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Medical Card Coverage and the Impact of Income Limit Freezes

Claire Keane¹, Simona Sándorová, Brendan Walsh

Abstract

Ireland is one of the few European countries without a universal healthcare system (UHC). Instead, a complex system of means-tested schemes that provide free access to various healthcare services or reduced cost medication exist. The most central component of this complex system is the Medical Card scheme, which is used to cover primary, community, and acute hospital healthcare costs for lower income groups. Despite the importance of the scheme, income limits for the scheme for most population groups have not increased since 2005, despite price inflation of 26% and wage inflation of 45% since then. To prevent the loss of Medical Cards due to social welfare benefit increases, a rule was introduced allowing those solely on welfare to retain their cards even if they were above the income limit. This decision created horizontal inequity and a work disincentive, whereby families who have the same income amount are treated differently if some of their income comes from employment. This research examines Medical Card coverage across different societal groups and estimates the impact of this lack of indexation on card holding. We estimate that cardholder numbers would be significantly higher if income limits had kept pace with inflation and that over 80,000 (or 6% of cardholders) now qualify due to the social welfare rule. The study highlights the horizontal inequity and work disincentive created by the social welfare rule and the need for indexation of income limits to ensure access to necessary medical care for those in lower income deciles.

Keywords: health policy, means-tested programme, indexation, benefit erosion.

JEL classification: I13, I14, I38

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1 Introduction

Unlike European countries, Ireland does not have universal healthcare (UHC) that provides universal and equitable access to primary, community, and hospital care to all, or the majority of their populations, either for a nominal fee or free at the point of delivery (Connolly et al., 2019; Burke et al. 2021).

While differences exist in the definition of UHC across countries (Burke et al. 2021), in general, European countries base decisions on providing healthcare on need, rather than ability to pay. In some countries, care is provided for free at the point of use, such as the National Health Service (NHS) across the constituent countries of the UK. While in other countries such as France, Norway, and Spain, small co-payments are often required to access care, or for prescribed medications, though access to public healthcare remains universal. In countries where traditional UHC models do not exist - such as the United States and Ireland in a European context - programmes such as Medicare and Medicaid (US) and the Medical Card (Ireland) provide care for free, or at reduced cost, to those at the bottom of the income distribution and to those perceived to have high needs for care. Due to the high potential cost of healthcare for many people in countries without UHC, access to these programmes offers significant monetary and access benefits to people who avail of them.

The Irish healthcare system includes a mixture of public and private funding and provision of health and social care services. For key healthcare services such as general practitioner visits (GPs), community-based therapy, and emergency department care in hospitals, the majority of citizens must pay out of pocket to access care.² In 2017 a cross-political party proposal called Sláintecare³ was published that recommended abolishing the current two-tier health system, and set out a ten year plan for achieving UHC in Ireland. Such an approach would remove or greatly reduce the out-of-pocket costs of healthcare. Currently, in the absence of a UHC model, publicly funded programmes, particularly the Medical Card and the GP Visit Card schemes, allow those in lower income groups free access to medical services.

While the development of UHC as proposed in Sláintecare has not occurred, a number of policies have been implemented to reduce the healthcare financial burden in Ireland. The number of people deemed eligible for GP Visit Cards, which entitled holders to free GP care, has increased since the

² GP care is privately provided with full cost payable to access care as is the case for private hospitals. Emergency Department care is provided in publicly funded hospitals with a fee of €100 for those not holding a Medical Card or referred by a GP.

³ Sláinte being the Irish for health.

publication of the Sláintecare report. Co-payments for inpatient care in public acute hospitals have also been eradicated. Monthly payment thresholds for prescription drugs have been reduced. While free contraception, IVF, and hormone replacement therapy, for women has also been introduced. However, no equivalent expansion in Medical Card eligibility that provides free access to a range of healthcare services has occurred.⁴

Access to many public health services such as community-based therapies, counselling in primary care, and the new chronic disease enhanced community care programme are often dependent upon holding a Medical Card. Medical Cards also provide non-health-related benefits such as a reduced rate of the Universal Social Charge (USC), exemption from Junior and Leaving certificate fees and free school transport. While the Medical Card scheme uses an income-means test to determine eligibility, the income thresholds have remained frozen in nominal terms since 2005 for those under 70 despite a rise of 26% in prices and 45% in wages up until 2022⁵. Medical Cards can also be provided to two main groups whose income may be above the income limit. The first of these are known as 'discretionary cards' and take into account the higher healthcare and living costs incurred by those with an illness or disability.⁶ The second was introduced in the early 2000's⁷ in response to frozen income limits and fears that standard social welfare increases could push families above the Medical Card income limits. A rule was introduced providing Medical Cards for those who solely rely on social welfare funding ('100% social welfare rule'). Therefore, eligibility for a Medical Card is now made by three main sets of rules: means-testing; discretionary cards and 100% social welfare income. This triplicity (triple criteria) approach in providing Medical Cards has received little attention from both the research and policymaker community.

Healthcare systems based on the ability to pay are by design more unequal than those based on need. In systems with higher co-payments, the costs are most acutely felt by the lowest income groups, who generally also need these services the most (Klavirus & Häkkinen, 1996). Schemes such as the Medical Card attempt to reduce this inequality by eliminating or significantly reducing costs for lower income groups.

⁴ Sláintecare recommended the establishment of health entitlement card called a Sláintecard to help transition to UHC. This card would grant people access to a comprehensive set of healthcare services free at the point of access, and would in effect replace the current system of Medical Cards, GP Visit Cards, and various means-tested schemes with a single, streamlined entitlement card.

⁵ CSO: [CPI](#) and [Average Weekly Earnings](#)

⁶ See Doorley et al. (2025) in the Irish context which estimates that the cost of disability is in excess of 50% of disposable income of households with disabled members.

⁷ It is difficult to establish when exactly the '100% social welfare' rule was established, it appears to have come into practice in 2003 according to Mangan (2004).

In this paper we examine how Medical Card coverage⁸ has changed since 2012. Given that changes in coverage rates across the population can vary due to various socio-demographic characteristics, we use a microsimulation model to examine the impact of the frozen income limits. The microsimulation approach allows us to estimate what Medical Card coverage rates would be if income limits had kept pace with price or wage inflation, as well as the associated cost to the exchequer if the limits were to increase. We then examine which population groups are most affected by the decision not to index income limits.⁹ In addition to the exchequer impact of such a move it is also important to acknowledge that capacity of the GP and wider healthcare system¹⁰ to absorb extra Medical Cards must also be considered, this is outside of the scope of this paper however – see Connolly et al. (2018) for an examination of expanding GP care in Ireland and associated issues.

In addition, headline social welfare rates have risen by over 40% since 2005 which has placed many payment rates, particularly those received by individuals of working age, above the income limit for a Medical Card. Therefore, we also use microsimulation to estimate the numbers of people who would not have an entitlement to a Medical Card if the ‘100% social welfare rule’ was not in place. Examining the impact of the 100% social welfare rule and the prevalence of discretionary Medical Cards is important in the wider discussion of expanding the Medical Card to other groups, allowing us to provide a more accurate estimate on the numbers that would benefit from such a policy.

The layout of the paper is as follows. Section 2 discusses the Medical Card scheme, Section 3 presents the data and microsimulation model used, Section 4 presents the results of the microsimulation analysis, while Section 5 concludes.

2 Medical Card Scheme

The Medical Card scheme was established out of the 1970 Health Act. The scheme was established to reduce the healthcare cost burden on low-income households and the Act stated that adults and their dependents have full eligibility for healthcare if they are “*unable without undue hardship to arrange a general practitioner, medical and surgical services for themselves and their dependents*” (Law Reform Commission 1970). Based upon the origins of the scheme, entitlement to a Medical Card is first awarded through a means test and is calculated on a family basis (i.e. couples and dependent children).

⁸ By coverage we mean actual holding of a Medical Card – some individuals who are eligible for a card may not actually hold one due to non-take-up.

⁹ Income limits for those over 70 did increase in 2020 from €500 to €550 for a single person and from €900 to €1,050 for a couple.

¹⁰ For example Nolan (2008) shows that those who gain a Medical Card tend to increase their annual number of GP visits per year. Additional public healthcare staff such as Public Health nurses, physiotherapists etc. may also be needed.

For those aged 70 and over the income limits are based on their gross income from all sources (pensions, earnings, interest etc.). For those aged under 70, means are calculated by summing net income¹¹ (i.e. after taxes and social insurance). Allowable expenses such as housing, childcare and travel-to-work costs are deducted from the applicant's gross income.

In addition, households that exceed income thresholds may qualify for a Medical Card if all of their income is derived from social welfare sources (the '100% social welfare rule'). This rule was introduced to avoid a situation where standard welfare increases put people above the income limit for a Medical Card. This creates a horizontal inequity, whereby families with the same total income above the income limit – one which derives entirely from social welfare and one which includes employment income – have different entitlements to a Medical Card. As such, perverse incentives to not enter the labour market may exist for those who fear losing their Medical Card. Those with specific care needs or who are judged to have healthcare costs that would result in an unfair burden on them, are eligible for what are colloquially termed “discretionary” Medical Cards. While language included in the original 1970 Health Act clearly provides some level of autonomy to decisionmakers when determining who to give a Medical Card no information exists on the criteria used to determine eligibility for discretionary cards for example, whether an individual would have to bear an “unfair financial burden” of healthcare costs, and this determination is left to a medical officer. This differs considerably from the defined criteria used for income-based and social welfare-based Medical Cards.

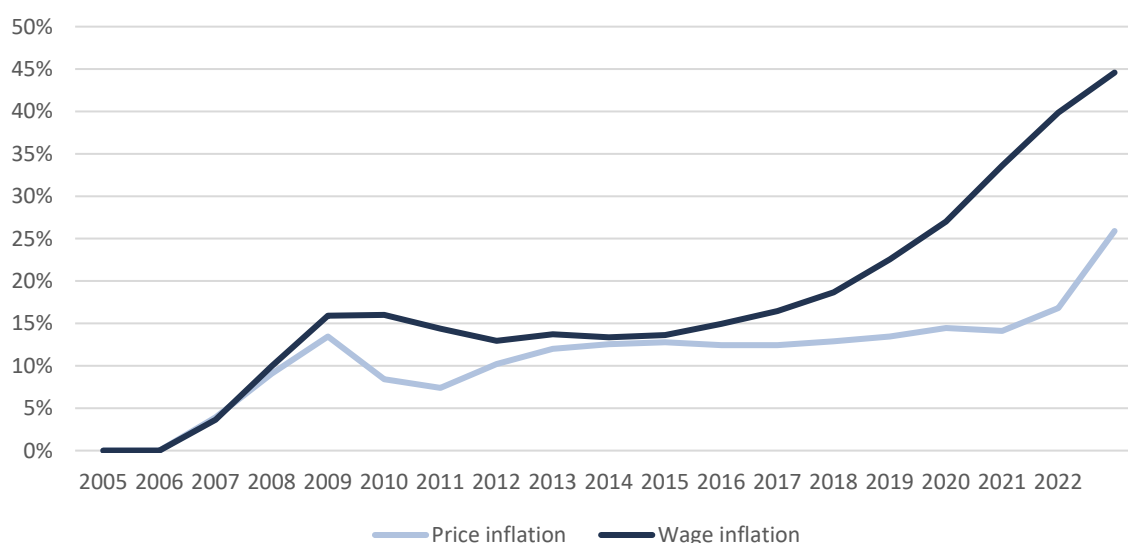
Therefore, while initially introduced to reduce healthcare cost burdens for lower income households, eligibility for a Medical Card is now predominantly made by three different sets of rules.

For those with income above the Medical Card limit other supports and government funded healthcare does exist – for example for those above the Medical Card income limit but below a higher threshold the GP-Visit Card scheme, introduced in 2005, provides free GP care for cardholders. These cards are now also awarded on an age basis for those over 70 and under 8 years of age. The GP-Visit Card income limits have been adjusted more frequently than those for Medical Cards, therefore we do not focus on them in this paper. The Drugs Payment Scheme also exists and caps monthly prescription medicine fees. Recent years have also seen the elimination of costs such as public in-patient hospital charges and contraceptive charges for women aged 17-35.

¹¹ While most social welfare payments are included there are some exceptions such as Child Benefit, Carer's Allowance etc. For those in receipt of Disability Allowance an earnings disregard of €427 is currently in place. For a full description of what is/is not included in the means test see <https://www.hse.ie/eng/staff/pccs/medical-card-and-gp-visit-card-assessment-guidelines.pdf>

Medical Card income thresholds¹² have remained frozen in nominal terms for those under 70 since 2005 despite a rise of 26% in prices and 45% in wages up until 2022¹³ (see Figure 1). In effect, the stagnant income thresholds represent a significant real drop in income limits over time. This stagnation is an anomaly in social services in Ireland as other social welfare payments and schemes have typically increased in real terms across time¹⁴, and there have been calls to match such schemes to inflation formally.¹⁵

Figure 1: Cumulative price and wage inflation 2005-2022



Source: CSO: [CPI](#) and [Average Weekly Earnings](#)

Figure 1 illustrates that the relative importance of the 100% social welfare rule has likely increased as a policy response as social welfare rates have tended to keep pace with wage inflation over time. Table 3 in the Appendix shows in more detail that this affects different welfare recipients differently. Taking the example of a single person aged 70 and over receiving the State Pension (Contributory) (SPC), and assuming no other income sources, this person faces a Medical Card income limit of €550 per week in 2022. The SPC rate of €179.30 in 2005 or €253.30 in 2022 puts them comfortably below the income

¹² The income limits are shown in Table 2 in the appendix

¹³ We focus on the time period 2005 to 2022. 2005 as it was the last time the Medical Card income limits rose and 2022 as this is the latest available data year available in the microsimulation model.

¹⁴ See Callan et. al (2019) which found that in practice in Ireland, in the absence of a formal indexation process, discretionary changes in tax bands/credits and welfare payments in recent decades have tended to keep pace with earnings growth.

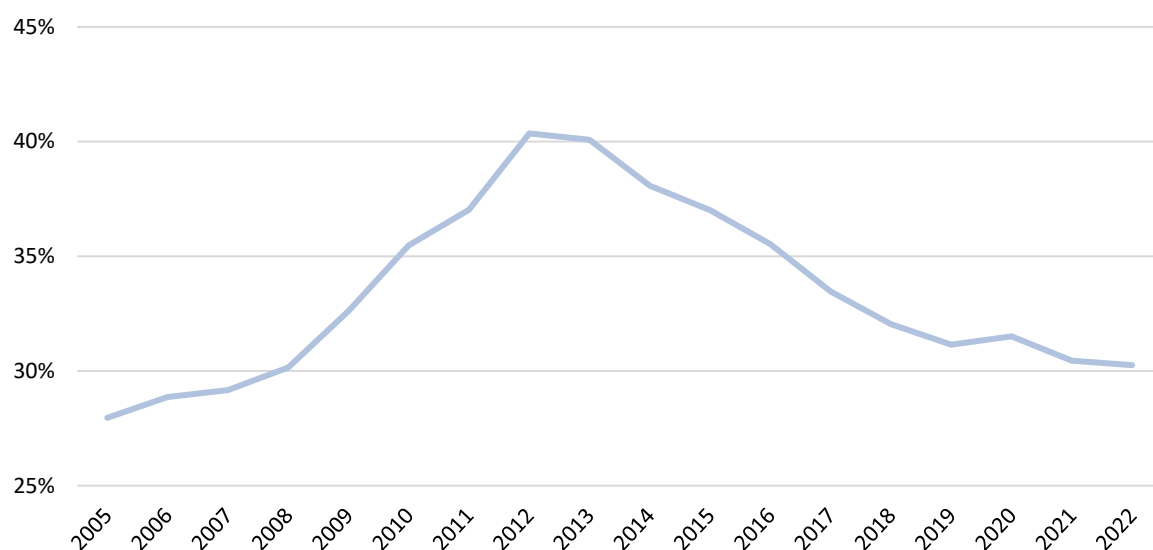
¹⁵ See IHREC (2023).

limit. However, among those under 70, eligibility impacts may arise. A single person receiving the SPC aged 66-69 faces an income limit of €201.50 per week to qualify for a Medical Card. While the 2005 €179.30 SPC rate was below this, in 2022 their SPC of €253.30 exceeds the income limit. Similarly, a single person of working age (under 66) with no dependants in receipt of the main unemployment benefit (Jobseekers Benefit) – would have received €148.80 in 2005 and €208 in 2022 per week. While their unemployment benefit in 2005 would be lower than their Medical Card income limit of €164 (if living with family) or €184 (if living alone), it would exceed it in 2022.¹⁶ We discuss these specific groups for illustrative effect, however this highlights the potential consequences were the 100% social welfare rule not in place.

Figure 2 shows the proportion of the population covered by a Medical Card between 2005 and 2022. Despite the freezing of income limits in 2005 Medical Card coverage increased from 28% in 2005 to 40% in 2012. During these years Ireland was experiencing the financial crisis and accompanying Great Recession which led to one of the largest relative falls in GDP and sharpest rises in unemployment across Europe (see Keane, 2014). There was also price and wage deflation (as shown in Figure 1). The negative impact on employment rates and incomes therefore led to sharp increases in cardholder numbers despite the freezing of income limits. The proportion of the population covered by a Medical Card has consistently fallen since 2012 declining from 40% in 2012 to 30% in 2022. This decline is due to a combination of factors – the lack of increase in the Medical Card income limits will play a role (particularly as wage growth has increased sharply over this time period, see Figure 1) as will the economic recovery resulting in increases in employment rates and incomes.

¹⁶ While those under 70 can allow costs such as housing and childcare against their income to qualify it is unlikely that they incur childcare costs if not in employment. They may also be in receipt of a housing support which would result in no/low housing costs.

Figure 2: Medical Cards recipients as % of total population 2005-2022¹⁷¹⁸



Source: Cardholder numbers are taken from administrative numbers reported by the Primary Care Reimbursement Service (PCRS) while population numbers are taken from the CSO population estimates

3 Data & The SWITCH Model

We use the Survey on Income and Living Conditions (SILC) data for the analysis. SILC is an annual, representative survey of Irish households that covers a broad range of questions on income and living conditions, including information on possession of a Medical Card or GP Visit Card.¹⁹ For the comparative analyses, we compare Medical Card coverage at its post Great Recession peak in 2012 and 2022²⁰, using the SILC Anonymised Microdata Files (AMF)²¹. In 2012, the total sample size was 11,891 individuals from 4,592 households. In 2022, the survey included 11,393 individuals from 4,655 households. The variable of interest – self-report possession of a Medical Card – was not asked for children in the household in 2012²², and therefore, only adults are included in the comparative analyses. This provides a final sample of 8,792 adults in 2012 and 9,143 adults in 2022. Common socio-

¹⁷ [PCRS Annual Reports](#)

¹⁸ While data for more recent years are available, we stop in 2022 to tie in with the analysis using the SWITCH model which is currently operating on 2022 data.

¹⁹ There may, of course, be misreporting of card status in the SILC data but a comparison of the proportion of the population covered by a card is reassuringly similar, see Figure 12 in the appendix.

²⁰ More recent SILC data is available, but the SWITCH model used in later analysis currently runs on 2022 data, therefore we use 2022 in this analysis also for consistency.

²¹ Provided by ISSDA.

²² This question was included in the 2022 questionnaire, but we exclude them for comparability with 2012 data.

demographic variables are available across both waves to allow us to examine socio-demographic differences in Medical Card coverage since 2012.

We use the ESRI's tax and benefit microsimulation model, SWITCH, to assess the hypothetical impact of an increase in income limits for the Medical Card means-test on the number of eligible recipients in 2022. SWITCH uses the more detailed SILC Research Microdata Files (RMF) 2022 for this purpose.²³ These data provide detailed income and socio-demographic information that allow for more accurate modelling of tax liabilities and welfare entitlements²⁴ and simulation of Medical Card entitlement. We group individuals into a family unit (as specified by the Medical Card rules) and simulate a family's entitlement to a Medical Card. Income data are based on administrative information on current income and therefore are free of any self-reporting error. Allowances that can be deducted from income for Medical Card assessment purposes such as housing costs and childcare costs are captured as self-reported data.²⁵ Travel costs are also not included in the data but we allow for an average travel to work cost per employee/self-employed person.²⁶ Importantly, these SILC data also captured self-reported information such as Medical Card possession, if they have any long-standing illness or longstanding health problems (i.e., chronic illness), employment status, disability status, and children present in household are also captured in the data.

As the means-tested Medical Card is awarded to all family members, discretionary cards are simulated if an individual in a family report holding a card in the underlying SILC data, while other family members do not. For single person households a discretionary Medical Card is simulated if the individual's income exceed the relevant income threshold, but they report having a chronic illness and holding a Medical Card.²⁷ ²⁸ Cards awarded under the '100% social welfare' rule are also simulated for families

²³ The Research Microdata Files for SILC are provided to the ESRI provided by the Central Statistics for the construction of the SWITCH model. The CSO does not take any responsibility for the views expressed or the outputs generated from this research

²⁴ For a full description of the SWITCH model see Keane et al (2023).

²⁵ Savings and financial assets are not reported in the data but are imputed from information on income from interest and the average financial market interest rate for the given year.

²⁶ This is calculated as €28 per month per employee/self-employed person based on the average distance travelled to work for drivers taken from Census 2016 (driving being the most common commuting method in Ireland) and the 18c per kilometre allowed under the Medical Card means test. This figure is potentially overstated for 2020-2022 with the uptake of remote work as a result of the Covid-19 pandemic.

²⁷ The survey simply captures the self-reported card status as 'Medical Card' but does not record if the card was awarded on a discretionary basis. As means-tested cards are awarded on a family basis, if an individual in the family reports having a card while other family members don't this is most likely a discretionary card. For single-person families this identification method cannot be used, therefore if we see a single person with means over the Medical Card limit who reports a chronic illness and holding a Medical Card we model them as having a discretionary card.

²⁸ Using this method we simulate that 3.7% of the total population hold a discretionary card holder, only slightly above reported administrative numbers of 3.5% in 2022 (see [PCRS annual report 2022](#)). This is likely due to the fact that we assume all single person households with a chronic illness avail of a discretionary Medical Card while in reality all of them may not apply/be awarded one.

that have incomes (net allowances) that exceed the relevant income threshold but whose income is all from social welfare.

There may be valid differences between simulated eligibility and actual card holding. Keane et al (2021) identified substantial non-take-up of Medical Cards i.e. whereby those eligible do not take up their entitlement. We thereby implement random non-take-up of Medical Cards in the simulation based on take-up rates estimated using the 2022 data. It is also not possible to simulate card entitlements on all grounds – for example it is not possible to simulate entitlement to a Medical Card for those over the income threshold but who retain them for up to 3 years after returning to employment after long-term receipt of certain benefits as we do not have information on benefit receipt over the last 3 years. We also do not simulate Medical Cards awarded on other non-means basis (such as a child with cancer etc.) as we do not have this information in the SILC data that underlies the model. There may be other reasons for difference, for example cards are awarded on a three-year basis and the recipient is required to report any (positive) change in financial circumstances, but this may not be reported in a timely manner.

We therefore examine how eligibility simulated by SWITCH and self-reported Medical Card possession overlap in the data. We also compare the simulated numbers for 2022 to administrative numbers on card holding for the same year. As shown in Table 1 the model slightly underestimates the self-reported number of Medical Cards in SILC when aggregated to the national population, and the administratively reported Medical Card numbers from the PCRS by 6% and 8% respectively. This is to be expected given that we cannot simulate eligibility for some groups where the card is awarded on a non-means tested basis as discussed above (retained Medical Cards, and Medical Cards provided based on certain health conditions etc.). Reported numbers will also show people who may no longer be eligible for a card due to increases in income. Overall, differences are relatively small.

Table 1: Simulated and reported Medical Cards in Ireland in 2022

	SWITCH modelling	Reported in SILC RMF (2022)	Reported by PCRS ²⁹ (2022)	% difference of modelled vs. reported in SILC	% difference of modelled vs. reported by PCRS
No. of Medical Card holders	1,448,764	1,543,312	1,568,379	-6.13%	-8.26%

Source: Authors' analyses of SWITCH, 2022 SILC AMF and PCRS administrative statistics.

In order to examine the impact of the freezing of income limits we estimate Medical Card coverage if income limits, allowances and disregards had been indexed between 2005 and 2022 by either price inflation (26%) or wage inflation (45%). The modelling of the Medical Cards in SWITCH includes the '100% social welfare' rule, where receipt is conditional on having no market income and social welfare being the only income source. To examine the importance of this rule, we simply disable this condition in SWITCH and subject everyone in the model to the means-test, regardless of their source of income.

4 Results: Medical Card Coverage 2012-2022

4.1 Employment Status

Figure 3 presents Medical Card coverage rates in 2012 and 2022 across key socio-demographic groups. We find that while Medical Card coverage overall reduced for adults between 2012 and 2022, certain socio-demographic groups such as the sick/disabled, unemployed and inactive saw an increase in Medical Card coverage of 2, 9 and 13 percentage points (pp) respectively during this period. Contrastingly, coverage rates amongst employees and the self-employed fell by 3.5 and 5 pp respectively, while students saw a 16 pp reduction. Students living at home are usually assessed against their parental income³⁰, those living away from home are assessed against their own income. According to a survey carried out by the Irish League of Credit Unions prior to the pandemic (April 2019)³¹, 74 per cent of third-level students reported working to cover costs. Therefore both dependent and independent students are likely affected by the freezing of income limits. The pattern of coverage

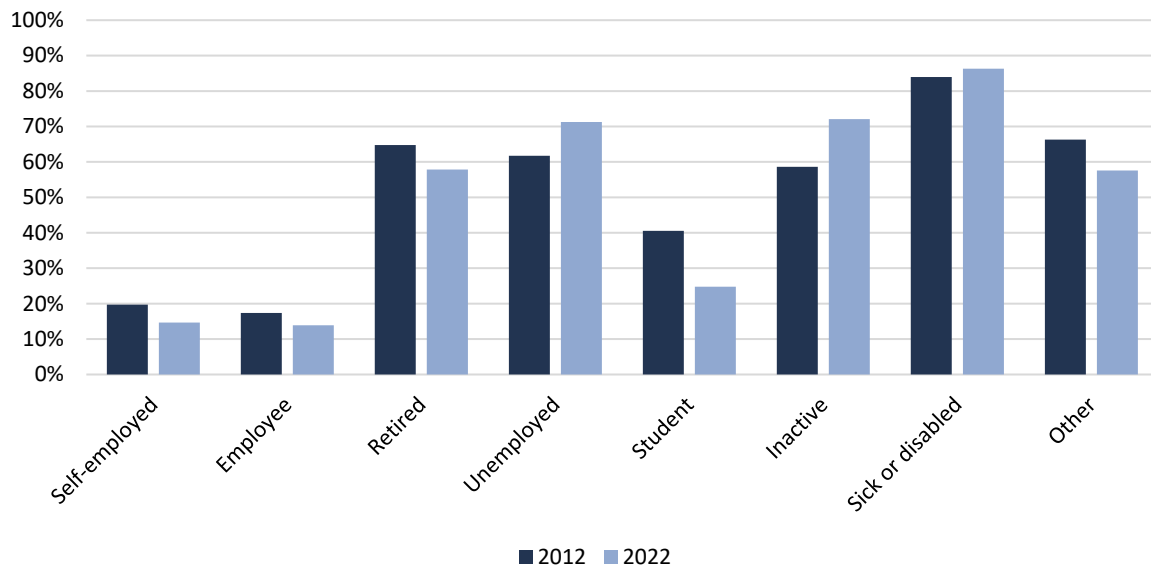
²⁹ [PCRS Annual Reports - Statistical Analysis of Claims and Payments 2022](#)

³⁰ They are deemed to be independent, and therefore assessed against their own income, if living with a parent but earning over a certain threshold.

³¹ See [https://www.creditunion.ie/news/latest-news/ilcu-survey-on-college-costs/#:~:text=Almost%20three%20quarters%20\(74%25\),third%20level%20students%20were%20surveyed.&text=The%20numbers%20saying%20they%20are,earning%20money%20has%20risen%20substantially.](https://www.creditunion.ie/news/latest-news/ilcu-survey-on-college-costs/#:~:text=Almost%20three%20quarters%20(74%25),third%20level%20students%20were%20surveyed.&text=The%20numbers%20saying%20they%20are,earning%20money%20has%20risen%20substantially.)

rates amongst these groups aligns with the hypothesis that due to frozen income limits and the existence of the 100% social welfare rule, we would anticipate a reduction in coverage of those receiving market (employee/self-employed) income, but consistent coverage rates among those not in employment.

Figure 3: Medical Card coverage by labour market status

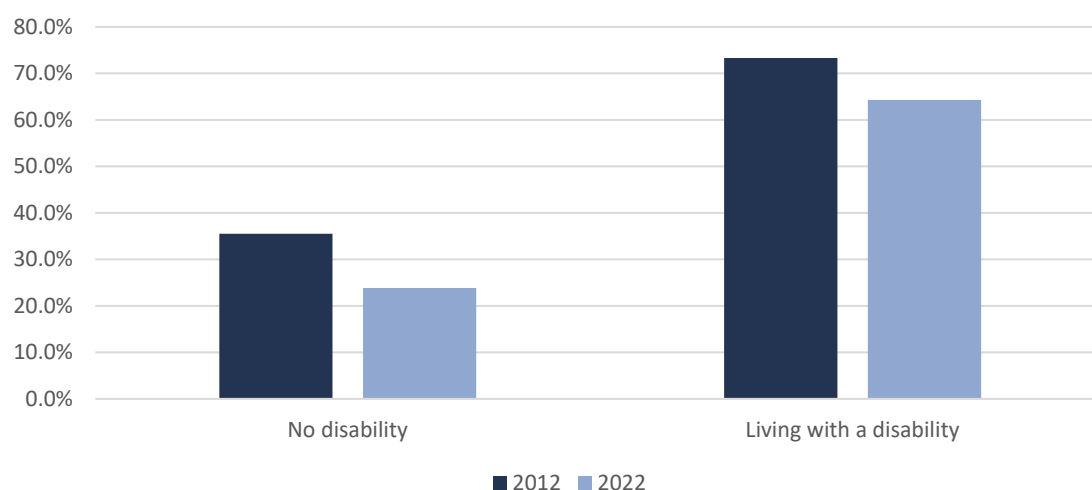


Source: Authors' analyses of 2012 and 2022 SILC AMF.

4.2 Disability Status

Figure 5 presents Medical Card coverage rates in 2012 and 2022 by disability status. Coverage rates are significantly higher for those with a disability. While the coverage rate has fallen for both groups the reduction has been smaller for those with a disability. This finding again aligns with the hypothesis that groups who are less likely to receive a Medical Card based upon their income, will also see smaller decreases in coverage rates. This is because firstly, individuals with a disability are more likely to qualify for a Medical Card under the 100% social welfare rule due to lower rates of employment OECD (2021), and consequently a relatively high rate of receipt of disability related social transfers. Secondly, those with a disability will be more likely to qualify for 'discretionary cards' as they will tend to have higher medical needs/costs.

Figure 4: Medical Card coverage by disability status



Source: Authors' analyses of 2012 and 2022 SILC AMF.

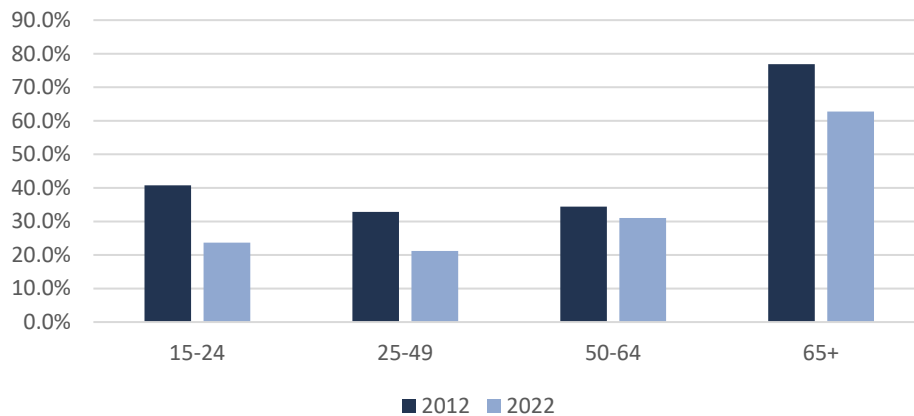
Notes: A person is defined as having a disability if they report having a chronic illness that limits them in their daily activities

4.3 Age Group

Examining card coverage by age (Figure 5) we see the sharpest reduction in card coverage (-40%) in the 15-24 age group followed by the 20-49 age group (-36% in coverage). The 50-64 age group experienced a 10% reduction in coverage while the drop was sharper, at 19%, for the 65+ category. While those over 70 do have more generous income limits, and were the only group to see an increase in the income limit in 2020, a substantial proportion of pensioners³² are not fully dependent on social welfare (e.g. the State pension) but are in receipt of a private or occupational pension which may, therefore, put them above the Medical Card income limit.

³² Using TILDA Nolan et al. (2019) found that of those aged 65+ who were retired 55% of men and 28% of women were in receipt of an occupational/private pension.

Figure 5: Medical Card coverage by age group

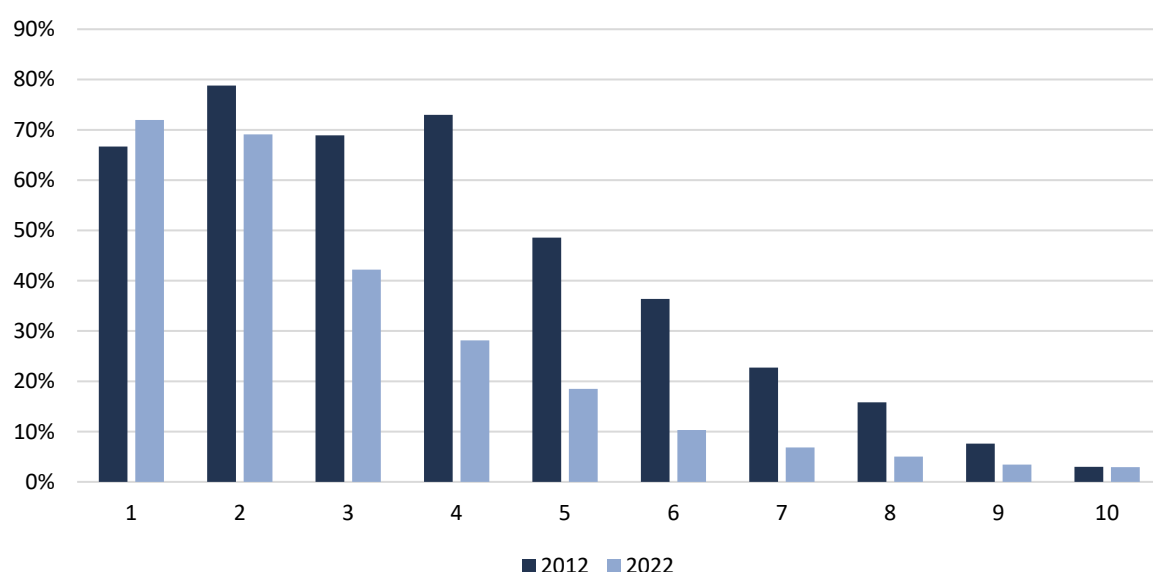


Source: Authors' analyses of 2012 and 2022 SILC AMF.

4.4 Income Distribution

Figure 6 presents Medical Card coverage rates in 2012 and 2022 across income deciles. It shows that all income groups saw a reduction in Medical Card coverage, except the lowest income decile (which saw a 5 pp increase). The largest decreases in coverage rates were observed for income deciles 3-5, where coverage rates decreased by 27-45 pp. Those in the lowest income decile are more likely to be reliant on social transfers, therefore the 100% social welfare rule likely has a protective effect here.

Figure 6: Medical Card coverage by household equivalised disposable income decile



Source: Authors' analyses of 2012 and 2022 SILC AMF.

Notes: Income deciles are calculated by grouping households, summing all members income and equivalising using the Irish national equivalence scale³³. The population is then split into ten groups ranked from the tenth with the lowest income up to the tenth with the highest income.

5 Impact of Frozen Income Threshold Limits

Results in Section 4 align with the hypothesis that those socio-demographic groups that are more likely to have non means-tested cards (i.e. discretionary Medical Cards, or Medical Cards via the 100% social welfare rule) have been more likely to maintain, or even increase, their Medical Card coverage. This means that there are specific groups that will have been disproportionately impacted by the income threshold limits for Medical Cards being frozen since 2005. In this section, we use the microsimulation model, SWITCH, to examine the impact of the freezing of the income limits by looking at two counterfactual simulation scenarios and show the changes in simulated Medical Card recipients³⁴, along with the exchequer cost³⁵, estimated across both scenarios (Figure 7). The cost of cards is calculated using information provided by the PCRS on the average cost of Medical Cards by age-group,

³³ The national equivalence scale attributes a weight of 1 to the first adult, 0.66 to each subsequent adult (aged 14+ living in the household) and 0.33 to each child aged less than 14.

³⁴ We simulate Medical Card receipt for both adults and children in this section.

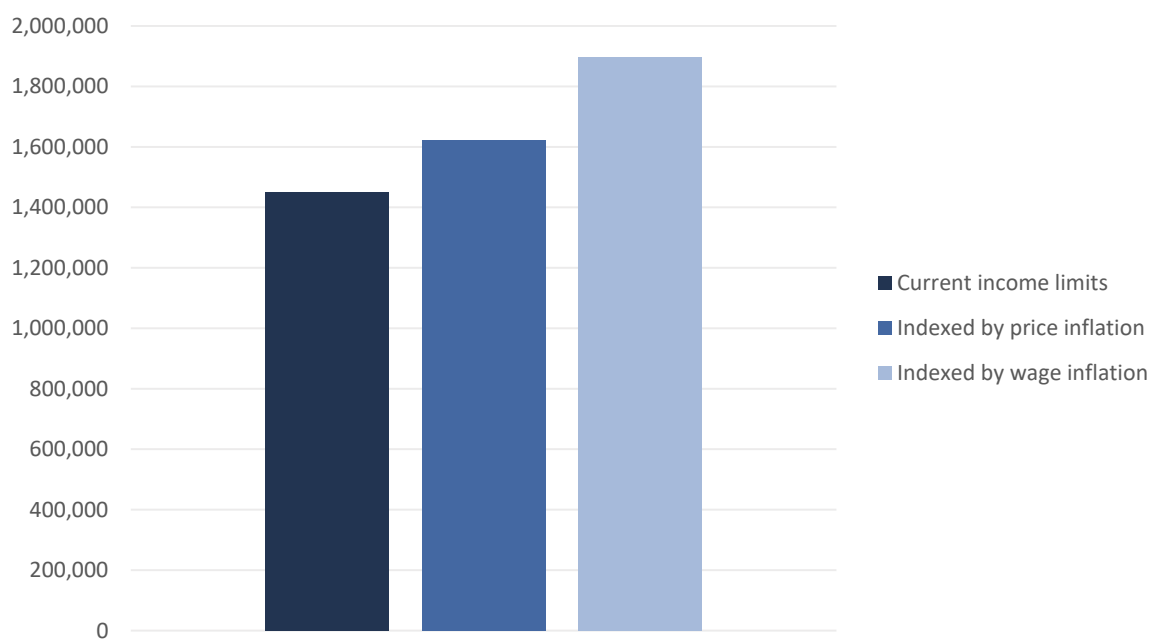
³⁵ We use information provided by the PCRS on the average cost of Medical Cards by age-group, see Table 4 in the appendix. The total exchequer cost is reduced by the cost of a GP-Visit card for those simulated to move from a GP-Visit Card to a Medical Card as income limits are increased.

(see Table 4 in the appendix). The total exchequer cost is reduced by the cost of a GP-Visit card for those simulated to move from a GP-Visit Card to a Medical Card as income limits are increased.

The scenarios examined are as follows:

- 1) 2022 Medical Card income limits are increased in line with the cumulative price inflation between 2005 and 2022, 26%. Under this scenario, we estimate that Medical Cardholder numbers would have been 12% (172,000) higher in 2022. This is estimated to cost €155 million.
- 2) 2022 Medical Card income limits are increased in line with cumulative wage growth over the same time period, 45%. Under this scenario, we estimate that Medical Cardholder numbers would have been 31% (447,000) higher in 2022. This is estimated to cost €400 million.

Figure 7: Medical Card recipients under different income limit levels



Source: Authors' calculations using SWITCH.

Based on simulated results from SWITCH, we also estimate that in 2022 discretionary cards make up 13% of all awarded Medical Cards, while 100% social welfare rule Medical Cards make up 6% (see

Figure 14 in the appendix), therefore we estimate that the vast majority of Medical Cards, 81%, are based upon being under the relevant income thresholds.³⁶

Frozen income thresholds are likely to impact population groups differently. This section outlines the impact across employment status, age groups, disability status, and income groups across our two simulation scenarios.

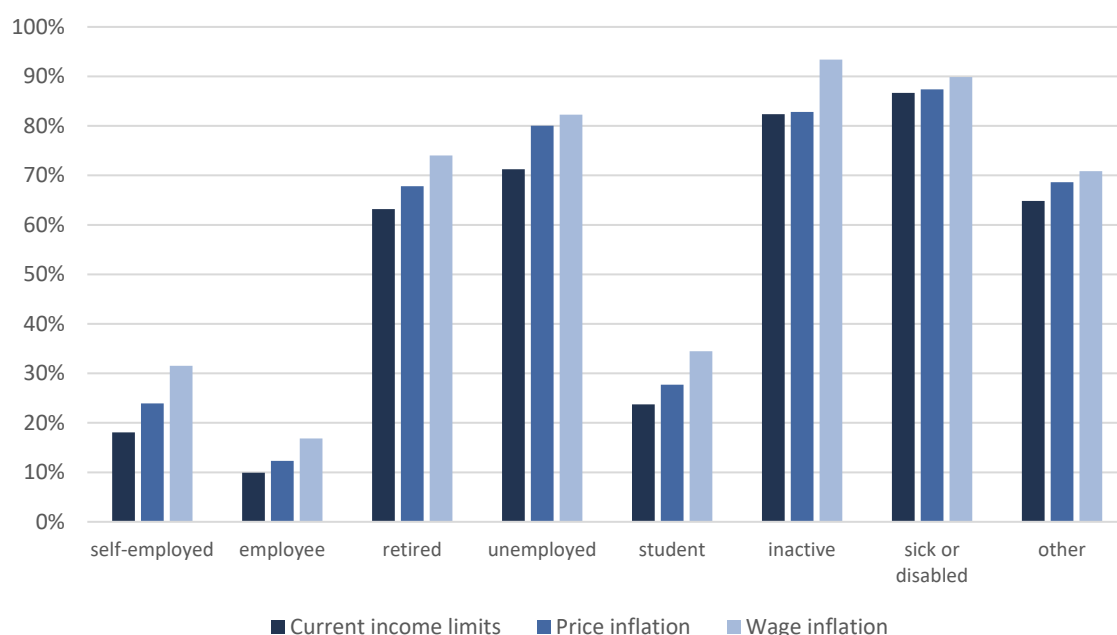
5.1 Employment Status

Figure 8 presents Medical Card coverage rates in 2022, and simulated rates across our two simulation scenarios by employment status. As expected, all groups would see Medical Card coverage rate increases under both scenarios. The sick/disabled group would see the smallest percentage rise (1-3 pp), and we discuss this in more detail in Section 5.2 below. The employed would see a rise in coverage of 2 pp if income limits were increased in line with price inflation and 7 pp if income limits were increased in line with wage inflation. The corresponding increases for the self-employed would be 6/14 pp. The retired/unemployed/student/inactive groups would all see a 10-11 pp increase in card coverage with wage inflation increases reflecting the fact that while some of these groups may be covered by the 100% social welfare income rule they³⁷, or other family members, may have some employment income - therefore the increase in income limits leads to a rise in coverage in these groups also.

³⁶ This is reassuringly similar to administrative numbers from the PCRS for 2022. They report that 12% of all awarded cards were discretionary, 3.5% of the total population – see HSE (2022). To our knowledge the number of cards awarded under the 100% social welfare rule are not published.

³⁷ For example those in receipt of State pensions, unemployment or illness/disability transfers can combine receipt of these transfers with some employment and therefore may not qualify under the social welfare rule also.

Figure 8: Proportion of Medical Cards recipients by labour market status

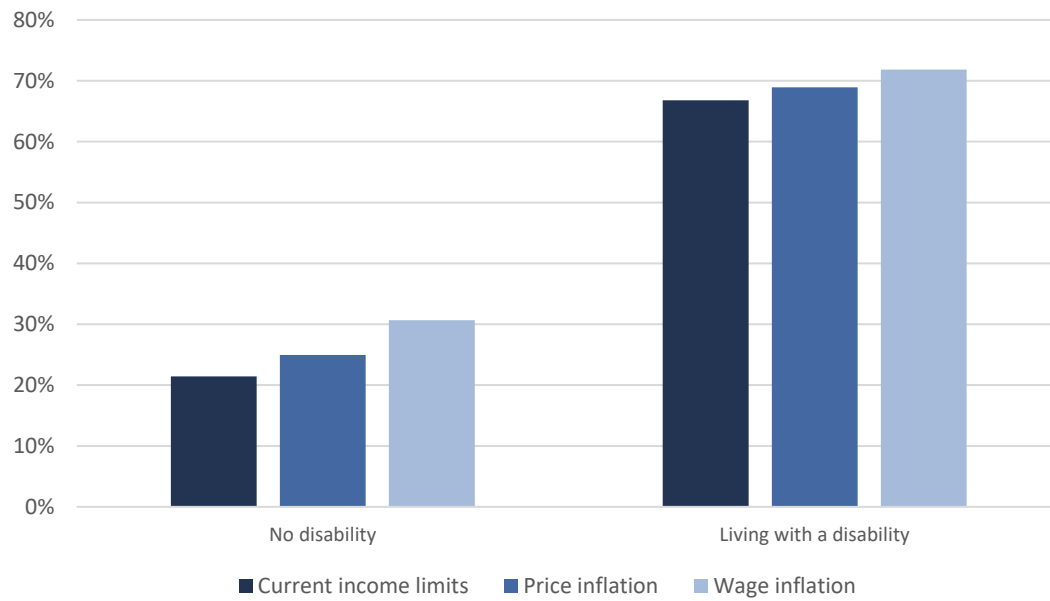


Source: Own calculations using SWITCH.

5.2 Disability Status

As Medical Card coverage rates tend to be higher in the population with a disability Figure 9 shows that increases in Medical Card coverage for those reporting a disability are proportionally smaller than for those without a disability were income limits to be increased. Individuals without a disability would see coverage rates increase by 9 pp, compared to a 5 pp increase for those with a disability. This is expected, as the share of discretionary Medical Cards among the total population of individuals with a disability is much higher than in the whole population, therefore partially shielding this group from the frozen income thresholds.

Figure 9: Proportion of Medical Cards recipients by disability status

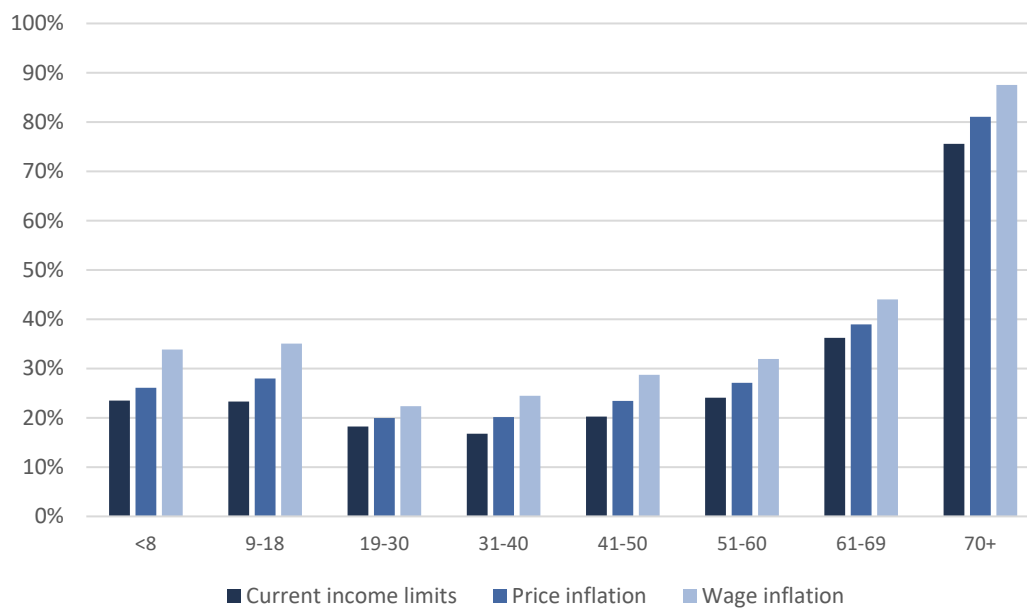


Source: Own calculations using SWITCH.

5.3 Age Group

Figure 10 shows simulated Medical Card coverage by age group under price and wage indexation of income limits. Card coverage would increase in each age-group but would be largest in percentage terms for those aged under 18.

Figure 10: Proportion of Medical Cards recipients by age

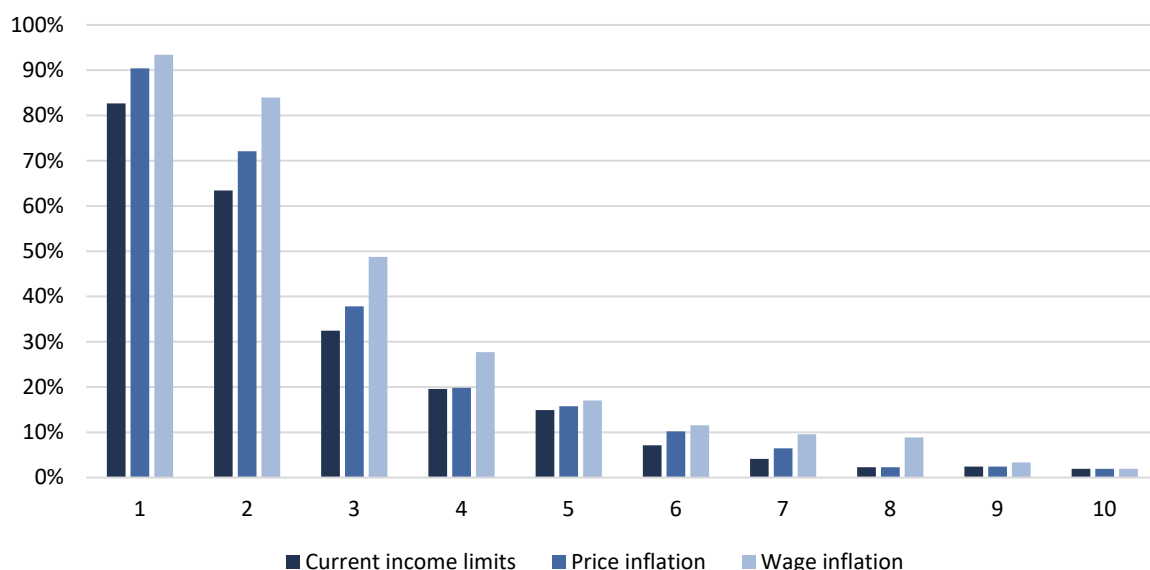


5.4 Income Groups

Figure 11 presents Medical Card coverage rates in 2022 by income decile, along with simulated rates for our two indexation scenarios. While coverage rates decline as we go up the income deciles - as expected with a mainly means-tested benefit such as the Medical Card - it is worth noting two things. Firstly, the deciles are based on the standard net household income, equivalised to take account of household size. The definition of means for the Medical Card income test differs in that it allows housing, childcare and travel-to-work costs against income, therefore those in middle- and higher-income deciles may still qualify if they have large costs such as these. Also, discretionary card coverage can be seen right up to the top income decile.

We find that while Medical Card coverage rates would rise across almost all income groups if the income limits were to be indexed. Small increases in rates are observed for income decile 1 as most in this group already qualify for a Medical Card but coverage would still rise from the current 83% to 93% with wage indexation of limits. However, we estimate that decile 2 would see a 21 pp increase in Medical Card coverage under the wage inflation scenario, and income decile 3 would see a 17 pp increase. Slightly smaller increases are simulated under the price inflation scenario.

Figure 11: Proportion of Medical Cards recipients by income decile



Source: Own calculations using SWITCH.

Notes: Income deciles are calculated by grouping together Medical Card assessment units³⁸, summing all members income and equivalising using the Irish national equivalence scale. The population is then split into ten groups ranked from the tenth with the lowest income up to the tenth with the highest income.

6 Removal of 100% Social Welfare Rule

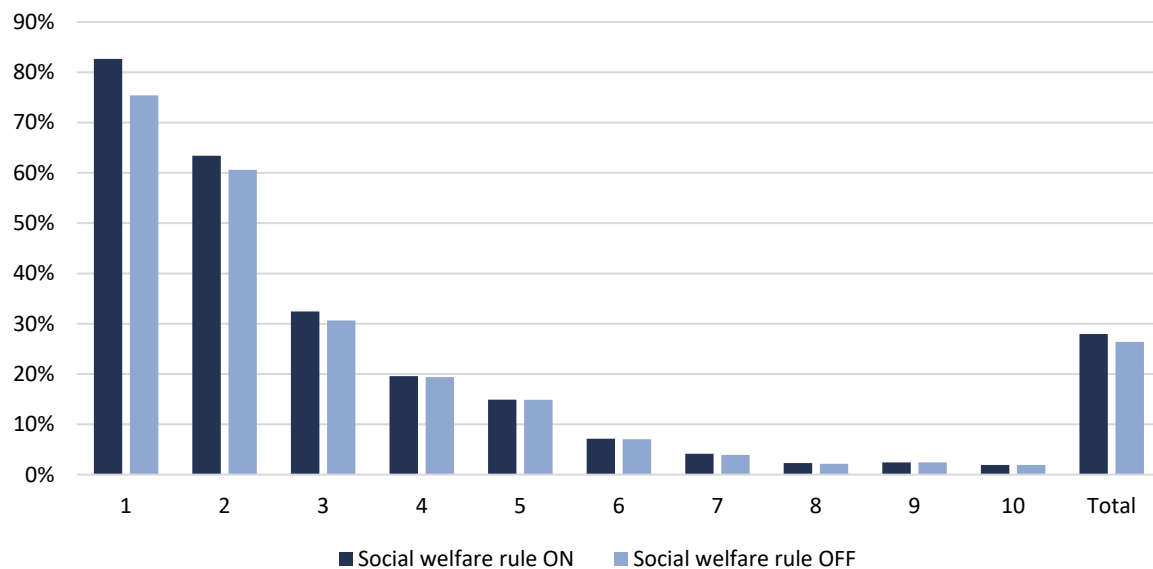
It is clear from Sections 4 and 5 above that those with a discretionary or 100% social welfare rule Medical Card are partially shielded by the freezing of Medical Card income thresholds. In this section, we present results using SWITCH to simulate the impact of removing the 100% social welfare rule (i.e., all employment and non-employment income subject to the income thresholds). As highlighted above, the SWITCH analyses estimate that 80,765 individuals receive a card on the 100% social welfare rule basis, which is about 5.5% of all cards.³⁹ We find that these individuals are mainly recipients of

³⁸ Households defined in the SILC data do not perfectly correspond to units on which Medical Card eligibility is assessed. Medical Card assessment units are only comprised of partners and dependent children under 16, or under 26 if they are defined as a financially dependent child.

³⁹ The Department of Social Protection report 2.3 million recipients (and 3.8 million beneficiaries i.e. including dependants) of social welfare schemes in 2022 (see <https://www.gov.ie/en/collection/743f2-annual-statistics-report-tables/>) – it is not possible however to determine how many of these had social welfare as their only source of income as some welfare schemes allow recipients to earn employment income. Others may have a spouse in receipt of employment income so that their family would not fall into the 100% social welfare rule for Medical Card purposes.

Jobseeker's Allowance, Disability Allowance and State Pension (Contributory). As shown in Figure 11, removing the 100% social welfare rule would have the largest negative impact on individuals in the bottom two income deciles. In income decile 1, the removal of this rule would reduce Medical Card coverage by 8 pp and 2 pp in decile 2.

Figure 12: Medical Card Coverage by Income Decile (with/without the 100% social welfare rule) as % of decile total



Source: Own calculations using SWITCH.

Notes: Income deciles are calculated by grouping together Medical Card assessment units, summing all members income and equivalising using the Irish national equivalence scale. The population is then split into ten groups ranked from the tenth with the lowest income up to the tenth with the highest income.

7 Conclusion

The Sláintecare report highlighted Ireland as one of the few European countries without a UHC, and set out a 10-year plan to achieve it. While important improvements such as the expansion of the GP Visit Card scheme, the removal of co-payments for public acute hospital inpatient care, and a reduction in monthly co-payments for prescription medication have occurred, access, equity, and affordability issues remain. Medical Cards remain the key mechanism used by the State to expand access to care and reduce the financial burden on people, especially those on lower incomes. Medical Cards remain vital for many people to access key community-based services including newly established enhanced community care programmes. However, since the publication of Sláintecare, Medical Card numbers have actually reduced, and the income limits for the scheme have not increased for those aged under

70 since 2005, despite cumulative price inflation of 26% and wage inflation of 45% since then. Therefore, understanding how many people may benefit if the Medical Card eligibility criteria changes, for example if income limits increased in line with inflation, provides evidence for policymakers on the potential number of additional Medical Card that may need to be issued were they to pursue a policy of Medical Card expansion.

This research examines Medical Card coverage across different societal groups and estimates the impact of this lack of indexation on card holding. Due to fears that increases in social welfare benefit rates, which have tended to keep pace with inflation (Callan et al, 2019), would result in a loss of a Medical Card, a decision was made to allow all those with welfare transfers as their sole income source to receive a card even if their income was over the income limit. This has created horizontal inequity and a work disincentive whereby families who have the same income amount are treated differently in terms of card entitlement if some of their income comes from employment.

Despite a freezing of the income limits in 2005, the proportion of the population holding a card grew between 2005 and 2012 due to the negative employment and income impacts of the financial crisis and accompanying Great Recession. Since 2012, Medical Card coverage has been in constant decline however, falling from 40% of the population in 2012 to 30% in 2022. This contrasts with GP-Visit cards where coverage has increased steadily over time, partly due to increases in the income limit for a GP-Visit card and partly due to its rollout on a age basis. Using data from the Survey of Income and Living Conditions, we show that Medical Card coverage over this time-period declined amongst groups with employment income - employees and the self-employed - while it actually grew amongst the unemployed and inactive. While more protected than those without a disability, coverage has still declined substantially amongst those reporting a disability, falling from 73% in 2012 to 64% in 2022. In terms of income groups, coverage has remained high amongst the bottom two income deciles but has fallen sharply for deciles three to six.

Using a microsimulation model we estimated the extent of benefit erosion, i.e. what card coverage would be if the income limits had grown by either price inflation or wage inflation. We estimate that cardholder numbers would be 172,000, or 12%, higher if the income limits had been increased by price inflation since 2005 and 447,000, or 31%, higher if they had been increased in line with wage inflation. The accompanying rise in cardholder numbers would be most strongly felt by the bottom three income deciles. While, of course, there would be a cost to the State to increase the income limits and increase Medical Card coverage rates (€155 million in the case of price indexation and €400 million in the case of wage indexation) the cost may not be as high as first envisaged. Firstly, individuals above the current Medical Card limit, but below the GP-Visit Card limit can currently qualify for a GP-Visit Card. Therefore,

the total cost is reduced by the fall in GP-Visit card numbers and associated outlay. In addition, nearly one-fifth of Medical Cardholders are people above the current income limits but hold a Medical Card due to discretionary/100% social welfare entitlements and therefore the card status and associated cost for these individuals will remain unchanged. In addition, there is evidence from Ireland that having a Medical Card increases engagement with the health system for preventive care services (e.g. cancer screening) despite these services being free to the extended population (Burns et al., 2012; Connolly and Whyte, 2019; Walsh et al., 2012). Therefore, increased card coverage may result in lower government healthcare expenditure in the longer term if it prevents illness.

We also use the model to estimate how important the '100% social welfare rule' is in ensuring card coverage amongst lower income groups. We estimate that just over 80,000 individuals receive a card on this basis, which is about 5.5% of all cards. Unsurprisingly, this rule helps protect primarily those in the first two deciles of the income distribution, which helps explain why the SILC data shows stable card coverage in deciles one and two between 2012 and 2022 despite the freezing of income limits.

Our results have important policy implications. They show the need to ensure indexation of income limits for the Medical Card in line with inflation to ensure that those on lower incomes do not lose card entitlement - and as a result face larger out-of-pocket medical expenses or forego necessary medical care - simply due to average wage increases that occur over time. The freezing of income limits also means a heavier reliance on discretionary cards and '100% social welfare' cards. Discretionary card coverage tends to be higher among employees and individuals in the higher income deciles, as they are less likely to be awarded a card based solely on a means-test. Indeed, if the standard equivalence scale adjustment used, which only takes account of household size, were to factor in the higher cost of living for those with a disability these individuals would be placed in a lower income decile (see Doorley et al, 2025). This highlights one of the issues with non-indexation - under the current system individuals with health conditions active in the labour market are more reliant on discretionary Medical Cards. These tend to be awarded in a less systematic manner and involve a more complicated application process, and therefore increased administrative burden, which requires a medical report from a GP or other qualified health professional and the provision of proof of medical expenses.⁴⁰ Indexation would help reduce reliance on discretionary cards – while around 13% of cards are discretionary this would drop to 9% if income limits were increased in line with price inflation, and further to 6% under wage inflation (see Figure 13 in the Appendix). Indexation in line with wage

⁴⁰ See <https://www2.hse.ie/services/schemes-allowances/medical-cards/other-types-of-medical-card/discretionary-medical-cards/> for more detailed information of the application process for discretionary Medical Cards.

inflation would virtually remove the need for the 100% social welfare rule and the associated inequity – while we estimate that 6% of all cards awarded under this rule it would fall to 3% with price indexation and just 0.1% with wage indexation.

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Appendix

Table 2: Income limits for Medical Cards in 2005 and 2022

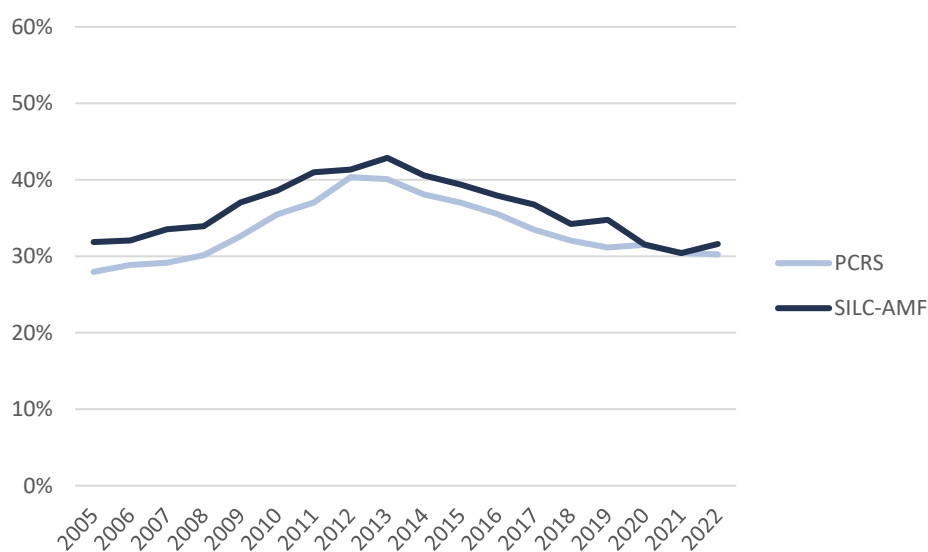
Income limits, allowances and disregards	2005/2022
Single person living alone aged 70 and over	€500/550/week
Married, co-habiting couple/single parent family aged 70 and over	€900/1050/week
Single person living alone aged 66 and over	€201.50/week
Married, co-habiting couple/single parent family aged 66 and over with dependants	€298/week
Single person living with family aged 66 and over	€173.50/week
Single person living alone aged 65 and under	€184/week
Married, co-habiting couple/single parent family aged 65 and under with dependants	€266.50/week
Single person living with family aged 65 and under	€164/week
Recipients of Disability Allowance	€427/week
Allowance for first two children under 16 financially dependent on applicant	€38/week
Allowance for 3rd and subsequent children under 16 financially dependent on applicant	€41/week
Allowance for first two children over 16 financially dependent on applicant	€39/week
Allowance for 3rd and subsequent children over 16 financially dependent on applicant	€42.50/week
Allowance for a dependant over 16 who is in full time 3rd level education, not grant aided	€78/week

Table 3: Headline social welfare rates in 2005 and 2022

Social welfare rates	2005	2022	% change
State Contributory Pension (max.)	€179.30/week	€253.30/week	41%
Increase for Qualified Adult (IQA) aged 66 and over (no age limit in 2022)	€138.50/week	€168.70/week	22%
Increase for Qualified Adult (IQA) aged 65 and under	€119.50/week	No longer exists	Not applicable
Increase for a Qualified Child (IQC) full rate (over 12 in 2022)	€19.30/week	€48.00/week	149%

Increase for a Qualified Child (IQC) half-rate (12 and under in 2022)	€9.65/week	€40.00/week	315%
State Non-Contributory Pension (max.)	€166/week	€242.00/week	46%
Increase for Qualified Adult (IQA)	€109.70/week	€159.90/week	46%
Increase for a Qualified Child (IQC) full rate	€16.80/week	Same as above	Not applicable
Increase for a Qualified Child (IQC) half-rate	€8.40/week	Same as above	Not applicable
Jobseeker's Allowance (max., previously known as Unemployment Assistance)	€148.80/week	€208/week	40%
Jobseeker's Benefit (previously known as Unemployment Benefit)	€148.80/week	€208/week	40%
Disability Allowance (max.)	€148.80/week	€208/week	40%
Illness benefit (previously known as Disability Benefit)	€148.80/week	€208/week	40%
Increase for Qualified Adult (IQA) – working age payments	€98.70/week	€138/week	40%
Increase for a Qualified Child (IQC) full rate – working age payments	€16.80/week	Same as above	Not applicable
Increase for a Qualified Child (IQC) half-rate – working age payments	€8.40/week	Same as above	Not applicable

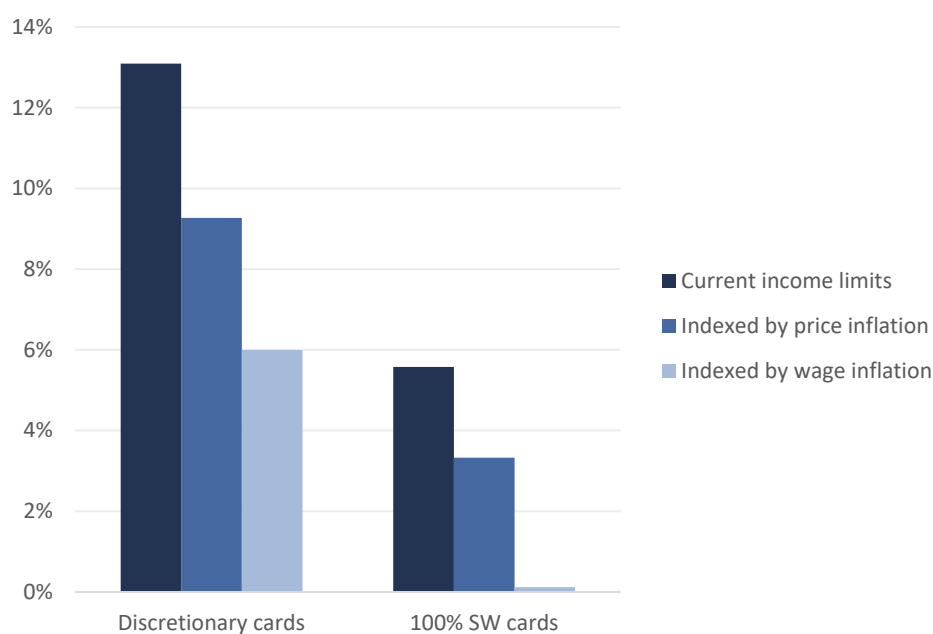
Figure 13: Medical Cards recipients as % of total population 2005-2022: PCRS and SILC



Source: PCRS published statistics and own calculations using the SILC AMF.

Notes: The PCRS statistics show the proportion of the population who hold a Medical Card, the SILC AMF numbers show the proportion of those age over 16 who hold a Medical Card as cardholding by those under 16 was not captured in earlier waves of SILC.

Figure 14: Discretionary and 100% Social Welfare Cards as Proportion of Total



Source: Authors' calculations using SWITCH.

Table 4: Medical Card and GPV Card Cost by Age-Group

Age	Medical Card	GP Visit Card
0-4 yrs	€437	€238
05-15 yrs	€314	€175
16-44 yrs	€832	€205
45-64 yrs	€1,521	€314
65-69 yrs	€1,973	€380
Over 70	€2,539	€750

Source: PCRS