An Roinn Coimirce Sóisialaí
Department of Social Protection

Report on Review of the Operation of the Treatment Benefit Scheme and Consideration of Options to Improve its Impact in Reducing Deprivation and Poverty

December 2021

Contents

1. Requirement for this report 1

2. Scope of report 1

3. Background 2

3.1 The Treatment Benefit scheme 2
3.2 Health Policy in Ireland and the link with poverty and deprivation 3
3.3 People At Risk Of Poverty or social Exclusion (AROPE) 6

4. Analysis of at risk of poverty groups 12

4.1 Income analysis 12
4.2 Employment status — employed and self-employed 12
4.3 People not qualifying including those at risk of in-work poverty 14
4.4 Extending Treatment Benefit coverage to child dependants of qualifying parents 17

5. Conclusion 19

6. Recommendations 20

Appendix 1: Extract from Roadmap 22
Appendix 2: Benefits available 24
Appendix 3: Eligibility and qualifying conditions 25
Appendix 4: Treatment Benefit data 28

Figures

Figure 1: CSO SILC data for Ireland 2014–2019 9

Figure 2: SILC 2019 infographic..... 10

Figure 3: People at risk of poverty or social exclusion 2015–2020, Eurostat 11

Figure 4: At Risk of Poverty thresholds 2014–2019, from Survey on Income and Living Conditions, www.cso.ie. 12

Figure 5: Breakdown of treatment benefit eligibility (as a percentage), by income band and by employment type 13

Figure 6: Treatment Benefit claim rate (as a percentage), within each income band and by employment type 14

Figure 7: Number of people with expired medical cards by year (source: Department of Health)..... 17

1. Requirement for this report

The *Roadmap for Social Inclusion 2020–2025*[1] aims to reduce the number of people in consistent poverty in Ireland and to increase social inclusion for those who are most disadvantaged. This report delivers on commitment number 57:

> *"Review operation of the Treatment Benefit Scheme and consider options to improve its impact in reducing deprivation and poverty".*

The relevant section of the Roadmap is set out at Appendix 1.

2. Scope of report

The Roadmap notes that reforms in healthcare costs have been of significant benefit to people classified as being at risk of consistent poverty, with 89% of them being in receipt of a medical card or GP Visit Card.

This report provides a brief background to the Treatment Benefit scheme and how the scheme intersects with national health policies and strategies. It then outlines what is meant by being at risk of poverty and deprivation. It analyses people at risk of poverty in terms of income, employment status, and people who do not meet the eligibility requirements for Treatment Benefit.

This report specifically considers the possibility of extending Treatment Benefit coverage to children of qualified contributors as the Roadmap suggests that "the extension of coverage to children of qualifying parents" should be reviewed in relation to Treatment Benefit.

The report puts forward a number of options to be considered. It concludes by making recommendations to improve the scheme's impact on deprivation and poverty.

[1] Roadmap for Social Inclusion 2020–2025, Ambitions, Goals, Commitments, Government of Ireland 2020

Recent reports on the Treatment Benefit scheme

This report builds on two reports on the Treatment Benefit scheme which were laid before the Houses of the Oireachtas in August 2020. The findings and recommendations of the reports are relevant to the matters of deprivation, poverty and social inclusion.

The Cost of Hearing Aids and the Adequacy of Financial Supports Available report[2] addressed the cost of hearing aids and the adequacy of financial supports available, taking into account the low level of hearing aid uptake in Ireland. Some of the recommendations are relevant to this report.

The Criteria to Qualify for Treatment Benefit report[3] reviewed the criteria to qualify for treatment benefit and specifically examined the number of contributions required for 25–65 year olds.

This report builds on this work, contains further data analysis and addresses other groups identified as vulnerable.

3. Background

3.1 The Treatment Benefit scheme

The Treatment Benefit scheme is funded by the Social Insurance Fund and administered by the Department of Social Protection (the Department). Treatment Benefit is a social transfer available to employees, self-employed and retired people with the required social insurance (PRSI) contributions and to their adult dependants (almost 2.25 million people in all). The number of PRSI contributions needed depends on a claimant's age, for example people aged over 25 must have paid contributions for a minimum of 5 years to qualify. Treatment Benefit provides full or partial funding for specified dental, optical and aural treatments, and medical

[2] Report under Section 23 of the Social Welfare (No. 2) Act 2019 on the Cost of Hearing Aids and the Adequacy of Financial Supports Available, August 2020

[3] Report Required under Section 24 of the Social Welfare (No. 2) Act 2019 on the Criteria to Qualify for Treatment Benefit report, August 2020

appliances (mainly hearing aids). Dental claims can be made every year, optical claims every second year and hearing aid claims every four years. (See Appendix 2 for details of eligibility criteria and the benefits available under the scheme.) Access to services is provided to insured contributors in an efficient and timely way by contracted private practices that are paid directly by the Department. It is also possible to have treatment in another EU member state — the customer is paid in these cases.

Treatment Benefit is the Department's largest individual scheme in terms of claims with over 1.3 million claims in 2019. The total cost amounted to €101.45 million, of which €8.65 million was re-imbursed to the HSE in respect of people who were dual qualified for treatment (under both Treatment Benefit and the HSE medical card scheme). The total for 2020 was lower at close to €90 million (including HSE re-imbursement) due to the Covid-19 pandemic. 44% of people eligible for Treatment Benefit in December 2020 had made at least one claim under the scheme in 2019. The inclusion of the self-employed in March 2017 led to a 17% increase in the volume of claims in 2019. The rate of take-up of dependant adults is extremely low, at under 2% of claims and under 3% of cost — most of this is for hearing aids.

The Programme for Government commits to a consideration of increasing all classes of PRSI over time to replenish the Social Insurance Fund to help pay for measures and changes to be agreed including treatment benefits (medical, dental, optical, hearing). Therefore, any enhancement to the Treatment Benefit scheme needs to be considered in the context of associated changes in PRSI contributions.

3.2 Health Policy in Ireland and the link with poverty and deprivation

Health policy in Ireland, under Sláintecare, is moving towards a universal single-tier health and social care system where the majority of care is delivered in the community, integrated across different services, and access is based on need rather than ability to pay[4].

[4] *Committee on the Future of Healthcare Sláintecare Report*, Houses of the Oireachtas 2017.

Any future development of the Treatment Benefit scheme must be considered in light of Sláintecare and the policy areas which correspond with the three benefits provided under the Treatment Benefit scheme. They relate to oral, optical and aural health:

- *Smile agus Sláinte — National Oral Health Strategy*, 2019;
- *Primary Care Eye Services Review Group Report*, HSE April 2017;
- *National Review of Audiology*, 2011.

In addition to the Treatment Benefit scheme, people in Ireland can currently avail of dental, optical and aural services via:

- HSE services for children (universal service);
- Medical card (over 1.5 million or almost 32% of population, Dec 2019);[5]
- Private care (with possible support from private insurance and/or tax relief from Revenue).

The ESRI[6] recently reviewed social transfers and deprivation in Ireland to estimate the effect of social transfers on deprivation, focusing on cash and non-cash payments tied to housing, childcare and primary health care. It found that vulnerable groups are the most likely to receive a medical card; that the majority of those in deprivation hold a medical card; and that the medical card has a positive effect in lowering the probability of deprivation.

Accordingly, it is expected that any changes to Treatment Benefit will have low direct impact on the majority of those in deprivation. However, people who are above the poverty and deprivation thresholds may still experience difficulty paying for non-urgent medical care.

There is considerable evidence that poor dental and oral health is associated with social deprivation.[7] Therefore Treatment Benefit has the capacity to ameliorate some

[5] 1,549,432 people or 31.5% of population on 31 December 2019, source: HSE.
[6] Maitre, B, Privalko, I and Watson, D, *Social Transfers and Deprivation in Ireland: A study of cash and non-cash payments tied to housing, childcare, and primary health services*, Dublin, DSP and ESRI, Nov 2020
[7] *Journal of Public Health and Epidemiology*, July 2015

effects of poverty and deprivation as it removes financial barriers to preventative care for eligible lower income households. This could translate into significant savings for both individuals and the State due to the high costs associated with serious interventions resulting from deferred treatment.

International poverty research shows a link between poverty and poor dental health. According to the World Health Organisation,

> Oral diseases disproportionally affect the poor and socially-disadvantaged members of society. There is a very strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases. This association exists from early childhood to older age, and across populations in high-, middle- and low-income countries.[8]

Medical cards play a key role in providing healthcare to those at risk of deprivation or poverty. The means testing for a medical card sets the following income limits:

- Single person living alone €9,568;
- Couple €13,858;
- Children (averaged at an allowance of €40 per child per week for 2 children) €4,160.

The following expenses are allowable, increasing the income limit: childcare costs; rent (not including amounts paid by Rent Supplement or Housing Assistance Payment); reasonable mortgage payments (after mortgage allowance and tax relief is deducted) on family home and other land or property; mortgage protection insurance and associated life assurance; home insurance; maintenance payments a person makes; nursing home, private nursing or home care costs for the applicant or spouse; costs of travelling to work, including public transport, driving expenses, carpooling costs.

[8] https://www.who.int/news-room/fact-sheets/detail/oral-health

The Department estimates that 35%–40% of all PRSI contributors are dual qualified for optical and dental treatments, this means that they qualify under both the HSE medical card scheme and the Treatment Benefit scheme. It should be noted that the Department reimburses the Department of Health for dental and optical treatments carried out by the Health Service Executive on people with both a medical card and PRSI entitlement[9]. The "dual qualified" percentage varies each year. There is nothing to prevent customers from availing of treatment under both schemes even where this is not medically necessary. Sharing of data under a service level agreement between the Department and the Department of Health has highlighted a level of dual funding, with some people getting dental or optical checks under both schemes.

Further work is required by the two departments concerned to examine this issue to ensure that dual claims are only provided for where there is a medical necessity for them.

3.3 People At Risk Of Poverty or social Exclusion (AROPE)

In Ireland, poverty data is collected by the Central Statistics Office (CSO) using the Survey on Income and Living Conditions (SILC) which is conducted annually. This is a household survey covering a broad range of issues in relation to income and living conditions. It is the official source of data on household and individual income and provides a number of key national poverty indicators, such as the at risk of poverty rate, the consistent poverty rate and rates of enforced deprivation. Using a combination of these measures gives us a more comprehensive picture of poverty in Ireland.

[9] Re-imbursement from Treament Benefit to the Health Service Executive is provided for in the Social Welfare Consolidation Act.

At risk of poverty

At Risk Of Poverty or social Exclusion (AROPE) is a broad term that corresponds to the sum of persons who are either at risk of poverty, or severely materially deprived, or living in a household with a very low work intensity.

This measure is also known as *relative poverty* or *income poverty*. It is measured by setting a *relative income poverty line*, which shows how an individual's or household's income compares to the average. In Ireland the poverty line is set at 60 per cent. This measure is used throughout the European Union to measure poverty and it enables comparisons to be made between member states.

Often, *median* income — the mid-point on the scale of all incomes in the State from the highest to the lowest — may be used rather than *mean* or average income as it gives a more accurate reflection of income levels. Average income figures tend to be distorted by very high incomes at the top end of the scale.

In Ireland, people are regarded as being at risk of poverty if their income is 60% below the national median equivalised disposable income after social transfers.

Material deprivation

This measure takes account of access to resources other than income. A *deprivation index* of items and activities that are generally taken to be the norm in a particular society is compiled. The organisation responsible for collecting poverty data usually develops the index.

People who are denied — through lack of income — items or activities on this index / list are regarded as experiencing relative deprivation. This is *enforced deprivation* as distinct from the personal choice not to have the items.

In Ireland, 11 basic items are used to construct the deprivation index:

- Unable to afford two pairs of strong shoes
- Unable to afford a warm waterproof overcoat
- Unable to afford new (not second-hand) clothes

- Unable to afford a meal with meat, chicken or fish (vegetarian equivalent) every second day
- Unable to afford a roast joint or its equivalent once a week
- Without heating at some stage in the last year through lack of money
- Unable to afford to keep the home adequately warm
- Unable to afford to buy presents for family or friends at least once a year
- Unable to afford to replace any worn out furniture
- Unable to afford to have family or friends for a drink or meal once a month
- Unable to afford a morning, afternoon or evening out in the last fortnight for entertainment.

Consistent poverty

This measure is also known as the *combined income-deprivation measure* of poverty. It combines relative income poverty with relative deprivation. People whose income falls below the relative income poverty line and who also experience relative deprivation are regarded as living in consistent poverty.

This is the official method used to set the national poverty target in Ireland: the figure for *at risk of poverty* is combined with the *material deprivation* indicators above to calculate the rate of *consistent poverty*.

See below the at risk of poverty thresholds in Ireland for the period 2014–2019. The national at risk of poverty rate in 2019 was 12.8% — this means that 12.8% of the population had an income below 60% of the median equivalised income.[10]

[10] Survey on Income and Living Conditions, https://www.cso.ie/en/releasesandpublications/ep/p-silc/surveyonincomeandlivingconditionssilc2019/povertyanddeprivation/

CSO-SILC 2019 Table 1.1 Summary of main results	2014	2015	2016	2017	2018	2019
Income	**€**	**€**	**€**	**€**	**€**	**€**
Nominal household disposable income						
Median	35,305	37,401	38,953	39,499	42,865	43,552
Mean	43,067	44,827	46,310	48,476	51,458	53,118
Nominal equivalised disposable income per individual						
Median	18,385	19,461	20,331	20,869	22,872	23,979
Mean	22,041	22,984	23,682	24,983	26,766	27,941
At risk of poverty threshold						
(60% of median income)	11,031	11,677	12,199	12,521	13,723	14,387
Poverty & deprivation rates	**%**	%	%	%	%	%
At risk of poverty rate	16.7	16.3	16.2	15.7	14.0	12.8
Deprivation rate[1]	28.9	25.4	21.0	18.8	15.1	17.8
Deprivation rate for those at risk of poverty	49.7	51.9	50.4	42.8	40.3	42.7
Consistent poverty rate	8.3	8.5	8.2	6.7	5.6	5.5
Income equality indicators						
Gini coefficient (%)	32.1	30.8	30.7	31.5	29.7	28.8
Income quintile share ratio	5.1	4.7	4.7	4.8	4.4	4.1

[1] *Experienced two or more types of enforced deprivation.*

Illustrative values (60% level)						
1 adult, no children	€11,031	€11,677	€12,199	€12,521	€13,723	€14,387
2 adults, 2 children	€25,592	€27,091	€28,302	€29,049	€31,837	€33,378

Figure 1: CSO SILC data for Ireland 2014–2019

The main results for SILC 2019 are presented below:

- The at risk of poverty rate was 12.8% in 2019 compared with 14.0% in 2018. This means that 12.8% of the population had an income below 60% of the median equivalised income.
- The at risk of poverty rate was 4.6% for those that described their principal economic status as 'at work'. This is termed in-work poverty.
- Enforced deprivation was experienced by 17.8% of the population, up from 15.1% in 2018. The deprivation rate for those at risk of poverty was 42.7% in 2019, up from 40.3% in 2018
- The consistent poverty rate was 5.5%.

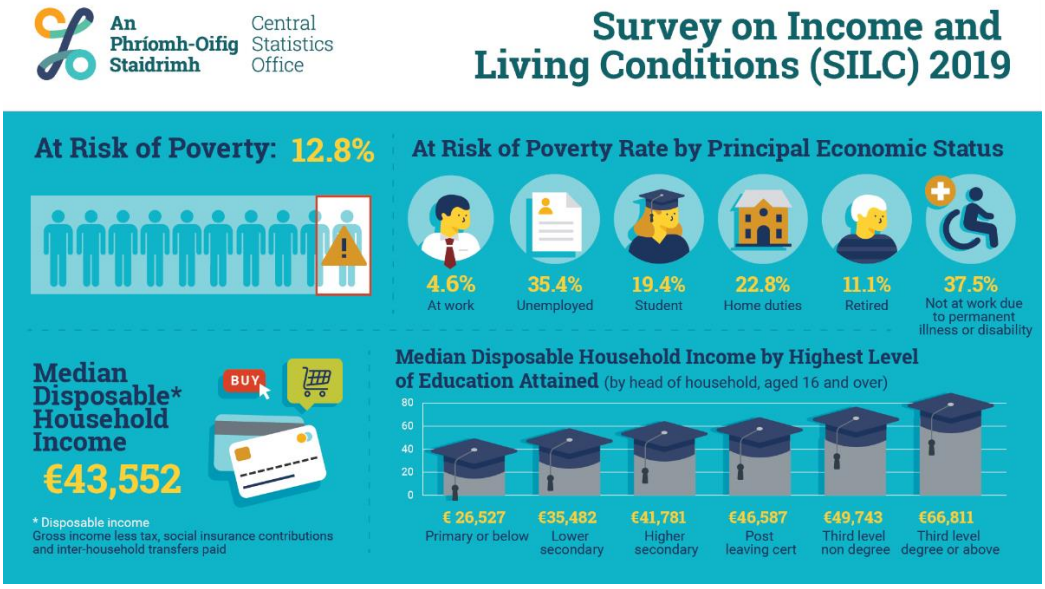

Figure 2: SILC 2019 infographic

Data from 2018 also show that lone parents (24.4%), children aged 0–17 (15.9%), and young adults aged 18–24 (15.7%) experienced higher at risk of poverty rates[11].

According to Eurostat,

> "Poverty and social exclusion harm individual lives and limit the opportunities for people to achieve their full potential by affecting their health and well-being and lowering educational outcomes. This, in turn, reduces opportunities to lead a successful life and further increases the risk of poverty. Without effective education, health, social, tax benefit and employment systems, the risk of poverty is passed on from one generation to the next. This causes poverty to persist and hence creates more inequality, which can lead to long-term loss of economic productivity from whole groups of society and hamper inclusive and sustainable economic growth."[12]

The following Eurostat table shows the percentage of people considered at risk of poverty or social exclusion across the EU in recent years.

[11] Trends in Social Inclusion Data for the period 2010–2018: Appendix 2, Government of Ireland 2020, Roadmap appendix doc

[12] https://ec.europa.eu/eurostat/cache/metadata/en/sdg_01_10_esmsip2.htm

People at risk of poverty or social exclusion (%)						
	2015	2016	2017	2018	2019	2020
European Union-28 countries (2013–2020)	23.8	23.5	22.4	21.8	21.4**	:
Belgium	21.1	20.9	20.6	20.0	19.5*	18.9*
Bulgaria	41.3	40.4*	38.9	32.8	32.8	32.1
Czechia	14.0	13.3	12.2	12.2	12.5	:
Denmark	17.7	16.8	17.2	17.0	16.3	15.9*
Germany (until 1990 former territory of the FRG)	20.0	19.7	19.0	18.7	17.4	:
Estonia	24.2	24.4	23.4	24.4	24.3	23.3
Ireland	26.2	24.4	22.7	21.1	20.6	:
Greece	35.7	35.6	34.8	31.8	30.0	28.9
Spain	28.6	27.9	26.6	26.1	25.3	:
France	17.7	18.2	17.0	17.4	17.9	:
Croatia	29.1	27.9	26.4	24.8	23.3	23.2***
Italy	28.7	30.0	28.9	27.3	25.6	:
Cyprus	28.9	27.7	25.2	23.9	22.3	:
Latvia	30.9	28.5	28.2	28.4	27.3	:
Lithuania	29.3	30.1	29.6	28.3	26.3	:
Luxembourg	18.5	19.1*	19.4	20.7	20.6	:
Hungary	28.2	26.3	25.6	19.6	18.9	17.8
Malta	23.0	20.3	19.3	19.0	20.1	:
Netherlands	16.4	16.7*	17.0	16.7	16.5	16.3***
Austria	18.3	18.0	18.1	17.5	16.9	17.5
Poland	23.4	21.9	19.5	18.9	18.2	:
Portugal	26.6	25.1	23.3	21.6	21.6	:
Romania	37.4	38.8	35.7	32.5	31.2	30.4
Slovenia	19.2	18.4	17.1	16.2	14.4	15.0
Slovakia	18.4	18.1	16.3	16.3	16.4	:
Finland	16.8	16.6	15.7	16.5	15.6	16.0
Sweden	18.6	18.3	17.7	18.0	18.8	17.9
United Kingdom	23.5	22.2	22*	23.1	:	:
*break in time series	** estimated		*** provisional			

Figure 3: People at risk of poverty or social exclusion 2015–2020, Eurostat

Although the rate of in-work poverty was 5.1% in 2018 according to SILC, the figure was 4.8% for the same year according to Eurostat[13], with Ireland having one of the lowest rates of in-work poverty.

[13] https://ec.europa.eu/eurostat/databrowser/view/tespm070/default/bar?lang=en

The next section looks at people at risk of poverty in Ireland in more detail and considers if Treatment Benefit can play a part in supporting them.

4. Analysis of at risk of poverty groups

4.1 Income analysis

In 2019 a single person was considered at risk of poverty with an income of less than €14,387 a year and a worker with a dependant partner and two children was considered at risk of poverty with an income of less than €33,378.

Nominal at risk of poverty thresholds by year						
	2014	**2015**	**2016**	**2017**	**2018**	**2019**
National income definition, national equivalence scale						
At risk of poverty threshold in €						
60% of median income	**11,031**	**11,677**	**12,199**	**12,521**	**13,723**	**14,387**
Illustrative values (60% level)						
1 adult, no children	11,031	11,677	12,199	12,521	13,723	14,387
2 adults, 2 children	25,592	27,091	28,302	29,049	31,837	33,378

Figure 4: At Risk of Poverty Thresholds 2014–2019, from [Survey on Income and Living Conditions, www.cso.ie.]

4.2 Employment status — employed and self-employed

Daly[14] states that a breakdown by employment status shows that in-work poverty is very much a phenomenon associated with self-employment. She notes that the self-employed are four times more likely to be in in-work poverty compared with employees and that Ireland has a high rate of self-employment. However, she notes that these figures need to be treated with caution and that the figures for the self-employed suffering deprivation are lower than for employees. She also emphasises

[14] Daly, Mary (2019). *ESPN Thematic Report on In-work Poverty-Ireland*, European Social Policy Network (ESPN), Brussels: European Commission.

a sectoral dimension here with a rise in self-employment among construction workers after the financial crisis.

The employed and self-employed (primarily paying PRSI Class S) demonstrate broadly similar percentage eligibility across income bands, except for the highest (€100,000+) band. The majority (56%) of those eligible for Treatment Benefit earned €35,000 or less and were responsible for 50% of claims in December 2020 (Figure 5). However, the average claim rate was 37% for those earning €35,000 or less while the average claim rate was 48% for higher earners (Figure 6). In the case of the self-employed the average claim rate only differed by 3% between those earning below (43%) or above (46%) €35,000. It may be therefore inferred that in general, those on lower incomes are less likely to claim their entitlements under Treatment Benefit. Promotion of the scheme among lower earners may increase its effectiveness.

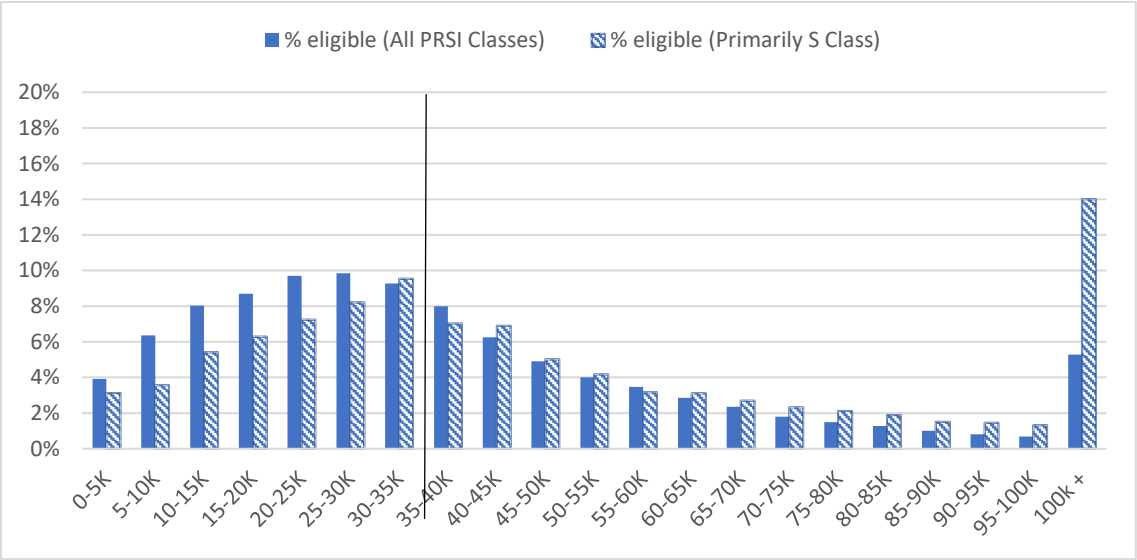

Figure 5: Breakdown of treatment benefit eligibility (as a percentage), by income band and by employment type

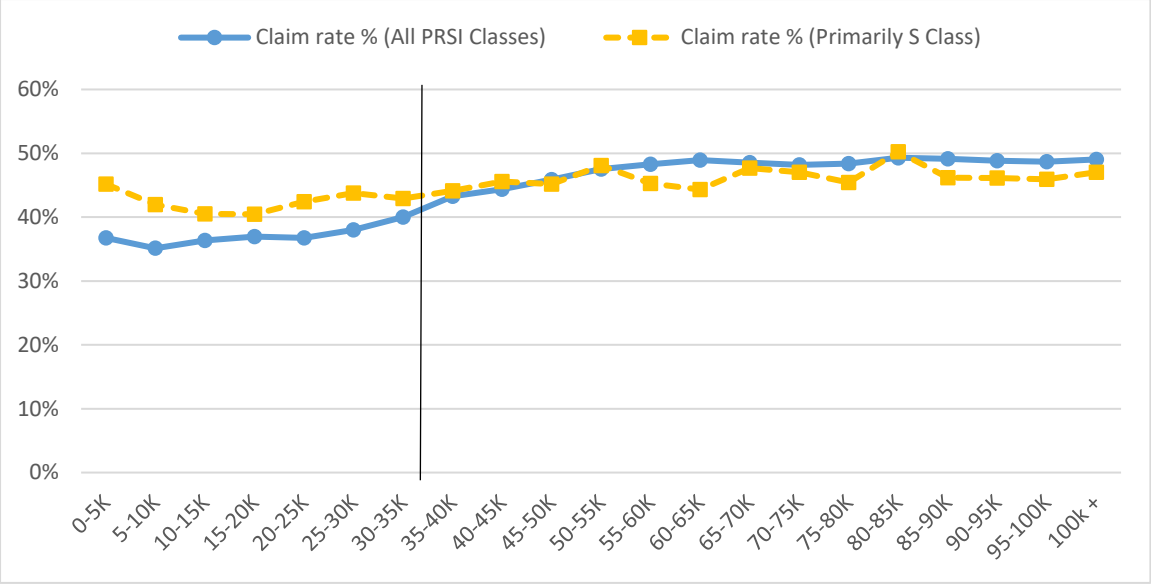

Figure 6: Treatment Benefit claim rate (as a percentage), within each income band and by employment type

Figure 5 illustrates that lower income groups make up a higher proportion of those eligible for Treatment Benefit compared to higher income groups. Combined with the high level of medical card coverage for lower income cohorts, this represents a significant level of support available for lower income households.

There has been an extensive expansion of access to the range of social insurance benefits by self-employed social insurance contributors in recent years without any increase in the 4% rate of contribution made by them. In effect, self-employed contributors, in return for a contribution of 11 percentage points lower than the combined employer and employee contribution of 15.05% made in respect of employed contributors, have access to benefits which comprise over 90% of the value of all benefits available to employed contributors.

4.3 People not qualifying including those at risk of in-work poverty

People aged over 25 must have paid a minimum of 5 years' contributions to qualify for Treatment Benefit[15]. Achieving this is sometimes an issue for certain groups in

[15] This is being reducd for young people aged 25–28 years from 28 May 2022.

the workforce: those who take up work for the first time; those who have been unemployed; those who spent time caring for others; returning emigrants; migrants from non-EU countries; older low paid civil servants (who started work pre-1995). Most people in this situation know they don't qualify for Treatment Benefit so the Department does not have figures on rejections for each cohort.

Some of these groups are typically eligible for a medical card and therefore have their medical needs met — long-term social welfare recipients, refugees and asylum seekers. Income earned up to €427 per week is not taken into account in the means test for the medical card for those who are in receipt of Disability Allowance and working.

In August 2020, the Department published a report on the criteria to qualify for Treatment Benefit[16].

That report recommended that a detailed data analysis to identify the numbers and types of contributors who do not qualify for Treatment Benefit and the reasons be carried out under this Report.

As a benefit payment, entitlement to Treatment Benefit is linked not only to the number of contributions but also to the class of contribution and the associated contribution rate — in general, contribution classes that pay a higher rate of PRSI enjoy a wider range of benefits. Those making contributions under classes B, C and D do not have an entitlement to Treatment Benefit, which is reflected in a much reduced contribution rate of 2.01% for Class B, 2.35% for Class D and nil for Class M.

The August 2020 report further recommended that the position of younger contributors who have not had the opportunity to build up the required contribution history should be addressed. Treatment Benefit is also unusual in that there is a significantly lower number of contributions required for those under 25 — this is not a feature of other benefit payments such as Jobseeker's Benefit, Illness Benefit or

[16] Report Required under Section 24 of the Social Welfare (No. 2) Act 2019 on the Criteria to Qualify for Treatment Benefit report, August 2020

Maternity Benefit. This reduced contribution requirement reflects the period needed to establish the requisite number of contributions after completing education. However, the report stated that it is evident that the employment history and contribution profile of a proportion of younger contributors is now such that they fail to meet the criteria for the scheme until they are in their late 20s. The report suggested that a way to address this is to increase the age at which the full 260 contributions are required from 25 to 29. This is estimated to cost between €1.5m and €2m per annum. Budget 2022 announced a reduction in the number of contributions required for young people aged 25–28 from 260 to 39 – this will be implemented from 28 May 2022.

The report also recommended that the cost of reducing the required number of contributions for all recipients to 208 (four years) and to 156 (three years) should be estimated to input into a discussion on the appropriate contribution level for Treatment Benefit in a budgetary context. This analysis is set out at Appendix 4.

The report also recommended that young people with hearing loss have specific support needs which should be dealt with comprehensively under the health system by the HSE rather than under the Treatment Benefit scheme.

People who have moved from welfare to work are usually able to retain their medical card for the first three years, providing access to health services without having to worry about cost. The 2020 Treatment Benefit report on qualifying criteria noted that some people who had been in receipt of an income support payment and who moved to employment might experience a gap in coverage in years 4 and 5 of their employment, after their medical card expired and before they became eligible for Treatment Benefit.[17] The 2020 report recommended that the position of people who experience this gap in coverage should be considered further in the context of this report.

[17] If a person has 260 contributions paid at any time, the key to requalification is having the 39 contributions paid in the relevant tax year. So if the person is working while in receipt of a medical card, he or she will have the 39 contributions in the governing contribution year. When they are no longer eligible for the medical card, they will be eligible for Treatment Benefit if they have the required 260 contributions from any time in their previous work history.

As part of the research for this report, figures from the Department of Health were reviewed to see how many people lost eligibility for their medical card in this situation and it turned out that the figure was very low. This is likely to be because they continue to be entitled to a medical card under means testing limits, either due to low pay or due to a high level of expenses such that their net pay was below the medical card limit. On this basis, it is considered that the current arrangements for retaining the medical card for three years is appropriate.

Retentions—Medical Cards	**Working—received welfare payment for more than 12 months**								
	2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Cards issued	242	358	475	483	850	854	815	231	4308
Currently in date	109	156	236	281	606	703	734	224	3049
Expired	133	202	239	202	244	151	81	7	1259
% Lost card	55%	56%	50%	42%	29%	18%	10%	3%	29%

Figure 7: Number of people with expired medical cards by year (source: Department of Health)

Finally, the 2020 report stated that any expansion of Treatment Benefit coverage for insured contributors would have budgetary implications and would need to be reviewed in the context of annual budgetary discussions and broader health strategies. It is also important to note that general extension of eligibility, either by changes to contribution requirements or otherwise, is difficult to target from a poverty perspective.

4.4 Extending Treatment Benefit coverage to child dependants of qualifying parents

Adult dependants of insured contributors are currently eligible for Treatment Benefit if they have a gross income of €100 or less per week and are not on a social

welfare payment, with some exceptions. Child dependants are not covered by the scheme.

The *Roadmap for Social Inclusion* indicated that the Government will review the operation of the Treatment Benefit scheme to consider if it can be improved to help reduce the impact of poverty, for example through the extension of coverage to children of qualifying parents.

Many studies by the ESRI[18] have highlighted the higher poverty rates of lone parents and people with disabilities and for their children. Given the higher costs that both groups have in going to work, particularly childcare costs, they are more likely to be at risk of poverty than other groups in the workforce.

Regan and Maitre[19] highlighted the fact that children have consistently experienced higher at risk of poverty rates than working age adults and older people since 2004. They also noted that children were the most disadvantaged group in relation to deprivation.

The *Sláintecare* strategy provides a framework for a health service where the majority of care is delivered in the community, care is integrated across different services, and access is based on need and not ability to pay.

Smile agus Sláinte emphasises the same ideals: primary care, integrated oral and general health, and prevention. It aims to support the provision of all levels of care by appropriate healthcare professionals in the most suitable settings. Given that the Smile agus Sláinte National Oral Healthcare strategy proposes to provide for universal dental treatment for children, the extension of coverage of Treatment Benefit for dental treatment to children of eligible contributors would lead to inefficiencies of dual entitlements and double claiming of treatments, which is already a problem in relation to adults. In addition, Smile agus Sláinte proposes a

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[18] *Profiling Barriers to Social Inclusion in Ireland: The Relative Roles of Individual Characteristics and Location*, McGuinness et al Research Series No 71, July 2018
Poverty Transitions in Ireland: An analysis of the CSO Longitudinal Survey on Income and Living Conditions (SILC) 2004–2015, Grotti et al, Dec 2017
[19] Regan and Maitre, *Child Poverty in Ireland and the Pandemic Recession*, ESRI, 2020

‘package of care’ approach which differs from the fee per service model used in the Treatment Benefit scheme.

Similarly, the *Primary Eye Care Services Review Group Report* focuses on service delivery by Primary Care Eye Teams, with one in each Community Health Organisation. It proposes improvements to eye care services for all, including children, continuing the focus of current health policy on prevention and on treatment in primary care settings where possible. Currently all children receive free screening for sight problems and can receive free care till they are 16.

This indicates that the universal approach proposed would meet the needs of all children and would ensure equal treatment for all irrespective of parental PRSI contributions. Again, it would avoid the inefficiencies of dual entitlements and double claiming of treatments, although this appears to be less significant than in the case of dental treatment.

5. Conclusion

Health policy for people at risk of poverty and deprivation is primarily the responsibility of the Department of Health. This report has shown that most people in this situation are in receipt of medical cards and therefore have access to free medical care.

Treatment Benefit is a benefit scheme — by definition it is paid to those with a contribution history through their work. This limits the extent to which the scheme can address poverty in a targeted way among those with limited work history.

The high level of medical card coverage together with the comparatively high level of Treatment Benefit entitlement among lower income groups, suggest that there is significant support available for those at risk of poverty.

Lower income groups have a higher level of eligibility for Treatment Benefit compared to higher income groups. However, those on lower incomes are less likely to claim their entitlements under Treatment Benefit. The rate of take-up of dependant

adults is also extremely low, at under 2% of claims and under 3% of cost — most of this is for hearing aids.

Sharing of data under a service level agreement between the Department and the Department of Health has highlighted a level of dual funding, with some people getting dental or optical checks under both schemes, even where there may not be a medical necessity for this.

The proposed universal approach to healthcare under various health strategies would meet the needs of all children and would ensure equal treatment for all irrespective of parental PRSI contributions. As such, this is a more effective approach than extending Treatment Benefit to qualified children. This also avoids the inefficiencies of dual entitlements and double claiming of treatments.

6. Recommendations

This report builds on the recommendations of the two reports written in 2020 on the Treatment Benefit scheme, referred to in Section 2 of this report.

The report notes that the key responsibility for meeting the health needs of those at risk of poverty and deprivation lie with the Department of Health, through its implementation of Sláintecare and the three national strategies for the development of dental, optical and aural health.

Any future changes that are implemented in the Treatment Benefit scheme should focus on reducing deprivation and poverty and should be undertaken in a targeted way.

The Programme for Government commits to a consideration of increasing all classes of PRSI over time to replenish the Social Insurance Fund to help pay for measures and changes to be agreed including treatment benefits (medical, dental, optical, hearing). Therefore, any enhancement to the Treatment Benefit scheme needs to be considered in the context of associated changes in PRSI contributions.

This report further examined the age at which the full 260 contributions are required. Budget 2022 announced a reduction in the number of contributions required for

young people aged 25–28 from 260 to 39 – this will be implemented from 28 May 2022.

Any more general change to contribution requirements would fall to be considered in an overall budgetary context and with due regard to the positon set out in the Programme for Government. The costings in this report are of assistance in this regard. However, changes to the contribution requirements on their own would not act as a targeted measure to address consistent poverty.

People who have moved from welfare to work are usually able to retain their medical card for the first three years As part of the research for this report, figures from the Department of Health were reviewed to see how many people lost eligibility for their medical card in this situation and it turned out that the figure was very low. It is considered that the current arrangement for retaining the medical card for three years is appropriate.

Better promotion of the scheme would improve the number of those at risk of poverty getting the benefit of their full entitlement. In particular, this promotion should raise awareness of the entitlement of adult dependents, as claims are very low among this cohort.

Further work should be undertaken by the Department and the Department of Health to examine the issue of dual entitlement to treatments to ensure that dual claims are only provided for where there is a medical necessity for them.

Appendix 1: Extract from Roadmap

Healthcare

Recognising that healthcare costs can impose a significant pressure on working families, the Government has already made a series of reforms that has seen the number of people having access to free GP services and medical cards increase by nearly 33% since 2007.

These reforms have been of significant benefit to people classified as being at risk of consistent poverty: 89% of people who are in consistent poverty have a medical or GP visit card, compared to 42% of people who are not in consistent poverty. In addition to these changes, the re-introduction and extension of the Treatment Benefit scheme giving access to optical and dental treatment has benefited workers, irrespective of income and irrespective of whether they are self-employed or employees, a change that will further reduce the rate of in-work poverty.

In order to further reduce the healthcare cost burden on families, the Government will, through its Sláintecare programme and the Smile agus Sláinte Oral Health policy, continue to improve and extend access to healthcare services, including developing options for access to a health service that is free at the point of delivery. As part of this approach it will consider if the 'Smile agus Sláinte' approach could be expanded to other services, such as ophthalmic services. It will also review the operation of the Treatment Benefit scheme to consider if it can be improved to help reduce the impact of poverty, for example through the extension of coverage to children of qualifying parents.

Inclusion Health Policy

Within Irish society there are socially excluded groups who experience extreme levels of health inequalities, with higher morbidity and mortality rates than the general population. They include people living with substance abuse, homeless people, those within the Traveller and Roma communities and people who have spent time in institutional care or in prison. People within these groups can live much

shorter lives compared to the rest of the population, with an average life expectancy for some of circa 40 years.

Inclusion health is a framework for driving improvements in health outcomes for these groups, encompassing research, policy coordination and services delivery. It aims to improve access to health and related services for these groups through coordinated and targeted actions.

The Department of Health commenced development of an Inclusion Health policy in 2019.

While health care is seen primarily as the responsibility of the Department of Health and the Health Service Executive, the Department of Social Protection also plays a part. It is responsible for administering the Treatment Benefit scheme which provides dental, optical and aural services to insured workers, the self-employed and retired people who have the required number of social insurance (PRSI) contributions.

Commitment 57: Review operation of the Treatment Benefit scheme and consider options to improve its impact in reducing deprivation and poverty

Appendix 2: Benefits available

Under the scheme, a person currently may qualify for:

- Dental benefit
    - annual oral examination[20]
    - payment of €42 towards either a scale and polish or, if clinically necessary, periodontal treatment, once a calendar year. If the cost of either cleaning or periodontal treatment is more than €42, the customer must pay the balance — capped at €15 for a scale and polish. There is no cap on the balance charged for periodontal treatment.
- Optical benefit
    - free eyesight test every 2 years, up to 3 repeat exams can be covered if clinically necessary
    - free spectacles or contribution of €42 if upgraded frames desired. Both reading and distance covered or bifocals
    - Contact lenses instead of glasses if desired
    - Repairs to glasses if required, maximum 2 in 2 years.
- Medical appliances (almost all claims are for hearing aids, along with a small number of specialised contact lenses)
    - up to €500 per hearing aid every four years
    - €100 for the repair of a hearing aid, one repair every four years
    - up to €500 per medically required contact lens every four years

[20] A complete oral examination of hard and soft tissue, medical and dental history, recording of missing teeth, diagnosis and treatment plan. The fee for examination includes any necessary intra-oral radiographs.

Appendix 3: Eligibility and qualifying conditions

To qualify, people must have paid class A, E, P, H or S social insurance (PRSI) contributions.[21] The number of social insurance contributions needed depends on age and are set out in detail below.

Age/Situation/ Dependants	Eligibility and qualifying conditions
Under 21	People may qualify if they have paid at least 39 contributions at any time.
Aged 21–24	People may qualify if they have paid at least 39 contributions and have: ○ at least 39 paid or credited contributions in the governing contribution year (Example: 2018 is the governing contribution year for claims made in 2020) OR ○ 26 paid contributions in each of the second and third last contribution years (Example: For claims made in 2020, the second last contribution year is 2018 and the third last contribution year is 2017)
Aged 25–65	People must have: ○ at least 260 paid contributions, and

[21] Serving members of the defence forces are not covered for dental or optical exams (these are to be provided by their employers) but they are covered once they have retired. Their spouses are covered.

	○ at least 39 paid or credited contributions in the governing contribution year (2018 is the governing contribution year for claims made in 2020), OR ○ 26 paid contributions in each of the second and third last contribution years. For claims made in 2020, the second last contribution year is 2018 and the third last contribution year is 2017
Aged 60 and over	If people qualify for benefit at age 60–65, they keep that entitlement for life.
Aged 66 and over	There are special rules and exceptions for people aged 66 and over. They must also be in one of the following situations: ○ have 260 social insurance (PRSI) contributions paid at any time and 39 paid or credited contributions in the governing contribution year or the year immediately before it. Note: The govering contribution year is the second last completed year before reaching 66 years of age. Example: If they were 66 in 2019, the governing contribution year is 2017. If they were 66 in 2020, the governing contribution year is 2018; have 260 social insurance (PRSI) contributions paid at any time and 26 paid contributions in both the governing contribution year and the year immediately before it. The governing contribution year is the second last completed year before reaching 66 years of age. If people satisfy these conditions when they reach pension age, they will remain qualified for life.
Illness/ unemployment	If people have retired on grounds of ill health or they are considered to be unemployed, they can apply for Illness Benefit or Jobseeker's Benefit. If they qualify for these benefits, they may

	be awarded credited contributions, which can be reckonable for extending coverage for Treatment Benefit.
Adult dependants	A spouse, civil partner or cohabitant may qualify in their own right if they have enough social insurance contributions. If they do not have enough social insurance contributions, they may still qualify for Treatment Benefit on the claimant's social insurance record. To do this, the claimant must qualify for Treatment Benefit and their spouse, civil partner or cohabitant must be dependent on them. A dependant spouse, civil partner or cohabitant must: ○ have a gross income (before deductions) of €100 or less per week. If earning more than €100 per week, they must have been dependent on you before entering or resuming insurable employment (at class A, E, H, P or S) ○ not be getting a social welfare payment, except Disablement Pension, Supplementary Welfare Allowance, Carer's Benefit or Child Benefit. If getting Carer's Allowance or State Pension (Non-contributory) they can qualify if they were dependent on you immediately before getting the allowance or pension If an insured person dies and the dependant spouse or civil partner was entitled to benefit at the time of the death, they keep their entitlement for as long as they remain widowed or a surviving civil partner.

Appendix 4: Treatment Benefit data

	CURRENT RULES		Eligibility based on 208 Weeks and amended GCY conditions			Eligibility based on 156 Weeks and amended GCY conditions		
AGE	Total Eligible	%	Total Eligible	New	% New	Overall	New	% New
Under 21 qualifiers	34,763	1.5%	34,763	0	0.0%	34,763	0	0.0%
21–24 qualifiers	95,203	4.2%	96,690	1,487	1.7%	96,690	1,487	0.9%
25–65 qualifiers	1,563,834	69.5%	1,637,631	73,797	85.7%	1,699,299	135,465	85.9%
66+ qualifiers	185,530	8.2%	187,489	1,959	2.3%	189,357	3,827	2.4%
Total	369,818	16.4%	378,714	8,896	10.3%	386,720	16,902	10.7%
	2,249,148	100.0%	**2,335,287**	**86,139**	100.0%	**2,406,829**	**157,681**	100.0%

	Eligibility based on 104 Weeks and amended GCY conditions			Eligibility based on 52 Weeks and amended GCY conditions			Claimants	
AGE	Overall	New	% New	Overall	New	% New		
Under 21 qualifiers	34,763	0	0.0%	34,763	0	0.0%	3,877	0.4%
21–24 qualifiers	96,690	1,487	0.7%	96,690	1,487	0.7%	33,633	3.4%
25–65 qualifiers	1,739,413	175,579	85.0%	1,754,294	190,460	83.9%	681,749	69.5%
66+ qualifiers	191,109	5,579	2.7%	192,140	6,610	2.9%	97,827	10.0%
Total	393,726	23,908	11.6%	398,279	28,461	12.5%	164,066	16.7%
		206,553	100%		**227,018**	100%	981,152	100%

The Relevant Tax Year (RTY) or Governing Contribution Year (GCY) is the second-last complete tax year before a claim begins, it is two years before the Benefit Year. So, for claims in 2020, the RTY or GCY is 2018, for claims in 2021, the RTY or GCY is 2019.

The current rules are as follows:

- Under 21 — Total paid contributions 39
- 21–24 — Total paid contributions 39; and 39 paid or credited contributions in GCY or at least 26 paid contributions in both GCY minus 1 and GCY minus 2
- 25–59 — Total paid contributions 260; and 39 paid or credited contributions in GCY or at least 26 paid contributions in both GCY minus 1 and GCY minus 2
- 60–65 — Total paid contributions 260; and 39 paid or credit contributions in GCY or at least 26 paid contributions in both GCY and GCY minus 1. People who qualify at age 60–65 keep that entitlement for life, so each year in which they might have been entitled is checked.
- 66 plus — Total paid contributions 260; and 39 paid or credited contributions in GCY or in GCY minus 1 or at least 26 paid contributions in both GCY and GCY minus 1).

Contributions, Governing Contribution Year rules	**260**	**208** and	**156** and	**104** and	**52** and
	current contributions and GCY rules	amended GCY rules	amended GCY rules	amended GCY rules	amended GCY rules
Additional number who would qualify		86,139	157,681	206,553	227,018
Total eligible	2,249,148	2,335,287	2,406,828	2,455,700	2,476,165

Additional people who would be eligible if rules changed — total contributions and Governing Contribution Year rules

The above table shows the number currently eligible for Treatment Benefit and the additional numbers who would be eligible if the number of contributions were reduced and the Governing Contribution Year rules were amended, with an easing of the rules in relation to the governing contribution year for those aged 21–65. Instead of the current requirement for 39 paid or credited contributions in the current governing year or 26 contributions in each of the two previous years, there is only a requirement for 26 in the Governing Contribution Year (GCY) or 26 in each of the two previous years. Additional costs vary from €3.5–9.3 million depending on which new rules are applied.

People eligible for Treatment Benefit	Claim rates	Av cost	Extra claims 208	Extra cost 208	Extra claims 156	Extra costs 156	Extra claims 104	Extra costs 104	Extra claims 52	Extra costs 52
Dental	37%	€58	31871	€1,848,518	58342	€3,383,836	76425	€4,432,650	83997	€4,871,826
Optical	20%	€70	17228	€1,205,960	31536	€2,207,520	41311	€2,891,770	45404	€3,178,280
Medical appliances	0.65%	€876	560	€490,560	1025	€897,900	1343	€1,176,468	1476	€1,292,976
Total extra cost				€3,545,038		€6,489,256		€8,500,888		€9,343,082