Prescription Medicines

Access, Funding and Hospital Demand

Republic of Ireland

Empirical Comparison
and Conditional Legislative Alternatives

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Contents

Findings

The experiment identifies a concrete design distinction: eligibility based on a person's existing scheme is different from eligibility based on an actual interruption of covered treatment caused by inability to pay. Removing charges only for Medical Card holders cannot remove a payment barrier experienced by a person outside that group. Reducing the Drugs Payment Scheme (DPS) ceiling can resolve the barrier for some households while leaving it in place for others. A cross-scheme treatment-affordability entitlement and universal zero charges both resolve the price barrier in the transactions in which their conditions are satisfied.

The existing JudgeAI comparator retains these two alternatives as tied on that access outcome. It does not select one national policy from the information presently identified. Their national comparison turns on the additional people reached, verification and delivery costs, treatment effects, and the consequences of funding for other patients and households. Those consequences have not been replaced with zero or with an assumed hospital saving.

Situation established in the comparison	Result from the access comparison	Consequence for legislation
Covered medicine is available, but the patient cannot advance the payment	Direct pharmacy payment and a usable prepaid instrument both defeat pay-then-refund	A no-cost entitlement must operate at dispensing, not depend on an unaffordable advance
A financially blocked patient is outside the existing privileged category	Cross-scheme barrier relief and universal relief both defeat category-only relief	Medical Card membership cannot serve as a complete proxy for this problem
The household can afford EUR 50 but not EUR 72, and the approved monthly bill is at least EUR 80	A EUR 50 ceiling, barrier relief and universal relief tie on receipt of treatment	A smaller ceiling reduction can suffice for this household, without proving that it suffices nationally
The medicine is unavailable	Charge removal alone does not establish receipt of treatment	Supply must be examined separately from financial entitlement
The pharmacy requires a payment undertaking and none exists	Predicted future bed savings do not deliver the medicine; committed financing does	Fund the medicine when supplied; account for later capacity and cash effects separately

The legislative alternatives developed below are therefore **a cross-scheme affordability entitlement and universal zero charges for approved reimbursable medicines**, with the common delivery and financing dependencies made explicit. These are conditional legislative alternatives, not a claim that the national comparison has produced a unique winner. The two detailed drafts instantiate the zero-charge alternatives in financially blocked transactions; they do not eliminate partial caps, clinical coverage or supply reform where those alternatives achieve the relevant outcomes. A globally novel policy is not asserted: the contribution here is the explicit comparison of the Irish configurations and their consequences.

The question and the Irish baseline

The initial question was deliberately broad: which arrangement for financing and supplying prescription medicines should Ireland adopt, taking account of patients, treatment, public services and the consequences of financing? Hospital demand was an outcome to investigate, not a presumption that subsidising medicines necessarily saves money.

Nine families were registered: existing arrangements; withdrawal or reduction of public subsidy; DPS ceilings of EUR 72 and EUR 50; abolition of GMS prescription charges; full coverage for specified clinical cohorts; full coverage where affordability interrupts treatment across existing scheme boundaries; universal zero charges for approved reimbursable medicines; and supply or pricing reform without a change in copayments. Existing policy was a comparator. Withdrawal was retained as an alternative rather than excluded by the orchestrator's policy preferences.

Current arrangement	Relevant baseline
Drugs Payment Scheme	EUR 80 per household per calendar month for approved prescribed medicines and eligible appliances; no means test; residence conditions apply [1]
Medical Card / GMS	Generally EUR 1.50 per item, capped at EUR 15 monthly; from age 70, EUR 1 and EUR 10; statutory exceptions remain relevant [2]
Long-Term Illness Scheme	Approved treatment for specified conditions is already free without a means test; unrelated medicines do not acquire the same entitlement [3]
Existing delivery support	The Medicines Optimisation Support Service began on 1 June 2026; its existing funding and work belong in the comparator [4]

The PCRS 2025 report, published in August 2026, records EUR 67.28 million in prescription charges. Its GMS, DPS and LTI claimant populations overlap; adding them would overstate distinct people. Its total expenditure covers services beyond medicines. These distinctions prevent an apparently generous policy comparison from charging the same people or counting the same benefit twice. [5]

The medicines framework agreements for 2026-2029 are also part of the baseline. Existing price concessions cannot be counted again as new money created by this proposal. [6]

What the empirical investigation established

Effects of removing charges

Two randomized studies provide directly calculable binary endpoints. The numerical inputs below are published counts, and the differences are calculated as intervention minus comparator. Each row remains a separate source-study endpoint; it is not an Irish population forecast.

Study and endpoint	Free provision	Usual provision	Difference, percentage points
New Zealand: any hospital admission	194/586	193/467	-8.22
New Zealand: any emergency-department visit	204/586	183/467	-4.37
New Zealand: death	19/586	13/467	+0.46
CLEAN Meds: appropriate adherence	153/395	112/391	+10.09
CLEAN Meds: serious adverse event	51/395	68/391	-4.48
CLEAN Meds: death	8/395	10/391	-0.53

The New Zealand study removed a NZD5 prescription charge for a selected deprived population. Its adjusted hospital-admission odds ratio was 0.70 (95% CI 0.54-0.90), while the primary bed-day endpoint remained inconclusive. The mortality point difference is not evidence that removing charges causes deaths. [7]

CLEAN Meds studied Ontario patients reporting cost-related nonadherence. Free essential medicines were usually delivered by mail, so price and delivery are not separately identified. Published appropriate-adherence improvement was 10.1 percentage points (95% CI 3.3-16.9). [8]

The broader evidence prevents automatic assignment of a fiscal dividend. MI FREEE found improved adherence, but its primary composite endpoint and total-spending estimate did not establish a certain reduction. ACCESS, in lower-income older Albertans, likewise did not establish a reduction in its primary composite outcome or total costs. ARTEMIS improved persistence without a demonstrated reduction in major cardiovascular events. [9-11]

Scotland's abolition experience did not yield a clear, robust overall hospitalization effect in the retrieved study. Irish evidence on charge introduction shows class-specific adherence changes, but abolition cannot simply be assigned the exact reverse of an introduction effect. [12-13]

A later CLEAN Meds cost analysis found lower median public healthcare expenditure. The study's medicine-cost line excluded the intervention medicines: the reported difference is not a complete net programme saving. The follow-up is the same randomized cohort, not an independent replication. [14]

Who remains exposed in Ireland

TILDA 2016, analysed in a 2025 publication, recorded 89 respondents reporting that they had not filled a GP prescription because of expense, among 5,341 answering that question. Of these, 42 had GMS coverage, 10 a GP visit card and 36 neither; one case is not classified by those reported counts. These observations concern adults aged 50 or older and the charges operating in 2016. [15]

This evidence changes the coverage model in a specific way: a financial barrier is observable both inside and outside the Medical Card group. It supplies neither current national prevalence nor the number whose adherence would improve following a waiver. The calculation therefore

uses it to check which groups a policy can reach, not to multiply a trial effect into an invented Irish annual saving.

The decision-relevant empirical object is the joint distribution of current entitlement, indication and medicine, household payment liability, ability to pay, interrupted treatment, clinical risk and subsequent service use. Marginal claim counts, disease totals and separate income tables are not substitutes for that linked object.

Computation and the research loop

The experiment used the existing local ontology, tensor-calibration routines, consequence and actor transforms, Domino propagation, complete-field comparison, and decision-directed sensitivity analysis. No model API was called. The existing criterion was retained; no policy weights were added. The active tensor's 413 registered targets and their fitted families were preserved in isolated supplements, with the newly measured endpoint registered explicitly. The production pointer was not replaced.

Two kinds of calculation were kept distinct. Source-study calculations used observed counts and measured endpoint contrasts. Conditional policy calculations used exact logical facts, such as whether an available covered medicine can be received when the patient cannot advance a charge and the pharmacy has a committed payer. A logical accessible/inaccessible state is not a calibrated population probability or a complete measure of a person's welfare.

Where the ontology was used

Empirical or legal question	Ontology projection / computation	How the result enters the analysis
Can the covered treatment actually be obtained?	Patient role; medication-access coordinate OW-ACCESS-024	Compares conditional payment and eligibility arrangements
What happened to hospitalization, emergency care and serious adverse events?	Reviewed endpoint projections OW-HEALTH-017, OW-HEALTH-013 and OW-HEALTH-016	Retains measured outcomes separately rather than replacing them with a generic benefit score
Is a mortality difference stable to sampling uncertainty?	OW-DEATH-00 and the native decision-analysis routine	Identifies sign-sensitive comparisons requiring further evidence
Which empirical contrast can affect the current ordering?	Shared-target sensitivities and covariance-direction replays	Directs further research to a particular comparison and input

These are endpoint projections. The access proxy in the adherence study also includes behaviour and delivery. The emergency-care projection is likewise declared as a proxy. Source-endpoint propagation terminates at the measured endpoint; no unmeasured Irish downstream causal chain is represented as learned.

What additional analysis changed

Input examined by the native decision analysis	Point comparison	Result of the registered local sensitivity probes	Research implication
CLEAN Meds appropriate adherence	Free provision preferred on the measured adherence projection	Preference remains under both plus/minus one-standard-error probes	More precision on this contrast alone is less immediately decisive than identifying missing Irish transport and funding effects
New Zealand mortality	Usual provision preferred at the observed point	One probe reverses the ordering	Do not treat the point difference as a stable policy conclusion
New Zealand hospital admission	Free provision preferred on the measured admission projection	Preference remains under both plus/minus one-standard-error probes	The observed admission contrast warrants Irish transport analysis; local stability does not establish an Irish effect

For adherence, the standard error was reconstructed from the rounded published 95% interval; it was not quoted as a separately reported statistic. The New Zealand admission and mortality probes use local normal approximations derived from the fitted count variances. The latter is a rare-outcome diagnostic; neither is the published adjusted odds ratio. These probes are not a joint confidence region or a certification of national robustness. Separate exact count-based uncertainty calculations remain in the computational record.

The loop therefore did more than add citations. Source calibration exposed which endpoint comparisons were sensitive. The financing comparison exposed the consequences for other service users as a potentially decisive input. The targeted Irish evidence checks the same coverage boundary and identifies barriers on both sides of Medical Card eligibility. Further refinement is directed to the Irish treatment and financing counterfactuals, rather than repeatedly improving the precision of an already favourable adherence point estimate.

This demonstrates executed traceability, local sensitivity analysis and targeted empirical refinement. It does not measure a clinical improvement caused by a deployed Irish policy. Determinism here means that the recorded inputs and the same computational rule reproduce the same result; it does not turn missing empirical consequences into known quantities.

Comparison of the nine policy families

The general comparison contains 24 explicitly conditional cases. All 36 pairs of the nine families are registered in each case: 864 pair records, of which 588 have identified inputs and were numerically compared. The remaining records are marked unresolved. These are conditional cases, not 24 sampled Irish demographic groups, and 864 is not a count of independent clinical experiments.

Policy family	What changes	What the comparison establishes
Existing arrangements	No reform	Can already secure treatment when the current charge is affordable or the medicine is exempt
Reduce or withdraw subsidy	More payment shifts to patients; possible public funds released	Can break access where the full price is unaffordable; the consequences of any released funds must also be established
DPS EUR 72	Lower monthly household ceiling	Sufficient for some households; insufficient below that affordability level
DPS EUR 50	Further reduction of ceiling	Reaches another affordability band; still leaves patients unable to advance EUR 50
Abolish GMS charges	Zero charge within GMS	Reaches affected card holders; does not by itself reach financially blocked people outside GMS
Clinical-group zero charge	Zero for specified indications or cohorts	Depends on actual clinical eligibility; a group boundary can leave other interrupted treatment outside
Cross-scheme barrier entitlement	Zero where payment blocks eligible treatment	Resolves the specified barrier if recognition and supply work; national reach and administrative effects require identification
Universal zero charge	Zero for all within the approved reimbursable entitlement	Resolves the specified financial barrier without a means or barrier test; broader cost and use effects remain material
Supply/pricing reform only	Procurement, prices or delivery; copayment rule unchanged	Can matter where price or supply actually changes access; an unspecified saving is not assigned an effect

For a non-GMS, non-LTI household outside a proposed clinical group, consider an approved monthly medicine bill of at least EUR 80. Let L denote the amount that can actually be advanced at the required time. The following access results assume valid prescribing, available supply and committed reimbursement.

Available amount L	Arrangements achieving receipt among the identified alternatives
Below EUR 50	Barrier entitlement; universal zero charge
At least EUR 50 but below EUR 72	DPS EUR 50; barrier entitlement; universal zero charge
At least EUR 72 but below EUR 80	DPS EUR 72; DPS EUR 50; barrier entitlement; universal zero charge

Available amount L	Arrangements achieving receipt among the identified alternatives
At least EUR 80	Existing arrangements also achieve access; removing an affordable payment is a financial change, not automatically an additional treated patient

Within each row these arrangements tie on the access coordinate. The table neither ranks their total effects nor silently substitutes “lowest public cost” for the existing normative criterion. Supply-only remains unresolved unless its actual effect is specified. If the patient can pay the entire price, withdrawal also need not interrupt this transaction; that does not establish its consequences for other people.

Financing and the hospital counterfactual

Arrangement	Annual public-finance anchor	Interpretation
DPS EUR 72	EUR 15.5m	Official static estimate based on March 2025 data
DPS EUR 50	EUR 63.9m	Same official costing basis
Abolish GMS prescription charges	EUR 67.28m	Replacement of observed 2025 charges, before changes in behaviour or administration
DPS zero charge	EUR 205.1m	Official static estimate, not a 2026 behavioural forecast
DPS zero plus GMS charge abolition	EUR 272.38m	Sum of the two stated anchors; mixed estimate/observed basis, not full programme cost
Clinical or barrier entitlement; supply-only; withdrawal	Not identified nationally	Unknown is not zero, and does not exclude the alternative

These are scheme-level anchors. The DPS costing includes its eligible appliance scope, whereas the drafted new entitlement concerns medicines; the combined figure is not a precise costing of Alternative B. The DPS estimates exclude demographic, eligibility and behavioural changes. [16] The EUR 272.38m combined anchor is approximately 0.994% of the announced EUR 27.4bn 2026 health allocation. This ratio describes scale; it does not identify available funding. Existing additional medicines allocations are already commitments. [17]

The budget identity must include additional medicine reimbursement, delivery, prescribing and monitoring, administration, actual hospital expenditure changes, and genuinely incremental receipts or rebates. Replacing a patient's payment with a government payment changes who pays; the same transfer is not also a net resource saving.

Three hospital quantities remain separate: admissions avoided, bed capacity released, and expenditure that can actually be released in cash. Average tariffs or average occupied-bed costs

cannot automatically price the third. The break-even relation is additional programme cost divided by verified cash saving per avoided episode, where that saving is positive. Without the second input, a precise break-even admission count would be invented.

When the preferred arrangement changes

The existing comparator first compares each actor's mean positive field change, sorted from the most affected actor, and then the sorted signed means. A financing-boundary calculation held the source-study non-adherence contrast fixed as a conditional medication-access projection and varied hypothetical consequences for another recipient of public services. The result changed when that other recipient experienced a positive adverse change. These hypothetical changes test a mathematical sensitivity of the existing rule; they are not empirically estimated Irish funding-displacement effects. It identifies why the source of finance cannot be omitted from the national decision.

Additional facts established	What follows for the choice
Targeted recognition reaches every financially blocked eligible patient, and universal coverage changes no other person's relevant outcomes	Targeted and universal arrangements remain tied on the identified consequences
Verification excludes or delays a financially blocked patient, while funded universal access reaches that person and other relevant outcomes remain equal	Universal access is preferred in that conditional comparison
Wider coverage displaces effective treatment for other patients	A favourable adherence estimate alone cannot establish that wider coverage is preferred; displaced treatment enters the same comparison
The charge reduction leaves a patient unable to obtain the medicine	A partial ceiling reduction does not achieve the access outcome for that patient
A procurement or delivery change makes the same medicine obtainable at the necessary time	It must be compared as an effective alternative, rather than excluded because it is not a subsidy

The second row is the symmetric implication of the executed access rule, not a measured rate of administrative exclusion. None of these conditions assigns an Irish prevalence or a national winner. The actionable result is a decision map: which additional fact changes which comparison.

Legislative architecture

The statutory design must preserve the distinction between an entitlement and an actual supply of medicine. For either legislative alternative, covered treatment must not require the very advance payment the intervention is intended to remove. The pharmacy must have a valid route to payment. Direct settlement and a genuinely usable prepaid arrangement remain tied where their other consequences are equal.

Under section 59(1D) of the Health Act 1970, pharmacy reimbursement and legally collectable GMS charges interact. Merely instructing a pharmacy not to collect a charge can leave the deduction in place. The entitlement and exemption must therefore be coordinated. The age 70 provisions in section 59A require the same treatment. [18]

A zero-charge statement must also specify its product boundary. The 2013 reimbursement-list and reference-price regime distinguishes approved products, conditions of reimbursement and above-reference-price payments. A clinically necessary medicine with no suitable available substitute is a different case from an elective preference for a costlier brand. The present drafts preserve that distinction and identify the further decision required rather than silently promising every marketed product free. [19]

Health-service funding must be carried through the lawful allocation and service-plan process under the Health Act 2004. A projection of future avoided admissions is an empirical estimate, not a payment authorization. [20]

The following alternative texts set out that architecture. Unresolved policy choices are expressly reserved in their schedules. They are not represented as enactment-ready final policy, and the orchestrator has not resolved them by preference.

Alternative A - Health (Treatment Affordability and Medicines Access) Bill

A1. Short title and interpretation

(1) This Act may be cited as the Health (Treatment Affordability and Medicines Access) Act [year].

(2) In this Act -

“Act of 1970” means the Health Act 1970;

“Act of 2004” means the Health Act 2004;

“Act of 2013” means the Health (Pricing and Supply of Medical Goods) Act 2013;

“Executive” means the Health Service Executive.

(3) The expressions “Reimbursement List”, “listed item”, “community pharmacy contractor”, “clinical exemption” and “reference price” have the meanings assigned to them by the Act of 2013.

A2. Cross-scheme entitlement

Section 59 of the Act of 1970 is amended by inserting after subsection (5) the following subsections:

“(6) The Executive shall arrange for the supply, without a covered patient charge, of a qualifying prescribed medicine to a person who -

(a) has full or limited eligibility under this Act, and

(b) has an established treatment-affordability barrier in respect of that medicine in accordance with Schedule 1 to the Health (Treatment Affordability and Medicines Access) Act [year].

(7) In subsections (6) to (12) -

‘qualifying prescribed medicine’ means a medicine on the Reimbursement List that is prescribed for the person by a person authorised by law to prescribe it and whose supply or reimbursement for that person satisfies the applicable conditions under the Act of 2013;

‘covered patient charge’ means the contribution otherwise payable by the person in respect of that supply under subsection (1A), subsection (2) or section 59A, excluding a difference payable under section 26 of the Act of 2013 except to the extent that an express exception under that section applies;

‘treatment-affordability barrier’ means the inability to obtain the qualifying prescribed medicine when needed because the covered patient charge cannot be met, as defined and established by the criteria and process set out in Schedule 1 to the Health (Treatment Affordability and Medicines Access) Act [year].

(8) Entitlement under subsection (6) shall not depend on the person holding a medical card or on the person's condition being included in the Long-Term Illness Scheme. This subsection does not dispense with the requirements of subsection (6)(a) or with lawful prescribing and reimbursement conditions.

(9) Supply under subsection (6) shall not be conditional on the person first incurring expenditure up to the amount prescribed for the purposes of subsection (2).

(10) The attribution of amounts paid for a supply under subsection (6), and of any amount remaining payable by a person, to the household expenditure calculation under subsection (2) shall be as specified in Part III of Schedule 1 to the Health (Treatment Affordability and Medicines Access) Act [year]. No entitlement or liability of another household member is varied otherwise than as expressly provided in that Part.

(11) Where the same supply is payable under another arrangement made under this section, the Executive shall reconcile the claims so that the same medicine and dispensing service are not reimbursed twice. Entitlements to free supply under subsection (3), and entitlements under other enactments, are not reduced by this subsection.

(12) Subsections (6) to (11) concern eligibility for financial support. They do not authorise the prescription, substitution or dispensing of a medicine contrary to any applicable enactment, or confer a right to a medicine merely because it is lawfully marketed."

A3. Medical-card charge exemption and pharmacy collectability

(1) Section 59(1C) of the Act of 1970 is amended by inserting after paragraph (c):

"(d) persons entitled to supply under subsection (6), in respect of the covered patient charge for the qualifying prescribed medicine supplied under that subsection."

(2) Section 59A of that Act is amended by inserting after subsection (4):

"(5) This section does not require payment of a covered patient charge from which a person is exempt under section 59(1C)(d)."

(3) For the purposes of section 59(1D), an amount from which a person is exempt under section 59(1C)(d) is not an amount collectable under section 59(1A). The Executive's settlement with a community pharmacy contractor shall reflect that exemption.

(4) This section does not extinguish a liability under section 26 of the Act of 2013 except where an express exception under that section applies.

A4. Access without a patient advance

(1) The Executive shall secure payment of the amount payable for a supply under section 59(6) to the community pharmacy contractor under the applicable lawful reimbursement and remuneration arrangements.

(2) The arrangements shall enable the entitled person to obtain the covered supply without first paying the covered patient charge. They may achieve this by direct settlement with the contractor or by a prepaid access instrument accepted by the contractor and backed by a secured payment commitment of the Executive.

(3) A prepaid access instrument used for subsection (2) shall not require the person to fund it, repay its covered value or incur a borrowing obligation in order to obtain the covered supply.

(4) A right to reimbursement after personal payment shall not, by itself, fulfil subsection (2) where the person cannot advance that payment.

(5) Nothing in this section fixes a new dispensing fee, pays twice for work already remunerated, or changes the clinical responsibilities of a prescriber or pharmacist. Any proposed additional service, remuneration or participation requirement shall be expressly specified in Part IV of Schedule 1.

A5. Relationship with existing medicine and appliance schemes

(1) Sections 17 to 24 of the Act of 2013 continue to apply to supply under the new section 59(6), including applicable listing, pricing, clinical and supply conditions.

(2) Discretionary supply of a non-listed item under section 23 of the Act of 2013 remains governed by that section. This Act does not convert that discretion into a general entitlement to every non-listed medicine.

(3) Existing entitlements concerning appliances, medicines supplied through other statutory arrangements and existing clinical exemptions remain in force. This Act does not transfer an existing free entitlement into a chargeable category.

(4) A restriction to an existing disease list or medical-card class shall not be reintroduced administratively as a substitute for the conditions in section 59(6).

A6. Funding and service-plan implementation

(1) Before implementation, the responsible expenditure determination and approved service plan shall identify the funds committed to the medicines and service liabilities created by this Act, through the processes in sections 30A to 33 of the Act of 2004 and the applicable provision of public money.

(2) The financial plan shall distinguish -

(a) the replacement of patient contributions;

(b) additional medicine supply and delivery expenditure;

(c) administration and any separately authorised professional services; and

(d) any identified effects on other funded services.

(3) Forecast reductions in admissions, bed occupancy or future service demand shall be stated separately from the committed funding in subsection (1). Such forecasts do not constitute an appropriation or, by themselves, a payment commitment to a pharmacy.

(4) Where an actual financial saving is relied upon, its availability and lawful commitment to these liabilities shall be established. This Act does not create an automatic right to transfer a forecast or realised saving from another service.

(5) No national appropriation, enrolment cap, expenditure ceiling or power to suspend an individual entitlement is specified by this section. Those matters, to the extent required for the selected configuration, are reserved in Part V of Schedule 1 and must be resolved consistently with the entitlement before implementation.

A7. Decisions, evidence and existing rights

(1) The persons authorised to determine an affordability barrier, the permitted evidence and the determination and review procedure shall be the provisions completed in Parts I and II of Schedule 1.

(2) This Act does not establish a right to qualify by self-declaration alone. Nor does it prescribe a means threshold, period of prior non-adherence, waiting period or automatic review interval in the absence of an express provision in that Schedule.

(3) A decision on financial eligibility is distinct from a clinical prescription. Nothing in this Act removes an existing right to lawful administration or judicial review.

(4) Any extension of the appeal machinery in section 47 of the Act of 1970, or any new statutory review procedure, shall be expressly enacted. It shall not be inferred solely from the creation of the entitlement in section 59.

A8. Commencement and transition

[Complete the commencement and transition provisions after the choices in Schedule 1 have been resolved. No commencement date, phased introduction, retrospective reimbursement, emergency interim entitlement or automatic renewal is selected by this draft. The funding and payment requirements in sections A4 and A6 must be capable of operation for the configuration brought into effect.]

Schedule 1 to Alternative A - provisions reserved for resolution

Part	Matter to be completed in legislative text	Current status
I. Barrier and scope	The operational definition of inability to meet the covered charge; whether and how sustained unaffordability differs from immediate liquidity shortage; the medicine/indication scope if narrower than the qualifying-medicine definition.	The conditional case establishes the barrier as a fact; it does not choose a population-wide verification rule or effect size.
II. Verification and review	Authorised decision-maker; evidence; decision process; determination timing; review and appeal; validity/renewal; consequences of error; treatment while a decision is pending.	Reserved. No self-certification right, numeric test, deadline, penalty or automatic review rule adopted.
III. Household accounting	Whether and to what extent State-paid amounts count towards another medicine's DPS household threshold; handling remaining patient contributions and mixed medicine/appliance claims.	Reserved distributional choice; not resolved by the cashless-supply comparison.
IV. Delivery	Direct settlement, prepaid instrument or both; any new provider participation obligation; payment mechanics; incremental professional services and remuneration; system-outage arrangements.	Both tested payment mechanisms remain admissible; no invented fee or service mandate.
V. Funding and commencement	Gross funded envelope and fiscal source; effects on displaced services; commencement; any reserve, spending control or staged rollout and its compatibility with entitlement.	National funding amount and implementation choice not determined. Forecast hospital capacity is excluded as a substitute for committed payment.
VI. Reference-price exception	Whether to enact the optional necessary-supply rider set out below; its verification and scope.	Separate conditional option. Elective brand preference remains under existing law unless expressly changed.

Alternative B - Health (Approved Medicines Without Patient Charges) Bill

B1. Short title and interpretation

(1) This Act may be cited as the Health (Approved Medicines Without Patient Charges) Act [year].

(2) In this Act, "Act of 1970", "Act of 2004", "Act of 2013" and "Executive" mean, respectively, the Health Act 1970, the Health Act 2004, the Health (Pricing and Supply of Medical Goods) Act 2013 and the Health Service Executive.

(3) Expressions concerning the Reimbursement List, clinical exemptions, reference prices and community pharmacy contractors have the meanings assigned by the Act of 2013.

B2. Universal entitlement within the existing full- and limited-eligibility population

Section 59 of the Act of 1970 is amended by inserting after subsection (5):

"(6) The Executive shall arrange for every person with full or limited eligibility under this Act to receive a qualifying prescribed medicine without a covered patient charge.

(7) In subsections (6) to (11) -

'qualifying prescribed medicine' means a medicine on the Reimbursement List that is prescribed for the person by a person authorised by law to prescribe it and whose supply or reimbursement for that person satisfies the applicable conditions under the Act of 2013;

'covered patient charge' means the contribution otherwise payable in respect of that supply under subsection (1A), subsection (2) or section 59A, excluding a difference payable under section 26 of the Act of 2013 except to the extent that an express exception under that section applies.

(8) Entitlement under subsection (6) shall not be conditional on holding a medical card, inclusion of the person's condition in the Long-Term Illness Scheme, a separate affordability test, or first incurring expenditure up to the amount prescribed for subsection (2).

(9) The reconciliation of a qualifying-medicine supply with an existing scheme shall not result in duplicate reimbursement for the same medicine or service. Existing entitlements to free supply are not reduced by that reconciliation.

(10) The treatment of mixed claims involving qualifying medicines and items outside subsection (6), including appliances, shall be as specified in Part I of Schedule 1 to the Health (Approved Medicines Without Patient Charges) Act [year].

(11) This section does not authorise prescribing, substitution or dispensing contrary to applicable law, and does not confer a general entitlement to non-listed medicines or to medicines merely because they are marketed."

B3. GMS and age-70 charge provisions

(1) Section 59(1C) of the Act of 1970 is amended by inserting after paragraph (c):

“(d) persons receiving a qualifying prescribed medicine under subsection (6), in respect of the covered patient charge for that supply.”

(2) Section 59A is amended by inserting after subsection (4):

“(5) This section does not require payment of a covered patient charge from which a person is exempt under section 59(1C)(d).”

(3) An amount exempted by section 59(1C)(d) is not collectable for the purposes of section 59(1D). The Executive's reimbursement of the pharmacy shall reflect the removal of that collectable amount.

(4) Existing contributions for items outside the scope of section 59(6) and section 26 liabilities remain governed by their applicable enactments, subject to any express amendment completed in Schedule 1.

B4. Supply without patient prepayment

(1) The Executive shall secure the payment due to the community pharmacy contractor for a qualifying supply under the applicable lawful reimbursement and remuneration arrangements.

(2) Those arrangements shall permit supply without a patient advance of the covered amount, whether through direct settlement with the contractor or an effective prepaid access instrument backed by the Executive's secured payment commitment.

(3) The person shall not be required to fund or repay the covered value of that instrument or to borrow in order to obtain the covered supply.

(4) A receipt-based reimbursement right alone is not compliance with subsection (2) for a person unable to advance payment.

(5) This section does not set a new fee or authorise duplicate payment for dispensing or other professional work already remunerated under an existing arrangement. Additional services or payments, if selected, shall be separately specified in Part II of Schedule 1.

B5. Medicines framework and existing entitlements

(1) The Reimbursement List, the applicable price, lawful prescribing requirements and conditions imposed under sections 17 to 24 of the Act of 2013 continue to govern a qualifying supply.

(2) Section 23 of that Act continues to govern discretionary supply of non-listed items. This Act does not replace that discretion with blanket coverage.

(3) Existing LTI and other free-supply entitlements remain operative. Reconciliation into the payment arrangements under this Act shall not make an existing free entitlement chargeable.

(4) The Act does not itself abolish an elective above-reference-price difference under section 26 of the Act of 2013. Any exception for a necessary supply without an available suitable alternative must be expressly enacted using the separately considered rider below or another selected provision.

B6. Funding and service-plan implementation

(1) The expenditure determination and approved service plan under sections 30A to 33 of the Act of 2004 shall identify the funds committed to the liabilities created by this Act before implementation.

(2) The plan shall distinguish replacement of patient contributions, additional supply, delivery and administration, any separately authorised professional services and the effects of financing on other services.

(3) Projected avoided admissions and released capacity shall be reported separately from committed funding. They shall not be treated as money appropriated for this Act or as a payment guarantee to a contractor.

(4) Reliance on an actual financial saving requires identification of available funds and a lawful decision committing them. No automatic reinvestment or budget-transfer power is created by this section.

(5) The amount and fiscal source of the commitment, and any proposed restriction on implementation, shall be completed in Part III of Schedule 1. A restriction shall not be left to contradict the universal entitlement by implication.

B7. Administration and existing rights

(1) The administrative process shall establish eligibility under the Act of 1970, the qualifying prescription and compliance with the applicable reimbursement conditions. It shall not introduce the affordability test excluded by section 59(8).

(2) Any new statutory decision or review process shall be expressly set out in Part IV of Schedule 1. This Act does not assume that the existing section 47 appeal automatically applies to every new section-59 determination.

(3) Nothing in this Act removes existing requirements of lawful administration, lawful processing of personal data, or access to judicial review, or converts an administrative funding determination into a clinical prescription.

B8. Commencement and transition

[Complete after Schedule 1 is resolved. No date, staged age/disease rollout, waiting period, retrospective refund or automatic review interval is inserted by this draft. Implementation requires the funded payment arrangements in sections B4 and B6.]

Schedule 1 to Alternative B - provisions reserved for resolution

Part	Matter to be completed	Current status
I. Non-medicine and mixed-claim interface	Household accounting where medicines become free but appliances or other items retain existing rules; any consequential amendment to DPS instruments.	Reserved. This bill's universal scope concerns approved prescribed medicines, not all appliances, consultation charges or marketed products.
II. Delivery and remuneration	Direct settlement, prepaid instruments or both; payment mechanics; participation; incremental professional services; outages.	Functional access requirement specified; exact mechanisms remain tied under the tested conditions. No new fee selected.
III. Financing and commencement	Current national gross cost including uptake; lawful fiscal source; consequences for other services; funding envelope; commencement and transition.	Static cost anchors are not enacted appropriations or a national dynamic forecast. No national winner or funding number assigned.
IV. Administration	Entitlement/claim verification; decision procedure; any appeal extension; evidence and data processing provisions needed for implementation.	Reserved. No new affordability test is permitted by this alternative.
V. Reference-price exception	Optional necessary-supply rider, verification and precise scope.	Reserved separate option; elective brand differences remain unchanged unless expressly legislated.

Optional rider for either alternative: necessary medicine above reference price

Status: separate conditional legislative option. This rider is not adopted by either alternative and is not claimed to be selected by the recorded access comparison. It addresses a different factual case: a clinically necessary qualifying supply cannot be obtained through an appropriate available product within the reimbursable amount. Existing clinical-exemption arrangements must first be identified; the same cost must not be funded twice.

Candidate amendment to section 26 of the Act of 2013: designate its existing text as subsection (1) and insert the following subsection (2):

“(2) The liability described in subsection (1) shall not arise in respect of a qualifying supply under section 59(6) of the Act of 1970 to the extent that -

(a) the requirements for necessary-supply relief specified in [the completed Schedule] are satisfied, and

(b) the Executive has secured payment of the difference to the community pharmacy contractor under the applicable funding arrangement.

Necessary-supply relief under this provision shall not arise solely from a patient's preference for a more expensive brand where a clinically appropriate product is available through the covered supply arrangement."

The completed rider must define who establishes clinical necessity and availability, the evidential procedure, the extent of covered difference, claims reconciliation and any review or interim mechanism. None of those matters is resolved by using the word "necessary". The corresponding new s.59(6) definition and s.59(5) savings language must be read with this express exception; if required for unambiguous drafting, s.59(5) should state that it preserves s.26 **as amended by this rider**. No general exclusion of section 26 for all schemes is implied.

Statutory correspondence and provenance

Draft feature	Verified legal interface	Status in these alternatives
New entitlement inside s.59	Health Act 1970 s.59, currently ending at (5) in the inspected consolidation	New subsections (6) onwards; avoids allocating s.59B.
Exemption and pharmacy settlement	s.59(1A), (1C), (1D), (4)	Exemption changes legal collectability so the pharmacist is not left financing an unchanged statutory charge.
Older GMS beneficiaries	s.59A	Express consequential charge carve-out.
DPS / LTI	s.59(2) / s.59(3); S.I. 77/2022	Covered supplies bypass the patient advance; remaining household consequences explicitly reserved.
List, conditions, prices	2013 Act, ss.17-24	Preserved baseline unless separately amended.
Reference-price difference	s.24, s.26, Health Act 1970 s.59(5)	Elective differences not silently abolished; necessary-supply rider is a separate option.
Appeal	Health Act 1970 s.47	New entitlement is not assumed automatically covered; additional provisions reserved.
Expenditure and service plan	Health Act 2004 s.30A, s.31, s.32, s.33	Actual funding commitment; predicted capacity kept separate.

Sources

[1] HSE, Drugs Payment Scheme; Health Services Regulations, S.I.77/2022.

[2] HSE, prescription charges.

[3] HSE, Long-Term Illness Scheme.

[4] HSE, reply to PQ53325/26, 24 July 2026.

[5] HSE, PCRS Statistical Analysis of Claims and Payments 2025, published August 2026.

[6] Department of Health, medicines framework agreements2026-2029.

[7] New Zealand free-prescription randomized trial, BMC Health Services Research.

[8] CLEAN Meds, two-year randomized results, PLOS Medicine.

[9] MI FREEE, New England Journal of Medicine.

[10] ACCESS randomized clinical trial.

[11] ARTEMIS randomized clinical trial.

[12] Prescription-charge abolition in Scotland, BMJ Open.

[13] Irish prescription charges and adherence, Pharmacoepidemiology and Drug Safety.

[14] CLEAN Meds, three-year cost follow-up, JAMA Health Forum.

[15] Larkin et al., out-of-pocket prescription expenditure; TILDA 2016 data, published 2025, Table 4.

[16] Oireachtas, written answers, 10 June 2025, Q1398-1399.

[17] Department of Health, EUR 27.4bn health budget for 2026.

[18] Health Act 1970, revised, sections 59 and 59A.

[19] Health (Pricing and Supply of Medical Goods) Act2013, revised, sections 17-26 and Schedule 3.

[20] Health Act 2004, revised, sections 30A-33.