced by these individuals.

Nevertheless, the fact that employment in general acts to exclude many supported renters from accessing a medical card may, at the margin, impact the decision by some in this group to take up employment. Any individual in full-time paid work will generally exceed the income thresholds, unless they receive significant additions to the limit for the number of dependents they have, or are able to deduct other costs which are allowed under the criteria. While all supported renters whose income is solely derived from social welfare are automatically entitled to a medical card, it is among employed supported renters where the welfare systems for housing and health diverge considerably.

Some of this divergence may be explained by the fact that income thresholds for medical cards have essentially remained stagnant since 2005. This is despite median household disposable income growing by 33 per cent between 2006 and

2021.[12] This may also explain some of the lower medical card rates among supported and private renters highlighted in Figure 5.3. However, at present Ireland does not index-link any other social welfare payments. In this respect, it has been noted as an outlier in the European context (Callan et al., 2019). As a result, index-linking medical card thresholds would likely need to come as part of a wider reform of the welfare system. One other area of divergence is that some housing payments such as the Housing Assistance Payment (HAP) differ across local authorities and may do a better job at reflecting the local cost of living effects. Housing support thresholds are also much higher: for example, the HAP maximum net income limits for a single person in Dublin, Kildare or Cork city is €40,000, and in 2023 the basic limits increased by €5,000 for all local authorities.[13] However, medical card income thresholds are fixed at the national level. Individuals in regions with a higher cost of living (e.g., Dublin and commuter counties) may need higher income to achieve the same standard of living. They may therefore have lower rates of medical card coverage under the current national thresholds, as eligibility thresholds do not account for differences in cost of living across regions.

Third, one of the key findings of this study is that medical card rates among individuals in the homeowners group in recent years exceeded that of private renters. The low rates of medical card among private renters, even those who may have a chronic illness or are unemployed, mean many in private renters are potentially at risk of a health shock increasing their financial burden substantially.

Even in the case where private renters have high disposable incomes, a further implication is that the financial stress of housing and healthcare costs can prevent renters in the private market from eventually progressing to homeownership. The Government's Housing for All plan lays out a pathway to support homeownership in Ireland, particularly for low- and middle-income households (Government of Ireland, 2021). Housing for All promotes a more diverse mixture of tenure types across four tenures – affordable, social, private rental and private ownership – to ensure that the needs of all sectors of society are met. Evidence-based targets are set out for each of these social, affordable and market delivery tenures, aligned with the National Planning Framework and agreed with local authorities. Such a policy reflects the demands of the Irish public: a recent Department of Housing, Local Government and Heritage (DHLGH) survey revealed that homeownership would be the preferred tenure type of 87 per cent of renters (Corrigan et al., 2019). However, achieving this requires a household to accumulate significant savings. With high housing and healthcare costs eroding incomes and thus savings, progressing to homeownership becomes increasingly difficult, particularly for low-

12 Authors' calculations based on CSO estimates. See https://www.cso.ie/en/releasesandpublications/ep/p-silc/surveyonincomeandlivingconditionssilc2019/income/.

13 See https://www.citizensinformation.ie/en/housing/local_authority_and_social_housing/applying_for_local_authority_housing.html#laf763.

and middle-income renters. It is possible that administrative costs, stigma or lack of awareness about medical card eligibility also underpin lower take-up of medical cards in this group, particularly for those in employment (Keane et al., 2021).

Policymakers have some potential levers to equalise medical card eligibility across tenure groups. Indexing income thresholds for medical cards will increase rates among low- and middle-income earners. This would have disproportionately large impacts on employed supported renters and lower earning private renters. Adjusting income threshold across regions, in order to account for differences in the cost of living, may also help equalise medical card eligibility across tenure groups. In reality, such regional adjustment may be difficult in practice, put increased work on local health offices and result in a scenario observed in social housing where families with the same income, and forms of income, are treated differently based upon where they live (Doolan et al., 2022).

There may also be merit in the argument that medical card eligibility criteria ought to place less focus on income as the primary determinant of eligibility, and instead be more cognisant of actual healthcare need. This would particularly benefit lower-income earners with a chronic illness that requires substantial healthcare use.

Alternatively, as set out in Sláintecare, the expansion of universal healthcare for the full population would equalise some of the inequalities found in this study. Such a move would also contribute towards the stated ambition of Sláintecare to achieve a health and social care system with 'equitable access to services based on need and not ability to pay'. Currently, some groups – including individuals with a terminal illness (with 24 months or less to live) – are eligible for a medical card, irrespective of household income.[14] The recent lowering of the Drug Payment Scheme thresholds to €80 per month, and the removal of public hospital inpatient costs (€80 per night, up to €800 per annum), may also reduce the financial burden for low-income groups. Furthermore, the expansion of free GP care to all under 8s in April 2023 will likely improve access to primary care services for children. With continued expansion of free GP services on the agenda, a larger number of people will be able to access the first rung of health and social care in Ireland. The ESRI estimates that expanding free GP care to all using an income-based approach would cost the State €381m to €881m by 2026 (Connolly et al., 2023). However, it is noted that continued expansion of free healthcare (including free GP care) would require commensurate expansion of supply (ibid.).

[14] See https://www.citizensinformation.ie/en/health/medical_cards_and_gp_visit_cards/emergency_medical_card.html#:~:text=You%20can%20get%20a%20medical,months%20or%20less%20to%20live.

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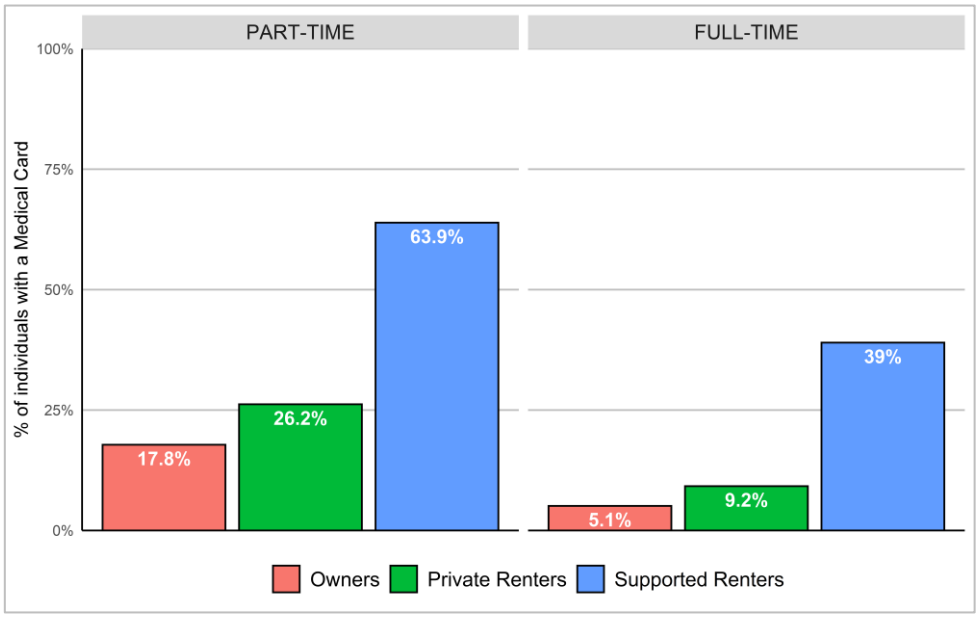
APPENDIX

Public healthcare coverage by employment type

FIGURE A1 PERCENTAGE OF INDIVIDUALS WITH A MEDICAL CARD BY TENURE TYPE AND EMPLOYMENT TYPE (PART-TIME VS. FULL-TIME), 2021 (AGED 18-64)



Source: Authors' calculations using EU-SILC 2021 data.

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