DISCRETIONARY MEDICAL CARDS: ETHICAL CONSIDERATIONS

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Abstract

The General Medical Service (GMS) scheme governs access to medical cards in Ireland. A medical card entitles the holder to free health services, including free GP care, inpatient and outpatient hospital services, and prescription medications. Eligibility for medical card cover is based on income, while those whose income is above the maximum threshold for eligibility may be granted a Discretionary card. This is on the basis that to fail to offer these cards would result in 'exceptional personal and financial burdens arising from medical or social circumstances' being placed on the applicant. In practice, this scheme covers many people with chronic, life-limiting illnesses. A recent governmental review of the Discretionary medical card scheme led to the cancellation and subsequent re-approval of 15,000 cards, and was met with much controversy both in the Dáil and in the media. Ultimately the ensuing debate centred on the issue of resource allocation, and arguments were made for and against the current means-based system of card allocation versus a disease-based model where factors other than income are taken into account in order to determine an applicant's eligibility for cover. This article examines some of the arguments both in favour and against these approaches, and questions whether the proposed changes to the scheme, as recommended by the Report of the Expert Panel on Medical Need for Medical Card Eligibility, meet the HSE's own stated policy targets of equity, fairness, proportionality, openness and accountability, solidarity, and sustainability.

Introduction

In Ireland, eligibility for free health care is based on the grounds of residency and means. The General Medical Service (GMS) scheme governs access to medical cards which entitle the holder to free health services, including free GP care, inpatient and outpatient hospital services, and prescription medications (although prescription charges do apply). The legislative basis for entitlement to medical cards is governed by Section 45 of the Health Act 1970[1]. This legislation has been subject to a number of revisions since its conception, yet still explicitly states that income and expenditure must be taken into account when assessing eligibility for free health services: 'Adult persons, who in the opinion of the Health Service Executive, are unable without undue hardship to arrange general practitioner medical and surgical services for themselves and their dependants' should be granted a medical card. Those who do not qualify for a medical card may be entitled to a GP visit card under Section 58 of the Health Act 1970 (as amended by the Health Amendment Act 2005), which similarly describes eligibility on the grounds that it would be "unduly burdensome" for the patient to provide GP services for themselves and their dependents[1]. People aged over 70, are assessed on gross income at higher thresholds and expenditure is not taken into account. However, if individuals demonstrate significant outgoings such as health expenses, this added expenditure may be taken into account in determining eligibility. As of July 2014, there were 1,804,376 medical card and 142,668 GP card users in Ireland. This equates to 39.3% and 3.11% of the population, respectively. These figures reflect a 57% increase in the number of medical card holders from the period 2004 to August 2014[4].

Discretionary medical card eligibility

The services which medical card holders are entitled to free of charge include GP visits, prescribed medicines, inpatient and outpatient services in public hospitals, medical services for mothers and infants and some dental, aural and ophthalmic visits. GP visit cards allow for GP services only[2]. Discretionary medical cards may be granted in exceptional circumstances when a person's weekly income (gross less tax, USI and PRSI) is in excess of HSE's stated guidelines. Currently the threshold is set at €184 per week for a single person under aged 66 living alone. This threshold changes in accordance with the number of dependents in the recipient's household, or if the application is made by a married/co-habiting couple or by civil partners[2]. Discretionary medical cards entitle the holder to access the same services as general medical cards do.

The HSE takes a number of factors into account when deciding eligibility for these discretionary medical cards. Again, the concepts of 'undue hardship' and being 'unduly burdensome' are expressed, with the act stating that 'the HSE must have regard to a person's overall financial situation and not just their income' when assessing a person's eligibility for discretionary medical card provision[3]. When the cost of providing medical care compromises one's ability to meet these essential costs, a discretionary medical card may be granted[3]. These discretionary medical cards have been the source of recent controversy, although in practice, the vast majority of medical cards are granted to applicants whose income is below the guideline. As of July 2014, there were 65,993 discretionary medical cards and 28,423 discretionary GP visit cards in circulation[4], amounting to a significant proportion of the health budget. The sitting government recently moved to review the eligibility of discretionary medical card recipients, resulting in the cancellation of a number of cards during the period 1 July 2011 to 31 May 2014.

CLINICAL POINTS

Current policy surrounding discretionary medical card allocation can appear to be subjective and discriminatory to the outside observer

While a disease-based approach has its merits, the government is right to be concerned about compiling a list of the "hierarchy of diseases" that would be required under such a scheme

Disease-based approaches have been implemented in other jurisdictions such as the State of Oregon, USA

Quality Adjusted Life Years (QALYs) may represent an objective method by which a disease-based allocation model could be constructed

Disease-based cover already exists in Ireland in the form of the long-term illness scheme. We believe this scheme is arbitrary and restrictive, and that there is scope for expansion of this policy to cover other debilitating illnesses

Ultimately it is clear that objective, transparent methods are required to assess discretionary medical card eligibility. While we welcome the debate on the merits of a means-based versus disease-based approach, we question whether new proposals put forward by the Expert Panel on Medical Need for Medical Card Eligibility meet the HSE's own stated aims of equity, fairness, proportionality, openness and accountability, solidarity, and sustainability

Recent eligibility review and resulting controversy

The allocation of discretionary medical cards has not been without its controversies. Approximately 17,000 discretionary cards were withdrawn between March 2011 and October 2011 in a recent governmental review of the scheme (2,300 were due to holders passing away)[5]. This fallout highlighted a great deal of weakness and discrepancy in the medical card system and, particularly in this case, the allocation of discretionary medical cards. In June of 2014, the government then announced they would be re-issuing the 15,000 discretionary medical cards withdrawn under the eligibility review "within a matter of weeks"[5]. The eligibility review of discretionary medical cards was also suspended and an expert panel was put in place to "advise on the broader issue" of medical card allocation. This panel published their report in September of 2014[4], in which, on the topic of discretionary medical cards, they cited the legacy issues in revoking medical cards granted to individuals with a disease that was unlikely to change. They conceded that much of these legacy issues came from the lack of a uniform approach to the granting of the discretionary medical cards in the various HSE districts prior to the centralisation, but admonished the HSE for not handling the matter more delicately. Furthermore, this controversy and the findings surrounding it may highlight the hazards of a non-objective/discretionary method of awarding medical cards, with many calling for a complete overhaul of the system.

Ethical considerations

Thus, the recent review and surrounding controversy focused on the core issue of eligibility: should medical card distribution be based solely on financial need, or should the severity and impact (either functional or financial) of a person's illness be taken into account? If the latter approach is favoured, to what extent should the nature of a person's illness be considered, and how exactly would the impact of each disease be measured? Decisions regarding the allocation of finite resources must be made, hopefully in a way that is fair, equitable and ethical. To this aim, the HSE has identified 6 principles on which all healthcare policy decisions should be made: equity, fairness, proportionality, openness and accountability, solidarity, and sustainability. Many people, including the current Fine Gael led coalition, believe that means-tested medical card distribution is the most appropriate way to achieve these aims[6]. This is based on the universal observation that the burden of illness is greatest in those of lower socio-economic status[7]. However, in the aftermath of public and media outrage regarding the cancelling of discretionary medical cards to children and adults with serious life-limiting illnesses, questions pertaining to the ethics of a solely income-based model of provision are raised.

This now begs the question; how would a system in which free healthcare is granted based on disease severity compare to the existing means-tested model, particularly in relation to achieving the HSE's ethical aims? Regarding equity and fairness, we believe there are doubts that the newly reviewed system is the best way forward. Specifically promises to de-centralise the decision process and to allow for flexibility with medical card provision could lead to new moral challenges. Take for example the "postcode lottery" phenomenon observed in the UK, where regional healthcare trusts make decisions on whether certain treatments are covered by the NHS[8]. This has resulted in notable regional inequalities in healthcare provision. It is entirely plausible that a similar phenomenon could emerge in Ireland over the coming years, where a patient's chance of securing medical cover differs according to geography. In order to overcome this inequity in the UK, new NICE guidelines have been drawn up in an attempt to base funding decisions on more objective analysis, by using Quality-adjusted life years (QALYs)[9]. With this in mind we wonder whether or not a similar system be employed in Ireland?

To ascertain the equity and fairness of disease-based provision, a system would have to be devised whereby the functional, financial, and/or psychological aspects of disease burden could be accurately measured, which is itself fraught with ethical challenges[10,11]. Options exploring a more nuanced approach to healthcare rationing have suggested the use of QALYs as a means by which the functional and not just financial aspects of disease can be considered when allocating treatment resources[12]. This would require the HSE or a relevant body to compose a list of diseases/treatments to be covered by the medical card, a policy initiative to which the government is somewhat justifiably opposed[13]. A similar approach to healthcare provision was adopted by the State of

Oregon in the United States, which consulted with the public at large in order to compile a list of services which would be covered by Medicaid for those under a specific income level[14]. A provisional list based on a cost-benefit algorithm came under considerable scrutiny for covering such procedures as toothcaps but not appendicitis[15]. This example demonstrated the difficulties underpinning the proposed illness-based model of health-care provision: how much moral weight should be given to competing influences such as cost-effectiveness, quality of life, financial hardship and pain/suffering? However, the inclusion of the public at large in the decision making process would seem to fulfil the HSE's goals regarding openness and accountability in making decisions regarding healthcare provision[20].

Issues around sustainability are invariably raised by a system of health provision based on medical need. What is the correct "hierarchy of diseases"? Who is to decide what diseases or treatments are worth covering? Minister for Health, Leo Varadkar, has raised his concern over such proposals, suggesting that resources would not stretch as far as the medical need of Ireland's populace would warrant - "If you look at the international classification of disease, things like overweight and obesity are considered to be illnesses, too, so you would be potentially extending medical cards to almost the entire population, which would not be realistic"[18]. In the aforementioned Oregon Example, healthcare benefits were expanded under the disease-based approach[20]. With 44% of the Irish population currently in possession of a medical card or GP visit card, would it be equitable to propose that the ever-decreasing majority pay for the increased medical card cover? Of course, it would be possible as in Oregon to decide a set line based on cost-effectiveness under which treatments would not be covered, although this raises its own ethical dilemmas[20]. Furthermore, if the aim of medical card provision is to support those who are unable to afford their own medical care; is it fair, equitable or sustainable to provide free cover to those who have the means to support themselves? This approach would surely go against the HSEs stated aim of "solidarity" in deciding policy decisions.

There are many valid arguments however, for providing medical cards to those with chronic or life-limiting illnesses irrespective of a patient's financial means. Individuals with diagnoses of chronic medical conditions such as motor neuron disease or chronic cardiac failure who do not possess a medical card incur major expenses for a wide number of reasons. They have increased medication costs, attend the GP more regularly and may have to be admitted to hospital frequently. Furthermore, without a medical card they may have difficulty accessing community services like public health nursing and primary care counselling, or acquiring appliances and tools from physiotherapy and occupational therapy in the community. There are also a whole host of incidental costs such as travel expenses, supplements and foodstuffs that add to a patient's financial burden[16].

Should medical card provision take these factors into account? Should consideration be given to the loss of life-years, reduction in quality of life, and psychological hardship incurred by those with chronic diseases? Moreover, can a financial cost be assigned to these sufferings? The existing legislation, whereby a discretionary card may be granted if it can be proven that the absence of provision of a medical card is unduly burdensome to the patient or will cause 'undue hardship', goes some way towards addressing this. However, there appears to be little clarity as to what constitutes 'hardship', particularly as the concept of 'exceptional personal and financial burdens arising from medical or social circumstances' is rather subjective. There is also a lack of instruction as to how much weight should be given to these contributing social and financial factors when it comes to deciding the eligibility of patients applying for medical cards. Thus, in spite of this legislation, many patients who suffer from ailments considered by many to cause undue hardship or to impose a financial burden will not qualify[7].

The long-term illness scheme is an existing disease-based model which provides free medical care to patients with the following conditions: mental handicap, mental illness (for people under 16 only), diabetes insipidus, diabetes mellitus, haemophilia, cerebral palsy, phenylketonuria, epilepsy, cystic fibrosis, multiple sclerosis, spina bifida, muscular dystrophies, hydrocephalus, parkinsonism, acute leukaemia and conditions arising from the use of thalidomide[1]. Implicitly this suggests that these diseases are so debilitating that it would be immoral to refuse a medical card to those diagnosed. With the huge changes that have been observed in both the diagnosis and treatment of several conditions over the last 40 years, perhaps the Health Act of 1970 is in need of some revision. For example, while diabetes mellitus is now a controllable chronic illness with reduced impact on a patient's quality of life, it is notable that it is explicitly covered by the scheme while a wide range of debilitating illnesses such as stroke, spinal injuries, and other severe congenital and acquired conditions are not. An expansion of the long-term illness scheme to cover a wider range of diseases and disabilities could go some way to alleviating the uncertainty and subjectivity currently overshadowing medical card provision. Again however, issues of sustainability and eligibility would inevitably feature in any debate on this issue, with an enormous range of diagnoses and an infinite number of combined diagnoses vying for coverage. The concept of a "hierarchy of diseases" would once again be a contentious issue. Furthermore, such a scheme could discriminate against patients whose symptoms don't neatly fit into restrictive diagnostic criteria, an issue which has been raised by the Irish cancer society[10].

Conclusion

The objective of this review was to highlight and explore the ethical and legal controversies surrounding policy and legislation that currently dictates discretionary medical card eligibility and distribution. The benefits and limitations of means-tested provision versus a disease-based model have been debated extensively throughout this period of HSE reorganisation. A means-tested approach is arguably much easier to categorise than disease-based models and this of course appeals to politicians and policy makers. The need to decide what illness is debilitating, chronic and costly enough to warrant a medical card is problematic particularly with the added challenge of fulfilling the 6 principles that health policy should uphold, and thus is a less appealing approach to policy makers. However, is it ethical to deprive people with severe chronic disease free access to medical care only because of the difficulty of defining parameters? Regardless of income, patients with chronic disease incur major expenses to pay for medication, access to therapeutic services and community support as well as frequent visits to general practitioners. Discretionary medical cards have until now provided free medical care to those with chronic illness at the discretion of the HSE, in a system that appears arbitrary and discriminatory to the outside observer. Therefore it is clear that objective methods and criteria are needed to avoid many of the issues that have arisen throughout this 3 year period of medical card revoking and reinstating.

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