World Health Organization

European Region

Improving access to mental health care for people with low incomes

Lessons from Ireland

Improving affordable access to health care

WHO Barcelona Office for Health Systems Financing

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Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.

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Abstract

In 2013 the Government of Ireland introduced the Counselling in Primary Care (CiPC) programme to provide free community-based counselling for people with mild to moderate mental health conditions who have low incomes and are eligible for a medical card. CiPC has helped reduce the risk of self-harm and suicide, but challenges remain including limited eligibility (only 25% of the population are eligible), constrained funding, staff shortages and long waiting times. This brief shows how CiPC has improved affordable access to mental health care for people with low incomes and identifies lessons learned for Ireland and for other countries.

Keywords

AFFORDABLE ACCESS
IRELAND
MENTAL HEALTH CARE
PRIMARY HEALTH CARE
HEALTHCARE FINANCING
HEALTH SERVICE DELIVERY
OUT-OF-POCKET PAYMENTS
UNIVERSAL HEALTH COVERAGE

UHC watch

5 things to know about UHC watch

A digital platform tracking progress on affordable access to health care in Europe and central Asia

#1

Indicator explorer for the latest numbers and charts

#2

Policy explorer for up-to-date analysis of coverage policy

#3

Country pages with data, policy options and resources

#4

Country-level and comparative analysis

#5

Examples of good practice

UHC watch
apps.who.int/dhis2/uhcwatch

About the series

This series of briefs provides policy-makers with information on steps they can take to improve affordable access to health care (financial protection).

Each brief:

- focuses on policy changes introduced in one or more health systems in Europe and central Asia;
- considers the implications of the policy change for out-of-pocket payments, financial hardship and unmet need for health care, particularly in people with low incomes; and
- identifies the lessons learned from this experience, both for the countries involved and for other countries.

The series covers a range of health system issues but always aims to highlight the role of health financing policy in improving affordable access to health care.

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Summary

A key factor affecting Ireland's ability to address its high burden of mental health conditions is limited entitlement to publicly financed community-based mental health care, especially for people with low incomes. To improve access to mental health care, the Government introduced the Counselling in Primary Care (CiPC) programme in 2013 – a national programme providing community-based counselling for people with mild to moderate mental health conditions who have low incomes and are eligible for publicly financed access to primary health care (people with a medical card). Evaluation has found that the CiPC programme has been highly effective in reducing the risk of self-harm and suicide, but challenges remain; the share of the population eligible to benefit is limited (only 25% of the population are eligible) and programme funding has been constrained, leading to staff shortages and long waiting times for treatment. This brief shows how the CiPC programme has contributed to better mental health in people with low incomes and offers lessons for Ireland and for other countries looking to improve affordable access to mental health care.

The policy challenge

Since the 1960s, the delivery of mental health care in Ireland has shifted away from psychiatric institutions towards community-based settings to expand access to services, improve quality of life for people with mental health conditions and strengthen continuity of care. Despite this progress, the prevalence of mental health disorders in Ireland (21%) was above the European Union (EU) average (17%) in 2019, driven by high rates of anxiety and substance use disorders (OECD/European Observatory on Health Systems and Policies, 2023); depression and anxiety alone affected almost 15% of the population in 2022 (Hyland et al., 2022).

A key factor affecting Ireland's ability to address the burden of mental health conditions is limited entitlement to publicly financed community-based mental health care. Primary health care typically serves as the first point of contact for people seeking mental health care but while all residents are entitled to publicly financed inpatient care – including specialist mental health care in psychiatric hospitals – only some residents are entitled to publicly financed primary health care: adults and children with very low incomes (31% of the population with medical cards) as well as children under 8 years old, adults over 70 years old and people with low incomes who are not eligible for medical cards (18% of the population with "GP visit cards") (see Box 1 for details).

In addition to limited entitlement to mental health care in primary health care, other barriers to accessing community-based mental health care include limited capacity due to lack of trained professionals, regional disparities in service availability and long waiting times for outpatient specialist consultations (OECD/European Observatory on Heath Systems and Policies, 2023).

As a result of limited entitlement and other access barriers, many people resort to paying out of pocket for private treatment or use the limited scope of mental health care covered through voluntary private health insurance (Box 1). Paying out of pocket or through private insurance is not an option for many people with low incomes, however, because of the high cost involved: private counselling typically costs €60–€80 per session and households with low incomes are much less likely than those with higher incomes to have private insurance (Johnston, Thomas & Burke, 2020).

To address long-standing financial barriers to accessing community-based mental health care, particularly for people with low incomes, the Health Service Executive – the public body responsible for purchasing and providing most publicly financed health care in Ireland – launched the Counselling in Primary Care (CiPC) programme in 2013. The CiPC programme provides free access to community-based mental health care for people with mild to moderate mental health conditions who have low incomes (up to €9568 a year for a single person under 65 living alone and €13 858 a year for a married or cohabiting couple aged under 65 with dependants in 2025) and are eligible for a medical card (see Box 1).

This brief shows how the CiPC programme has contributed to better mental health in people with low incomes and offers lessons for other countries looking to improve affordable access to mental health care.

Box 1. Entitlement to publicly financed health care in Ireland

Ireland is often described as having an unusually complex, two-tiered system of entitlement to publicly financed health care (OECD/European Observatory on Health Systems and Policies, 2023; Lancet Regional Health – Europe, 2025). While everyone in Ireland is entitled to inpatient, maternity, immunization and emergency care in public facilities, regardless of residence or administrative status, entitlement to publicly financed outpatient care is much more limited.

The population is divided into two main entitlement groups (category I and category II) based on income and age (Johnston, Thomas & Burke, 2020).

- People in Category I are adults with low incomes and their children– about 1.56 million people (31% of the population) in 2025 – who hold a medical card granting them access to the full range of publicly financed health care, including primary health care visits, outpatient prescribed medicines and other forms of outpatient care (HSE, 2024a). In 2025 the eligibility income threshold is set at €9568 a year for a single person living alone under 65 and €13 858 a year for a married or cohabiting couple under 65 with dependants (HSE, 2025a). A small number of people obtain discretionary medical cards on the basis of "undue hardship", regardless of income (HSE, 2014).

- People in category II (69% of the population in 2025) are not entitled to a medical card and must pay the full cost out of pocket for most outpatient care (HSE, 2022).

Two other coverage schemes provide additional benefits on the basis of age or health status.

- "GP visit cards" provide access to primary health care visits to selected people if they are not eligible for a medical card (around 18% of the population in total): children under 8, adults over 70 and households with a median annual income of under €46 000.

- The Long-Term Illness Scheme covers selected medicines and medical products for people with selected conditions or disabilities, regardless of their medical card status (around 4% of the population) (HSE, 2023).

Many people buy voluntary private health insurance to obtain faster access to elective treatment in public hospitals and treatment in private hospitals, including mental health care. In 2024 around 47% of the population – mainly people with higher incomes – had private insurance (Health Insurance Authority, 2024a; Johnston, Thomas & Burke, 2020). Regulation stipulates that all private insurance policies should provide a minimum level of hospital benefits. For mental health care, the minimum benefit amounts to 100 days of care in a calendar year, although some insurers offer more than this (St. Patrick's Mental Health Services, 2025). There are no minimum benefits for outpatient mental health care.

Source: UHC watch (2025).

The policy change

The Health Service Executive established the National Counselling Service (NCS) in 2000 to provide publicly financed counselling and psychotherapy for people who had experienced abuse in childhood. In 2006, following the launch of *A Vision for Change* (Department of Health, 2006), a new framework for accessible, community-based and specialist mental health care, the NCS set up a pilot initiative offering counselling in primary health care for people in the Health Service Executive north-east region with medical cards (see Box 1) and mild to moderate mental health conditions (Ward, 2007; McDaid, 2013).

Informed by the experience of the NCS pilot, the Health Service Executive established the CiPC programme in 2013 to extend publicly financed counselling to adults across the whole of Ireland with medical cards and some other groups of people (e.g. former residents of a mother and baby home,[1] family members impacted by the Stardust Inquest[2] and people who have experienced abuse in childhood). In 2025 1.23 million adults (around 25% of the population) were eligible for CiPC services (HSE, 2025b).

CiPC provides people referred by a primary health care provider with up to eight sessions of free counselling. Additional sessions may be provided based on clinical need. Counselling takes place in 240 locations (primary care centres, NCS counselling locations and community-based centres), which were gradually rolled out across the country in 2013 and 2014. Furthermore, the remote counselling options (by video or telephone) introduced during the coronavirus disease pandemic to maintain continuity of care have now been integrated into normal service delivery.

The NCS has clinical and operational responsibility for the programme, which is organized by regional CiPC clinical coordinators. Around 60% of counsellors in the CiPC programme are employed directly by the Health Service Executive and 40% are contracted.

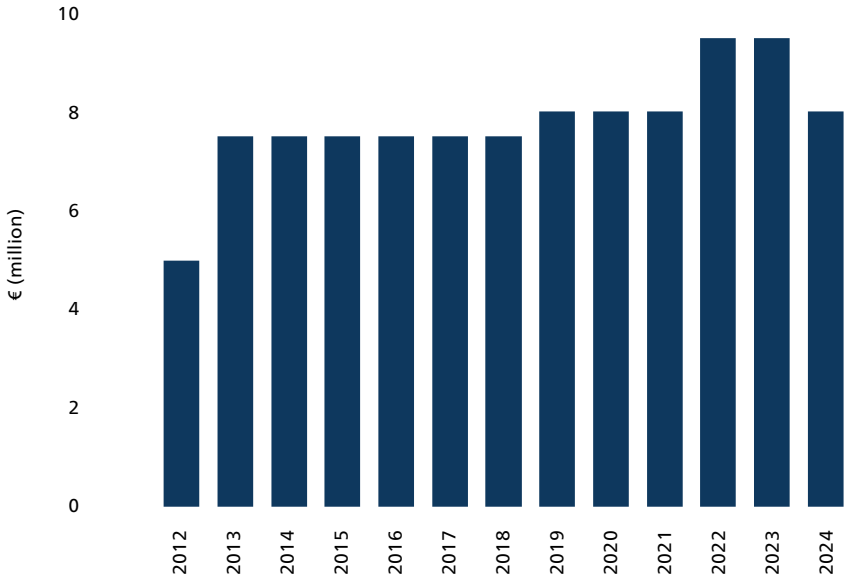
Initial funding allocated to the CiPC programme was set at €5 million a year in 2012 and increased to €7.5 million a year from 2013 to 2018 (Fig. 1). The allocated budget has increased slightly since then. A larger than usual increase in the allocated budget in 2022 and 2023 aimed to address long waiting times.

Despite the allocated budget increase in recent years, funding remains constrained and limits the CiPC programme's ability to scale up to meet rising demand. However, the CiPC programme remains a policy priority for the Department of Health, which is responsible for allocating the health budget, and recent national strategies have strengthened policy alignment in support of the programme's continuity (Box 2).

1. Mother and baby homes were state- and church-run institutions that operated mainly during the 20th century to house unmarried pregnant women experiencing stigma and difficult social conditions.

2. The Stardust Inquest is a formal investigation aimed at determining the cause of the 1981 Dublin nightclub fire that killed 48 people and establishing accountability.

Fig. 1. Annual allocated funding for the CiPC programme



Source: Department of Health, data provided to the authors on request, 2025.

Box 2. Recent national strategies reinforcing the CiPC model

In 2017 Ireland introduced *Sláintecare* [healthcare], a comprehensive 10-year reform plan aimed at providing universal access to the full range of publicly financed health care, including primary health care (Committee on the Future of Healthcare, 2017). Its three main objectives are to expand health and well-being; reduce and remove user charges (co-payments) for outpatient prescribed medicines and inpatient care; and to strengthen primary health care, social care and mental health care. *Sláintecare*'s vision of access based on need rather than ability to pay is closely aligned with the aims of the CiPC programme.

Access to community-based mental health care gained further momentum in 2020, with the adoption of the new national mental health policy *Sharing the Vision: A Mental Health Policy for Everyone* (Department of Health, 2020). This 10-year strategy builds on Ireland's first national suicide prevention strategy *Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015 – 2024*, which was supported by targeted funding and intersectoral collaboration (Department of Health, 2015). *Sharing the Vision: A Mental Health Policy for Everyone* sets out a comprehensive framework for reform, including the integration of mental health care in health and social care delivery, improved continuity of care and enhanced service coordination. Both initiatives emphasize counselling as a first-line treatment for mild to moderate mental health conditions and call for an expansion of mental health care in community and primary health care settings.

Source: UHC watch (2025).

Policy impact

Use of the CiPC programme has increased over time. In 2024 there were 20 619 referrals from primary health care to the programme, up from 5153 in 2013 (Fig. 2). Referrals fell sharply in 2020 due to the coronavirus disease pandemic but have grown steadily since then. The number of counselling sessions provided by CiPC grew rapidly from under 10 000 a year in 2013 to reach a peak of nearly 67 000 in 2017 (Fig. 3). The number of sessions fell in 2020 at the onset of the pandemic but have slowly grown since then, partly due to the availability of remote options.

Fig. 2. Number of referrals a year made through the CiPC programme

Source: Department of Health, data provided to the authors on request, 2025.

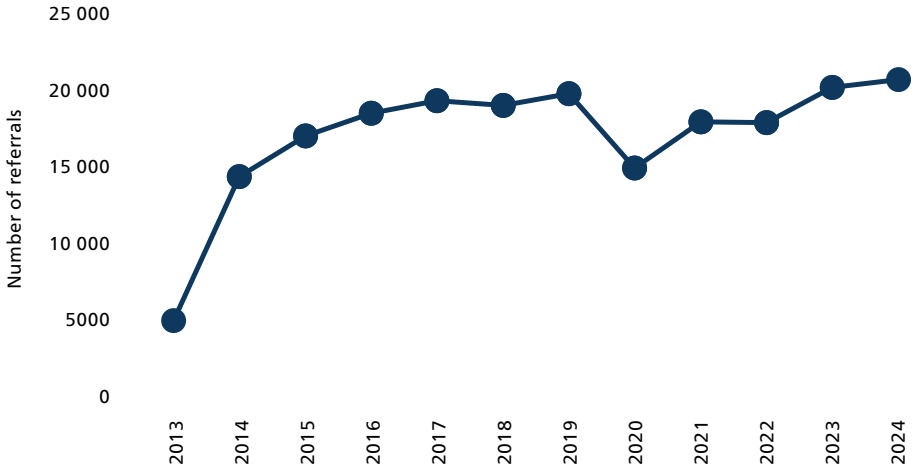
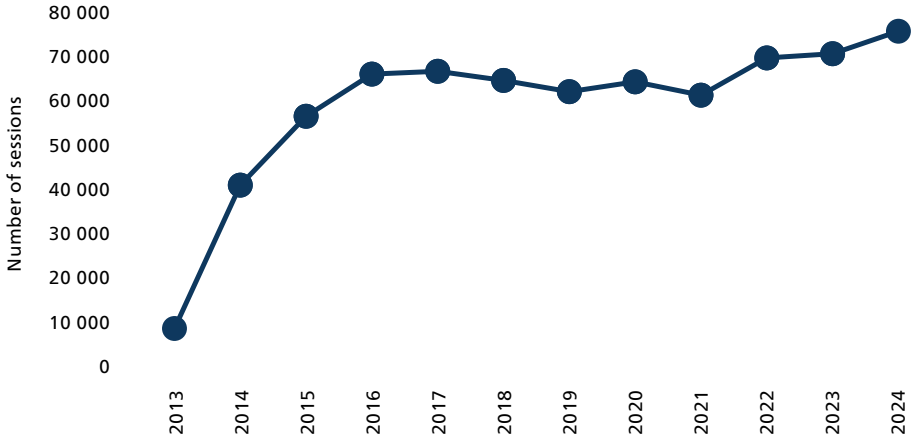


Fig. 3. Number of counselling sessions a year delivered through the CiPC programme

Source: Department of Health, data provided to the authors on request, 2025.



Evidence from the CiPC National Evaluation carried out by the Health Service Executive in 2022 confirmed the clinical effectiveness of the programme. Nearly three quarters (72%) of the 3000 people who took part in the Evaluation showed clinical improvement or recovery after counselling and indicators of self-harm and suicide risk fell from 27% to 9% (HSE, 2022). Primary health care providers reinforced these findings: 80% reported that participation in the programme had improved clinical outcomes (HSE, 2022).

Despite its evident success, the CiPC programme faces two main challenges. First, for those eligible for the programme, there are long waiting times for referral and treatment, reflecting both funding and capacity constraints; at the end of 2024 over 2600 people had been waiting for more than 3 months for an initial assessment or to access ongoing CiPC counselling. Second, eligibility is limited to adults with medical cards and a few other groups of people (about 25% of the population in total), so the programme can only improve affordable access to mental health care for a relatively small share of the population. In the CiPC National Evaluation, 85% of general practitioners reported having patients who would have benefited from counselling but were not eligible for the CiPC programme or were deterred by long waiting times.

The expansion of the CiPC programme remains a policy priority for the Department of Health and the Minister for Mental Health. As a first step, the Department of Health and the Health Service Executive are working to incrementally expand access to CiPC and, ultimately, to provide universal access to the programme, in line with *Sláintecare*. To do this the Minister for Mental Health allocated an additional €2 million to the programme's budget in 2025, which will be available yearly on a recurring basis. Providing universal access to the CiPC programme would triple the eligible population from 1.23 million to 3.93 million and could generate around 52 000 additional referrals per year (HSE, 2024b). Meeting this additional demand will in turn require an increase in the counselling workforce from 200 to 600, as well as an expansion of clinical and administrative infrastructure to address persistent waiting times and improve the programme's effectiveness.

Lessons learned

Leveraging existing means-tested entitlement schemes to target people with very low incomes can improve affordable access to mental health care, but eligibility restrictions leave many people behind. By linking free counselling to existing means-tested entitlement schemes (medical cards) the CiPC programme has minimized administrative costs and ensured that people with very low incomes are able to access mental health care. However, the Government recognizes that this is not enough to improve affordable access for everyone with mild to moderate mental health conditions and is planning to extend entitlement to all adults.

Stable funding and capacity planning are essential to ensure timely access to counselling. Despite recent budget increases, funding remains limited and has constrained the CiPC programmes's ability to scale up and meet growing demand for counselling, leading to long waiting times. Because long waiting times are stressful for patients and can lower the value of treatment when it is finally provided, Government plans to expand entitlement will need to be accompanied by additional funding and a clear plan to develop the capacity required.

Wider health system reforms have helped to reinforce the CiPC model. National strategies such as *Sláintecare* and *Sharing the Vision: A Mental Health Policy for Everyone* have strengthened policy alignment around improving affordable access to community-based mental health care for everyone, supporting the programme's continuity and expansion.

Monitoring programme effectiveness offers valuable evidence in support of a phased expansion. The CiPC National Evaluation carried out in 2022 was the first practice-based assessment of the programme's outputs and clinical outcomes. Its findings offer valuable evidence of the CiPC programmes' effectiveness and provide a benchmark to inform expansion.

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