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FOREWORD

This *Survey* is published on the responsibility of the Economic and Development Review Committee of the OECD, which is charged with the examination of the economic situation of member countries.

The economic situation and policies of Ireland were reviewed by the Committee on 24 November 2022. The draft report was then revised in light of the discussions and given final approval as the agreed report of the whole Committee on 2 December 2022.

The Secretariat's draft report was prepared for the Committee by Müge Adalet McGowan, Patrizio Sicari, Douglas Sutherland, Kei Oguro and Natia Mosiashvili, under the supervision of Vincent Koen. Editorial support was provided by Michelle Ortiz, Sisse Nielsen and Jean-Rémi Bertrand.

The previous *Survey* of Ireland was issued in February 2020.

Information about the latest as well as previous Surveys and more details about how *Surveys* are prepared is available at www.oecd.org/eco/surveys

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BASIC STATISTICS OF IRELAND, 2021[1]

(Numbers in parentheses refer to the OECD average)[2]

LAND, PEOPLE AND ELECTORAL CYCLE							
Population (million)	5.0			Population density per km²	73.0	(38.7)	
Under 15 (%)	20.5	(17.6)		Life expectancy at birth (years, 2020)	82.2	(79.7)	
Over 65 (%)	14.9	(17.7)		Men (2020)	80.4	(77.0)	
International migrant stock (% of population, 2019)	17.1	(13.2)		Women (2020)	84.1	(82.5)	
Latest 5-year average growth (%)	1.1	(0.5)		Latest general election	February 2020		
ECONOMY							
Gross domestic product (GDP) and Modified gross national income (GNI*)	GDP	GDP	GNI*[3]	Value added shares (%)			
In current prices (billion USD)	503.9		276.7	Agriculture, forestry and fishing	1.1	(2.6)	
In current prices (billion EUR)	425.9		233.9	Industry including construction	43.1	(27.7)	
Latest 5-year average real growth (%)	8.6	(1.5)	4.5	Services	55.9	(69.7)	
Per capita (thousand USD PPP)	107.6	(50.7)	59.1				
GENERAL GOVERNMENT							
	% of GDP		% of GNI*[3]		% of GDP		% of GNI*[3]
Expenditure	24.8	(47.2)	45.2	Gross financial debt (OECD: 2020)	65.9	(129.8)	120.0
Revenue	23.2	(39.5)	42.2	Net financial debt (OECD: 2020)	40.9	(81.0)	74.4
EXTERNAL ACCOUNTS							
Exchange rate (EUR per USD)	0.85			Main exports (% of total merchandise exports)			
PPP exchange rate (USA = 1)	0.79			Chemicals and related products, n.e.s.	62.3		
	% of GDP		% of GNI*[3]	Machinery and transport equipment	15.2		
Exports of goods and services	134.4	(29.7)	244.7	Miscellaneous manufactured articles	10.1		
Imports of goods and services	95.0	(29.8)	172.9	Main imports (% of total merchandise imports)			
Current account balance	14.2	(0.2)		Machinery and transport equipment	38.8		
Net international investment position	-131.6			Chemicals and related products, n.e.s.	26.5		
Modified current account balance[3]	6.1		11.1	Miscellaneous manufactured articles	11.4		
LABOUR MARKET, SKILLS AND INNOVATION							
Employment rate (aged 15 and over, %)	59.4	(56.2)		Unemployment rate, Labour Force Survey (aged 15 and over, %)	6.2	(6.1)	
Men	64.7	(64.1)		Youth (aged 15-24, %)	14.8	(12.8)	
Women	54.3	(48.7)		Long-term unemployed (1 year and over, %)	1.8	(2.0)	
Participation rate (aged 15 and over, %)	63.0	(60.3)		Tertiary educational attainment (aged 25-64, %)	53.7	(39.9)	
Average hours worked per year	1,775	(1,716)		Gross domestic expenditure on R&D (% of GDP, 2020)	1.2	(3.0)	% GNI*[3] 2.3
ENVIRONMENT							
Total primary energy supply per capita (toe)	2.7	(3.8)		CO_2 emissions from fuel combustion per capita (tonnes, 2019)	6.8	(8.3)	
Renewables (%)	11.5	(11.6)		Water abstractions per capita (1 000 m³, 2009)	0.2		
Exposure to air pollution (more than 10 µg/m³ of PM 2.5, % of population, 2019)	0.6	(61.7)		Municipal waste per capita (tonnes, 2019, OECD: 2020)	0.6	(0.5)	
SOCIETY							
Income inequality (Gini coefficient, 2018, OECD: latest available)	0.292	(0.315)		Education outcomes (PISA score, 2018)			
Relative poverty rate (%, 2018)	7.4	(11.7)		Reading	518	(485)	
Median disposable household income (thousand USD PPP, 2018)	28.9	(25.5)		Mathematics	500	(487)	
Public and private spending	% of GDP		% of GNI*[3]	Science	496	(487)	
Health care (OECD: 2020)	6.7	(9.7)	12.3	Share of women in parliament (%)	22.5	(32.4)	
Pensions (2017)	3.8	(8.6)	7.0	Net official development assistance (% of GNI, 2017)	0.3	(0.4)	
Education (% of GNI, 2020)	4.2	(4.4)	5.9				

[1] The year is indicated in parenthesis if it deviates from the year in the main title of this table.

[2] Where the OECD aggregate is not provided in the source database, a simple OECD average of latest available data is calculated where data exist for at least 80% of member countries.

[3] Modified gross national income and modified current account balance are national indicators to capture the underlying dynamics of the domestic Irish economy. See Box 1.1 for details.

Source: Calculations based on data extracted from databases of the following organisations: OECD, International Energy Agency, International Labour Organisation, International Monetary Fund, United Nations, World Bank and Irish Central Statistics Office.

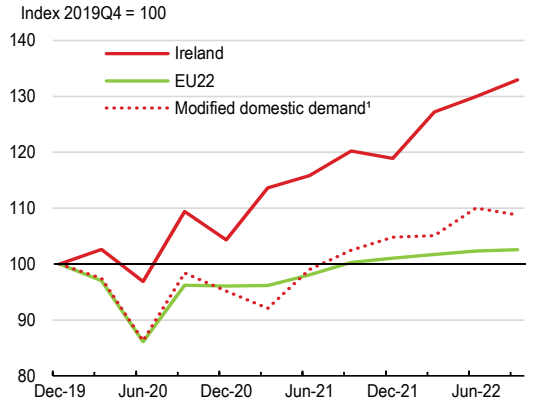
Executive Summary

Challenges remain despite the well-managed COVID crisis

The economy weathered the COVID-19 pandemic and is coping well with the repercussions from Russia's war of aggression against Ukraine. The government reacted forcefully to shield households and businesses from both shocks. Buoyant exports from the multinational sector and very high vaccination rates helped the economy recover strongly when the strict lockdown was lifted (Figure 1).

Figure 1. Exports continue to support growth

Gross domestic product, volume



Note: 1. Excludes those large transactions of foreign corporations that do not have a big impact on the domestic economy.
Source: OECD, National Accounts database and Central Statistics Office.

StatLink https://stat.link/duixek

The reopening of the economy was accompanied by a strong bounce-back in activity, but inflationary pressures emerged. High inflation, while still driven by elevated energy prices, has become more broad-based, especially through higher transport and service costs. In addition, property prices have been rising, reflecting strong demand, past underinvestment, and a sluggish supply response. The government has acted to offset some of the energy price shock.

High inflation and low confidence are set to lower domestic demand. On the external side, exports of multinational-dominated high-growth sectors will continue to support GDP growth, albeit at a decelerating rate (Table 1). While inflationary pressures are projected to gradually abate, war-related factors may keep up inflation, thereby denting domestic demand and slowing the economy further.

Table 1. Economic growth is slowing

Annual rate of change unless noted[1]	2021	2022	2023	2024
Real GDP	13.4	10.1	3.8	3.3
Modified total domestic demand[2]	5.9	8.0	0.9	3.1
Unemployment rate (% of labour force)	6.2	4.7	5.3	5.1
Core consumer price inflation	1.7	4.8	4.6	3.0

Note: 1. OECD Economic Outlook 112 projections for 2022-24, not taking into account the quarterly data released on 2 December 2022 for 2022 Q1-Q3. 2. Excludes those large transactions of foreign corporations that do not have a big impact on the domestic economy.
Source: OECD Economic Outlook 112 database.

Labour markets have been resilient in the face of the pandemic, and labour shortages are increasing in some sectors, such as construction. Despite gains in labour force participation for youth and women, those with lower educational attainment continue to struggle to secure and retain employment. During the pandemic, the government has expanded training using digital technologies and the development of additional apprenticeship schemes, particularly for sectors – such as construction – that are in high demand.

The financial sector appears to have weathered recent shocks relatively well. Banks have returned to profitability and continue to work down their non-performing loans. Innovation in the sector has continued apace with growing digitalisation and the rising importance of Fintech.

The financial sector faces some structural problems. Mortgage arrears remain important and their low resolution may limit credit supply. Returns on equity are low and two banks are withdrawing from the market, raising concerns about concentration. The rise of lending by non-banks creates risks that need to be monitored closely.

Fiscal policy is currently performing well, but pressures loom

Fiscal policy had enough room to react to the crises forcefully. While spending rose, strong revenue growth meant budget balances did

not deteriorate as much as elsewhere in the OECD. However, fiscal policy is facing a number of pressures in the short run and on its longer-term sustainability.

The strong rebound in the economy allowed the authorities to withdraw COVID-19 support measures for households and firms. Thanks to excess corporate tax receipts, the budget is expected to move back into balance in 2022, despite substantial government support related to the energy shock. The government has put part of these extra receipts in the National Reserve Fund. A new fiscal rule is also trying to make spending less procyclical and avoid creating backlogs of spending that are currently a challenge for policymakers.

High inflation is putting pressure on the government to increase spending, which may undermine the new spending rule before it gains sufficient credibility to constrain policy. Additional persistent stimulus to demand should be avoided in the current context of high inflation. Any further fiscal support for vulnerable households should be temporary and targeted, and should be designed to maintain incentives for energy savings.

In the longer term, several underlying pressures will create threats to fiscal sustainability. The plans to raise the state pension age have been abandoned, and the September pension reform is centred around increasing social security contributions. More rapid population ageing will push up health costs. Climate change objectives will require government support over the coming decades. The recent multilateral agreement on corporate taxation could reduce the buoyancy of receipts, although effects are very uncertain.

Improving housing affordability is a priority

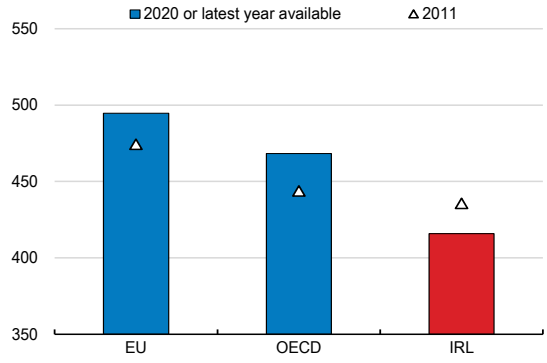
The sharp increases in house prices in recent years have heightened affordability concerns. The housing stock has hardly kept pace with the rise in the number of households, and remains low (Figure 2). After the lifting of the lockdown, housing market pressures intensified, causing house prices to rise rapidly. Accommodation is hard to find, particularly for lower-income families.

The government has launched an ambitious Housing for All initiative. The programme seeks to improve zoning, planning, land availability and provision of social housing. Public investment in housing is being increased. The policy aims to increase homeownership and affordability, in a break with earlier policy efforts to ensure neutrality between ownership and renting.

Boosting residential accommodation will require action to enable a stronger supply response. The regulation and permitting system is complex and slow, and housing developments can be subject to judicial review, further slowing supply. The new planning system gives back the primary decision to the local level, which requires additional expertise and resources to make it effective and timely. In addition, construction costs are elevated and the demand for workers in the sector exceeds supply. The State is also a large landowner of sites that could be developed. Finally, expanding housing supply needs to be better embedded in planning for transport and infrastructure.

Figure 2. Housing markets face supply pressures

Dwellings per thousand inhabitants



Source: OECD, Affordable Housing database.

StatLink https://stat.link/hdj5bm

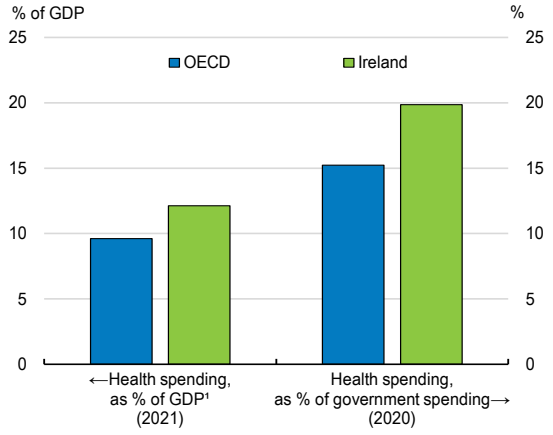
There is scope for efficiency gains in healthcare

Health gains have been impressive over recent decades. Life expectancy is now amongst the best in the OECD and the population rates their health as good.

Improving spending efficiency, reducing waiting times and simplifying the interaction of different parts of the system are key.

Spending on healthcare is now comparatively high. After a period of retrenchment, spending on health has risen recently and is now high in comparison with other OECD countries. It also accounts for a sizeable share of government spending (Figure 3). This largely reflects high costs. Pay is high and pharmaceutical spending does not make the most of low-cost alternatives. As ageing begins to accelerate, spending pressures are projected to increase. Already spending on long-term care is elevated. Achieving efficiency gains will be important in addressing these pressures.

Figure 3. Spending on healthcare is high



1. Health spending for Ireland is computed as share of GNI*.
Source: OECD, Health Expenditure and Financing database; and OECD, National Accounts database.

StatLink https://stat.link/vkgtri

The government has initiated a far-reaching overhaul of the health sector. The Sláintecare reforms will reconfigure the sector by moving away from a largely hospital-based system to one that will better integrate primary, community and long-term care. This will also involve some decentralisation, with the creation of Regional Health Areas. Effective implementation should remove the burden on expensive hospital care, improve data availability and governance as well as financial reporting and management, and allow for some simplification of the complex interactions between the private and public elements of the system.

Progress will require overcoming some longstanding problems. The period of spending retrenchment has left a number of legacy issues. Waiting times are long with private patients able to jump queues causing concerns about a de facto two-tiered system. Past underinvestment in buildings and equipment is slowly being corrected, but will take time to overcome fully. Working conditions, particularly during the COVID-19 pandemic, are difficult and attracting and retaining staff is a concern.

Reducing greenhouse gas emissions requires bold reforms

Ireland did not meet its 2020 emission reduction target. In addition, greenhouse gas emissions per capita are amongst the highest in the OECD, partly due to the importance of agriculture. The government has adopted demanding reduction targets for 2030 and 2050, seeking to reach net zero emissions by mid-century.

A major plank of abatement policy is the establishment of carbon budgets and sectoral emissions ceilings. Emission reductions in the power generation sector is key to obtaining overall emission reductions. Ireland has already begun to develop renewable resources, but development of additional onshore and offshore wind generation capacity will require major investment, including in the grid infrastructure to ensure it can deal with more intermittent supply. It will be important to frontload the reforms to streamline and simplify the planning and judicial review process in order to facilitate the investment needed to meet the climate targets. The transport sector accounts for around one-fifth of greenhouse gas emissions.

The agriculture sector presents particular difficulties for abatement. Achieving methane emission reductions has proven to be difficult and the dairy herd has actually been growing, making the targets even more difficult to reach. Without more progress in agriculture, meeting the 2030 target will require greater effort from other sectors. This will raise the overall costs of reductions substantially.

Main findings	Key recommendations
Improving macroeconomic policy and fiscal sustainability	
The rapid rise in energy prices has been a large shock to households and the government has reacted by softening the blow.	Target support on the most vulnerable households, while keeping the impact on domestic activity broadly neutral.
Fintech and credit provision by non-banks are on the rise.	Ensure adequate supervision and regulation of non-banks by the Central Bank of Ireland.
There is a need to strengthen the ability of fiscal policy to address future shocks. High inflation is putting pressure to increase government spending, which has led to a temporary breach of the new spending rule in 2022-23.	Continue to put excess windfall tax receipts in the National Reserve Fund. Consider strengthening the expenditure rule by giving it legislative status.
The government cancelled the planned increase in the state pension age during the pandemic. The new pension reform aims to address structural shortfalls in the social security funds by increasing social security contributions.	Re-introduce the planned rise in the state pension age and link the statutory retirement age to life expectancy at retirement.
Pursuing structural reforms and providing housing	
The labour market participation of those with low education attainment remains low and labour market shortages are rising in some sectors.	Continue to support training and apprenticeships in areas of the economy where labour supply is in high demand.
Low housing and rental supply leads to high prices and low affordability. *Housing for All* is an ambitious strategy, but implementation challenges are large in the near term.	Prioritise supply-side policies in the implementation of the *Housing for All* Strategy.
Permitting delays and judicial reviews constrain housing supply.	Expedite the streamlining of planning and judicial review processes, for example by establishing a special division in the High Court with sufficient tools, resources and technical capacity to reduce delays.
Housing for All gives some of the planning responsibilities back to local planning authorities.	Address capacity issues in the planning system and sufficiently resource local planning authorities.
Keeping Ireland healthy	
Home care for the elderly incurs lower societal costs, but when the patient becomes sicker, the costs rise and the quality of care diminishes.	Establish integrated funding and service delivery to offer home care and admission to long-term residential care when needed.
The Single Assessment Tool is a key IT tool to support enhanced operational integration across all health and social long-term care providers, enabling large efficiency gains and the provision of more effective person-centered care services.	Accelerate the implementation of the Single Assessment Tool across the country in order to move towards more effective person-centered care services.
The Sláintecare reforms are overhauling the Irish healthcare system. The system is currently overly centralized, complex and biased towards expensive hospital-based treatments.	Implement the reforms to create Regional Health Areas and rebalance healthcare delivery across primary, community and long-term care and hospitals.
The success of Regional Health Areas will depend on a suitable funding system and data availability. The funding system is currently fragmented across care settings and lacks transparency, limiting the traceability of healthcare spending. Monitoring the health system is hindered by its complexity, lack of adequate information, fragmented data governance and underdeveloped digital infrastructure.	Introduce a Population-Based Resource Allocation funding model, as planned, to improve financial reporting and management and strengthen equity in health outcomes. Prioritise reforms to enhance the take-up of a unique health identifier across health services and centralise governance and appropriate national health information functions within a single independent body.
Achieving net zero emissions by 2050	
Planning and permitting delays coupled with judicial review concerning major investments slow the development of renewable energy capacity and through increasing uncertainty deter investment and raise prices.	As a matter of urgency, expedite the planning process to reduce uncertainty concerning major investments in wind turbine capacity.
Reducing emissions in the transport sector requires action across many policy dimensions.	Realign transport policies to reduce private car ownership and facilitate the provision and use of low- or no-carbon travel alternatives.
The overall costs of abatement will rise substantially if agriculture does not contribute more to emission reductions.	Ensure that farmers face stronger economic incentives to reduce emissions in line with the rest of the economy, such as by pricing methane emissions.

1 KEY POLICY INSIGHTS

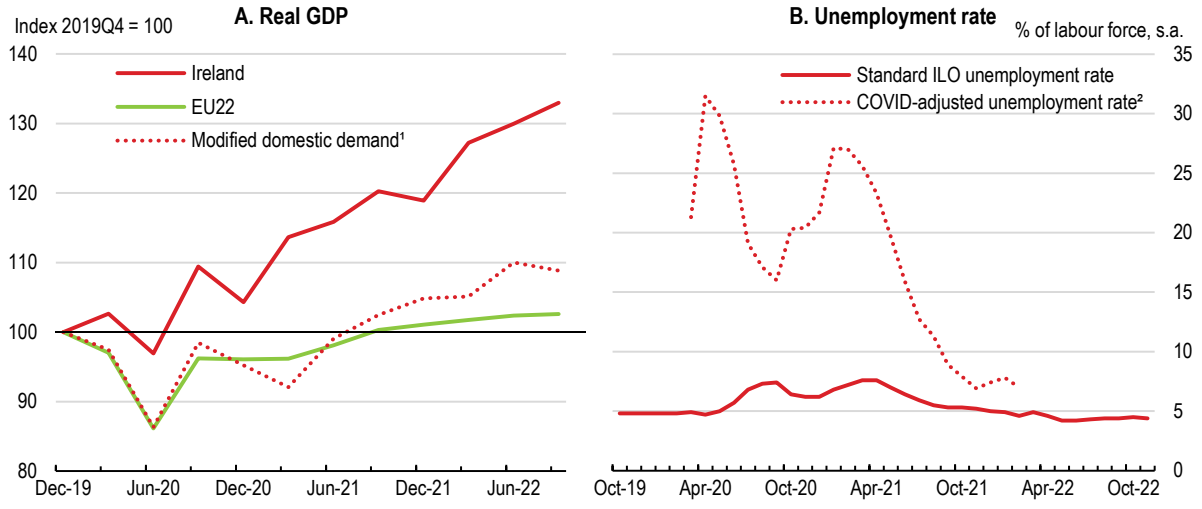
In recent decades, Ireland made impressive strides in developing its economy and raising living standards. This progress has allowed the economy to weather the COVID-19 pandemic and cope effectively with the repercussions from Russia's war of aggression against Ukraine. The economy has recovered, but inflationary pressures emerged and while the outlook is favourable, risks are tilted to the downside. The financial sector appears to have withstood the recent shocks, but faces some structural problems, including high legacy mortgage arrears. Fiscal policy had enough room to react to the crises forcefully and shield households and businesses from the full weight of the shocks. A number of pressures will affect fiscal policy in the short run and its sustainability over a longer horizon, including ageing, ensuring adequate supply of affordable housing, and combatting climate change. Labour force participation is still weak for those with lower education attainment and rising house prices are creating affordability concerns. The government has launched an ambitious Housing for All initiative to boost residential accommodation, which will require action to enable a stronger supply response. Ireland did not meet its 2020 emission reduction target. A major plank of abatement policy is the establishment of carbon budgets and sectoral emissions ceilings. The agriculture sector presents particular difficulties for abatement.

1.1. Having withstood the COVID-19 shock, the economy faces further challenges

In recent decades, Ireland made impressive strides in developing its economy and raising living standards. Life expectancy at birth is now among the highest in the OECD, from relatively low levels in the 1990s, and the population's self-reported health status was the best in the European Union in 2019. Thanks to a highly redistributive tax and transfer system, inequalities in disposable income are limited. The gap between the highest and lowest disposable incomes, as well as measures of poverty rates, are among the smallest in the OECD. Moreover, education is high quality with limited impact of socio-economic status. The relatively-young and well-educated population has been a key pull factor in the country's successful strategy to attract foreign direct investment, together with a supportive business environment.

The economy weathered the COVID-19 pandemic and is coping effectively with the repercussions from Russia's war against Ukraine. The lockdown was one of the strictest in the OECD and vaccination rates rose to amongst the best in the OECD. Benefitting from fiscal space, government policy reacted forcefully to support firms and households and preserve worker attachment to firms. Exports from the multinational part of the economy benefited from strong demand for medical and information communication technology goods and services. As a result, trend headline GDP growth remained robust while modified domestic demand, a national indicator that excludes globalisation-related investment in aircraft for leasing and on-shored intellectual property assets (Box 1.1), declined by 4.8% in 2020, before returning to pre-pandemic levels in the third quarter of 2021 (Figure 1.1, Panel A). The reopening of the economy was accompanied by a strong bounceback in activity and the unemployment rate dropped quickly (Panel B). The war in Ukraine has affected the Irish economy through the slowdown in global demand, particularly in major European trading partners, and the surge in energy and food prices, but the government announced a wide set of measures to support households and firms.

Figure 1.1. Robust external demand and extended income support sustained the economy



1. Excludes those large transactions of foreign corporations that do not have a big impact on the domestic economy.
2. The COVID-adjusted unemployment rate is an estimate of the share of the labour force that was not working due to unemployment or COVID-related absences.
Source: OECD, National Accounts database; Central Statistics Office; and Eurostat.

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Ireland faces challenges to sustain growth and improve well-being over the longer term. To wit, the country's ambitions to overhaul the health system to improve quality of care and value for money, ensure affordable housing and achieve a just carbon transition. In each area, substantial public spending is potentially needed and ensuring spending efficiency will be required. While the fiscal position is currently strong, with buoyant revenues, risks loom and cost-efficient policies will be needed.

Box 1.1. Different measures to capture the underlying dynamics of the domestic Irish economy

To better capture the underlying dynamics of the Irish economy, the Central Statistics Office publishes some alternative metrics, such as Modified Domestic Demand (MDD) and Modified Gross National Income (GNI*). The former measures domestic demand, but excludes volatile components of investment spending by multinationals, namely on-shored intellectual property assets and investment in aircraft for leasing, which have very little impact on the domestic economy. GNI* goes further by taking into account the import content of domestic expenditure and the contribution to growth from domestic net trade (i.e., excluding multinational dominated trade), thereby allowing for a comprehensive assessment of productivity trends. In particular, relative to the standard GNI, GNI* excludes the factor income of firms that have re-domiciled their headquarters to Ireland, as well as the depreciation of trade in on-shored intellectual property assets, R&D service imports and aircraft owned by aircraft-leasing companies. A related alternative metric is the modified current account balance (CA*), which removes a number of globalisation-related distortions, including trade and depreciation of intellectual property assets and aircraft related to leasing along with profits of redomiciled firms. Table 1.1 presents some of the main variables presented in the Basic Statistics Table at the start of this Survey as a share of GNI*.

Table 1.1. Selected variables as a share of GNI* and GDP

2021	% of GNI*	% of GDP
General government expenditures	45.2	24.8
General government revenues	42.2	23.2
General government gross financial debt	120.0	65.9
General government net financial debt	74.4	40.9
Exports of goods and services	244.7	134.4
Imports of goods and services	172.9	95.0
Modified current account balance	11.1	6.1
Gross domestic expenditure on R&D	2.3	1.2
Public and private spending on health	12.3	6.7
Public and private spending on pensions	7.0	3.8
Public and private spending on education (% of GNI)	5.9	4.2

Source: OECD, National Accounts database; Central Statistics Office; World Bank, World Development Indicators; OECD, Health Expenditure and Financing database; OECD, Social Expenditure database; Department of Finance (2021), *Forecasting GNI* - Detailing the Department of Finance Approach*, Dublin; Central Statistics Office, *Modified GNI;* and Department of Finance (2019), *The Balance of Payments in Ireland: Two Decades in EMU,* Dublin.

Health care reform is a major political initiative. While measures of health sector performance are good overall and the system weathered the COVID-19 pandemic better than initially feared, care provision is relatively expensive and facing mounting spending pressures as the population begins to age rapidly. The Sláintecare reform presents opportunities to reform a complex healthcare system and provide more integrated cost-efficient care. At the same time, the government is facing the legacy of past underinvestment in the sector and the build-up of long waiting lists, which will need to be addressed over time.

Spending pressure has also emerged in the housing sector. A prolonged period of underinvestment, combined with a legal and regulatory system that hinders supply, account for a relatively old housing stock, housing shortages (particularly in the rental market) and weak housing supply. This has put upward pressure on house prices and rents and has led the government to introduce the *Housing for All* reforms in 2021. Addressing the issue will require sustained effort and faces implementation challenges, including labour shortages in the construction sector. Labour mobility, in turn, is affected by housing shortages and costs.

A third major pressure on policy is addressing climate change. Having missed the abatement target in 2020, the government has adopted a net-zero greenhouse gas emission target for 2050 with an interim target for 2030 and has begun to elaborate policies to meet them combining market-based and regulatory measures. Meeting the targets cost-efficiently will require significant reforms. Furthermore, investment needs in the transport sector and energy efficiency improvements in the existing housing stock will add to the demand for labour in construction, which should be addressed urgently. Achieving emission reductions in agriculture is difficult without a major downsizing of the sector, possibly calling for greater effort elsewhere. In addition, the regulatory and legal barriers facing major investments are also potential constraints on maximising the potential of renewables.

Despite openness to new technologies, spillovers to domestic firms from the multinational sector have been limited, resulting in modest productivity growth (OECD, 2020a). In addition, certain groups face difficulties maintaining attachment to the labour market and heightened risk of poverty. Measures fostering the acquisition of digital and green construction skills and improving access to finance for innovative SMEs, would likely boost participation and productivity in the domestic-oriented economy.

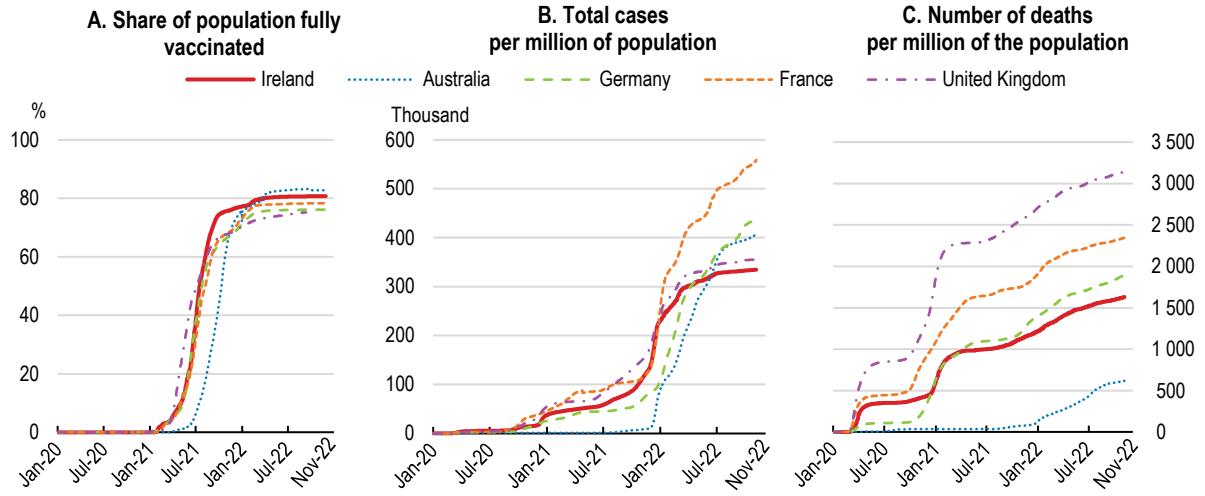
Against this background, the key messages of this Survey are:

- Current revenue buoyancy has allowed Ireland to weather the COVID-19 pandemic and the repercussions of the Russia's war of aggression against Ukraine, but action will be needed to put public finances on a sounder footing in the face of foreseeable pressures from ageing, including by addressing pro-cyclicality in spending and not delaying measures to meet the longer-term challenges.
- Past underinvestment in housing and the need to reduce greenhouse gas emissions call for major investments. The government is boosting investment in these areas, but action is also required to reduce regulatory and legal hurdles, to reduce uncertainty and high transaction costs, which could derail progress on both fronts.
- The government has launched a major reform of the health sector, Sláintecare. The sector is complex, relatively expensive and suffering from legacy issues, such as elevated waiting lists, that will be difficult to resolve quickly. Moving to a more integrated system of primary, community and hospital care offers solutions. It will be important to seek out efficiency gains and avoid raising spending to address short-run pressures.

1.2. Growing uncertainties will dent the pace of the recovery

During the pandemic, Ireland experienced several waves of infection and implemented strict containment policies and lockdowns involving curfews and the closing of non-essential businesses. This had a severe impact on the domestic-oriented sectors of the economy, with private consumption falling by around 12% in 2020. At the same time, strong external demand for pharmaceuticals, medical supplies and other pandemic-related goods and services – including information and communication technologies – boosted profits in sectors dominated by multinational enterprises and enabled Ireland's total economy to avoid a recession, unlike virtually all other OECD economies. Strong roll-out and take-up of vaccines supported a gradual re-opening of activities in mid-2021, as sanitary conditions eased somewhat, and helped contain the impact of the Omicron variant on Ireland's health system (Figure 1.2).

Figure 1.2. Success in vaccination helped overcome COVID-19



Source: OECD calculations based on Our World in Data.

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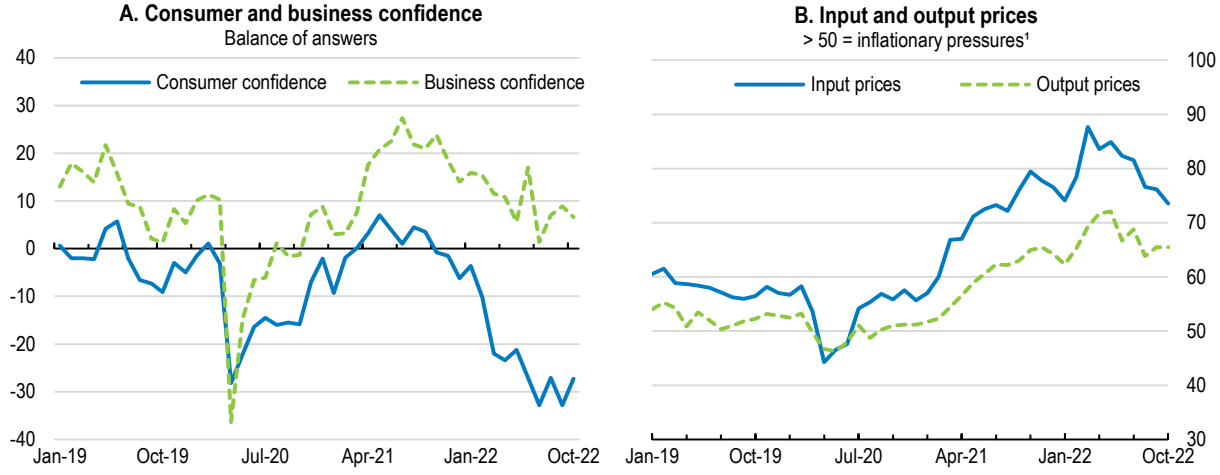
The domestic economy grew strongly in the first half of 2022 as the positive impetus from the full relaxation of containment measures partly compensated for higher inflation and uncertainty exacerbated by Russia's invasion of Ukraine. Growing wages and household excess savings, which still remain well above pre-pandemic levels, sustained consumer spending, as the economy reopened. However, with the sharp fall in consumer confidence (Figure 1.3, Panel A) and high inflation, private consumption growth moderated in the third quarter of 2022. The fall of confidence was less pronounced among businesses, which largely passed rising costs on to consumers (Panel B). Nevertheless, high uncertainty, lower real household disposable incomes and tightening financial conditions are weighing on domestic firms' business outlook.

The labour market recovered strongly in the aftermath of the pandemic. The simultaneous winding down of the emergency pandemic unemployment payments and the employment wage subsidy schemes led to a rebound in the labour force. At the same time, job vacancies remain high at 1.5% (0.8% in the first quarter of 2020), but lower than the EU average of 2.9% in the third quarter of 2022. The pandemic also affected job transitions. In late 2021, 45% of people who returned to work were with another employer – 31% in the same sector and 14% in a different sector (Department of Social Protection, 2022).

Figure 1.3. The risks to the recovery are considerable



1. Composite of manufacturing and services sectors.
Source: European Commission, Business and Consumer Surveys; and AIB / HIS Markit PMI indices.

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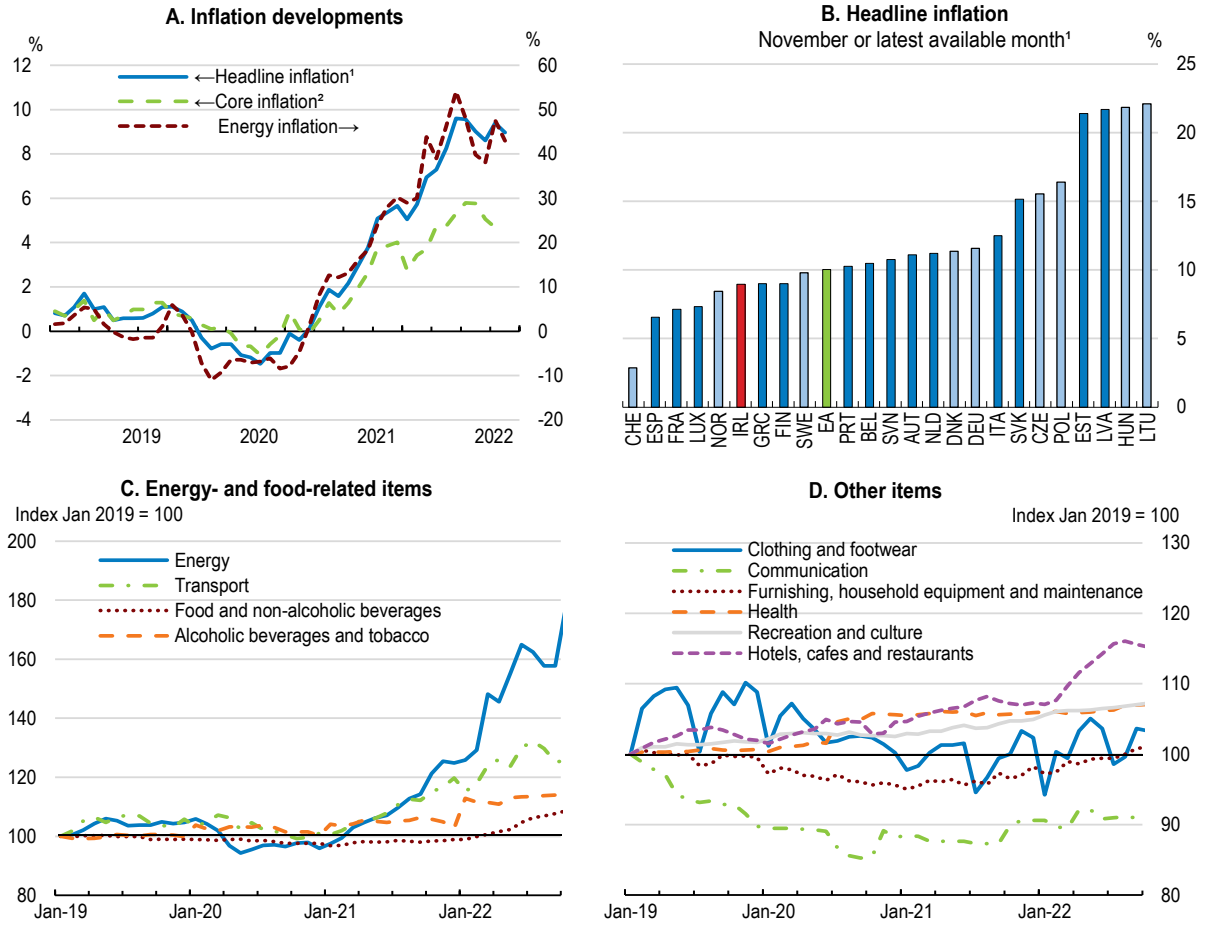
Consumer price increases, while still driven by high energy prices, have become more broadly-based (Figure 1.4). Headline inflation was 9% in November, albeit below the 10% euro area average, and energy prices were up by 43%. Firming prices of transport, hospitality, and recreational services, in the wake of the full re-opening of the economy, contributed to the rise in core inflation, which stood at 4.7% in October. The share of goods recording price increases of over 5% increased to almost 60%. Soaring prices of energy and other essentials disproportionately affect poorer households (CSO, 2022) – particularly elderly, youths and lone parents (ESRI, 2022), which can further raise inequalities before taxes and transfers. Elevated input costs coupled with reduced demand pose a threat to SMEs relying on household discretionary spending.

Figure 1.4. Inflationary pressures have become broad-based

Harmonised indices



1. Preliminary estimates for November; light blue bars are October values.
2. Excluding energy, food, alcohol and tobacco.
Source: Eurostat, Monthly Harmonised Index of Consumer Prices.

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Public support measures to limit the adverse impact of surging energy bills are sizeable. The first set of measures (0.6% of 2021 GDP and 1.1% of GNI*) included means-tested fuel allowances and some additional lump-sum payments to recipients, electricity credits, temporary reductions in fuel excise duties and VAT rates on electricity and gas, and a 20% reduction in public transport fares. The one-off and temporary cost-of-living package announced in Budget 2023 (€2.7 billion in expenditure and €1.7 billion in tax measures) extends these initial policies. It also includes additional welfare payments to all social protection recipients, an additional child benefit payment, support to eligible students, additional allocation

of funds to support public services and community organisations (€300 million) and a new business energy support scheme (€1.2 billion). The share of targeted measures increased from 11% in the initial package to 40% in the new package (Central Bank of Ireland, 2022a), which is welcome (see below for a discussion).

Direct macroeconomic risks from Russia's war against Ukraine are limited, as Ireland's goods trade with Russia, Ukraine and Belarus is modest (Box 1.2). However, specific shocks could hit agriculture and some industries dependent on specialised energy inputs. As for trade in services, the aircraft leasing industry could be affected, although the impact on the domestic-oriented economy would be negligible. Following the Government's commitment not to cap their number, Ireland had welcomed around 62 000 Ukrainian refugees by early November (equivalent to 1.2% of the country's population), with state accommodation provided to about two thirds of them. At the same time, Ireland's financial support for Ukrainian beneficiaries of temporary protection to cover basic need is amongst the EU's most generous (OECD, 2022). Budget 2023 allocates €2 billion to provide support to refugees. Measures currently under discussion to meet their accommodation needs, in a context already marked by severe housing imbalances, include the building of modular housing on public serviced sites, reconversion of vacant or unused buildings and monthly allowances to assist Irish households with hosting costs.

Box 1.2. The impact of Russia's war of aggression against Ukraine

Ireland's trade links with Russia, Ukraine and Belarus are modest and, as a result, the direct macroeconomic risks are limited. However, specific shocks could hit agriculture and some industries dependent on fertilisers and specialised energy inputs. Total exports to and imports from Russia were €3.7 billion and €0.65 billion, respectively, in 2020, accounting for around 1% of total exports and 0.2% of total imports.

The main exports to Russia have been computer services (50%), aircraft leasing (25%) and pharmaceutical products (5%). Ireland has become an international hub for special purpose vehicles engaged in aircraft leasing. The war will have a sizeable impact on the Irish aircraft leasing industry, which currently manages over €100 billion in assets. About 150 planes are rented to Russian airlines and there are significant uncertainties over the possibility to recover these Irish-owned planes from Russia, which recently introduced new legislation allowing foreign aircrafts to be registered in the country. Reversals in aircraft leasing activities will likely create some volatility in future GDP numbers, through changes in both investment flows and imports.

Imports of goods from Russia account for around one-half of a percentage point of total goods trade and are mainly composed of energy products and fertilisers. Ireland sourced only 6% of its oil imports from Russian suppliers in 2021 – and no gas at all. On the other hand, the share in the imports of coal, coke and briquettes hovers around 65-70%, but this accounts for only around €140 million or 0.13% of total imports. More than 25% of Ireland's imports of fertilisers came from Russian manufacturers. Business services account for around one-half of total imports from Russia.

Around 70 firms connected to Russia with total assets of €62 billion are involved in funds activity in the Irish Financial Services Centre. However, the impact of these firms on the domestic economy in terms of corporate taxation and administrative costs paid is quite low. While liquidity and solvency issues for these firms may raise reputational risk for the Irish financial sector, these assets are not owned by Irish firms and households.

The secondary impacts through energy prices and demand from European economies are more pronounced. Rising costs of energy and fertilisers are putting upward pressure on home heating, transport and food prices, which are among households' largest spending items. The slowdown in activity in major trading partners reduces demand for exports, although the composition of exports enabled them to remain resilient despite weaker demand.

The unwinding of COVID-19 pandemic support and the effects of renewed inflationary pressures have the potential to increase business insolvencies. As in most OECD countries, insolvencies did not pick up even after the phasing out of emergency support measures (PWC, 2022a). However, insolvencies increased by 49% in the third quarter of 2022 compared to a year ago, even though they remain below pre-pandemic levels (PWC, 2022b). Around 4% of active Irish businesses may require restructuring, liquidation, or some form of company dissolution (McCann and McGeever, 2022). In this context, the Small Company Administrative Rescue Process (SCARP), introduced in 2021, is welcome. Relative to the more formalised examinership legal alternative, SCARP's streamlined insolvency process could effectively accelerate the debt restructuring proceedings of insolvent but still viable SMEs, and the exit of zombie firms. Nevertheless, given the possibility that creditors may challenge proposals in court and the difficulties very small companies may face in funding even modest professional fees associated with restructuring, effective monitoring will be key.

The multinational portion of the economy saw a dramatic surge in exports during the pandemic (Figure 1.5, Panel A), thanks to the concentration in goods and services in high demand, in particular pharmaceutical goods, medical devices and ICT services, and geographically diversified markets (Figure 1.6). The new trading relations with the United Kingdom do not yet include restrictions on Irish exports of goods to Great Britain, and thus do not appear to have derailed Irish exports, while rising energy prices are pushing up the value of imports from the United Kingdom (Figure 1.5, Panel B). However, risks remain around the future of the Northern Ireland Protocol and the trading relationship with the United Kingdom. The United Kingdom has not yet implemented fully the Trade and Co-operation Agreement, whose checks on imports could hurt Irish exports. Trade with the rest of Europe has been affected. The loss of cabotage opportunities on the UK landbridge has led to a switch to shipping directly to Europe, mainly France. The port of Dublin has become an important node for European trade and has managed successfully to reorient shipping to accommodate more unaccompanied haulage, but further expansion may require greater development of other ports, such as Rosslare.

Figure 1.5. Trade has remained robust despite potential obstacles

Note: Panel A shows export volumes; Panel B shows the 5-month centred moving average.
Source: OECD, National Accounts database; and Central Statistical Office.

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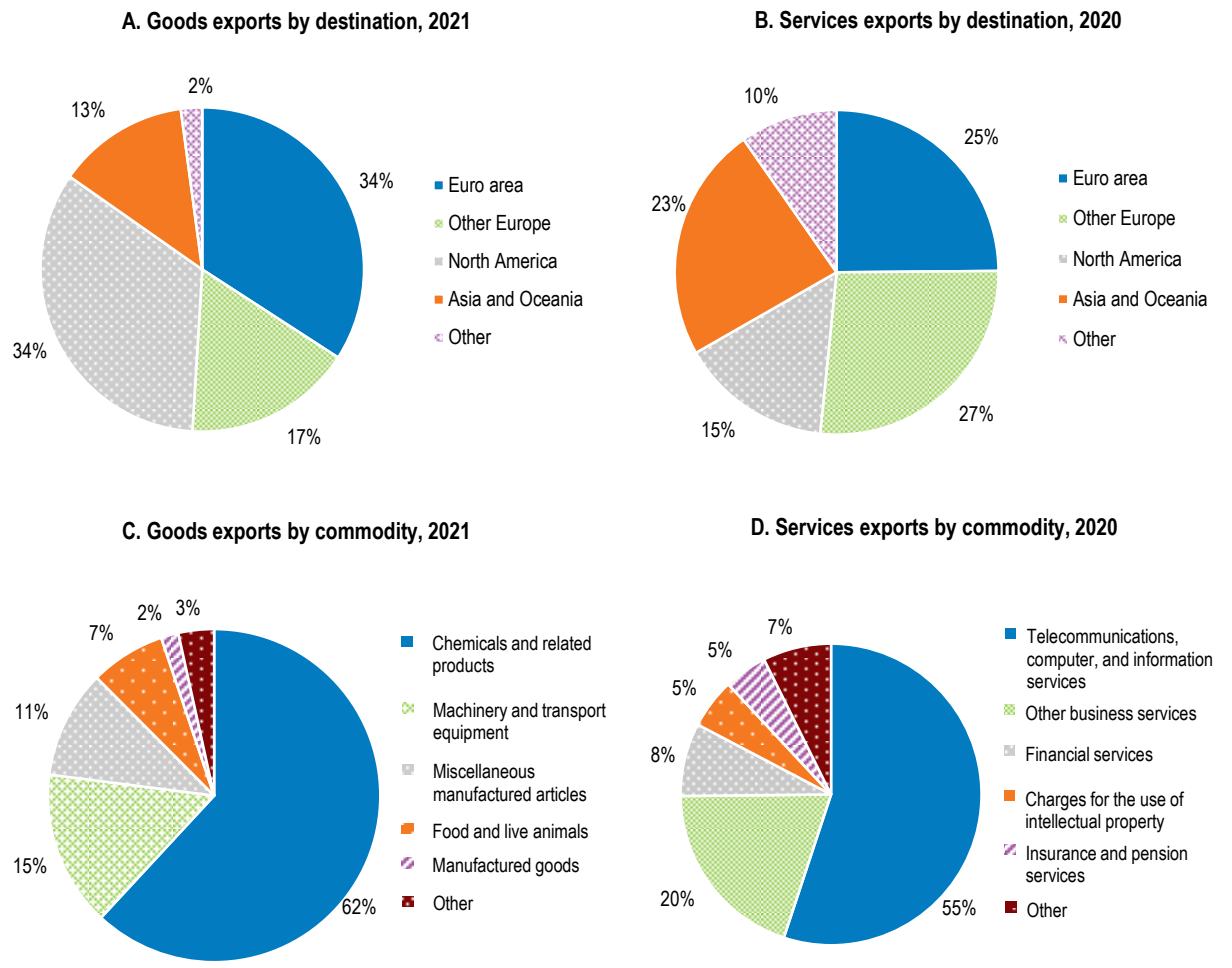
GDP and modified domestic demand growth are projected to be 10.1% and 8%, respectively, in 2022, reflecting the post-pandemic rebound in activity in the first half of the year. Going forward, falling real incomes due to inflation will hold back consumer spending up to 2023, despite significant wage growth. High costs and low confidence will reduce firms' incentives to invest. Public investment support through

the National Development Plan will partly offset weaker private business and residential investment, with Budget 2023 allocating €11.7 billion to capital expenditure in 2023. Modified domestic demand will thus only grow by 0.9% next year, before rebounding to 3.1% in 2024. As exports in multinational-dominated sectors, though moderating, will remain supportive, GDP is projected to grow by 3.8% in 2023 and 3.3% in 2024 (Table 1.2). Inflation is projected to gradually ease by 2023, but with still relatively elevated core inflation.

If funding costs were to rise faster than expected, some domestic firms might downsize or ditch their investment plans. Additionally, protracted uncertainties around the full implementation of Brexit agreements may weaken firms' competitiveness. Persistently high input price inflation, while weighing on firms' profitability, could also hamper the fiscal sustainability of the ambitious government agenda to subsidise residential construction and retrofitting, in a bid to boost housing supply and ease pressure from high house prices and rents. These, however, could increase further because of additional demand for accommodation triggered by growing numbers of Ukrainian refugees. Furthermore, energy supply disruptions in the winter of 2023-24 could affect growth, including through weaker external demand. On the upside, GDP growth may turn out stronger, as multinational-dominated exports of pharmaceutical and medical goods may be more resilient than foreseen to slowdowns in major trading partners. In addition, other lower probability threats to the outlook could derail the recovery (Table 1.3).

Figure 1.6. Exports are geographically diversified and largely chemicals and ICT services



Source: OECD, International Trade Statistics database.

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Table 1.2. Growth is projected to slow

	2019	2020	2021	2022	2023	2024
	Current prices (EUR billion)	Percentage changes, volume (2020 prices)				
GDP at market prices	**355.7**	**5.6**	**13.4**	**10.1**	**3.8**	**3.3**
Private consumption	104.2	- 11.9	4.5	5.7	1.3	3.1
Government consumption	42.8	10.4	6.1	2.5	- 0.3	- 0.8
Gross fixed capital formation	193.5	- 17.0	- 39.1	2.7	4.1	3.1
Final domestic demand	340.6	- 12.4	- 18.0	4.9	2.1	2.3
Stockbuilding[1]	4.3	0.5	0.4	0.3	- 0.6	0.0
Total domestic demand	344.9	- 12.1	- 18.0	4.1	1.0	2.4
Exports of goods and services	455.7	11.1	14.0	12.5	5.4	4.0
Imports of goods and services	444.8	- 2.2	- 8.3	9.4	4.7	3.8
Net exports[1]	10.9	16.9	27.9	7.9	3.0	1.9
Memorandum items						
Modified total domestic demand[2], volume	_	- 4.8	5.9	8.0	0.9	3.1
GNI*[3]	_	-4.6	15.4			
GDP deflator	_	- 0.5	0.4	6.1	4.1	1.9
Harmonised index of consumer prices	_	- 0.5	2.4	8.4	7.2	2.9
Harmonised index of core inflation[4]	_	- 0.1	1.7	4.8	4.6	3.0
Unemployment rate (% of labour force)	_	5.8	6.2	4.7	5.3	5.1
Household saving ratio, net (% of disposable income)	_	21.6	20.2	16.8	14.6	12.4
General government financial balance[5] (% of GDP)	_	- 5.0	- 1.7	0.2	1.1	1.7
General government financial balance[5] (% of GNI*)	_	- 9.4	- 3.0			
General government gross debt (% of GDP)	_	72.1	65.9	59.8	56.2	52.9
General government gross debt (% of GNI*)	_	134.9	120.0			
General government debt, Maastricht definition[6] (% of GDP)	_	58.2	55.4	49.4	45.7	42.5
General government debt, Maastricht definition[6] (% of GNI*)	_	108.9	100.9			
Current account balance (% of GDP)	_	- 6.8	14.2	16.4	18.9	18.7
Modified current account balance[7] (% of GNI*)	_	6.6	11.1			

Note: OECD Economic Outlook 112 projections for 2022-24 with updated annual national account historical data for 2020 and 2021 but not taking into account the quarterly data released on 2 December 2022 for 2022 Q1-Q3.
1. Contributions to changes in real GDP, actual amount in the first column.
2. Excludes those large transactions of foreign corporations that do not have a big impact on the domestic economy.
3. Excludes the factor income of firms that have re-domiciled their headquarters to Ireland, as well as the depreciation of trade in on-shored intellectual property assets, R&D service imports and aircraft owned by aircraft-leasing companies.
4. Harmonised index of consumer prices excluding food, energy, alcohol and tobacco.
5. Includes the one-off impact of recapitalisations in the banking sector.
6. The Maastricht definition of general government debt includes only loans, debt securities, and currency and deposits, with debt at face value rather than market value.
7. Modified current account balance removes a number of globalisation-related distortions, including trade and depreciation of intellectual property assets and aircraft related to leasing along with profits of redomiciled firms.
Source: OECD, Economic Outlook 112 (database) and Central Statistics Office.

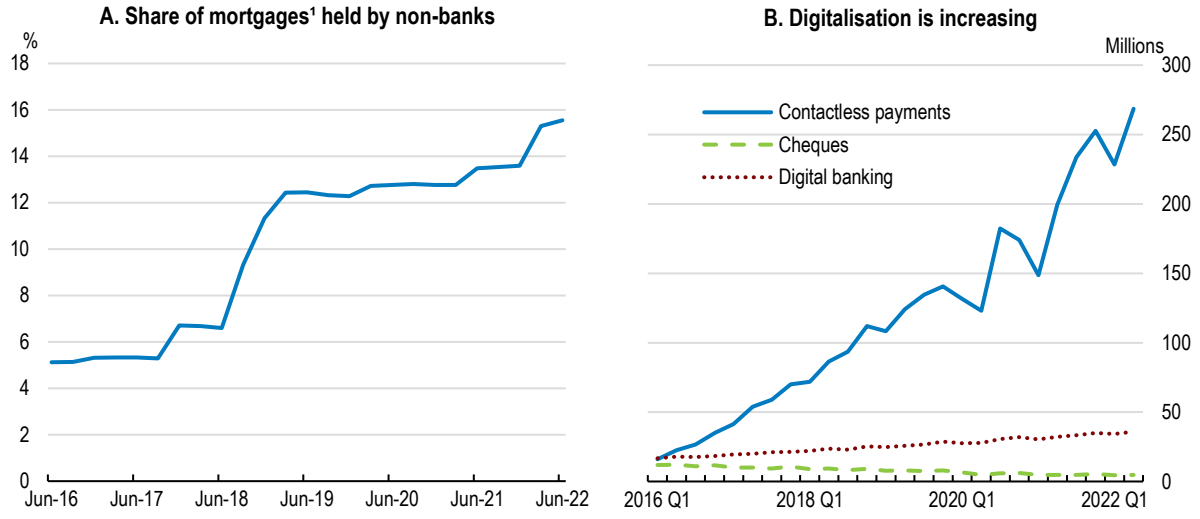
Table 1.3. Low-probability events that could lead to major changes to the forecast

Shock	Likely outcome	Policy response options
Escalating trade tensions	Some exporters could face difficulties in accessing key markets.	Help vulnerable companies identify new market opportunities.
Outbreak of a new vaccine-resistant COVID variant	New waves of vaccine-resistant infections could potentially lead to new lockdown measures, further reducing confidence and lowering domestic consumption.	Monitor health developments closely and continue to encourage vaccination, including booster shots. Keep contingency plans for moving to online work where possible and maintain stocks of personal protective equipment even as infection rates slow.
Cyberattacks could halt operations in the financial sector or in key infrastructure.	Interrupted access to key services could disrupt economic activity.	Work to identify potential weaknesses and how to ensure continuity of service and data security.

1.3. The financial sector is facing legacy and new challenges

The financial sector has withstood the COVID-19 pandemic. Retail banks returned to profitability after the losses incurred during the first year of the pandemic. Credit growth picked up from the lows during the lockdowns, largely driven by non-financial corporate sector borrowing. Non-bank financial institutions are growing in importance (Figure 1.7, Panel A). Non-performing loans on banks' balance sheets have been falling steadily for both businesses and households, partly driven by loan sales to other parts of the financial system. Furthermore, residential mortgages no longer account for the majority of non-performing loans, representing further progress in addressing the legacy of the 2008 burst of the housing bubble. Finally, the COVID-19 pandemic has spurred further digitalisation, with strong growth in the use of digital and contactless means of payment (Panel B).

Figure 1.7. The financial sector is somewhat less dominated by banks and increasingly digital



1. Mortgages for primary residences.
Source: Central Bank of Ireland; and BPFI.

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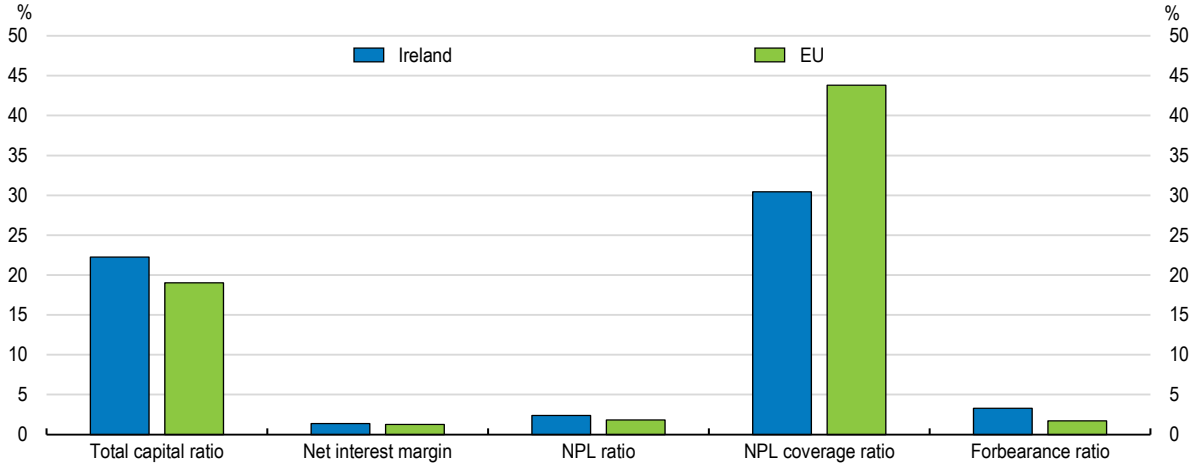
Even so, a number of structural issues remain, some stemming from the legacies of the 2008 global financial crisis. Mortgage arrears are still relatively elevated and non-performing loans in the commercial sector are also above pre-pandemic norms. Borrowing costs are relatively high and retail banks' return on equity is somewhat lower than elsewhere in the European Union. This is partly a reflection of restructuring costs incurred to lower operating costs and diversify income sources. However, capital ratios exceed the EU average (Figure 1.8) and a higher inflation environment may offer opportunities to increase profits.

Retail banks account for around 60% of lending by the banking sector, and the announced withdrawal of two of the five retail banks will increase concentration in the sector, as their businesses are expected to be largely taken over by the remaining three (IMF, 2022a). To some degree, the growing importance of non-bank financial institutions will mitigate the potential reduction in competition. New services are being offered by the recent entrants, such as digital payment services and Irish customers appear to be relatively receptive to innovation. However, these non-bank financial institutions do not offer a full suite of banking services and potentially benefit from an uneven playing field, not being subject to the same regulatory measures. Prudential supervisors need to keep a careful eye on developments, both to protect customers and prevent the build-up of financial risks in the non-bank sector. The Central Bank of Ireland has been taking action to ensure consumer protection. In 2022, it fined two of the large banks around €100 million each over their actions of denying tracker mortgages or not passing decreasing market interest rates onto borrowers with tracker mortgages. In October 2022, the Central Bank of Ireland launched a review of the consumer protection code, which is welcome.

Figure 1.8. Capital ratios are somewhat higher than the EU average
Q2 2022



Note: NPL refer to non-performing loans.
Source: European Banking Authority.

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Macroprudential tools served to support the financial sector during the recent crises. During the pandemic, the Central Bank of Ireland set the countercyclical capital buffer (CCyB) to zero. The institution-specific capital buffers for the systemically important institutions range between 0.5 and 1.5%. The Central Bank of Ireland announced an increase in the CCyB rate to 0.5% in June 2022 (effective from June 2023) and indicated that, depending on the evolution of macro financial conditions, a CCyB rate of 1.5% is expected to be announced by mid-2023. The expected tightening of the countercyclical buffer should be followed through, given the economy's exposure to external shocks.

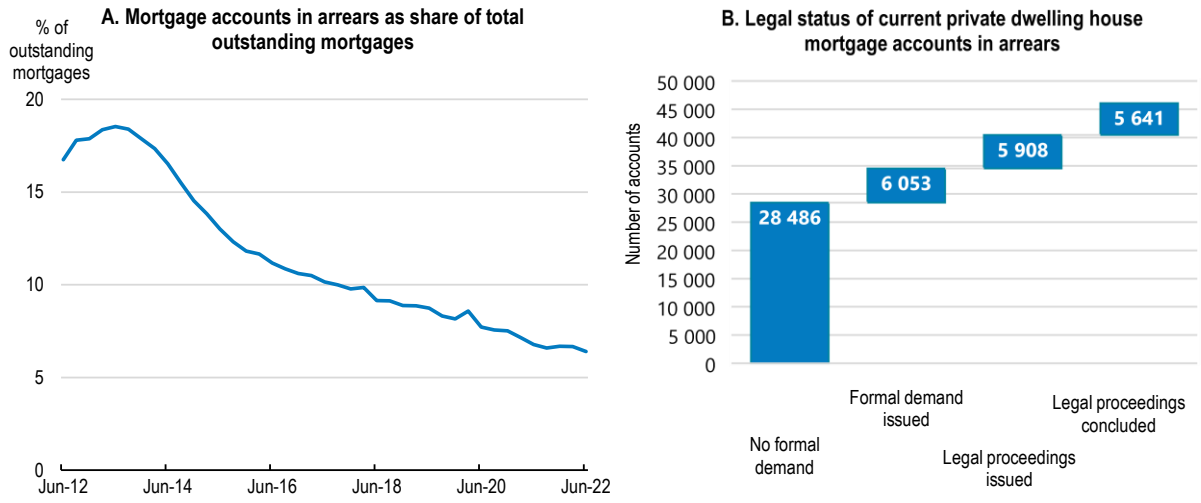
1.3.1. Dealing with mortgage arrears

The ratio of non-performing mortgage loans at 3.6% was higher than the EU average of 1.7% in the first quarter of 2022. Despite a steady decline in recent years, mortgage arrears as a percentage of outstanding mortgages were still around 6.4% in June 2022, concerning about 46 000 principal dwelling houses (Figure 1.9, Panel A). Of these, no formal demand for legal proceedings had been issued for 62% and 1.4% had been restructured (Panel B). Resolving mortgage arrears remains a significant problem. Lenders are required to adhere to the Central Bank of Ireland's Code of Conduct on Mortgage Arrears and follow a Mortgage Arrears Resolution Process. Around 21 000 primary residences have been in arrears for over

two years. About half these were either restructured or the account holder was co-operating with the mortgage holder. Of the remaining, when the account is not co-operating and thereby loses the protection of the Mortgage Arrears Resolution Process, the lender had issued legal proceedings for about one half of the accounts. The ability of banks to enforce collateral is weak and time consuming. The number of homes repossessed by banks when borrowers have been delinquent remains very low. In the second quarter of 2022, just 11 principal dwelling homes and two buy-to-rent houses were repossessed on the basis of a court order. For primary residences, this is notwithstanding 5 641 legal cases having been concluded in the second quarter of 2022 with arrears outstanding. Furthermore, another 5 908 legal cases were in process in the second quarter of 2022, of which around one third had been ongoing for over five years since the first court hearing (Central Bank of Ireland, 2022b), partly reflecting the frequent adjournment of mortgage arrears cases before the courts.

Figure 1.9. Outstanding mortgage arrears are a legacy of the property collapse

Q2 2022



Source: Central Bank of Ireland.

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Addressing these legacy issues will require flexible and innovative policies, given the relatively low repayment capacity of a large number of debtors (Kelly et al., 2021). The *2020 Economic Survey of Ireland* recommended granting creditors a collateral possession order for a future date to speed up non-performing loan resolution. Greater use of the 'suspended' possession order, like in the United Kingdom, could encourage engagement between the borrower and lender by granting lenders a collateral possession order which is suspended for a future date, with the suspension conditional on the borrower complying with well-defined criteria. For example, suspended possession orders in the United Kingdom allow the borrower to remain in the residence while continuing to pay off arrears. If the conditions are not met, the creditors can ask the courts to issue an eviction order. However, care should be taken to avoid unintended consequences, such as encouraging collateral to be run down by debtors.

Besides creating vulnerabilities, low resolution rates of mortgage arrears might be contributing to the low credit supply by banks to private households and small construction firms, with banks favouring lending to real estate investment trusts. At least half of households who rent from a local authority and from the private market are unable to access the credit needed to purchase a property at the median price of a dwelling in Dublin based on current loan-to-income (LTI) mortgage criteria (Government of Ireland, 2021a). Following a review of its 2015 macroprudential framework for mortgage lending, the Central Bank of Ireland relaxed its lending standards in October by raising LTI limits for first-time buyers from 3.5 times of annual gross income to four times and increasing loan-to-value limits for second and subsequent buyers from

80% to 90%. While these changes can help improve affordability in the face of rising interest rates and costs, they can also increase housing demand and prices and financial stability risks. Hence, they should be monitored closely.

The share of new mortgage lending from non-bank lenders has increased from less than 3% in 2018 to 13% in 2021 (Gaffney, Hennessy and McCann, 2022). Non-banks now account for almost one third of new lending in the refinancing and buy-to-let segments of the market. Non-banks have been reducing interest rates more rapidly than banks since 2018, and were charging a lower average rate to first-time buyers than retail banks in 2021 (Central Bank of Ireland, 2022c). Some of these lenders have responded to tighter global financial conditions with increases in interest rates for prospective new mortgage borrowers since the summer of 2022. Rising potential risks from non-bank lending to financial stability should be addressed. The monitoring of non-bank lenders beyond those engaged in mortgage activities should also be expanded (IMF, 2022b).

Non-banks are also playing an active role in the commercial real estate market (CRE), with property funds accounting for nearly 44% of the CRE market (Central Bank of Ireland, 2021a). Given the size of the sector, the impact of widespread forced sales by Irish property funds on the CRE market on financial and macroeconomic stability could be significant. The Central Bank of Ireland has introduced macroprudential measures in the non-bank sector, targeting those Irish-domiciled investment funds with over half their assets in the Irish property market and thus are particularly exposed to domestic real estate shocks. The new measures introduce liquidity timeframe guidance and a leverage limit tailored to these investor funds, with an aim to safeguard the resilience of this growing form of financial intermediation (Central Bank of Ireland, 2022d). Such stronger macroprudential measures for non-banks can help address vulnerabilities posed by those property funds with high levels of leverage and liquidity mismatch. They can also help level the playing field with banks.

1.3.2. Innovation in the financial sector

Fintech is relatively well-developed in Ireland (Ziegler et al., 2021), and is expected to expand further with new advances in technology and increased demand following the pandemic. For SMEs, non-bank lenders account for an estimated 37% of the value of total new lending (Heffernan et al., 2021). Such forms of finance can both introduce competition to the traditional banking sector and provide access to finance for entities that have trouble obtaining credit from traditional banks. Indeed, bank financing has been relatively expensive, particularly for SMEs in Ireland (National Competitiveness and Productivity Council, 2021a). In the context of the government's International Financial Services Strategy *Ireland for Finance*, the Department of Finance established the Fintech Steering Group, and FinTech and digital finance is a priority theme in the 2022 *Update to the Ireland for Finance Strategy.* Enterprise Ireland launched the 'Start in Ireland' portal aimed at supporting entrepreneurs (including Fintech firms) at different stages of development with information for potential, new and existing start-ups (Government of Ireland, 2022a).

While allowing space for innovation to improve access to digital financial services, ensuring resilience and managing risks arising from Fintech are also key. Since many of these lenders rely on market-based funding rather than insured deposits, the resilience of this supply of financing may be more vulnerable to a downturn or higher interest rates and pose legal and administrative challenges for recovery resolution. Since 2018, the Innovation Hub of the Central Bank of Ireland has enabled informal engagement with these lenders about regulations. The Central Bank recently increased its supervision of regulated Fintech institutions, whose number went from low single digits to 40 in the past four years. A letter of supervisory expectations circulated in December 2021, including on regular reporting and establishing risk frameworks and exit strategies, asked for compliance reviews by institutions. However, many financial service providers remain unregulated. Hence, ensuring regulators have the power to obtain relevant information from such providers, as recommended by the *2020 Economic Survey of Ireland,* is also crucial.

Table 1.4. Past OECD recommendations on financial stability and actions taken

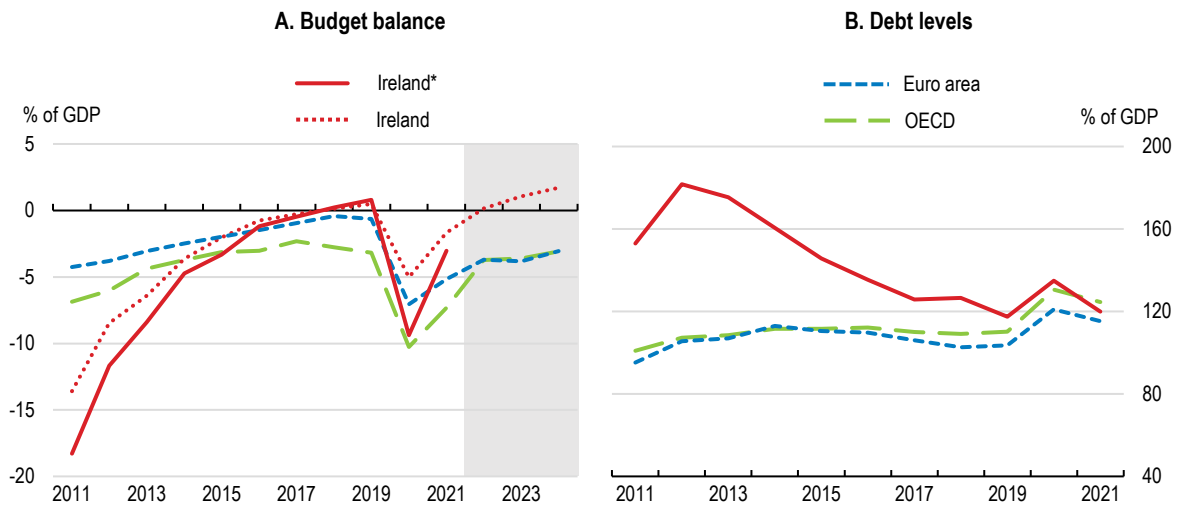
Recommendations in past surveys	Actions taken since 2020
Consider granting lenders a collateral possession order for a future date.	No action taken.
Raise provisioning requirements for non-performing loans, including by implementing new European Union regulations related to provisioning.	EU Regulation 2019/630 on minimum loss coverage for non-performing exposures is implemented in Irish law.
Introduce a systemic risk buffer to boost banks' capital in order to further safeguard financial stability.	In 2020, the Central Bank of Ireland was given powers to set the systemic risk buffer and identify exposures and subsets of institutions to which it applies.
Ensure regulators have the power to obtain relevant information from unregulated financial service providers.	No action taken.

1.4. Ensuring fiscal sustainability is key

1.4.1. The budget position is currently favourable

The economic rebound is helping to repair public finances. The robust interventions in the face of the pandemic pushed up public spending dramatically, causing budget deficits and debt to balloon, albeit by less than the rest of the OECD on average (Figure 1.10). At the same time, revenues surged, particularly personal and corporate income taxes. The budget deficit shrank in 2021 as the boost to exceptional spending - the pandemic unemployment payment and wage subsidy schemes - was wound down. The budget position is projected to return to balance by 2022, thanks to exceptionally high levels of corporation tax receipts. A spending rule, limiting permanent spending increases to 5% per annum (broadly the sum of trend growth of an underlying measure of economic activity assumed to be 3% and the 2% inflation target) over the medium term, was recently introduced, which improves the fiscal framework (Box 1.3).

Figure 1.10. The budget position is projected to return to balance



Note: Ireland* uses GNI* as a denominator instead of GDP. Debt is government gross financial liabilities.
Source: OECD Economic Outlook (database); and Central Statistics Office.

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In September, the government announced a package of one-off measures (€4.4 billion) to cushion the effects of high inflation on households and firms, and budgetary measures for 2023 (€6.9 billion). Budget 2023 implies an increase in the core expenditure growth rate from 8.1% to 9.1% in 2022 and from 5% to 6.3% in 2023, compared to the April Stability Programme (Government of Ireland, 2022b). The announced overall fiscal stance, which aims to balance between providing support and not adding to inflation, is broadly appropriate.

Around half of the announced temporary measures are targeted (Irish Fiscal Advisory Council, 2022a), while some (electricity credits, double child benefit payment, extension of the VAT and excise reductions on fuel, gas, and electricity) remain untargeted, as in many other OECD countries. As surging energy prices represent a terms-of-trade shock, which is arguably permanent given the expected path of fossil fuel prices, economic agents ultimately need to adjust. In this context, cushioning the blow should not become an obstacle to this process, which at the same time represents a potential constraint on fiscal policy if the measures become entrenched. Furthermore, to ensure greater fiscal and environmental sustainability, such measures should be withdrawn or phased out, and additional persistent stimulus to demand should be avoided in the current context of high inflation. Any further fiscal measure, if needed, should be temporary and better target poorer households, particularly in the event of major increases in food prices, keep the impact on domestic activity broadly neutral and be designed not to distort price signals so that incentives for energy savings are maintained.

Box 1.3. Ireland's domestic fiscal framework

As a member of the European Union, the public finances in Ireland are subject to the provisions of the Stability and Growth Pact (SGP). The EU fiscal framework seeks to ensure sound public finances within the Union, avoiding excessive deficits and/or debt levels and encouraging appropriate counter-cyclical fiscal policy. The SGP is a rules-based framework within which Member States' budgetary decisions are made. Ireland's domestic fiscal framework was set out in the Fiscal Responsibility Act 2012, and mirrors the European framework. That same year, the Irish Fiscal Advisory Council was formally established, which assesses the government's forecasts, compliance with fiscal rules and fiscal stance. In 2013, a Medium-term Expenditure Framework introduced three-year government and ministerial expenditure ceilings.

In view of the challenges related to the measurement of both the size and cyclical position of the Irish economy, the Irish Government decided to reinforce the fiscal framework and introduced a domestic expenditure rule in 2021, whereby permanent spending is allowed to increase by 5% per annum (broadly the sum of trend growth of an underlying measure of economic activity assumed to be 3% and the 2% inflation target) over the medium term (Department of Finance, 2021). This rule is designed to meet the dual objectives of expanding public services while maintaining public finances on a sustainable trajectory.

To minimise the risk of relying on volatile and unpredictable receipts to fund permanent increases in expenditure, the Government has also published a new metric, the underlying fiscal balance (GGB*), which excludes estimates of 'excess' corporation tax (CT) receipts, as these are potentially transitory. The Department of Finance uses scenario analyses to quantify the level of 'windfall' receipts, i.e., the amount that cannot be explained by underlying drivers (Department of Finance, 2022). These include, among others, comparing: *i)* the current share of CT receipts with its long-run average share (2000-21) in both total tax receipts and GNI*; *ii)* actual CT receipts to a scenario where CT increased in line with GNI* growth from 2014 onwards (2014 is chosen as it is prior to the level shift in CT receipts in 2015 and preceded, in general, the significant changes in intellectual property on-shoring that have taken place in recent years); and *iii)* CT receipts with a scenario in which CT payments by foreign multinationals increase in line with wages in the foreign-owned sector from 2014 onwards. The spending rule aims to ensure that expenditure policy is decoupled from windfall tax revenues, and in particular from 'excess' corporation tax receipts, in the years ahead.

Source: Department of Finance (2019), *Addressing Fiscal Vulnerabilities*, Dublin; Department of Finance (2022), *De-Risking the Public Finances – Assessing Corporation Tax Receipts,* Dublin; and Department of Finance (2021), *2021 Summer Economic Statement*, Dublin.

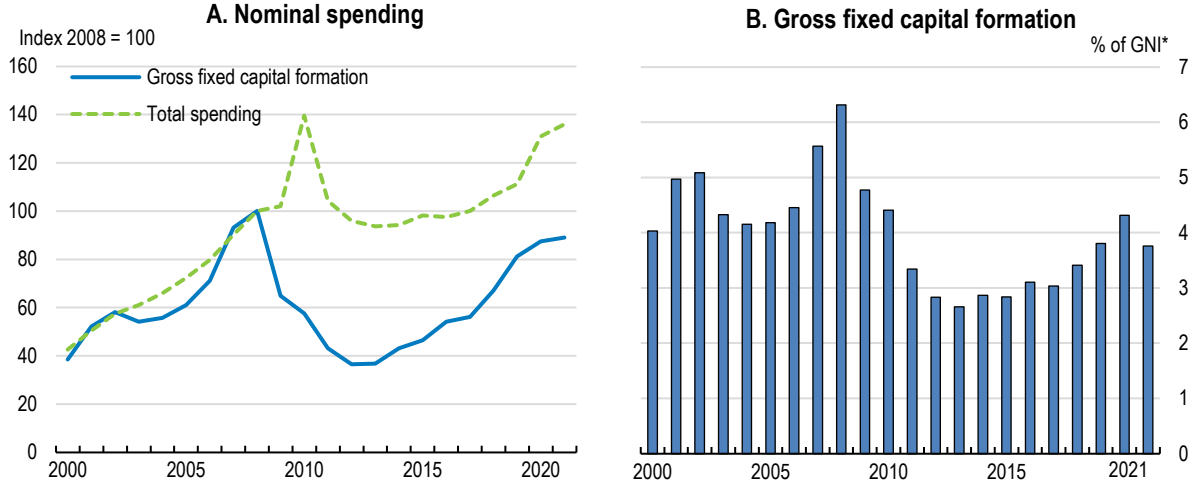
While pressure on spending has increased, revenues have been extraordinarily buoyant. Corporate and personal income tax receipts have soared on the back of surging profits and strong employment and wage growth, and consumption tax revenues also grew strongly. In 2021, total tax revenues rose by 20% over

2020 (more than €11 billion). Corporate taxes amounted to €21.1 billion at the end of November 2022, amounting to an annual increase of €7.6 billion. Government tax revenues are heavily dependent on corporate tax receipts, accounting for over one-fifth of total revenues in 2021 and rising to one fourth in the first half of 2022. The extremely strong export performance of the major multinationals in the pharmaceutical, medical goods and information and communications technologies sectors account for some of the buoyancy. However, this creates a vulnerability to more subdued export performance in the future and a reconfiguration of the location of production and intellectual property in response to changes in the international tax environment. Just ten companies account for about one half of all corporate income tax receipts.

Various estimates suggest that EUR 6 billion to 9 billion of revenues are potentially transitory and could leave Ireland (Irish Fiscal Advisory Council, 2022b; Department of Finance, 2022a). Without these excess (windfall) receipts, the fiscal balance would be a deficit of €8 billion (-3.1% of GNI*), compared to a surplus of €1 billion (0.4% of GNI*) in 2022 (Government of Ireland, 2022b). Against this background, upside revenue surprises should be saved in the National Reserve Fund (so-called Rainy Day Fund, created in 2019, but liquidated due to the pandemic) as a way of reducing reliance on potentially transient forms of income, while preparing for long-term fiscal challenges, rather than facilitating an upward creep of spending. By design, the Fund has caps on yearly and overall contributions of EUR 500 million and EUR 8 billion, respectively. In September, the government announced the replenishing of the fund with €2 billion in 2022 and €4 billion in 2023, which was approved by a resolution by the lower house of Parliament. These caps should be lifted to make the fund more effective, and contributions more automatic and further windfall tax revenues should be continued to be directed to the Fund.

In the past, fiscal policy has been pro-cyclical (Cronin and Mcquinn, 2017). Notably around the 2008 global financial crisis (GFC), the boost in spending before and the sharp retrenchment after the peak were pronounced. As is often the case, the retrenchment in spending was felt more severely in investment (Figure 1.11). Not only does pro-cyclicality increase the amplitude of the shock, but it has longer-term impacts through the curtailment of longer-term spending, particularly investment. Some of the challenges confronting policymakers today, such as housing and healthcare, are a legacy of the need to cut spending too quickly during the GFC. In this regard, while revenues are exceptionally strong, recurrent spending should not be allowed to drift up.

Figure 1.11. Government spending has been quite volatile, particularly public investment



Note: Figures are for public spending and public gross fixed capital formation.
Source: Central Statistical Office.

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The establishment of the Irish Fiscal Advisory Council in 2012 has provided a constraint on fiscal policy and warnings against excessive spending growth during the economic expansion (Bach, 2020; Jonung, Begg and Tutty, 2016). Output gap-based estimates of the structural balance are too uncertain in a small very volatile economy, such as Ireland, to provide a useable anchor for fiscal policy. As such, the move to the recently introduced country-specific spending rule is a pragmatic approach to bring more predictability to fiscal policy. The planned increase in spending to cushion households from high inflation (see above) will temporarily push spending above the new 5% rule. Going forward, it will be important to return to adherence to the new rule as soon as possible to move fiscal policy onto a more predictable stable spending path to reap the full benefits, including greater resilience to future shocks.

The fiscal framework could be further improved to recognise the impact of tax measures, give it legislative status, capture the full range of general government spending, and link it to debt targets (Irish Fiscal Advisory Council, 2022b). The legislative requirement should be considered as it would imply a clearer specification of the rule and could be linked to a "comply or explain" requirement to improve its effectiveness. It will be important to align these with forthcoming changes to EU fiscal rules. Publishing departmental expenditure ceilings would also improve the transparency of the rule (Irish Fiscal Advisory Council, 2021). In addition, longer-horizon medium-term budgets should be prepared. Moreover, it is essential to regularly update and publish the cost of the government's major medium-term commitments discussed below (e.g., achieving climate objectives, implementing the health care reform, Sláintecare, and pensions).

1.4.2. Over the longer run, fiscal pressures will emerge

A number of underlying pressures and recent policy changes combine to create threats to fiscal sustainability in the long run. Substantial spending growth is in store for housing, ageing, health and the energy transition. Moreover, changes in international taxation with the agreement of the OECD/G20 Inclusive Framework on Base Erosion and Profit Shifting in October 2021 may have implications for Ireland's tax revenues since the agreement calls for a higher statutory income tax rate for large firms registered in Ireland.

Pension sustainability

As the population begins to age more rapidly, state pension expenditures are projected to rise from 3.8% of GNI* in 2019 to 7.9% in 2050 and 9.2% in 2070 (Pensions Commission, 2021). Including public sector pensions, pension expenditures would rise from 7.4% of GNI* in 2019 to 12.1% by 2050 (Department of Finance, 2021). Increasing longevity is projected to create an annual shortfall in social security contributions of around €2.4 billion in 2030, which will increase steadily to €13 billion in 2050 (Pensions Commission, 2021).

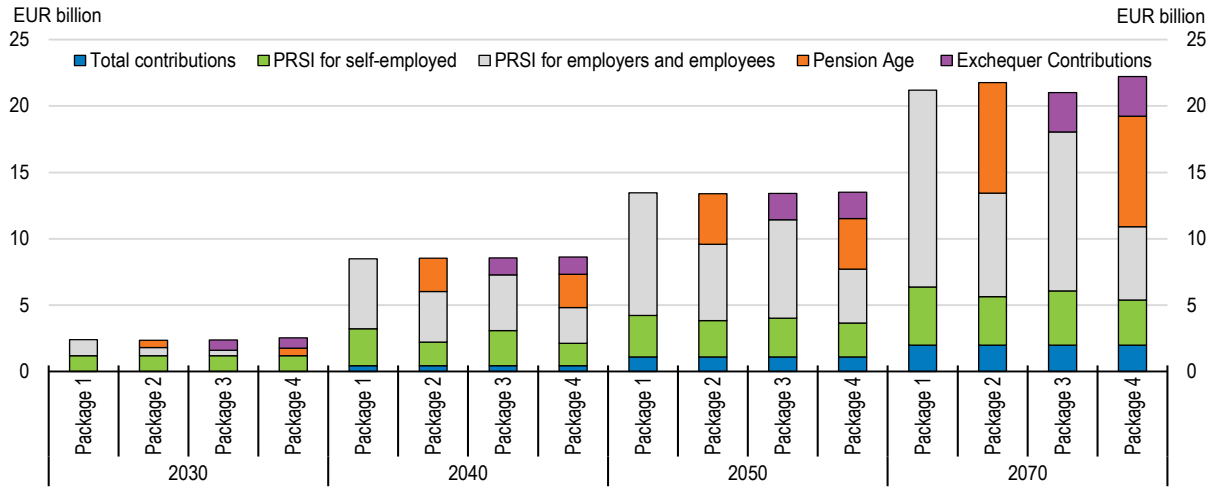
A planned increase in the state pension age, to ensure future sustainability, by one year to 67 at the beginning of 2021 and to 68 in 2028 was repealed. In addition, a pathway to early retirement was opened by the amendment of existing rules for jobseeker benefits for those required to retire under a contract of employment at 65 through the introduction of a new benefit for 65 year olds in 2021 (one year before the state pension age, with a payment matching that of unemployment benefits but without job-search requirements). A 2021 review by the Pensions Commission set out a preferred reform option (Package 4), which includes gradual increases in the pension age from 2028, higher social security contributions for employees, employers and the self-employed, and other unspecified funding sources (mostly likely further tax increases or spending reductions elsewhere) (Figure 1.12).

The pension reform announced in September puts the burden of adjustment on social security contributions (Pay-related Social Insurance) rather than the state pension age, which is kept at 66. The reform provides incentives for those who continue to work beyond 66 to receive a higher pension payment from 2024, moves towards to a total contributions approach to link pension rates to the number of working

years and paid contributions (to be phased in the next 10 years from 2024), and commits to review and adjust the level and rate of increase in social insurance rates every five years. In addition, a number of aspects are designed to improve equity: an enhanced state pension provision for long-term carers from 2024 and a commitment to explore the design of a scheme to provide a benefit payment for people who, following a long working life (40 years or more), are not in a position to remain working in their early 60s. Finally, the reform will introduce measures that allow, but do not compel, an employee to stay in employment until the state pension age, while the Pensions Commission had recommended to avoid setting retirement ages in employment contracts before the state pension age, which could further help close the gap between effective retirement age of 63.6 and the state pension age of 66.

Figure 1.12. Pension reforms should utilise a mix of policy tools

Contributions of policy reforms to projected shortfalls



Note: PRSI refers to pay-related social insurance. All packages include PSRI increases for the self-employed of 4% to 10% initially by 2030, followed by increases of 3.5 percentage point (pp.) by 2040 and 1.1 pp. by 2050 in Package 1, 2.95 pp. by 2040 and 0.15 pp. by 2050 in Package 2, 2.8 pp. by 2040 and 0.9 pp. by 2050 in Package 3, and 2.4 pp. by 2040 and 0.1 pp. by 2050 in Package 4. PSRI increases employers and employees each face are of 0.6 pp. by 2030, 1.6 pp. by 2040 and 1.1 pp. by 2050 in Package 1, 0.3 pp. by 2030, 1.6 pp. by 2040 and 0.15 pp. by 2050 in Package 2, 0.2 pp. by 2030, 1.55 pp. by 2040 and 0.9 pp. by 2050 in Package 3, and no increase by 2030, increases of 1.35 pp. by 2040 and 0.1 pp. by 2050 in Package 4. Packages 2 and 4 include an increase in the state pension age gradually from 2028 to 67 by 2031 and from 2033 to 68 by 2039. Packages 3 and 4 include exchequer contributions of 10% of state pension contributory expenditures.
Source: Pension Commission (2021).

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While some measures are in line with the recommendations of the Pensions Commission, two main concerns and uncertainties remain. First, while some of the reforms, such as the move to a total contributions approach, incentives to work to age 70, and possible increases in the taxation of older individuals, can make the pension system more sustainable, there are no calculations of the fiscal impact of the reform. For example, higher pensions for retiring at age 70 could be cost-neutral, depending on the design (Pensions Commission, 2021). Second, the Pension Commission's report stated that a mix of different measures, including a gradual increase in the state pension age to 67 between 2028 and 2031 and to 68 in 2039, should be part of the policy mix, as using any one of the policy levers by itself to meet the projected shortfalls would require such an extreme change that it would be almost impossible to implement. Keeping the pension age at 66 puts more pressure on the tax system and will increase labour costs. For a worker on a typical annual wage of about €35 000, around €1 800 additional taxes per year would be needed in the coming decades (Irish Fiscal Advisory Council, 2022b). Hence, an increase in the pension age should be part of the reform package.

In the medium term, a more ambitious change to make reforms long-lasting, without a need for constant political negotiations over short-term solutions, would be to adopt an automatic adjustment mechanism, as

some EU countries have (e.g., Denmark, Finland, the Netherlands), to help lower uncertainties affecting financial sustainability. For example, the introduction of an automatic link between the retirement age and life expectancy would lower pension spending by one percentage point of GDP in Ireland in 2070 (European Commission, 2021a).

Health

Along with pension spending, the healthcare sector is a major driver of public spending in the longer term. The impact of ageing is projected to raise health and long-term care spending from around 8.5% of GNI* in 2019 to as much as 13.2% in 2050 (Irish Fiscal Advisory Council, 2020). In the short run, the costs of implementing Sláintecare to reform the healthcare sector by moving away from a largely hospital-based system to one that will better integrate primary, community and long-term care, reducing waiting lists and addressing the legacy of underinvestment (see Chapter 2) are weighing on public finances.

Climate change, housing and infrastructure

The government has committed to meeting a net-zero greenhouse gas emission target by 2050, with an interim target for 2030. The National Development Plan has identified avenues for green investment (e.g., energy efficiency in buildings, sustainable mobility), while around half of the recovery and resilience plan funds are allocated to the green transition (see below). As the government is still elaborating the policies to meet these targets, the full fiscal implications cannot be quantified yet. However, these policies are likely to involve stepping up green public investments and a variety of incentives for households and businesses to take action. The 2021 Climate Action Plan indicates that investment needs of around 2% of GNI* annually would not yield a positive return and by implication require government support or regulation (Government of Ireland, 2021b). Other estimates highlight that the cost of meeting the 2030 targets could be higher if sectors where emission reductions are difficult to achieve in the short to medium run, such as agriculture, are not required to make the same abatement effort. In these conditions, required public spending to achieve much larger cuts in emissions from energy could double (FitzGerald, 2021).

The *Housing for All* Strategy has committed €20 billion over the next five years to address the housing shortage by improving zoning, land availability, and provision of social and affordable housing (see below for details). In addition, spending on infrastructure to meet the greenhouse gas emission reduction targets will require substantial public spending. This includes putting in place the infrastructure to harness the potential for renewable energy and increase the use of electrification in both the transport and residential and commercial buildings. As part of the National Development Plan, the government plans to increase capital spending to 5.4% of GNI* and keep it roughly at that level to address some of the key infrastructure needs. This is about a one percentage point increase from 2020 and if maintained would help limit the pro-cyclicality of investment spending. This would potentially boost output by 0.7 to 0.9% by 2030 (Conroy, Casey and Jordan-Doak, 2021). However, the number of construction workers is constrained and the competing demands of increasing housing supply and climate change mitigation may bid up prices in the sector absent efforts to boost supply.

Taxation of multinational enterprises

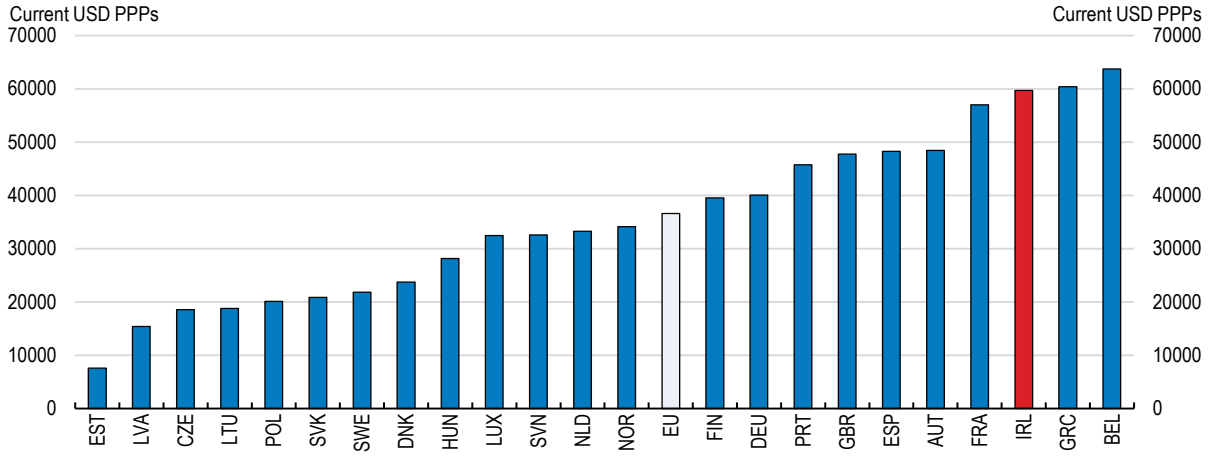
In October 2021, Ireland joined the Inclusive Framework on Base Erosion and Profit Shifting. This will mark a sea change with Ireland obliged to raise its corporate income tax rate from 12.5% to 15%. The current Irish corporate income tax rate was phased in starting in 1996 (there was a special rate for manufactures of 10% and before that, an exports profits tax relief meant the effective rate was 0%). The international tax agreement is set to be implemented in 2023 at the earliest. The revenue consequences are uncertain, but government estimates suggest a revenue loss of around €2 billion compared with business as usual once Pillars 1 and 2 are fully implemented.

Debt sustainability analysis

Debt levels are already elevated, at 100.8% of GNI* in 2021 (as against an EU average of 75.1% of GDP). On a per capita basis, they are quite high compared with other EU countries (Figure 1.13), suggesting limited room for further increases without heightening risks to fiscal resilience. While the short-term outlook for fiscal policy is relatively benign and debt levels are projected to decline, in the longer term, as the various spending and revenue pressures begin to materialise, the picture is more worrying. According to OECD projections, public debt will not stabilise by 2050 without significant reforms (Figure 1.14).

Figure 1.13. Debt on a per capita basis is elevated

Gross government debt per capita, 2021 or latest available data



Note: Data for the United Kingdom refer to 2020.
Source: OECD calculations based on OECD, National Accounts database.

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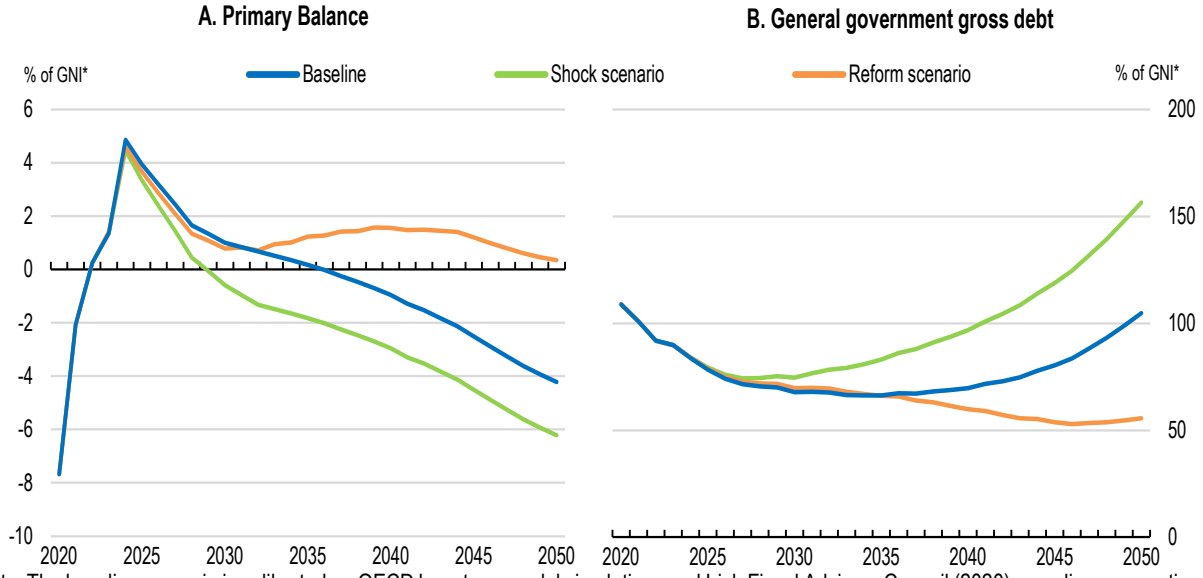
Figure 1.14. Reforms are needed to ensure debt sustainability



Note: The baseline scenario is calibrated on OECD long-term model simulations and Irish Fiscal Advisory Council (2020) spending assumptions, adjusted for recent fiscal outturns. The shock scenario assumes a gradual erosion of tax revenue (€4 billion per annum by 2032, at 2020 constant prices). The reform scenario builds on the shock scenario assuming pension reforms following package 4 proposed by the Pension Commission, an improvement in public sector cost efficiency (mainly in the health sector phasing in 15% gain in spending efficiency over 20 years). All scenarios include ageing costs.
Source: OECD secretariat calculations.

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Table 1.5. Past OECD recommendations on fiscal and pension policies and actions taken

Recommendations in past surveys	Actions taken since 2020
Use windfall corporate tax revenues to pay down general government debt or to further build up the Rainy Day Fund.	As set out in the Programme for Government, windfall gains, such as excess corporation tax receipts, the NAMA surplus and the drawdown of the Rainy Day Fund, have been utilised to reduce the Exchequer borrowing requirement. In September 2022, the government announced the replenishing of the Rainy Day Fund, renamed National Reserve Fund, with €2 billion in 2022 and €4 billion in 2023
Delink the Christmas bonuses of welfare recipients from revenue outturns and systematically include these amounts in government budget plans.	No action taken.
Create domestic fiscal rules based on measured modified gross national income (GNI*) and an estimate of potential output growth that is tailored to the Irish context.	An expenditure rule was introduced in 2021, allowing permanent expenditure to increase in line with the economy's estimated trend growth rate. Tax revenues will be allowed to fluctuate in accordance with the economic cycle without amending the ceiling.
Continue to set, and report progress against, medium-term government debt targets as a share of GNI*.	Recent budget and summer economic statements only reported government debt as a share of GNI*.
Streamline the Value Added Tax system, moving from five rates to three.	Options to streamline the VAT system, including the reduction in the number of VAT rates, are in discussion as part of the Tax Strategy Group papers.
Reassess property values more regularly for the purposes of calculating the local property tax. At the same time, protect those low-income households adversely impacted.	The Finance (Local Property Tax) (Amendment) Act 2021 provides that property valuations will be reviewed every four years, increases the income threshold for tax deferrals and reduces the interest rate on deferred taxes.
Implement the main proposals of the Sláintecare report, establishing a single-tiered health service that provides universal access to primary care.	Progress in 2021 includes additional beds and primary care centres, the new general practitioner's direct access to diagnostics scheme, increased funding for home support, reduction in waiting lists and the establishment of 49 Community Healthcare Networks, 15 specialist teams for older persons and two chronic disease management teams.
Ensure that all legislative requirements for the National Service Plan are fulfilled by the Health Service Executive.	An additional weekly flash reporting sets out a close to real time estimate of the cumulative expenditure on each COVID-19 measure and a monthly working capital report has been instituted by the Health Service Executive to the Department of Health.
Index future increases in the state pension benefit to inflation. Implement the planned increase in the state pension age to 68 by 2027 and link changes to life expectancy thereafter.	In September 2020, the government announced that a smoothed earnings method to calculate a benchmarked/indexed rate of State pension payments would be introduced as an input to the annual budget process from 2023. The legislative provisions for increasing the State Pension Age were repealed in the Social Welfare Act 2020 and are not part of the pension reform announced in September 2022.

1.5. Labour and product markets meeting the economy's needs

The national recovery and resilience plan (Box 1.4) includes a number of initiatives which can improve employment (boosting digital skills and improving active labour market policies for jobseekers) and productivity growth of domestic firms (supporting their digitalisation, reducing barriers to investment, such as regulatory barriers to entrepreneurship, housing affordability and skill shortages). According to calculations by the European Commission, not including the impact of structural reforms, the plan can lift Ireland's GDP by 0.3-0.5% by 2026 and create 6 200 additional jobs (European Commission, 2021b). Ireland also published an Economic Recovery Plan in 2021, which among other initiatives, aims to create 50 000 additional training places by 2025 to boost employment (Government of Ireland, 2021c). Box 1.5 quantifies the potential impact of some of the structural reforms discussed in this Survey.

Box 1.4. Ireland's recovery and resilience plan

Ireland's recovery and resilience plan (€989 million in grants, 0.3% of 2019 GDP) includes 25 measures (16 investments and 9 reforms) and is structured around three axes:

1. Green transition (52.4%): to encourage a shift from private cars to rail transport, promote energy efficiency in residential and public buildings and businesses, and support bio-diversity (restoration and rehabilitation of wetlands to change land use from peat extraction to carbon sequestration).
2. Digitalisation (29.4%): to support the digitalisation of the public sector, especially the healthcare system, the digitalisation of SMEs and the promotion of digital skills (e.g. provide connectivity and ICT equipment to disadvantaged learners in schools).
3. Social and economic recovery and job creation: to support access to the labour market and upskilling of workers with a focus on green and digital skills, boost the quality of higher education (e.g. new education and training programmes in technological universities, regional innovation hubs) and lifelong learning, to increase the supply of social and affordable housing and support the fight against money laundering.

Source: Government of Ireland (2021d), *National Recovery and Resilience Plan*, Dublin.

1.5.1. Boosting employment and labour mobility

Labour force participation at around 80% (for those aged 25-64) is above the OECD average and well above the rates prevailing in the 1990s. Following the pandemic, participation rates increased for many groups, such as female, young and older workers, likely reflecting cyclical factors, tight labour markets and remote working, but they remain low for those with lower educational attainment. At the same time, job vacancies remain high at 1.5%, but lower than the EU average of 2.9%. According to an October 2021 survey, difficult-to-fill vacancies were high in life sciences, information technology, construction, health and financial activities (SOLAS, 2021). Skill mismatches play a role as do disincentives embedded in the tax and benefit system and in some cases barriers to geographical mobility, although the rise of remote work could help the latter (SOLAS, 2022). Addressing these issues would help raise participation and for some groups reduce the incidence of poverty.

Changes in the structure of the economy after the pandemic could complicate labour force attachment as sectors that often serve as pathways into employment, such as the hospitality sector, may slim down. Other uncertainties include the extent to which international migration contributes to labour force growth in the future. Ukrainian refugees can help alleviate some labour shortages if they are well integrated into Irish labour markets. Around 64% of them are of working age (aged 20-64), of which 68% are women. Ireland has provided them with work rights, access to housing and health, social welfare payments where appropriate, as well as vocational training and job assistance to speed up their integration (OECD, 2022a). However, the employment rate of refugees remains low at 14.8% so far, with language as the main barrier to labour market entry.

Box 1.5. Potential impact of reforms on growth and the fiscal balance

Table 1.6 broadly illustrates the growth impact of some key structural reforms proposed in this Survey. The fiscal impacts presented in Table 1.7 do not take into account indirect effects, such as those induced by the positive impact of the reforms on growth and public revenues, and some recommendations are not quantifiable.

Table 1.6. Potential impact of selected proposed reforms on GDP per capita

Policy		10 year effect
Improve the business environment (Section 1.5.2)	Improve the OECD PMR indicator by 0.2% to the average of the quartile of countries with the most competition-friendly competition policy settings.	1.5%
Address remaining gaps in corruption (Section 1.5.2)	Improve the institutional framework conditions (rule of law) by 0.1% to the OECD average.	1.4%
Increase training and employment (Section 1.5.2)	Increase ALMP spending per unemployed as a % of GDP per capita by 0.6% to the OECD average	0.9%
Total		**3.8%**

Note: These estimates are illustrative. The impact on the level of GDP per capita is estimated using historical relationships between reforms and growth in OECD countries. The model does not capture policy-induced changes in deep-rooted preferences like risk aversion and their subsequent effects on economic variables. These numbers are similar to those in the *2020 Economic Survey of Ireland*.
Source: OECD calculations based on (Égert and Gal, 2017).

Table 1.7. Illustrative direct fiscal impact of selected recommended reforms

Reform	Medium-term fiscal impact (savings (+)/ costs (-)) (% of GDP)
Improve health spending efficiency (Chapter 2)	+1%
Support to new training programmes (Section 1.5.2)	-0.6%

Note: The policies are to: *i)* close half the gap of current health spending as a share of GNI* in Ireland with the OECD average health spending as a share of GDP; and *ii)* increase ALMP spending per unemployed as a % of GDP per capita by 0.6% to the OECD average.
Source: OECD calculations.

Providing the skills needed

Ireland is nearing the end of a 10 year skills strategy in 2025 to create a well-trained and skilled labour force capable of responding to the needs of the economy. An OECD Skills Strategy project is currently assessing how the strategy might need to be adapted to ensure that it is still fit for purpose (OECD, forthcoming). The evolution of the economy in recent years has shown growing demand in some sectors, not least construction more recently, but also in high-tech activities. The implications of the Climate Action Plan dictate that some sectors of the economy will diminish in importance and workers will need to change jobs, pointing to the importance of helping workers acquire new skills and find new employment opportunities. Hence, the focus of the recovery plan on strengthening access to training, particularly for digital skills, is welcome.

The public employment services have been given more resources and reorganised to help workers into employment more effectively. Greater use of digitalisation during the pandemic has allowed online interactions, which a majority of jobseekers prefer and helps tailor programmes to the individual. Online meetings have also facilitated interactions with a broader range of potential employers. As an emergency response to COVID-19 pandemic, eligibility for online further education and training programmes (e.g., e-College) were extended. In the construction sector, training efforts are carried out with employers and targeting the skills in short demand and aiming to bring greater innovation into the sector. Since 2016, 41 new ones have been added to the existing 25 more traditional craft apprenticeships, including one in the healthcare sector, and Budget 2023 includes additional support for craft apprenticeship programmes. Whereas in the past apprenticeships were mainly taken up by males, the take-up is now more gender-

balanced. The developments in job search and training are laudable and should be evaluated over time to ensure they do contribute to better job outcomes and the best use of public funds. This can inform the elaboration of the next national skills strategy. Innovative training, however, should not become a barrier to entry, for example by creating occupational licensing.

Boosting female labour force participation

Ireland has made significant progress in increasing female labour force participation rates after the pandemic, but there is still room for improvement. Female labour force participation surpassed pre-pandemic levels (56%), reaching an all-time high of 60% in the final quarter of 2021, but has declined slightly to 59.1% in the third quarter of 2022. This improvement was particularly in sectors less affected by COVID-19, possibly driven by the use of remote work insofar as women are more likely to work from home. Hence, facilitating flexible work arrangements and opportunities to telework, including through investment in digital infrastructure, could yield further gains. Various policies to expand quality childcare capacity and affordability introduced in recent years have also played a role. The National Childcare Scheme was expanded with increased subsidised hours and eligibility for subsidies and the allowance of subsidies to be used for after-school care. A €221 million new scheme for core funding for early learning and care and school age childcare was introduced in 2022. Budget 2023 increases the childcare hourly universal subsidy from 50 cents to €1.40. Continuing to provide adequate public financial support for childcare and measures to expand childcare capacity is key.

Reducing disincentives to participate

The tax and benefit system can present disincentives to participate or participate more fully. Effective marginal tax rates can be quite high at different income thresholds. The Irish tax and benefit system contains a number of “cliff edges” where tax liabilities jump or benefit entitlements suddenly fall when income exceeds a certain level, creating strong disincentives to increase income beyond these levels (Browne et al., 2018). For example, such cliff-edges and step-effects arise when earnings surpass the liability threshold for pay-related social insurance (at €352 per week) and universal social charge (at €13 000 per year), and when working more than three days a week on low levels of pay, leaving individuals ineligible for a partial jobseekers allowance payment (Commission on Welfare and Taxation, 2022). The income threshold to qualify for social housing, in relation to the high cost of housing, can also limit labour market participation or hours worked. In addition, the medical card (which exempts families from fees for medical services) is withdrawn when family income exceeds a certain amount (OECD, 2020a).

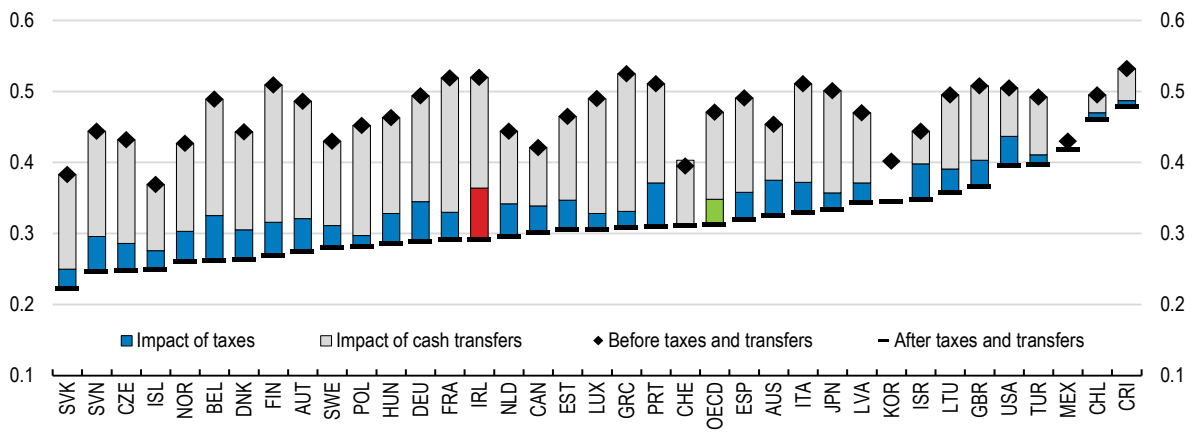
Reforms to the tax and benefit scheme, should nonetheless bear in mind the impact on equity. The tax and transfer system has a relatively strong redistributive impact (Figure 1.15). However, the flip side of this is that the tax base is very narrow, with almost one-in-three workers paying little or no income tax in 2021, and the bottom 50% of taxpayers contributing just 4% to the overall income tax take (Department of Finance, 2022b and 2022c). If corporate income tax revenues decline, reconsidering the personal income tax base will acquire increasing saliency. The exclusion of large numbers of individuals from the personal tax system should be reconsidered to broaden tax bases and remove cliff-edge effects (Commission on Welfare and Taxation, 2022). The government has committed to develop a medium-term roadmap for personal taxation reform by Summer 2023. The Irish Fiscal Advisory Council has highlighted the need to improve data to quantify the Commission’s proposals, calculating that, based on the proposals they are able to quantify, tax revenues as a share of GNI* could increase by 5.3 percentage points (Casey, 2022; IFAC, 2022c). In this context, introducing more tax bands and rates would smooth the progressiveness of income taxes at lower incomes and prevent income threshold effects that create disincentives to work. These should be combined with means-tested cash transfers for the low-income households to prevent any undesired impact of spreading the tax burden more broadly.

Facilitating mobility

Housing policies can hinder workers' geographical mobility. Residential mobility rates within countries, defined as the percentage of individuals that changed residence within five years, at around 20%, is slightly above the OECD average, but much lower than 30-40% in Australia and Nordic countries (Causa and Pichelmann, 2020). The homeownership rate at around 70% in Ireland is around the OECD average of 71.5%. Homeownership is often associated with a higher cost of moving than renting. The lack of available rental housing in major cities is creating difficulties for the recruitment of workers, including newly qualified nurses. Tenants of social housing are also less likely to move residence than private-sector renters. Evidence from across OECD countries suggests that cash housing allowances tend to mitigate some of the impact of housing support on mobility (Causa and Pichelmann, 2020). However, this needs to be balanced with the effect of cash transfers/housing vouchers on prices when supply is not forthcoming. The *Housing for All* Strategy that encourages homeownership through a shared-equity scheme to help purchase a newly built property for first-time buyers (discussed below), might exacerbate labour mobility challenges. Reducing policy-driven barriers to housing supply, for example reforming poorly designed land-use and planning policies, may facilitate moving (see below).

Figure 1.15. Household income inequality is relatively low

Household income distribution, Gini coefficient[1], 2019 or latest available year



1. Scale from 0 ("perfect equality") to 1 ("perfect inequality").
Source: OECD, Income Distribution database (IDD).

StatLink https://stat.link/6qil8k

1.5.2. Improving the business environment

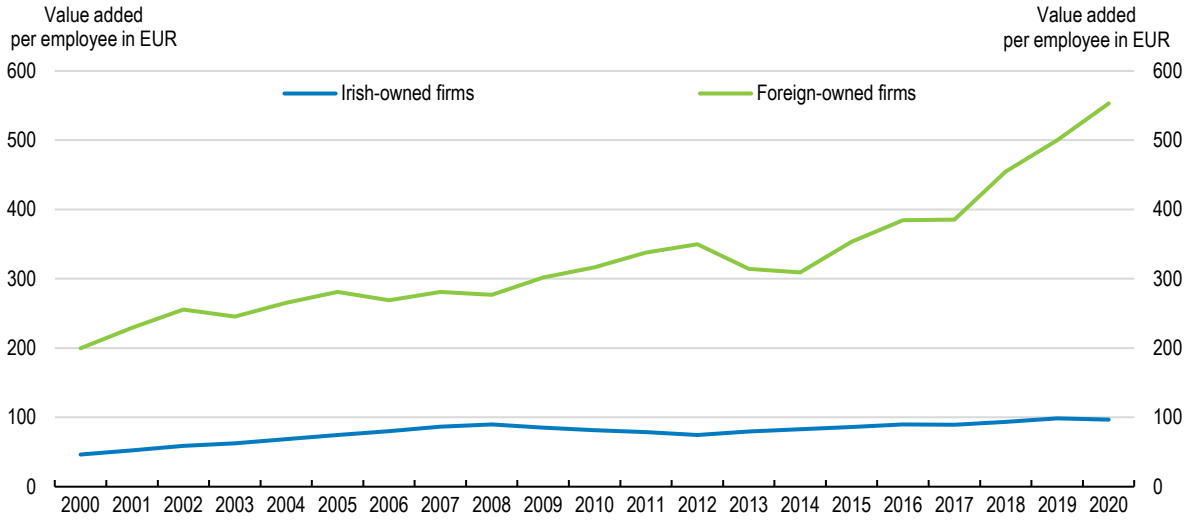
Increasing SME productivity

Business dynamism and the start-up rate are relatively low in Ireland. In 2020, Ireland's enterprise birth rate of 6.7% was lower than the European average of 8.9%. In addition, new firm-level research suggests that convergence in productivity levels of new entrants towards the level of incumbents is driven by the exit of the lowest productivity entrants rather than a broad-based catch-up across surviving entrant firms (Lawless and Rehill, 2022). Following a sharp decline of 30.4% in the second quarter of 2020, new company registrations recovered swiftly (National Competitiveness and Productivity Council, 2021b). Irish SMEs are innovative, but they are not very active in international markets (OECD, 2019). While the 2018 OECD product market regulations indicators show that the regulatory burden in Irish product markets is close to the OECD average, regulatory burdens on start-ups are relatively high, driven mainly by complex regulatory procedures and the system for licences and permissions. Ireland's recovery plan will introduce the SME test, asking policy makers to consider the potential burden any proposed regulations or legislation

places on SMEs, which is expected to help lower regulatory obstacles to SME growth. Linking other existing licensing portals to the Integrated Licence Application Service and requiring licensing authorities without online procedures to participate would also help. The recovery plan states that a single SME portal, with an aim to reduce the administrative burden on SMEs, is under consideration. This is a welcome initiative and should be implemented as soon as feasible.

The productivity gap between foreign and domestic firms and sectors remains large (Figure 1.16). The labour productivity of domestic companies increased on average by 0.7% per annum between 2011 and 2020, well below that of multinationals, which increased by 9.4%. The different trajectories during the pandemic suggest that the differences widened even further. Supporting closer economic links between foreign-owned firms and SMEs across and within industries via trade linkages, labour mobility and innovation cooperation could help raise productivity levels of SMEs. SMEs also lag in some digital respects, such as enterprise resource planning and customer relationship management, which will become increasingly important with the digital transformation. The recovery plan includes measures to support the digitalisation of SMEs, such as the establishment of Irish European digital innovation hubs. The creation of clusters could also help bridge the productivity gap.

Figure 1.16. Labour productivity of local firms remains low



Source: Department of Enterprise, Trade and Employment, Annual Business Survey of Economic Impact 2020 Report.

StatLink https://stat.link/mo2v5e

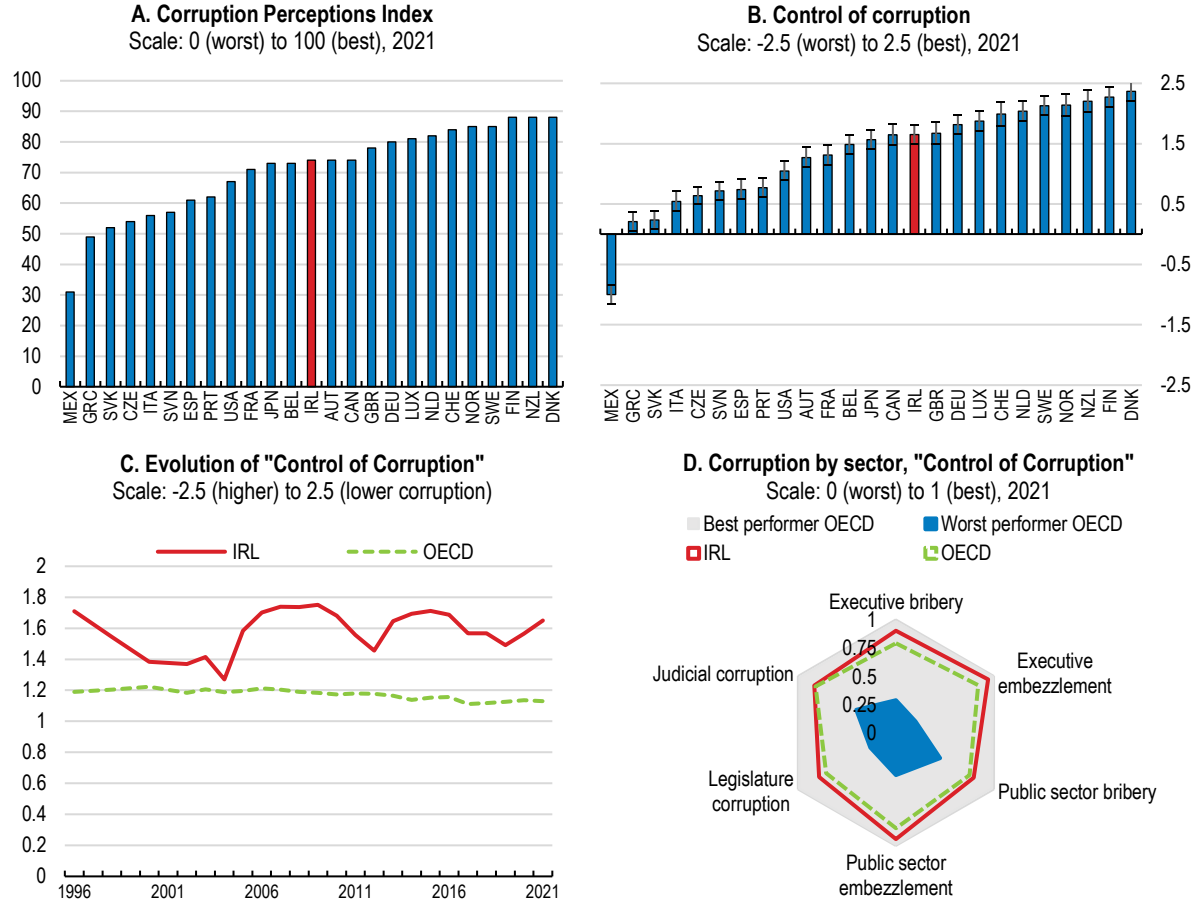
Fighting corruption

Indicators of perceived risks of corruption in the public sector suggest Ireland ranks in the middle of the OECD (Figure 1.17, Panel A), though it is better placed on the control of corruption (Panels B-D). However, Ireland's performance remains relatively poor in comparison to European Nordic countries or other small and open OECD economies, like New Zealand and Switzerland. According to a European Commission survey, 59% of Irish citizens consider that corruption is widespread, against an EU average of 68% (European Commission, 2022a). Similarly, 60% of Irish citizens think corruption is part of the country's business culture, broadly in line with the EU average, and only 42% would know where to report a possible case of corruption, were they to experience or witness one, as against 46% of EU citizens.

The government is overhauling the criminal legislative framework to counter corruption more effectively. Following the 2018 consolidation of bribery and corruption laws, which made failure to report violations to authorities a criminal offence, an in-depth review of anti-corruption and anti-fraud criminal justice enforcement was launched (European Commission, 2021c). Completed at end-2020, the assessment resulted in a set of recommendations that were later streamlined into an implementation plan focussed

primarily on legislative, structural and resourcing measures. The selected recommendations included the establishment of a cross-sectoral Advisory Council supporting the government's strategic and policy decisions on economic crime and corruption, together with a formal forum of senior representatives from relevant bodies, to enhance inter-agency coordination and information sharing (Department of Justice, 2020). The forum has met regularly since June 2021 and the establishment of the Advisory Council was completed in May 2022. Additional support to anti-corruption policy should come from the introduction of a new bid-rigging cartel offence and the strengthening of the Competition and Consumer Protection Commission's investigative powers, as recommended in the above review, but not yet implemented.

Figure 1.17. Ireland is not among the best performers in addressing corruption



Note: Panel B shows the point estimate and the margin of error. Panel D shows sector-based subcomponents of the "Control of Corruption" indicator by the Varieties of Democracy Project.
Source: World Bank; Transparency International; Varieties of Democracy Institute; University of Gothenburg, and University of Notre Dame.
StatLink https://stat.link/y068ki

Resources devoted to investigating and prosecuting economic crimes and corruption have risen only gradually. This weighed on investigative effectiveness due to the growing number of cases detected and handled. In particular, lack of access to adequate technology enabling the examination of large amounts of multi-sourced electronic data delayed investigations of the Garda Anti-Corruption Unit, recently established within the National Economic Crime Bureau (European Commission, 2021c). At the same time, initiatives are being taken to ease barriers to access justice, namely through increased efforts to tackle high litigation costs and lengthy court proceedings, and to promote the digitalisation of justice (European Commission, 2022a).

Ireland's regulatory framework for public sector ethics is complex and fragmented. Forthcoming legislative reform proposals are expected to consolidate divergent national- and local-level rules governing the disclosure of interests, assets and donations, as well as the imposition of sanctions, which fuelled uncertainty on their actual application, resulting in a perceived lack of penalties for civil servants breaching ethical requirements (Department of Public Expenditure and Reform, 2021). This is to be complemented by an overhaul of oversight structures and enhanced streamlining of declaration proceedings. Assigning greater powers and resources to the Standards in Public Office Commission would improve its effectiveness in pursuing compliance with codes of conduct and monitoring irregularities.

Amendments to the 2014 Protected Disclosures Act, approved in July 2022, could help ensure more effective tackling of corruption. The new rules – implementing a 2019 EU Directive – are set to extend whistleblower protection beyond standard workers, to include volunteers, unpaid trainees, job applicants, as well as shareholders and board members. Additionally, they will require private organisations with at least 50 employees to set up procedures for protected disclosures and relative feedback, whilst smaller entities will be temporarily exempted from implementation in light of the relatively high compliance costs (Department of Public Expenditure and Reform, 2022a). At the same time, by identifying the unauthorised disclosure of a whistleblower's identity as a criminal offence, together with any retaliatory proceeding or attempt to hinder a person from reporting, the new legislation will improve whistleblower's protection versus employers, strengthening incentives to report corruption cases.

Implementation of the OECD Anti-Bribery Convention has progressed, but some issues remain pending, namely with reference to the liability of legal persons and the width of the 'foreign official' definition (Department of Justice, 2020). Efforts to extend mutual legal assistance with non-EU countries, either through designations under the law or treaties, should continue.

Table 1.8. Past OECD recommendations on labour markets and productivity and actions taken

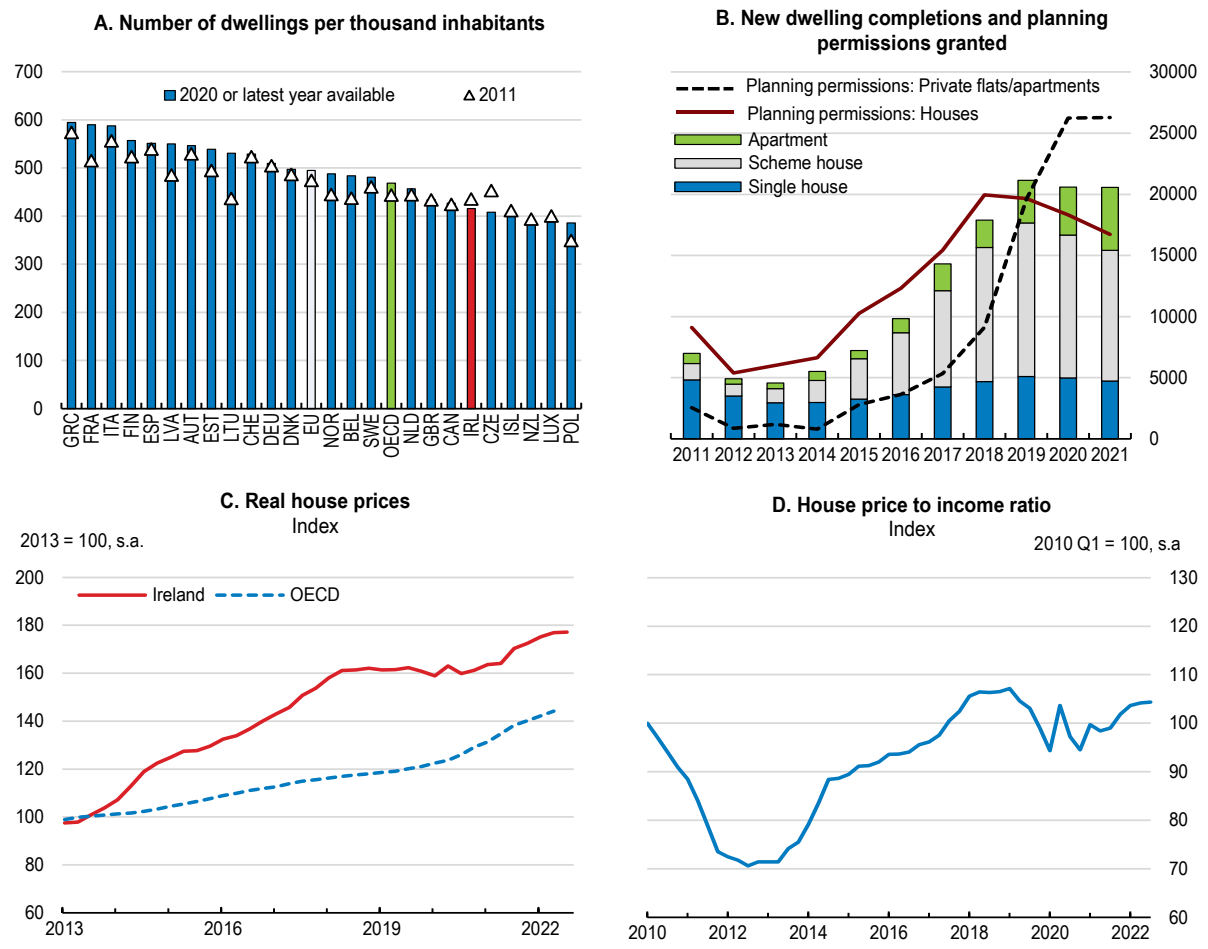
Recommendations in past surveys	Actions taken since 2020
Monitor business licensing requirements and the systems that facilitate them, including by linking more licensing procedures with the Integrated License Application Service.	No action taken.
More actively establish and promote distance learning programmes.	In response to the pandemic, eligibility for online training programmes (e.g., eCollege) was extended to the public, from a previous system where they could only be accessed by referral from those on the live register.
Couple adequate public financial support for childcare with measures to expand childcare capacity.	The National Childcare Scheme was expanded with increased subsidised hours and eligibility for subsidies and the allowance of subsidies to be used for after-school care. A €221 million new scheme for core funding for early learning and care and school age childcare was introduced in 2022. Budget 2023 increases the childcare hourly universal subsidy from 50 cents to €1.40.
Require those freelance platform workers who are effectively dependent employees to pay a Pay-Related Social Insurance premium equivalent to that paid by dependent employees and introduce an employer contribution.	No action taken.
Prioritise implementation of the EU Directive 2019/1152 to extend the coverage of minimum standards for workers and cost-free training to all forms of dependent employment.	Work is ongoing to transpose the Directive, but has been delayed from the deadline of August 2022.
Give the Irish Competition and Consumer Protection Commission adequate enforcement powers to fight anti-competitive behaviour, including the capacity to impose sufficient penalties on competition law infringements to ensure a deterrent effect.	The Competition (Amendment) Act 2022 expands the Competition and Consumer Protection Commission's powers to fine firms for breaches of competition law and encourage whistleblowing on cartels.
Introduce the "digital postbox" system and develop new digital government services that improve citizens' interactions with public administration.	The digital postbox is in early pilot stage with initial users.

1.6. Affordable housing is a major challenge

1.6.1. Rising housing prices create affordability concerns

More than a decade of underinvestment following the 2008 property market crash has decreased the housing stock per capita. Between 2009 and 2017, Ireland's total estimated housing stock grew by only 35 000 units, while the population grew by 263 000. The number of dwellings per 1000 inhabitants decreased from 436 in 2011 to 416 in 2019, against an average increase from 444 to 468 in the OECD (Figure 1.18, Panel A). The composition of the housing stock is also insufficient to meet the increased demand for rental apartments. After increasing by 40% annually between 2017 and 2019, lockdowns due to the pandemic limited the number of annual dwelling completions in 2020-21 (Panel B). Construction activity picked up after the re-opening of the economy. The number of housing commencements increased substantially and the number of new home completions for the first three quarters of 2022 was 20 807, but the gap between supply and demand remains large. The government estimates net additional housing needs to be around 33 000 per year to 2030, with 14 000 around the Greater Dublin Area.

Figure 1.18. Housing markets face price and supply pressures

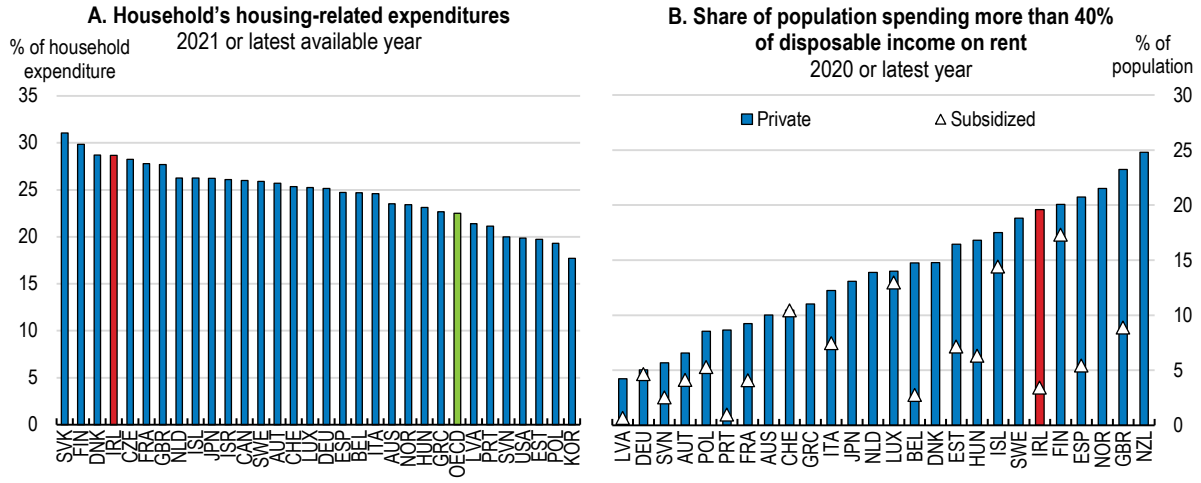


Note: In Panel A, refer to statlink for details on country-year coverage. In Panel B, scheme house refers to houses that form part of a multi-unit development of two or more houses connected to a single Electricity Supply Board network. In Panel D, price-to-income ratio refers to nominal house prices divided by nominal disposable income (household disposable income after taxes and transfers divided by population) per person.
Source: OECD, Affordable Housing database; Central Statistics Office; OECD, Analytical House Price Indicators; and OECD, National Accounts database.

StatLink https://stat.link/fwi9e1

Real house prices and the ratio of house prices to income have been increasing (Figure 1.18, Panels C-D). Real house prices increased by 4% year-on-year in the third quarter of 2022. Housing affordability is a long-standing challenge, with relatively high housing-related costs as a share of total household costs at 25.6%, compared to the OECD average of 22.6%, and a relatively high share of population spending more than 40% of their disposable income on private rents (Figure 1.19). With persistent housing shortages, house prices have outpaced household income, worsening housing affordability, especially for low-income tenants and homebuyers around Dublin. The number of years of gross disposable income required by an average household to buy a 100 square meter dwelling is 16.3 in 2021, among the highest in the EU (European Commission, 2022b). Budget 2023 allocates €6.2 billion to support housing supply and affordability, including measures on rents (e.g., a €500 income tax credit for renters) and social housing.

Figure 1.19. Housing affordability is a concern



Note: In Panel A, data represent the relative share of housing-related expenditures, namely, housing, water, electricity, gas and other fuels, in households' final consumption expenditure, based on National Accounts. Detailed methodological note can be found at Housing Affordability indicators - OECD. In Panel B, due to data limitations, tenants at subsidised rates are included into the private market rent category in the Netherlands, Denmark, New Zealand and Sweden. Detailed methodological note can be found at Housing costs over income - OECD.
Source: OECD, National Accounts database; and OECD, Affordable Housing database.

StatLink https://stat.link/ihkagq

1.6.2. The Housing for All Strategy is ambitious, but near-term effects might be limited

A 2021 spending review of housing policies identified a number of trends and issues (Government of Ireland, 2021a). These include the increase in house prices, driven by high construction costs, speculative land hoarding by landowners and developers restricting the supply of development land, and related low affordability, and pro-cyclicality of publicly provided funding support to housing, with the slowdown of social housing development during recessionary periods undermining the long-term and timely supply of social housing. In addition, urbanisation and changes in household formation (smaller units) have shifted the demand to smaller rental housing. While this has driven growth of private institutional investors in the rental market, supply remains low.

Fragmented approaches to housing reforms in the past have failed to deliver a big enough response to these structural problems. The ambitious *Housing for All* Strategy (Box 1.6), which includes improving zoning, planning, land availability, and provision of social housing, has an overall target of 300 000 new homes by 2030, including 54 000 affordable homes (new buildings for purchase or rent). The strategy considers the economic and social consequences of a systemic all-government policy approach, which is welcome, but it will take time to deliver significant results. It will be important to prioritise supply-side measures as policies that stimulate demand further given the existing supply-demand imbalances could increase price pressures in the near term.

Box 1.6. Housing for All

In September 2021, the government introduced the *Housing for All* Strategy (around €20 billion over the next five years) with four main objectives: *i)* supporting homeownership and increasing affordability; *ii)* eradicating homelessness, increasing social housing delivery and supporting social inclusion; *iii)* increasing new housing supply; and *iv)* addressing vacancies and efficient use of existing stock.

In addition to the pledge to support the building of more than 300 000 new dwellings by 2030, the plan includes measures aimed at increasing the delivery of affordable homes to either purchase or rent at subsidised prices, providing more social housing, simplifying planning legislation, increasing funding for land acquisitions and infrastructure spending by local authorities, enhancing land value sharing mechanisms, introducing urban development zones and a new tax aimed at activating vacant land for residential purposes. It also introduces a national affordable purchase shared-equity "First Home" scheme for newly-built homes in private developments (maximum of 8 000 by 2026), a local authority led affordable purchase scheme (28 000 by 2030) and a new form of tenure (Cost rental), with rents at least 25% below market level and a target of 18 000 homes by 2030.

Source: Government of Ireland (2021e), *Housing for All - a New Housing Plan for Ireland*, Dublin.

Housing for All adds the "First Home" affordable purchase shared-equity scheme to help purchase a newly built property to the existing schemes for first-time buyers: the "Help-to-Buy" incentive, which provides a tax refund of up to 10% of the purchase price under certain conditions, and the "Local Authority Home Loan" scheme providing lower cost mortgages to first-home buyers who are unable to obtain funding in the mortgage market. The "First Home" scheme, jointly supported by the state and participating mortgage lenders, aims to bridge the gap for eligible purchasers between their combined deposit and mortgage, and the price of the new home. Under the scheme, the equity facility can be up to 30% of the house value (maximum 20% if also using Help-to-Buy incentive), and will be junior to the mortgage from the participating lending institution (i.e., absorb losses before the mortgage in case of borrower default). A household-specific income limit (the assessment is based on the maximum mortgage available to the applicant household falling short of the amount required to purchase the home), and region-based house price caps (ranging between €250 000 and €500 000) apply. While the Central Bank of Ireland has amended mortgage measures to clarify the participation of retail banks in the shared-equity scheme, it recommends a regular review of the scheme and adjustment, if needed (De Búrca, Kelly and O'Brien, 2021).

While the impact of the plan on supply will take time in terms of delivery and for the effects to feed through to prices, the different schemes to support first-time buyers have the potential to increase price pressures in the short run in a supply-constrained market. For example, a help-to-buy scheme in the United Kingdom, while delivering some benefits in some areas (Box 1.7), was not effective in supply-constrained areas. A recent evaluation of the Irish "Help-to-Buy" scheme found that the scheme was poorly targeted (Department of Finance, 2022d), but given the current economic situation, it was extended another two years with Budget 2023, suggesting that such schemes might be hard to withdraw once introduced. Hence, stimulating demand further given the existing supply-demand imbalances should be carefully considered. The "First Home" scheme should continue to be kept narrowly targeted and limited in size. Establishing reporting mechanisms and evaluation procedures to assess the impact of this sequencing of the rollout of demand and supply side policies is key.

Box 1.7. The Help-to-Buy scheme in England

The Help-to-Buy scheme, introduced in 2013, provides an equity loan up to 20% (40% in London). It is wholly state-funded and the equity loan is repayable after a maximum of 25 years or on the sale of the property. The proportion of the scheme in total housing transactions has increased from around 4% in 2015 to 6.5% in 2020, reaching 8% in London.

A number of evaluations suggest that the scheme has resulted in substitution rather than additionality in mortgage markets (Benetton et al., 2019). A 2020 evaluation found that while it increased homeownership and house construction, around three-fifths of buyers could have bought a property without the support of the scheme (National Audit Office, 2019). The scheme boosted construction without affecting prices in some locations, but in areas with severe long-run supply constraints, such as London, it increased house prices with little impact on construction volumes and aggregate mortgage lending (Carozzi, Hilber and Yu, 2020).

1.6.3. Addressing supply constraints is key

High construction costs, labour and skill shortages, complex regulations, cumbersome judicial reviews delaying construction projects, the underuse of publicly-owned land for residential construction, as well as complex and restrictive rent legislation, which limit buy-to-rent properties coming onto the market, constrain housing supply.

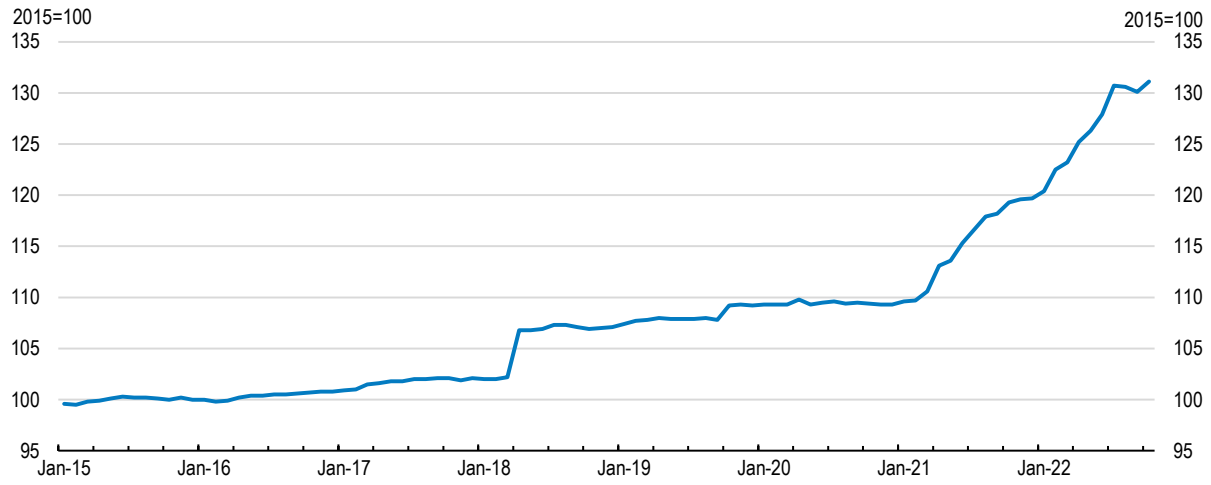
The rising cost of housing construction may affect the cost-effectiveness of planned spending increases on housing and delay the delivery of the relevant plans (Figure 1.20). The cost of building and construction materials, which had increased by only 1.2% per year on average since 2016, increased by 21% in July 2022 from a year earlier, reaching 47% for steel and reinforcing metal. Brexit (given that Ireland is dependent on the United Kingdom for some materials), and the war in Ukraine exacerbating supply bottlenecks are pushing up construction costs further this year. A Sector Employment Order, which came into effect in February 2022, sets relatively high statutory minimum rates of pay and other conditions for workers in the construction sector. This may boost the supply of labour, but can also add to costs. An ongoing residential construction cost study and the statutory register established for construction providers in 2022 can help. On the other hand, the 5% levy on certain concrete products introduced in Budget 2023 could be passed on to future residents of newly built properties, which may impact housing affordability.

The relatively low productivity of the construction sector in international perspective contributes to high construction costs (Russell et al., 2021; Department of Public Expenditure and Reform, 2020). The *Housing for All* Strategy aims to improve innovation and productivity of the residential construction sector. A modern methods of construction (MMC) leadership and integration group has been established to bring together different stakeholders, and a number of initiatives to spread the use of MMC in residential construction are in progress (Built to Innovate, which extends Enterprise Ireland's innovation and productivity schemes to domestically-focused construction firms, and a Demonstration Park for MMC). A Construction Technology Centre to increase industry-academic collaboration has been established, and the Foreign Direct Investment Agency (IDA Ireland) is working on attracting more international construction firms to boost capacity. The Construction Sector group facilitates regular open dialogue between the government and the construction sector to increase efficiency and digital adoption. These efforts should be continued, and be frontloaded, especially given the added constraint of labour shortages in the sector. Incentivising the use of rigorous planning processes and modular and prefabricated solutions as well as investments in digital technology and advance automation via public procurement can also boost productivity in the sector (McKinsey, 2017).

Availability of skilled staff is the most common cited barrier to investment in the construction sector, followed by regulations (European Investment Bank, 2021), and job vacancies in the construction and real estate sectors have increased since 2016. This partly reflects the fact that non-Irish workers in construction (40 700 at the peak in 2007) have left, and the number of individuals entering construction-related education and apprenticeships has been small since the property bust (Tedin and Faubert, 2020), even though it rose in 2021. The *Housing for All* targets imply an estimated rise of total labour demand from housing construction from approximately 40 000 full-time equivalent workers now to 67 500 by the middle of the decade, with the total demand peaking at just over 80 000 towards the end of the decade (Expert Group on Future Skill Needs, 2021). To address the gaps, A Build Digital Project to support digital skills, new apprenticeship opportunities and a campaign targeted at school leavers to build up capacity in the sector are envisaged, but there will be a lag to deliver results. In 2022, the Future Building Initiative was launched to facilitate the matching of employers' vacancies to jobseekers seeking employment, which is welcome.

Figure 1.20. High construction costs constrain housing supply

Industrial Price Index (Excluding VAT), building and construction materials and wages



Source: Central Statistics Office.

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Using publicly-owned land for residential construction may improve housing affordability. The State is often one of the major landowners of undeveloped land. In 2018, publicly-owned land was estimated to have capacity for the development of over 50 000 housing units, which could be utilised for social or affordable housing (NESC, 2018). *Housing for All* tasked the Land Development Agency to develop and regenerate relevant public land for housing, which will largely be made available for affordable and social housing. Part of these developments should increase the supply of smaller apartments rather than the traditional larger houses.

Using public land to increase apartment supply can complement the Croí Cónaithe (Cities) Scheme, a fund to support the building of apartments for sale in big cities (target of 5 000 apartments up to 2025). Around 12% of dwellings in Ireland are apartments, compared with around half in the European Union, even though over half of Irish households include just one or two people. In 2021, only around one fifth of apartments with planning permissions was completed, in contrast to the completion of almost all houses with permissions. It is important that appropriately-sized dwellings in the right locations are built to match demand and to ensure that firms in cities can attract skilled labour from within and outside Ireland.

Housing developments are also subject to planning and permitting delays, and often to legal challenge. A survey of residential developers found that 40% set aside 11-15 months to receive permission and 42% allow at least 16 months, while 61% expect an additional 12 months for appeals and judicial reviews

(National Competitiveness and Productivity Council, 2022). The 2021 Planning and Development (Large Scale Residential Development) Act introduced mandatory timelines to speed up the process for large developments (100 housing units or more and student accommodations comprising of 200 or more bed spaces). The streamlining of planning and judicial review processes should be prioritised. The Attorney General is currently conducting a review of the planning code, with a view to facilitate greater clarity and long-term visibility in planning outcomes. It is expected that the review will propose the establishment of a new division of the High Court for planning and environmental issues, and wider reforms to reduce the number of judicial reviews, which would be welcome.

The new planning system also gives back the primary decision-making to the local level, while the *An Bord Pleanála (Board)*, Ireland's national independent planning, will be in charge of appeals. The aim is to increase transparency and public participation and reduce the number of judicial review applications, but international evidence suggests that a high degree of decentralisation can result in more restrictive land-use policy settings (OECD, 2021a). Furthermore, a number of reviews in 2021-22 have highlighted the insufficient resourcing of the planning departments of local authorities (National Competitiveness and Productivity Council, 2022). Hence, it will be important to ensure that local planning offices are adequately resourced with staff and expertise to prevent delays in the approval process for housing and other critical social and physical infrastructure.

There are also some concerns that the prioritisation of housing over other social and physical infrastructure (healthcare, education, water, electricity, etc.) could delay planning permissions in these areas (National Competitiveness and Productivity Council, 2021a). Such infrastructural deficits can indirectly affect housing. For example, almost 25 000 homes in Dublin were on hold in the last quarter of 2021 due to a lack of water supply (Government of Ireland, 2022c), which mostly reflects the complex planning processes. The planned introduction of a serviced land tax and a land value sharing mechanism to strengthen links between housing investment and complementary infrastructure development can help.

A vacant site levy was introduced to increase land availability and reduce land inflation. Since 2019, the levy was 7% of the market value of the land (up from 3% in 2018), and paid to the local authority each year. It had some limited impact in supporting land development. In April 2019, 360 vacant sites were registered, 162 of them in Dublin, with many local authorities citing barriers to the implementation of the levy due to difficulties in interpreting the law and identifying vacant sites and their ownership, and the lack of resources for administering the levy. Eight out of 31 local authorities still did not have an active register in the third quarter of 2020, and in the period between January and October 2020, a total of around €1.2 million was collected, mostly in Dublin. This has highlighted the need for a more centralised approach and clarity to minimise administrative costs.

Budget 2023 provided an update on the implementation of a Residential Zoned Land Tax (3% rate), announced in Budget 2022, to replace the vacant site levy, as recommended in the *2018 and 2020 OECD Economic Surveys of Ireland,* and the Commission on Welfare and Taxation. The tax will be administered by revenue commissioners, which should lower administrative costs for local authorities. It should have broader scope than the existing vacant site levy, as it will apply to all lands zoned and serviced for housing that are mapped and in scope. However, the applied rate is only 3%, as against the 7% previous levy, which could limit its effectiveness. The government has committed to evaluate the rate and adjust it, if needed, which should be followed through. The replacement will have a two (three) year lead-in-time for land zoned before (after) January 2022, due to the need for a large-scale mapping exercise, which is currently being rolled out, with the draft maps published in November.

1.6.4. Policies to boost rental supply and stabilise rent costs could have unintended consequences

Macroprudential measures have helped curb house price inflation in the owner-occupied sector since 2018, but prices in the rental sector continued growing to levels well above those prior the 2008 crisis. Rents for new tenancies in the first quarter of 2022 were 9.2% higher than a year ago (Residential Tenancies Board, 2022a), with a higher increase outside of Dublin. Rental supply has reached historic lows, partly reflecting greater recourse to remote work. The number of newly registered tenancies has declined on a year-on-year basis by 32% in the first quarter of 2022. The share of notices of termination due to owners selling the property more than tripled in the second quarter of 2022 compared to the last quarter of 2019 (RTB, 2022b), and the number of private, largely small-scale landlords in the private rental sector has declined, with many properties becoming owner-occupied (Central Bank of Ireland, 2021b).

A number of policies over the past decade might have had unintended consequences in terms of limiting rental supply. The ban on bedsit accommodation (one bedroom and shared cooking facilities), which came into effect in 2013, aimed to prevent the use of inadequate dwellings for modern habitation in terms of heating and sanitation. However, it had adverse implications for some low-income tenants in city centres, increasing homelessness, and created extra demand and price pressures for other segments. Tax allowances for accommodation, such as the “Section 23 relief”, allowing investors to offset rental income against the cost of the property, less its site value, contributed to excess supply of housing in rural areas during the construction boom, but also improved supply in cities. While the withdrawal of these tax allowances in 2008 helped improve public finances and removed the associated negative externalities (Government of Ireland, 2022c), it might have restricted supply in the short run. One side effect of these tax allowances was that unlike in the rest of Europe, where institutional investors play a central role in the provision of rental accommodation, those investors were effectively priced out by the tax break, for which they could not qualify (Lyons, 2021).

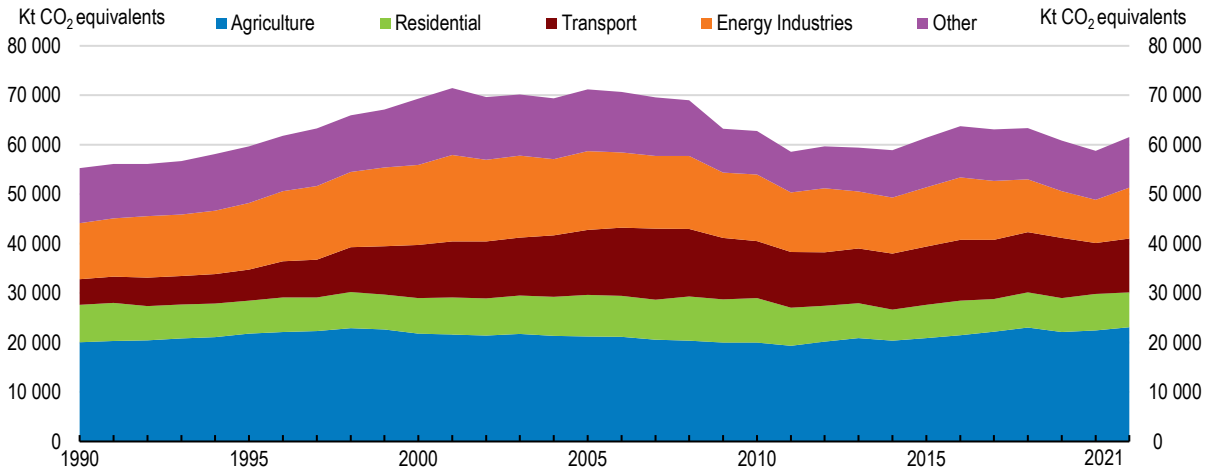
In an attempt to limit the rate of rent inflation, price controls were introduced in December 2016, which limited the rate of increase in rents to 4% per year in areas designated as Rent Pressure Zones (RPZs), which was decreased to 2% per year, with the 2021 Residential Tenancies (Amendment) Act. According to a 2019 evaluation, the rate of price inflation across all RPZs fell from just over 9% for the seven quarters before the regulations to just under 6.4% in the seven quarters since, while there was no change in non-RPZ areas (Ahrens, Martinez-Cillero and O'Toole, 2019). However, the effect in Cork, Dublin and the surrounding areas was less significant. Rental price caps can change investment dynamics and behaviour of buyers and sellers. While providing short-term alleviation to sitting tenants in terms of price increases, rent controls impose price rigidities that may have a detrimental effect on the quality and quantity of supply in the medium to long term (OECD, 2020b). Together with high sale prices, rent controls in RPZs and a more complicated compliance framework might be driving the decreasing number of tenancies registered, with mainly small landlords leaving the rental market (European Commission, 2022b). Other ongoing initiatives to help renters include the Cost Rental Equity Loan mechanism to deliver 750 cost rental homes in 2023, and the rent tax credit valued at €500 per renter per year, which is expected to reach 400 000 people in rental accommodation.

Reducing the complexity and restrictiveness of rent legislation may increase the number of buy-to-let properties coming onto the market. According to a recent survey, the main factors influencing buy-to-let properties coming onto the market are rental legislation, landlords coming out of negative equity and low returns (SCSI, 2021). Growing interest in build-to-let by institutional investors has helped contain the decrease in rental stock. International institutional capital has become a major source of finance for residential property developments, making 80% of annual residential investment between 2017 and 2019 (Lyons, 2021).

1.7. Lowering greenhouse gas emissions

Ireland has relatively high emissions of greenhouse gas, somewhat larger than the OECD average in 2020 (11.6 and 10.6 tonnes of CO_2 equivalents per capita, respectively). Greenhouse gas emissions peaked in the early 2000s (Figure 1.21), and while generally on a downward path since then, they have risen again recently, with emissions increasing by 4.7% in 2021 compared to 2020, to 1.1% above 2019 levels (EPA, 2022). At a sectoral level, emissions in energy industries and industrial processes have decreased substantially since the mid-2000s. Limiting emissions from the agriculture and transport sectors (36% and 18% of total greenhouse gas emissions, respectively, in 2020) remains challenging.

Figure 1.21. Greenhouse gas emissions remain above 1990 levels



Source: Environmental Protection Agency.

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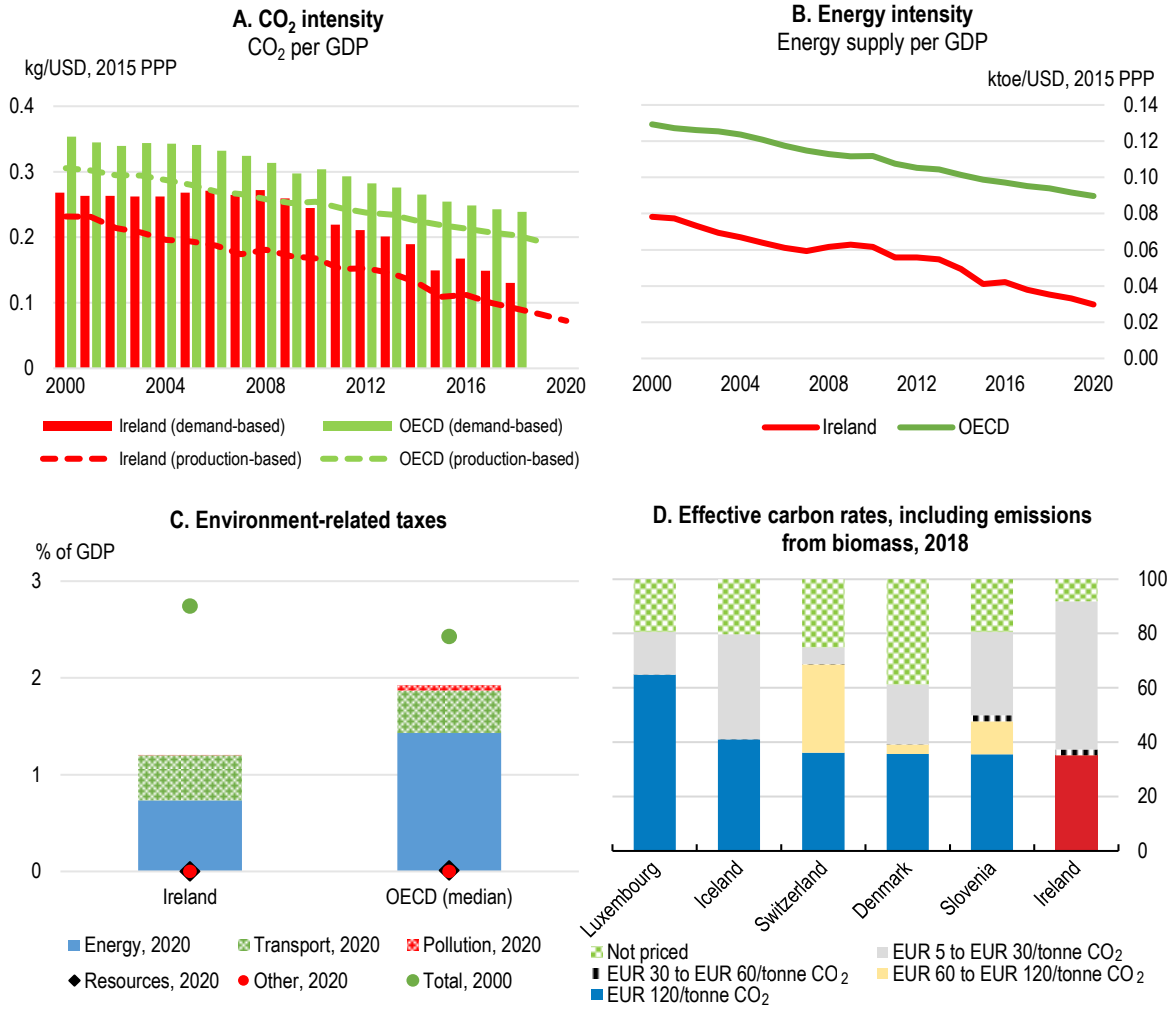
While greenhouse gas emissions have decoupled from economic growth and energy intensity declined (Figure 1.22, Panels A-B), strong population and economic growth with limited abatement in agriculture and transport has hindered meeting emission reduction targets. Around one quarter of Ireland's greenhouse gas emissions are covered by the European Union Emission Trading System. Greenhouse gas emissions outside the emission trading system exceeded the target of a 20% reduction under the EU's Effort Sharing Decision and the government will need to buy emission credits to ensure compliance. Furthermore, emission projections suggest that Ireland will also fail to meet the 2030 target under the EU's Effort Sharing Regulation, without additional measures.

Against this background, the government is laying out the legislative basis to strengthen climate change policy. The 2021 Climate Action and Low Carbon Development Act commits to achieve net zero greenhouse gas emissions by 2050**.** To reinforce this commitment, Parliament enshrined into law a binding interim target to reduce emissions by 51% (relative to 2018 levels) by 2030. In order to meet this interim target, emissions should decrease at an average annual rate of 7% up to 2030, which highlights the ambitious nature of the most recent climate objectives, given that comparable reductions have only occurred around major economic downturns. As noted earlier, achieving these goals will require major investments, whose benefits have increased further with high energy prices. The Climate Action Advisory Council considers that delaying emission reductions will increase the costs of mitigation, and that buying credits may lock in current technologies (Climate Change Advisory Council, 2021).

Meeting the 2030 and 2050 emission reduction targets will be challenging (Figure 1.23). Environment related taxes are relatively low (Figure 1.22, Panels C-D). The tax on carbon has been increasing. Even faced with inflationary pressures, Budget 2023 includes a €7.5 increase to €48.5, and the tax rate will rise

gradually annually to €100 by 2030. The sequenced increase in the carbon tax rate is expected to reduce emissions (and GDP). Offsetting some of the distributional consequences will require means to recycle these revenues to vulnerable households. Evidence from a number of OECD countries suggests that such policies appear necessary for households to support abatement (Dechezleprêtre et al., 2022). Hence, it is welcome that the government has committed to use these revenues for retrofitting, welfare supports for vulnerable households, and green agriculture initiatives, to be implemented in each budget (Department of Public Expenditure and Reform, 2022b).

Figure 1.22. Environmental taxes are relatively low



Note: Panel A includes CO_2 emissions from combustion of coal, oil, natural gas and other fuels. Gross Domestic Product (GDP) is expressed at constant 2015 USD using PPP.
Source: OECD, Green Growth Indicators.

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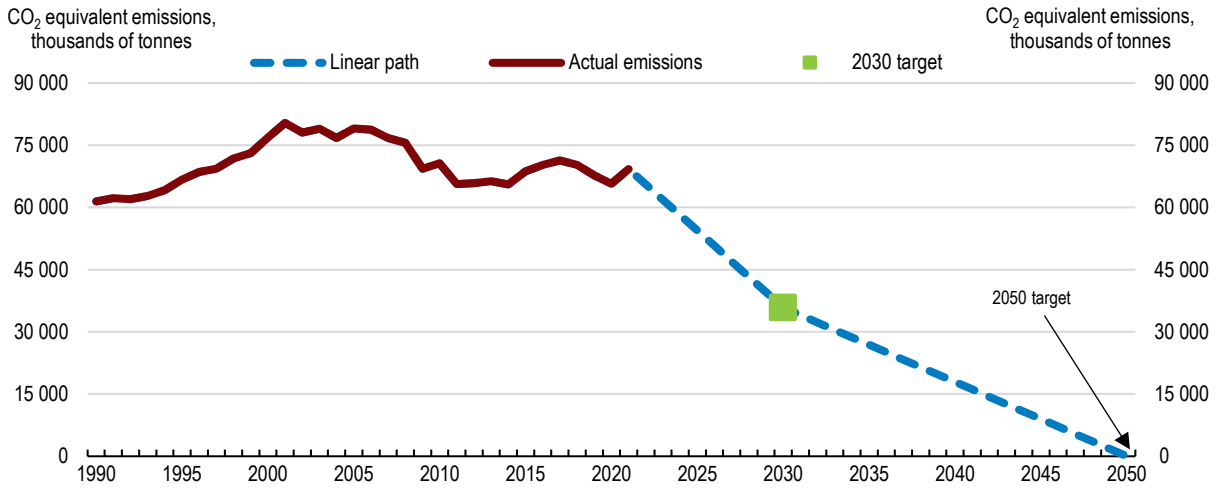
A major plank of abatement policy is the establishment of carbon budgets and sectoral emissions ceilings to apply to different sectors of the economy. Parliament adopted its first carbon budget programme in April 2022, underpinned by sectoral Climate Action Plans. The carbon budgets set the path of reductions required over five-year periods to meet the greenhouse gas emission targets. These are then distributed to different sectors of the economy, reflecting the estimated opportunities for them to reduce their emissions. The sectoral ceilings were set in July 2022, ranging from targeted reductions in emissions of 75% in electricity to 25% in agriculture by 2030 (Government of Ireland, 2022d). These ceilings depend on the possible abatement costs, such that sectors where emission reductions are difficult in the short run

face less demanding targets than others. In this way, there is some burden sharing across sectors. However, this approach may not harmonise marginal abatement costs and increase the overall costs of mitigation. The Climate Action Advisory Council has stated that there is a need to clarify consistency of these ceilings with the carbon budgets and include the land use sector as soon as possible (Climate Action Advisory Council, 2022).

Figure 1.23. Emission reduction targets are challenging



Note: Greenhouse gas emissions including land use, land-use change and forestry (LULUCF). The linear path is the interpolated path to the emission reduction targets relative to 2018 levels for 2030 (-51%) and 2050 (net zero emissions) as stated in the 2021 Climate Action Plan.
Source: Environmental Protection Agency and OECD secretariat calculations.

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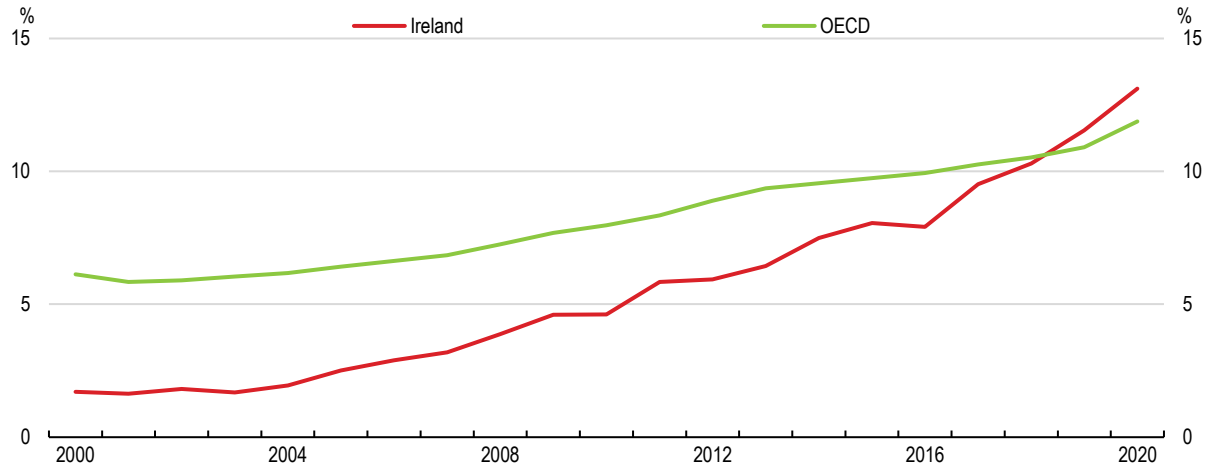
1.7.1. Increasing the contribution of renewables

Emission reductions in the power generation sector are key to obtain overall emission reductions and would also improve energy security in the current context of heightened energy supply uncertainty. The share of renewables in electricity generation has risen and more carbon-intensive forms of electricity generation have declined in importance (Figure 1.24). Renewables accounted for 13.5% of energy consumption in 2020 – below the 16% EU Renewable Energy Directive target – and 40% of electricity production. The Climate Action Plan targets a substantial boost to around 70-80% of electricity generated by renewables in 2030 to contribute to a 60-80% reduction in greenhouse gas emissions from the electricity sector compared to 2018. Meeting this target will require major new investment in generation capacity - both onshore and offshore wind turbines - as well as the associated infrastructure.

The investment in new capacity is complicated. Integrating more intermittent supply requires complementary investment to ensure security and continuity of supply. This includes sufficient transmission capacity and the ability to balance supply and demand across the network. Investment in these network facilities and the wind turbines themselves face potentially long and uncertain lead times to obtain planning permissions and then overcome judicial reviews. A major project can expect to take three to four years in planning and permitting and then in judicial review before construction work commences. As such, installing network capacity in time to meet the 2030 intermediate emission reduction target is difficult in the current planning framework. Measures to expedite the process and stop unwarranted barriers derailing investment projects are likely needed to ensure sufficient capacity is installed in time. The planning reform programme, due to be finalised at the end of 2022, should be implemented as a matter of urgency to help streamline and simplify the planning and judicial review process.

Figure 1.24. Renewable energy use has risen

Share of renewables in primary energy supply



Source: OECD, Green Growth Indicators.

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1.7.2. Greening transport

Transport accounts for around one fifth of greenhouse gas emissions, with emissions having risen since the early 1990s. The 2021 Climate Action Plan targeted a massive shift from internal combustion engine vehicles to around one million electric vehicles (passenger cars and light commercial vehicles) by 2030. Around 20 000 passenger electric vehicles (battery-powered and plug-in hybrid electric vehicles) were registered in 2021. The current subsidies for electric vehicles are expensive and take-up has been limited, although rising more recently. The subsidies have tended to be regressive in that generally wealthier households purchased the new electric vehicles eligible for the grant offered by the Sustainable Energy Authority of Ireland. In reaction, the subsidies have been capped and restricted to lower-cost vehicles more recently. Continuing to support private passenger car dependency has additional drawbacks with congestion around the major urban areas a major issue. Cities across the OECD have adopted a suite of measures, including congestion charging, increasing the price of parking or reducing its availability, and changing roads to alternative use. Congestion charges in Ireland could help reduce the associated social costs, including the impact on health.

Reducing reliance on privately-owned passenger cars and providing alternatives should be prioritised. This includes providing the infrastructure for low or no carbon transport. The 2022 National Sustainable Mobility Policy, which runs to 2030, aims to move towards greener transport that is better integrated and facilitating a variety of mobility options for individuals (including walking, cycling, micro-transport, on-demand and high-occupancy shared transport and public transport). These goals should be prioritised and guide the redefinition of Ireland's electrification strategy (OECD, 2022b). Greening transport in this direction requires work in several areas, including street redesign, spatial planning that is focused on increasing proximity, and support for shared mobility (OECD, 2021b). Efforts to communicate to people the benefits of sustainable transport systems are also key. The combined effects of encouraging switching away from internal combustion engines, including by reflecting the social and environmental costs, and providing viable lower or no emission alternatives will help meet the ambitious emission reductions in the transport sector.

1.7.3. Emission reductions in businesses and households

Foreseen emission reductions in the enterprise sector are smaller at 35% by 2030 from 2018 levels. 71% of the emissions in the sector are covered by the European Union Emission Trading System. Within the sector (e.g., in the cement industry), the possibilities of reducing emissions further are likely limited (Box 1.8). Other enterprises will be liable to the carbon tax, which is gradually increasing until 2030. For firms, the Public Service Obligation levy, which is charged to all electricity users, is a fixed charge rather than use-based, which reduces the incentives to minimise electricity consumption under normal conditions (i.e. before the current energy price hikes). Households face a lower charge.

Box 1.8. Cement production in Denmark and difficulties in reducing emissions

Abatement efforts in the cement industry are difficult to achieve. The ubiquity of cement use in construction and the lack of alternative materials combined with the energy use and chemical reactions in its production, makes cement an important source of greenhouse gas emissions (Miller et al., 2021). Worldwide, cement accounts for around 7% of total anthropogenic emissions. Without technological advances, policies to mitigate cement production emissions within a country are likely to lead to carbon leakage when cement is imported.

Other OECD countries are also grappling with how to achieve emission reductions in the cement industry. The Danish cement industry consists of a single producer, Aalborg Portland, which is the world's largest exporter of white cement. Aalborg Portland is the largest single emitter of CO_2 in Denmark, responsible for more than 4% of national emissions in 2018 (2.2 million tonnes). Industrial process emissions from cement production are subject to emission pricing under the EU ETS. The government has entered into a cooperation agreement with Aalborg Portland that secures greenhouse gas emission reductions of 0.5 million tonnes of CO_2e by 2030. Rather than reducing production, the emphasis is on replacing fossil fuels, using clay instead of chalk to reduce process emissions and using excess heat for district heating of homes in Aalborg. More expensive technologies, notably carbon capture, may be needed to make further cuts (OECD, 2021c).

The housing stock and commercial real estate have made some progress in reducing emissions, partly thanks to reduced coal use in open fires and greater thermal efficiency. However, progress has stalled since 2014. A large share of housing now relies on oil-fired space and water heating. In 2020, oil products accounted for around two-fifths of final residential energy use (Ó Cléirigh, 2020). As a result, greenhouse gas emissions in the residential sector are elevated in comparison with other OECD economies.

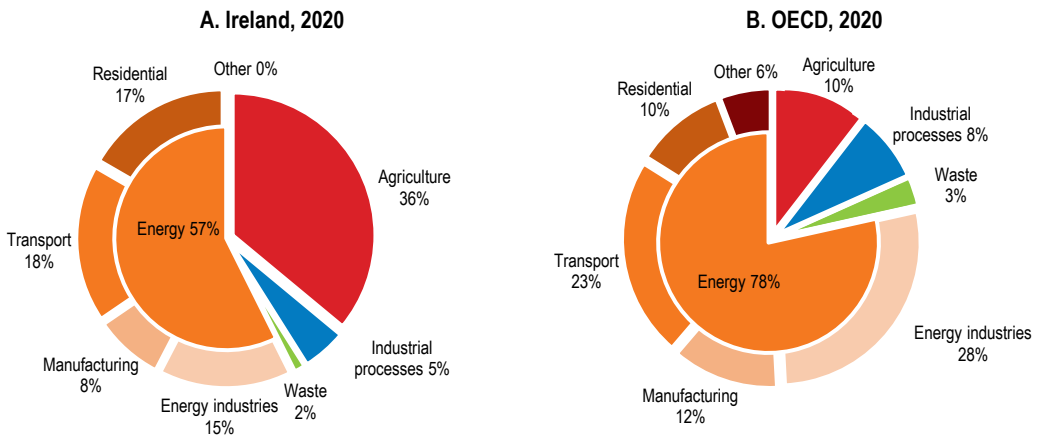
Further progress in reducing emissions will require moving away from oil-fired heating, greater use of renewables, such as installing heat pumps, and retrofitting the existing housing stock with energy saving materials. Reducing dependence on oil-fired heating would insulate Irish households from oil price shocks in the future. The government has pledged to support households, allocating €8 billion to 2030 with the aim of achieving 500 000 home energy upgrades, with Budget 2023 allocating funding for 37 000 houses. This is estimated to reduce emissions in the sector by at least one third. Households most at risk from energy poverty are eligible for free upgrades. However, some cash-constrained households may be unable to invest without additional support. The costs of retrofitting an energy inefficient home to the required standard can exceed €50 000, of which the grants could cover up to half. Even with substantial reductions in energy use, the capital costs will not be recouped for decades (FitzGerald, 2021). Households not wishing to take on additional debt would be eligible for higher grants, but the investments would be limited to thermal insulation. The availability of construction workers may present a constraint on progress, given competing demands from residential construction and infrastructure projects. Already a backlog has built up. In this regard, working to lift supply by increasing the inflow of workers will be important.

1.7.4. Reducing emissions in agriculture

Unlike most other OECD countries, the share of agriculture in emissions is high at around 36% of emissions (Figure 1.25). Only in New Zealand is the share larger. Agriculture is the largest sectoral contributor to greenhouse gas emissions, with emissions coming from livestock, the use of fertilisers, manure management and grasslands. Furthermore, the dairy herd has been growing. The greenhouse gas emissions generated are mainly by methane from livestock, which is more potent than carbon dioxide, but stays in the atmosphere for shorter periods.

Figure 1.25. Agriculture accounts for a large share of emissions

GHG emissions share (excluding land use, land-use change and forestry)



Source: OECD, Greenhouse Gas Emissions database.

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Agriculture contributes indirectly to emissions from land use and land use change, which account for around 7% of total emissions. These emissions are mainly driven by drainage of grasslands on organic soils. Business as usual projections suggest emissions will continue to increase. Programmes to manage grasslands, rewetting wetlands as well as reforestation could contribute to abatement efforts.

There is no target for methane emission reductions in Ireland. Internationally, due to the difficulties of cutting methane emissions (without either reducing livestock numbers or incurring high abatement costs), methane reduction targets are often set separately from those for other greenhouse gases. For example, New Zealand has treated agriculture separately from other sectors, with specific targets for biogenic methane and nitrous oxide emissions. New Zealand also has plans to subject agricultural greenhouse gas emissions to a carbon tax. A partnership between the government and the agricultural sector was established to prepare a pricing mechanism, including the development of on-farm accounting and reporting systems for greenhouse gas sources and sinks (OECD, 2022c). If insufficient progress is made in developing the system for implementation, agriculture will become liable to the emission trading scheme that is New Zealand's principal abatement instrument.

The Irish government has released its *Food Vision 2030* Strategy, with the aim of transforming agriculture to become a leader in sustainable food systems over the next decade. The Strategy foresees significant improvements in Irish farming, especially on issues related to air/water quality and biodiversity (Government of Ireland, 2022e). The goals on climate action, on the other hand, are less ambitious. Emission reduction targets for agriculture were set at 25%, lower than the overall objective of cutting total greenhouse gas emissions by 51% by 2030 (relative to 2018 levels).

The relatively modest emission reduction targets for agriculture shift a much larger burden of responsibility to non-agricultural sectors to meet the national mitigation commitment. FitzGerald (2021) estimates that government spending would need to rise by around 0.6% of GNI* annually until 2030 to cut agricultural emissions by 33%. Higher spending will have knock-on effects through the higher implicit tax burdens depressing GDP growth. The costs of shifting the burden to non-agriculture sectors are high because additional abatement in other sectors will be difficult and expensive to achieve.

Table 1.9. Past OECD recommendations on environment and actions taken

Recommendations in past surveys	Actions taken since 2020
Gradually raise the carbon tax rate according to a schedule that is well communicated to households and businesses; use some of the revenues to fund new green investment and measures that offset any adverse distributional effects.	The 2020 Finance Act legislated for a 10-year trajectory of annual carbon tax increases, reaching a rate of €100 per ton CO_2 by 2030. Revenues are used for retrofitting, welfare supports for vulnerable households, and green agriculture initiatives.
Continue to invest in public transport, and consider further promoting digital-based ride sharing and the introduction of congestion charging.	Over €2.5 billion was invested in public transport infrastructure, services and technology in 2020-21.
Consider introducing minimum energy efficiency standards for existing dwellings used for rental.	The Housing for All Strategy commits to implementing Minimum BER standards for private rental properties from 2025.
Pursue full and early implementation of cost-effective measures for the abatement of carbon emissions from agriculture, particularly those related to afforestation.	The targeted agricultural modernisation and organic farming schemes were expanded in 2021-22. A land use review and Project Woodland, a framework to reform the regulation and vision for forestry, were launched in 2021.

Recommendations on macroeconomic and structural policies

MAIN FINDINGS	RECOMMENDATIONS (key ones in bold)
Improving macroeconomic policy and fiscal sustainability	
The rapid rise in energy prices has been a large shock to households and the government has reacted by softening the blow.	**Target support on the most vulnerable, while keeping the impact on domestic activity broadly neutral.**
Mortgage arrears remain large and the process of resolution cumbersome and slow, with low rates of collateral possessions.	Facilitate the standardisation of the suspended possession order to resolve mortgage arrears.
Fintech and credit provision by non-banks are on the rise.	**Ensure adequate supervision and regulation of non-banks by the Central Bank of Ireland.**
The countercyclical capital buffer was reduced during the pandemic.	Implement the planned tightening of the countercyclical capital buffer.
There is a need to strengthen the ability of fiscal policy to address future shocks. High inflation is putting pressure to increase government spending, which has led to a temporary breach of the new spending rule in 2022-23.	**Continue to put excess windfall tax receipts in the National Reserve Fund.** **Consider strengthening the expenditure rule by giving it legislative status.** Publish multiyear baseline expenditure plans with the headline ceiling**.**
The government cancelled the planned increase in the state pension age. The new pension reform aims to address structural shortfalls in the social security funds by increasing social security contributions.	Estimate the impact of the announced pension reform on the sustainability of the pension system. **Re-introduce the planned rise in the state pension age and link the statutory retirement age to life expectancy at retirement.**
Pursuing structural reforms and providing housing	
The labour market participation of those with low education attainment remains low and labour market shortages are rising in some sectors.	**Continue to support training and apprenticeships in areas of the economy where labour supply is in high demand.**
The pandemic forced the public employment service and training services to innovate by using more digitalisation.	Review the effectiveness of innovations in helping jobseekers and providing training and use results to prepare the next national skills strategy.
Female labour force participation rates have been increasing, but there is still room for improvement.	Continue to couple adequate public financial support for childcare with measures to expand childcare capacity.
The tax and benefit system presents some disincentives to participate or participate more fully.	Consider introducing more tax rates and bands to prevent income threshold effects that create disincentives to work, combined with targeted means-tested support to vulnerable households.
Regulatory burdens on start-ups are relatively high, driven mainly by complex regulatory procedures and the system for licenses and permissions.	Continue to reduce the administrative burdens on SMEs by creating a Single SME portal, as planned.
Despite an improved legislative framework, resourcing of anti-corruption enforcement is limited, while the complex regulatory framework for public sector ethics is a source of uncertainty.	Complete the overhaul of the anti-corruption legislation and the reform of the statutory framework for ethics in public life.
Low housing and rental supply leads to high prices and low affordability. *Housing for All* is an ambitious strategy, but implementation challenges are large in the near term.	**Prioritise supply-side housing policies in the implementation of the Housing for All Strategy**.
Construction costs and labour shortages in the construction sector have been rising.	Continue policies to improve innovation in the construction sector and upskill construction workers.
Permitting delays and judicial reviews constrain housing supply.	**Expedite the streamlining of planning and judicial review processes, for example by establishing a special division in the High Court with sufficient tools, resources and technical capacity to reduce delays.**
The First Home scheme, which aims to support first-time home buyers. could put upward pressure on house prices, given low housing supply.	Continue to keep the First Home scheme narrowly targeted and limited in size.
Housing for All gives some of the planning responsibilities back to local planning authorities.	**Address capacity issues in the planning system and sufficiently resource local planning authorities.**
Achieving net zero emissions by 2050	
Planning and permitting delays coupled with judicial review concerning major investments slow the development of renewable energy capacity and through increasing uncertainty deter investment and raise prices.	**As a matter of urgency, expedite the planning process to reduce uncertainty concerning major investments in wind turbine capacity.**
Reducing emissions in the transport sector requires action across many policy dimensions.	**Realign transport policies to reduce private car ownership and facilitate the provision and use of low- or no-carbon travel alternatives.**
The overall costs of abatement will rise substantially if agriculture does not contribute more to emission reductions.	**Ensure that farmers face stronger economic incentives to reduce emissions in line with the rest of the economy, such as by pricing methane emissions.**
Retrofitting the existing housing stock with insulation and energy saving technologies will stretch the construction sector.	Ensure an adequate inflow of workers to construction training and apprenticeships.

References

Ahrens, A., M. Martinez-Cillero and C. O' Toole (2019), *Trends in Rental Price Inflation and the Introduction of Rent Pressure Zones in Ireland*, ESRI, Dublin.

Bach, S. (2020), *Fiscal Councils' Impact on Promoting Transparency and Accountability in Public Finance Management.*

Benetton, M., P. Bracke, J. Cocco and N. Garbarino (2019), "Housing consumption and investment: evidence from shared equity mortgages", *Bank of England Working Paper,* No. 790.

Browne, J., H. Immervoll, R. Fernandez, D. Neumann, D. Pacifico and C. Thévenot (2018), "Faces of joblessness in Ireland: A people-centred perspective on employment barriers and policies", *OECD Social, Employment and Migration Working Papers*, No. 209, OECD Publishing, Paris.

Carozzi, F., C. Hilber and X. Yu (2020), "On the economic impacts of mortgage credit expansion policies: Evidence from help to buy", *CEP Working Paper*, No. 1681.

Casey, E. (2022), "Potential impact of Commission on Taxation and Welfare proposals", *Irish Fiscal Advisory Council Analytical Notes*, No. 17.

Causa, O. and J. Pichelmann (2020), "Should I stay or should I go? Housing and residential mobility across OECD countries", *OECD Economics Department Working Papers*, No. 1626, OECD Publishing, Paris.

Central Bank of Ireland (2022a), *Quarterly Bulletin 2022Q4*, Dublin.

Central Bank of Ireland (2022b), *Residential Mortgage Arrears and Repossessions Statistics*, Dublin.

Central Bank of Ireland (2022c), *Financial Stability Review 2022: I*, Dublin.

Central Bank of Ireland (2022d), *Financial Stability Review 2022: II*, Dublin.

Central Bank of Ireland (2021a), *Macroprudential Measures for the Property Fund Sector,* Dublin.

Central Bank of Ireland (2021b), *Financial Stability Review 2021:I,* Dublin.

Central Statistics Office (2022), *Estimated Inflation by Household Characteristics September 2022*, Dublin

Climate Change Advisory Council (2022), *Statement of the Chair on Sectoral Emissions Targets*, Dublin.

Climate Change Advisory Council (2021), *Annual Review 2021*, Dublin.

Commission on Taxation and Welfare (2022), *Foundations for the Future*, Dublin.

Conroy, N., E. Casey and E. Jordan-Doak (2021), *Ireland's Next Ramp-up in Public Investment,* Irish Fiscal Advisory Council.

Cronin, D. and K. Mcquinn (2017), *The Cyclicality of Irish Fiscal Policy Ex-ante and Ex-post.*

De Búrca, Ó., R. Kelly and E. O'Brien (2021), "A financial stability perspective on the First Home shared equity scheme", *Central Bank of Ireland Financial Stability Notes*, No.12.

Dechezleprêtre, A., *et al* (2022), "Fighting Climate Change: International Attitudes Toward Climate Policies", *OECD Economics Department Working Papers*, No. 1714, OECD Publishing, Paris.

Department of Finance (2021), *Submission to Commission on Pensions*, Dublin.

Department of Finance (2022a), De-Risking the Public Finances – Assessing Corporation Tax Receipts, Dublin.

Department of Finance (2022b), *Department of Finance Submission to the Commission on Taxation and Welfare*, Dublin.

Department of Finance (2022c), *Income Tax: Tax Strategy Group, 22/02,* Dublin.

Department of Finance (2022d), *Help to Buy Scheme Review: Final Report*, Dublin.

Department of Justice (2020), "Review of structures and strategies to prevent, investigate and penalise

economic crime and corruption", *Report of the Hamilton Review Group*, November, Dublin.

Department of Public Expenditure and Reform (2022a), "Transposition of the EU Whistleblowing Directive", *Regulatory Impact Analysis of the Protected Disclosures (Amendment) Bill 2022*, Dublin.

Department of Public Expenditure and Reform (2022b), *The Use of Carbon Tax Funds 2023*, Dublin.

Department of Public Expenditure and Reform (2021), "Reform and Consolidation of Ireland's Statutory Framework for Ethics in Public Life", *Public Consultation*, Dublin.

Department of Public Expenditure and Reform (2020), *Pre-Covid-19 Productivity Research in Construction Sector*, Dublin.

Department of Social Protection (2022), *Trends in Post-PUP Employment: Examining the Employment Transitions of Those Closing Their Pandemic Unemployment Payment Claims,* Dublin.

EPA (2022), Ireland's Final Greenhouse Gas Emissions: 1990-2022, Environmental Protection Agency.

ESRI (2022), *Quarterly Economic Commentary*, Autumn 2022, Dublin.

European Commission (2022a), "2022 Rule of Law Report – Country Chapter on the Rule of Law Situation in Ireland", *Commission Staff Working Document*, Brussels.

European Commission (2022b), *In-depth Review for Ireland*, Brussels.

European Commission (2021a), The 2021 Ageing Report. Economic and Budgetary Projections for the EU Member States (2019-2070), Brussels.

European Commission (2021b), *Analysis of the Recovery and Resilience Plan for Ireland*, Brussels.

European Commission (2021c), "2021 Rule of Law Report – Country Chapter on the Rule of Law Situation in Ireland", *Commission Staff Working Document*, Brussels.

European Investment Bank (2021), *EIB Investment Survey: Ireland Overview.*

Expert Group on Future Skill Needs (2021), *Labour Demand Estimates for Ireland's National Housing Targets, 2021-2030.*

FitzGerald, J. (2021), *The Macroeconomic Implications of Carbon Budgets for Ireland*, Climate Council.

Gaffney, E., C, Hennessy and F. McCann (2022), "Non-bank mortgage lending in Ireland: recent developments and macroprudential considerations", *Central Bank of Ireland Financial Stability Notes,* No.3.

Government of Ireland (2022a), *Ireland for Finance Progress Report 2021*, Dublin.

Government of Ireland (2022b), *Budget 2023*, Dublin.

Government of Ireland (2022c), "Evaluating the trajectory of rising construction costs in the Irish housing sector", *Economic Insights*, Summer 2022, Dublin.

Government of Ireland (2022d), Government announces sectoral emissions ceilings, setting Ireland on a pathway to turn the tide on climate change, Dublin.

Government of Ireland (2022e*), Implementation Plan: Food Vision 2030: A World Leader in Sustainable Food Systems,* Dublin.

Government of Ireland (2021a), *Spending Review: Housing*, Dublin.

Government of Ireland (2021b), *Climate Action Plan 2021*, Dublin.

Government of Ireland (2021c), *Economic Recovery Plan 2021*, Dublin

Government of Ireland (2021d), *National Recovery and Resilience Plan,* Dublin.

Government of Ireland (2021e), *Housing for All - a New Housing Plan for Ireland,* Dublin.

Heffernon,T. et al. (2021), "The role of non-bank lenders in financing Irish SMEs", *Central Bank of Ireland, D*ublin.

IMF (2022a), *Ireland: Financial Sector Assessment Program - Technical Note on Bank Supervision,* Washington DC.

IMF (2022b), *Financial System Stability Assessment*, Washington DC.

Irish Fiscal Advisory Council (2022a), Flash Release: Budget 2023, Dublin.

Irish Fiscal Advisory Council (2022b), *Pre-Budget 2023 Statement*, Dublin.

Irish Fiscal Advisory Council (2022c), *Fiscal Assessment Report*, Dublin.

Irish Fiscal Advisory Council (2021), *Fiscal Assessment Report*, Dublin.

Irish Fiscal Advisory Council (2020), *Long-term Sustainability Report*, Irish Fiscal Advisory Council.

Jonung, L., I. Begg and M. Tutty (2016), "How is the Irish Fiscal Advisory Council performing? An independent evaluation of the first years of IFAC", *Lund University, Department of Economics Working Papers*, No.3.

Kelly, J., P. Lyons, F. McCann and E. O'Brien (2021), "Long-term mortgage arrears: Analytical evidence for policy considerations", *Central Bank of Ireland Financial Stability Notes,* No. 8.

Lawless, M. and L. Rehill (2022), *Productivity Heterogeneity across Firm Types,* Dublin.

Lyons, R. (2021), *Institutional Investment and the Private Rental Sector in Ireland*.

McCann, F. and N. McGeever (2022), "Enterprise policy issues for distressed businesses following the unwinding of pandemic supports", *Central Bank of Ireland Financial Stability Notes,* No.9.

McKinsey (2017), *Reinventing a Route to Higher Productivity in the Construction Sector*.

Miller, S., G. Habert, R. Myers and J. Harvey (2021), "Achieving net zero greenhouse gas emissions in the cement industry via value chain mitigation strategies", *One Earth*, 4(10), 1398-1411.

National Audit Office (2019), *Help to Buy: Equity Loan Scheme – Progress Review.*

National Competitiveness and Productivity Council (2022), *Ireland's Competitiveness Challenge 2022*, Dublin.

National Competitiveness and Productivity Council (2021a), *Ireland's Competitiveness Challenge 2021*, Dublin.

National Competitiveness and Productivity Council (2021b), "Firm dynamism and productivity", *National Competitiveness and Productivity Council Bulletin*, 21-5.

Ó Cléirigh, B. (2020), *Energy Security in Ireland: 2020 Report*, Sustainable Energy Authority of Ireland.

OECD (forthcoming), *OECD Skills Review: Ireland*, OECD Publishing, Paris.

OECD (2022a), *Rights and Support for Ukrainian Refugees in Receiving Countries*, OECD Publishing, Paris.

OECD (2022b), *Redesigning Ireland's Transport for Net Zero: Towards Systems that Work for People and the Planet,* OECD Publishing, Paris.

OECD (2022c), *OECD Economic Surveys: New Zealand 2022*, OECD Publishing, Paris.

OECD (2021a), *Brick by Brick: Building Better Housing Policies,* OECD Publishing, Paris.

OECD (2021b), *Transport Strategies for Net-Zero Systems by Design,* OECD Publishing, Paris.

OECD (2021c), *OECD Economic Surveys: Denmark 2021*, OECD Publishing, Paris.

OECD (2020a), *OECD Economic Surveys: Ireland 2020*, OECD Publishing, Paris.

OECD (2020b), *Housing and Inclusive Growth*, OECD Publishing, Paris.

OECD (2019), *SME and Entrepreneurship Policy in Ireland,* OECD Publishing, Paris.

PWC (2022a), "The impact of government supports on business failure levels during the COVID-19 pandemic", *Act Now: From Recovery to Growth*, Price Waterhouse Coopers, Dublin.

PWC (2022b), *Restructuring Update: 2022Q3*, Price Waterhouse Coopers, Dublin.

Rental Tenancies Board (2022a), *Rent Index, 2022Q1*, Dublin.

Rental Tenancies Board (2022b), *Notice of Termination received by RTB*, Dublin.

Russell, H., I. Privalko, F. Mcginnity and S. Enright (2021), *Monitoring Adequate Housing in Ireland*.

SCSI (2021), *Residential Property Report: 2021 Outlook*.

SOLAS (2021*), Difficult-to-fill Vacancies Survey*, 2021, Dublin.

SOLAS (2022), *Shifting Sands,* Dublin.

Tedin, M. and V. Faubert (2020), "Housing affordability in Ireland", *EC Economic Brief*, No. 61, Brussels.

The Pensions Commission (2021), *Report of the Commission on Pensions*, Dublin.

Ziegler, T. et al. (2021), *The 2nd Global Alternative Finance Market Benchmarking Report*.

2 Health sector performance and efficiency

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Overall, the health of the Irish population has improved substantially during recent decades and is quite good compared with other OECD countries. However, spending is elevated, partly reflecting a system that is strongly based on hospitals. Population ageing is exacerbating spending pressures. In addition, the health sector is dealing with past underspending, particularly in capital outlays in the years following the global financial crisis, that have constrained service delivery, contributing to substantial waiting lists and heavy pressure on staff. The government has initiated wide-ranging reforms, termed Sláintecare, with the aim of broadening the coverage of universal care, decentralising provision and enhancing the integration of primary, community and hospital care. The reforms are complicated, reflecting a healthcare system that is complex and at times opaque. This is particularly the case with the interaction of the public and private parts of the system in which private patients enjoy easier access to care, leading to concerns about a two-tier healthcare system. The creation of new regional health areas is set to support more decentralised decision-making, but information systems to track spending and reform implementation need an overhaul. The COVID-19 pandemic has diverted policy-making attention just as the reforms got underway, but stepping up the efforts to address legacy issues and move forward on the reforms is now key to meet the coming challenges while using resources effectively.

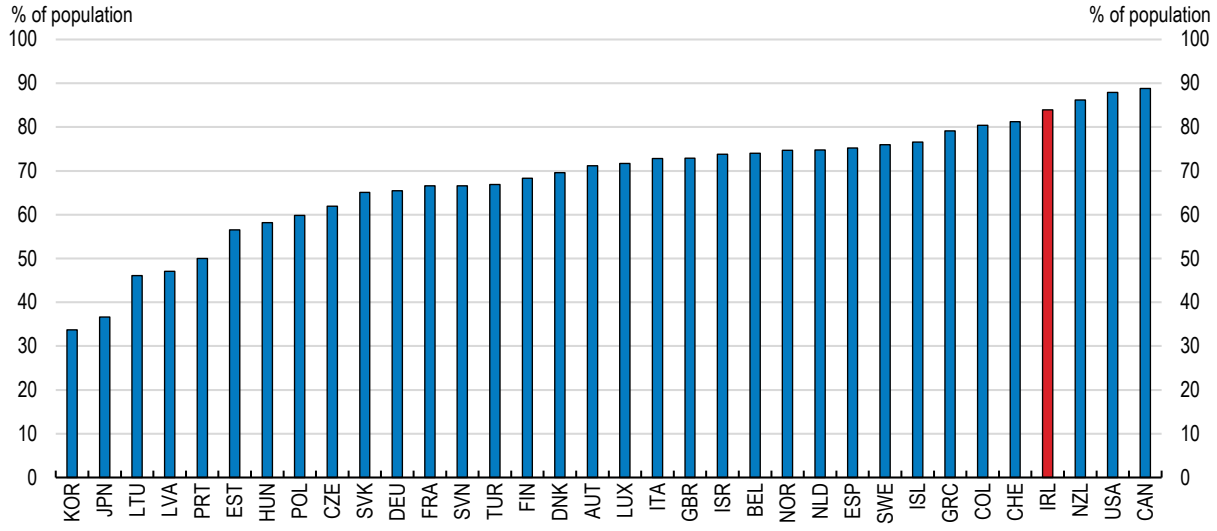
2.1. The health of the nation

2.1.1. Health trends and comparisons

The health of the Irish population improved considerably during recent decades. In comparison with other OECD countries, the population's self-reported health status was amongst the best before the pandemic (Figure 2.1). Life expectancy at birth, in particular, rose to 80.8 years for men and 84.7 years for women in 2019 (among the highest in the OECD) and 6.8 and 5.5 years above their levels in 2000, respectively (Figure 2.2). In addition, the share of the working age population reporting moderate or more severe levels of depression decreased to 4.8% by 2019, 40% lower than in 2014, and somewhat below the EU average (Eurostat, 2019). Ireland's population is thus relatively healthy, but differences in health status remain significant across income groups.

Figure 2.1. Self-reported health status was good before the pandemic

Share of the population aged 15 and older with good/very good health, 2019



Note: Results for Canada, Colombia, New Zealand and the United States are not directly comparable due to methodological differences in the survey questionnaire resulting in a bias towards a more positive self-assessment of health.
Source: OECD, Health Statistics database.

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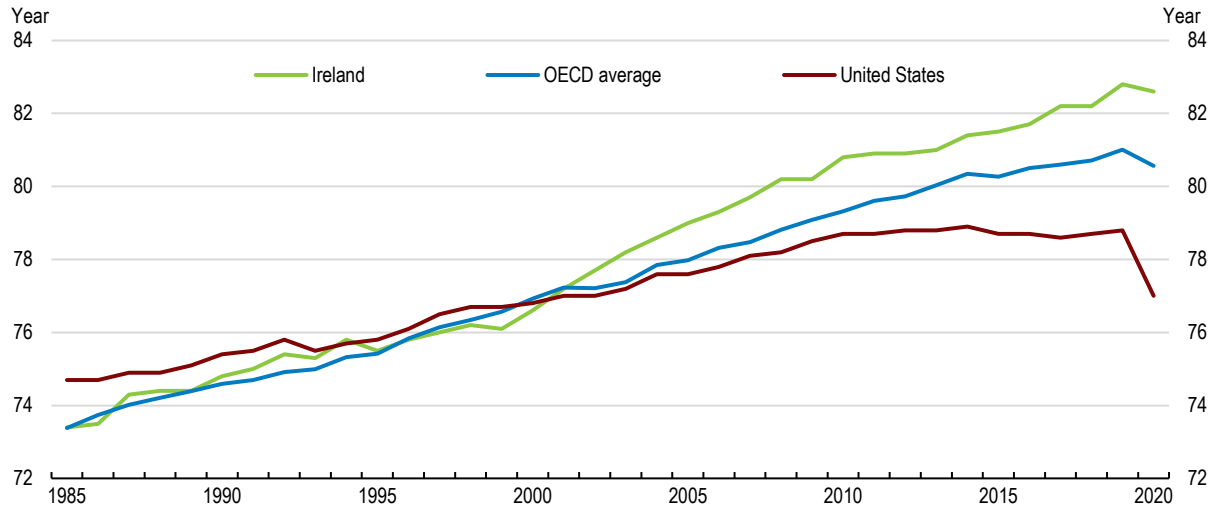
The share of deaths caused by cancer in overall mortality was higher than the EU average before COVID-19, while pre-pandemic estimates of Ireland's cancer incidence rate – the number of new cases registered in a given year normalised by the population – put it as the highest in the European Union in 2020 (OECD, 2021a). This suggests cancer prevention and care will represent priority areas, especially after COVID-19. Relatively high cancer morbidity is partly driven by behavioural risk factors, e.g., smoking, binge drinking and unhealthy dietary habits. Whilst smoking rates have decreased significantly in recent decades, adult overweight and obesity rates are of growing concern, together with alcohol abuse. More than one fifth of Irish adults reported regular heavy alcohol consumption in 2019, but evidence suggests that heavy drinking among 15-year-olds is less widespread in Ireland than across the European Union. Efforts to reduce alcohol consumption could be reinforced by the recent strengthening of alcohol control policies, including the introduction of minimum unit pricing.

Figure 2.2. Losses in life expectancy due to COVID-19 have been limited after substantial gains
Life expectancy at birth



Source: OECD, Health Statistics database.

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2.1.2. Healthcare access and use

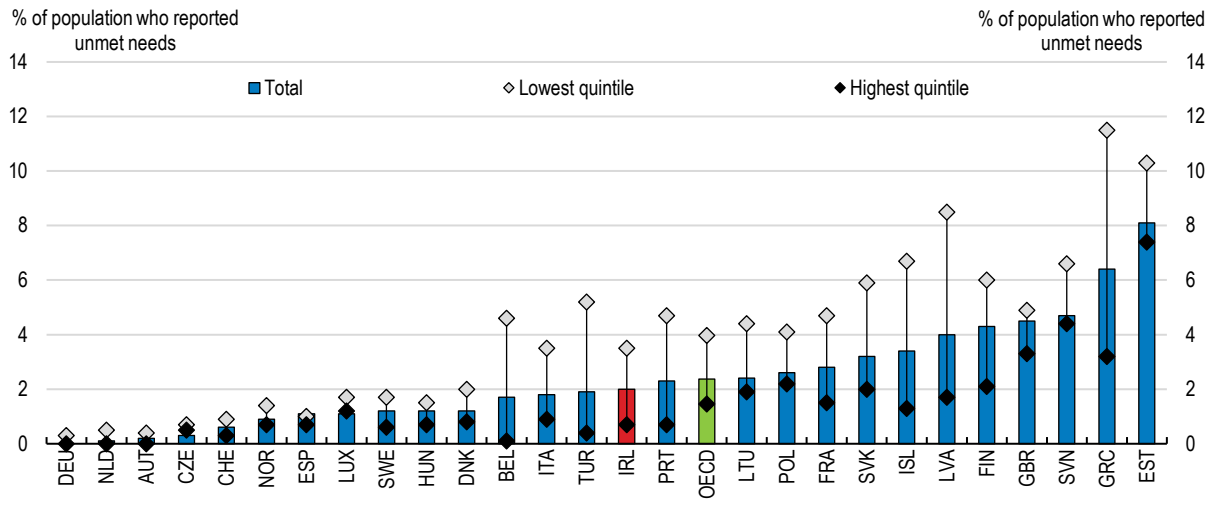
Quality of care is generally good, as suggested by age-standardised mortality rates somewhat below the OECD average for both preventable and treatable causes (OECD, 2021a). However, there are widespread inefficiencies. The COVID-19 crisis highlighted significant weaknesses in the public health system, affecting its resources as well as its organisation. This came on top of a degree of dissatisfaction about a *de facto* two-tier system, emphasised by extremely long waiting lists for hospital inpatient and outpatient consultations. Healthcare is largely funded by the State, which accounted for 78.3% of total current health expenditures in 2021 (3.8 percentage points above 2019), while the remaining part is roughly equally covered by household out-of-pocket payments and voluntary private insurance schemes. Buyers of voluntary private health insurance (PHI), though, enjoy faster access to several public hospital healthcare services than lower-income individuals eligible for free care (Medical cardholders). At the same time, rising costs of specialist consultations and specific treatments have resulted in increased unmet care needs among low-income households and younger age cohorts with weak PHI coverage. These adverse outcomes stress the need to balance the trade-off between efficiency and equity, while reforming Ireland's complex health system. For instance, measures resulting in increased public spending should avoid providing incentives to free-ride subsidised public care to those who could bear a greater share of its costs. Conversely, if not well-designed, policies shifting part of the burden of costly healthcare onto the private sector, such as through higher out-of-pocket payments, could undermine the broader objective of ensuring more vulnerable households have timely access to care.

The pandemic has likely aggravated shortcomings and heightened the risk of poorer health outcomes, as access to care for non-COVID related health conditions was limited. Additionally, though decreasing considerably in 2020, most likely due to patients avoiding – when possible – hospitalisation for fear of contagion, avoidable hospital admissions remain relatively high for conditions like asthma and Chronic Obstructive Pulmonary Disease (COPD), which are largely treatable in primary care. Reforms to foster primary care, expand the medical staff and the provision of integrated services, combined with measures to address the main drivers of avoidable deaths (Healthy Ireland Initiative), are currently being outlined and implemented in the context of the ten-year Sláintecare strategy (see below).

The Irish population's self-assessment of unmet healthcare needs is somewhat lower than in the average of European OECD countries (Figure 2.3). However, waiting times in Ireland have grown, notably for outpatients, and implicitly affect a much larger share of the population (Figure 2.4). The pandemic has seen outpatient waiting lists increase further, particularly for those waiting for over 18 months. For inpatient and day cases, the numbers waiting for short periods has declined, probably reflecting patients deferring medical assistance. However, like in other OECD countries during the pandemic, the numbers waiting for longer periods has risen, reversing some success during the late 2010s in reducing the numbers of those waiting for over six months.

Figure 2.3. Self-reported unmet healthcare needs are around average

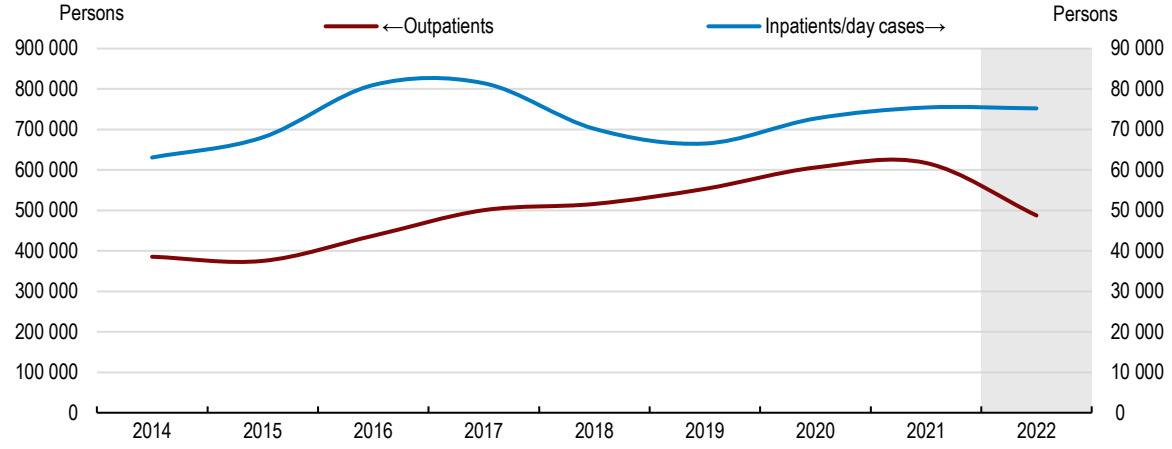
Unmet needs for medical examination by income quintile, 2021 or latest available year



Note: Includes unmet needs due to financial, geographic, or waiting time reasons. Data for Norway, Slovenia, Switzerland, and Türkiye refer to 2020; data for Iceland and the United Kingdom refer to 2018.
Source: Eurostat, EU-SILC database.

StatLink https://stat.link/i1sk9c

Figure 2.4. Waiting lists are large



Note: The shaded area corresponds to the government's projection for 2022.
Source: Department of Health, The 2022 Waiting List Action Plan.

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Comparing waiting times across countries is difficult as like-for-like data are often not available. Furthermore, Ireland's relatively weak digital infrastructure complicates matters. Key national healthcare

datasets are in the custody of nine different institutions, which adopt different patient unique identifiers and have no linkage at the national level (Oderkirk, 2021). Besides, there are no national electronic health records, except for some specific clinical populations or systems (Walsh et al., 2021). Tracking patients from General Practitioner (GP) referral to discharge is thus not always possible in Ireland, also due to inadequate reporting standards and the incomplete coverage of the Individual Health Identifier, whose adoption accelerated in the context of COVID-19 vaccination programmes. The official measures identify waiting times as the period between the patients' registration in the waiting list for a specified procedure (following specialist assessment) and a designated cut-off date. According to this metric, across 13 OECD countries with comparable data for seven public elective procedures, mean and median patient waiting times in Ireland rank in the middle: below most Eastern European countries, but well above those in the United Kingdom, Sweden and New Zealand (OECD Health Statistics, 2022).

Waiting list measures based on the number of patients registered at a certain point in time may be unreliable gauges of pressures due to the impossibility of identifying patients opting to use the private sector or opting out of the treatment altogether. In addition, patients may die while still waiting. Estimated waiting times from specialist assessment to treatment across comparable official data from other OECD countries for cataract surgery and hip and knee replacement procedures suggest Ireland ranks poorly, e.g., third or fourth longest waiting times out of 17 countries (Brick and Connolly, 2021).

2.1.3. The impact of COVID-19

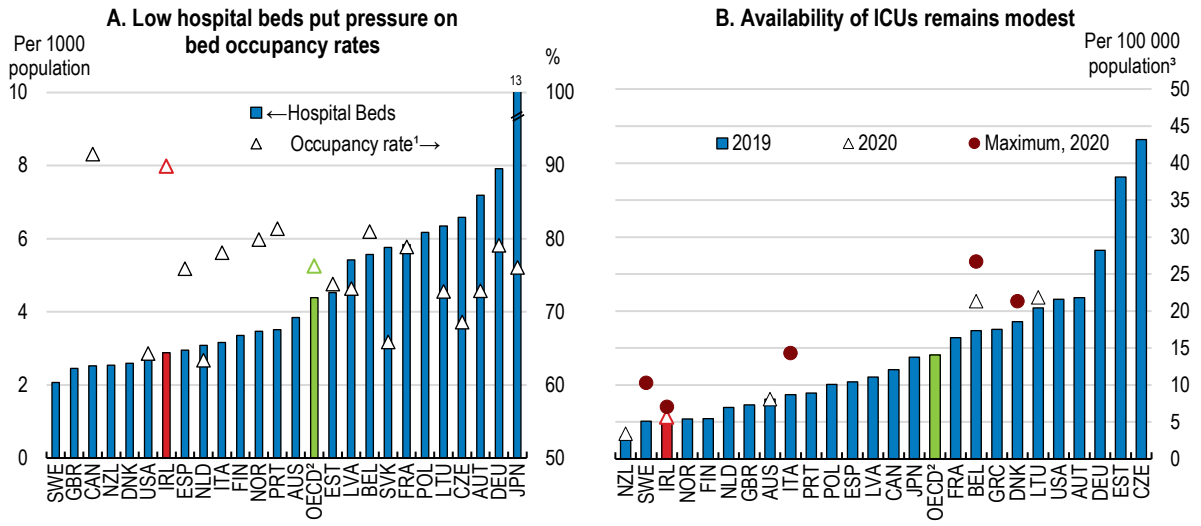
When the COVID-19 pandemic struck in early 2020, Ireland's health system was relatively ill-prepared to cope with its consequences. Highly centralised and largely relying on expensive hospital-based care services, the health system suffered several imbalances. Mostly a legacy of the procyclicality of health spending, such as the cuts after 2008 and of weak capital investment in health infrastructure up to the 1990s (Hennessy et al., 2021), the existing capacity constraints included understaffing, outdated hospital infrastructure, low numbers of hospital beds associated with inpatient bed occupancy rates well above international safety standards and, finally, weak ICU facilities (Figure 2.5; Humphries et al., 2021; Shine and Hennessy, 2022; Kennelly et al., 2020).

Ireland's pandemic response prioritised ring-fencing the sustainability of hospital care services from the systemic risk posed by surging COVID-19-related admissions. This objective shaped the authorities' decisions to promptly impose social distancing – coupled with contact tracing – and mobility restrictions to limit the diffusion of the virus. This included the repeated introduction of strict national lockdowns in March, October and late December 2020 (Humphries et al., 2021), when evidence of a rising number of infections suggested heightened risks of marked deteriorations in hospitalisation patterns.

Swift reorganisation of processes and resources prevented hospitals from being overwhelmed by the successive waves of COVID-19 variants. Early in the pandemic, the government established free universal care at the point of delivery for all COVID-19-related diagnosis and care services. In addition, it temporarily suspended all routine and non-essential health and social care services, which added further strain on already stretched waiting lists for diagnostics, elective non-urgent surgery or inpatient consultations. This allowed the concerned staff to be mobilised and redeployed in COVID-19 care units (Burke et al., 2021). On specific occasions, staff redeployment even exceeded the boundaries of the public sector. Indeed, the Health Service Executive (HSE), the publicly-funded national provider of health and personal social services, allowed its staff, particularly nurses and healthcare assistants, to be relocated – if willing – in private nursing homes, to assist them in tackling COVID-19. That was justified by the need to address nursing homes' severe staff shortages due to illness, which made it hard to ensure patients were properly cared for. At the same time, GPs supported the process by assuming the role of first point of contact for individuals with suspected symptoms, which was mainly performed via phone or video consultations (Kennelly et al., 2020). Moreover, as part of the efforts towards enhanced surge-based capacity, hospitals

often reconverted anaesthetic rooms or post-operatory beds into ICU stations, while mobilising recently retired workforce and setting up training modules for redeployed non-ICU staff.

Figure 2.5. Hospital capacity constraints were significant at the onset of the pandemic
2019 or latest year available



1. Occupancy rate of curative (acute) care beds.
2. Unweighted average across 27 countries with available data in Panel A; 33 countries in Panel B.
3. Data for Ireland cover critical care beds only; data for Slovenia include neonatal and paediatric ICU beds; data for the United Kingdom refer to England only.
Sources: OECD, Health Statistics database; and OECD, Health at a Glance 2021.

StatLink https://stat.link/beyn10

The involvement of private hospitals took some of the pressure off the public system, even though only part of their capacity was actually activated. In order to boost public acute care capacity, in March 2020, the government temporarily placed private hospitals under HSE's governance. According to the agreement, the HSE had access to private hospitals' capacity for a period of three months, for a payment of €287 million. During this period, no private work was allowed in private hospitals, although continuity of – essential – care to existing private patients was ensured. Based on this 'safety net' agreement, public patients gained access to 2 300 beds and 47 ICUs in 18 private hospitals, for an overall number of about 50 000 procedures (Committee of Public Accounts, 2021). Concretely, the scheme never used more than 45% of private hospitals' capacity, which raised some cost-effectiveness concerns, especially considering that, based on the agreement's terms, some private patient treatments, ordinarily funded by private insurances, were paid through the public purse (Houses of the Oireachtas, 2020). Moreover, the agreement, which was not initially negotiated with representatives of hospital staff (Mercille et al., 2021), excluded about 600 fully private practitioners, who were unable to continue the care relationship with their patients and were only offered the one-way solution of accepting temporary public-only hospital contracts, with no real clarity on their indemnities.

In light of the lessons learnt with the first agreement, and to prepare for a second wave of the pandemic, the government changed tactics and prioritised additional capacity based on specific needs. HSE entered into bilateral agreements with individual private hospitals to generate surge capacity via increased competition in streamlined public tenders, to be issued whenever the sustainability of public acute care was put at risk by rising infections. In its September 2020 Winter Plan, the HSE clearly outlined private hospitals' key role in supporting public patients' enhanced access to elective care via reduced waiting lists and providing essential ongoing care. This was formalised in the Safety Net II agreement, at the beginning of the third wave in January 2021, which, while allowing for ongoing treatment of private patients, foresaw

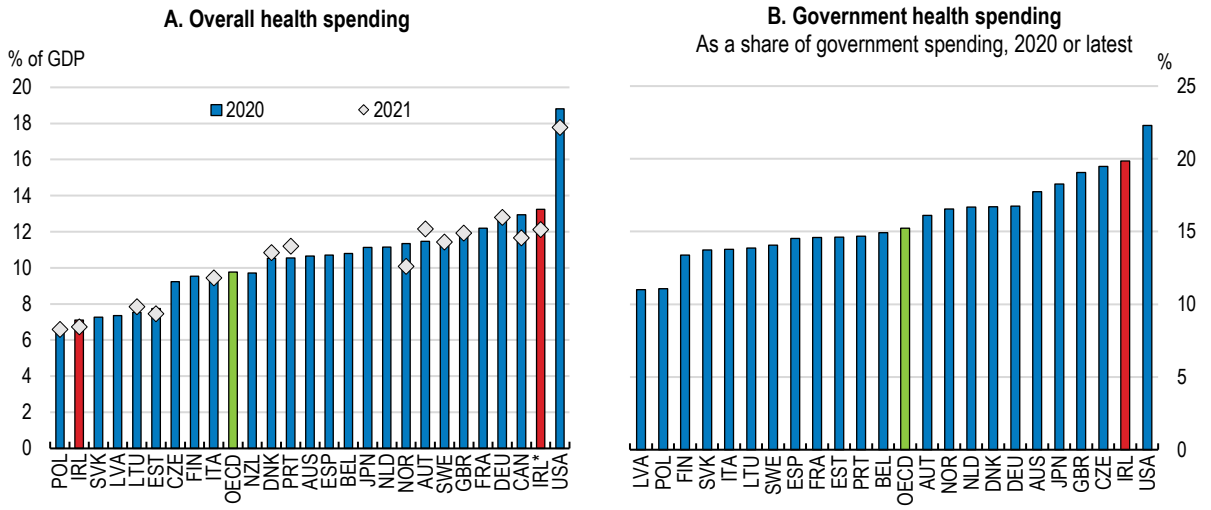
private hospitals supporting the health system by making available a fixed 30% of their own capacity, plus an additional share negotiable on an as-needed basis. Later on, effective containment of new infections allowed the HSE to gradually release most of the private hospitals involved from the revised scheme.

Initiatives to significantly step up hospital bed capacity are ongoing. Since 2020, more than 2 000 acute, critical and community beds have been added, while the last two budgets allocated funding to deliver 250 additional beds in 2023 (Government of Ireland, 2022). In 2021-22, €77 million of additional funding was earmarked to increase national critical care capacity – currently at around 320 ICUs – to 340 beds by 2023, while the recruitment of skilled critical care staff was prioritised (HSE, 2022a). These efforts are welcome and achieving the objective of 446 ICUs by 2031 (Shine and Hennessy, 2022), established in the 2020 Strategic Plan for Critical Care, should be prioritised.

2.2. Health spending

Overall, spending on health is high, particularly in light of a relatively young population. At the same time, health care is expensive in comparison with other European countries (Lorenzoni and Dougherty, 2022). The standard metric of spending as a share of GDP is complicated by the multinational nature of the Irish economy. When using the measure of national income that adjusts for the multinational sector, Ireland is one of the high spenders (Figure 2.6, Panel A). Spending on health accounts for one fifth of total public spending (Panel B). This partly reflects the fact that Ireland, in contrast to many other OECD countries and OECD System of Health Accounts guidelines (OECD, 2018; Wren and Fitzpatrick, 2020), includes some of the social care components of long-term care expenditure (assistance services that enable a patient to live independently, payments to family care givers or home-care services expenditures) in health spending. Providing an estimate of health-related social expenditure, as currently under discussion, would improve financial reporting in the health sector.

Figure 2.6. Spending on healthcare is high



Note: IRL* denotes health spending for Ireland as a share of modified gross national income (GNI*).
Source: OECD, Health Expenditure and Financing database; and OECD, National Accounts database.

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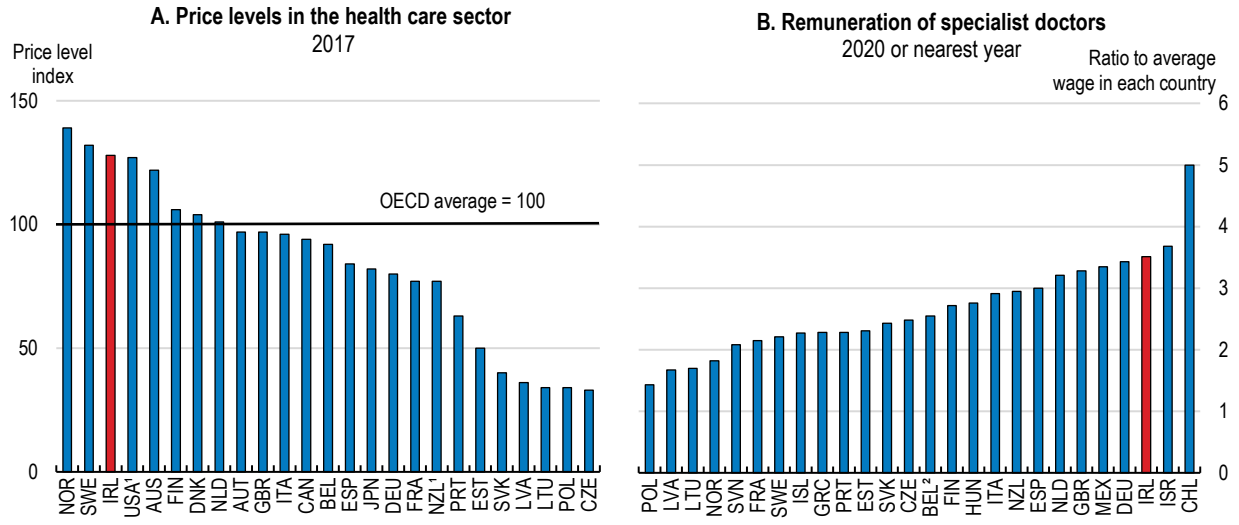
Health spending is subject to cost pressures largely stemming from ageing and death-related costs, the costs of new technologies (including pharmaceuticals), and increased demand as incomes rise. For example, at present, there are relatively few alternatives to staff spending time with elderly patients, particularly those with dementia. As average incomes rise across the economy, attracting staff into the long-term care sector requires higher salaries, pushing up health spending without necessarily seeing

compensating productivity gains. In Ireland, the global market for trained personnel is another factor bidding up salaries, on the back of pay costs already accounting for about one third of HSE's current expenditures in recent years (HSE, 2022b). At the same time, the COVID-19 pandemic emphasised the need for enhanced investment in machinery and equipment, which was close to the OECD average but below that of several European peers before the pandemic (OECD, 2021a). As a result of these pressures, health care costs in Ireland are relatively elevated, notably in hospitals (Lorenzoni and Dougherty, 2022), and compensation is quite high for some groups (Figure 2.7).

Figure 2.7. Health care is subject to cost pressures



1. For hospitals, PPPs are estimated predominantly by using salaries of medical and non-medical staff (input method).
2. Estimate for Belgium includes practice expenses, which results in an over-estimation.
Source: OECD, Health at a Glance 2021; and OECD, Health Statistics database.

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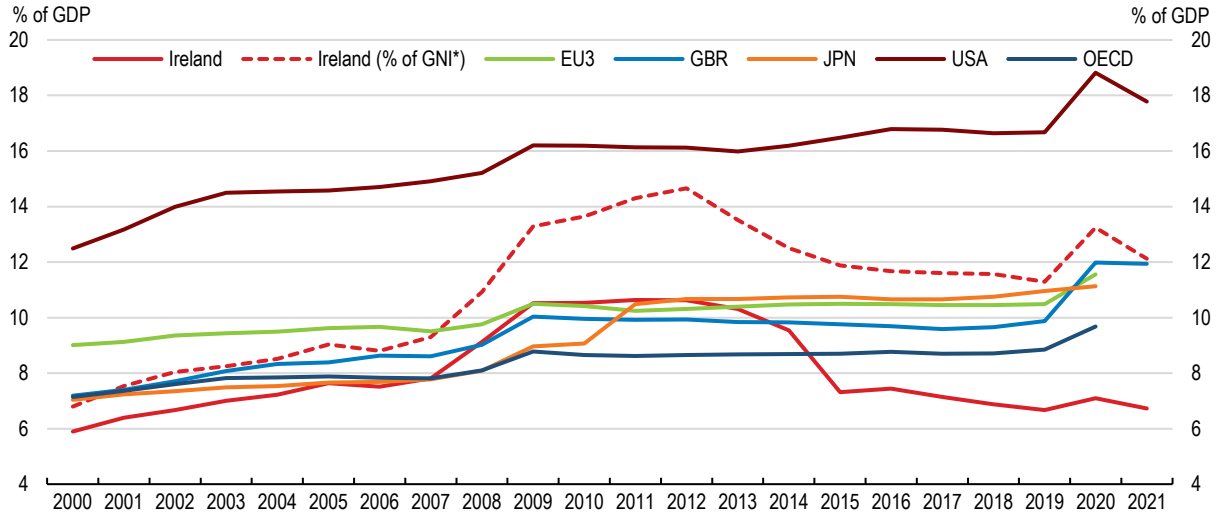
Spending has been relatively volatile in recent decades, reflecting the retrenchment of government outlays following the 2008 global financial crisis (Figure 2.8). The squeeze on spending was not uniform. Recognising an imbalance between higher numbers of nurses relative to doctors and other health professionals, the spending squeeze was mainly felt by nurses and midwives (Figure 2.9). In addition, in line with a more general trend across government functions, public capital spending on health was sharply cut back until recently (Figure 2.10). Besides its impact on the system's capacity, the significant pro-cyclicality of spending has triggered concerns about equity in access and the well-being of poorer households during downturns (Nolan et al., 2014).

The private health insurance contribution to financing current health spending rose in the wake of the 2008 global financial crisis. The government, in a drive to rein in public spending, introduced prescription charges for medical card holders, while curtailing their dental care benefits, and increased user charges for several outpatient consultations and treatments. As a result, the share of the private sector in the financing of health expenditure peaked at about 30% in 2013 (Figure 2.11, Panel A), before dropping by 4 percentage points by 2019 with the economic recovery. Household out-of-pocket payments grew at an average nominal annual rate of less than 1% in the five years preceding the pandemic, remaining among the lowest in the OECD (Panel B). The leading role of the state during the pandemic further reduced the share of private health financing.

Figure 2.8. Current health spending has been comparatively volatile



Note: GNI* represents modified Gross National Income at current market prices. EU3 stands for Germany, France and Italy. EU3 and OECD represent unweighted averages for composing countries. The system of Health Accounts was implemented in 2011, resulting in a methodological break in 2011.
Source: OECD, Global Health Expenditure database.

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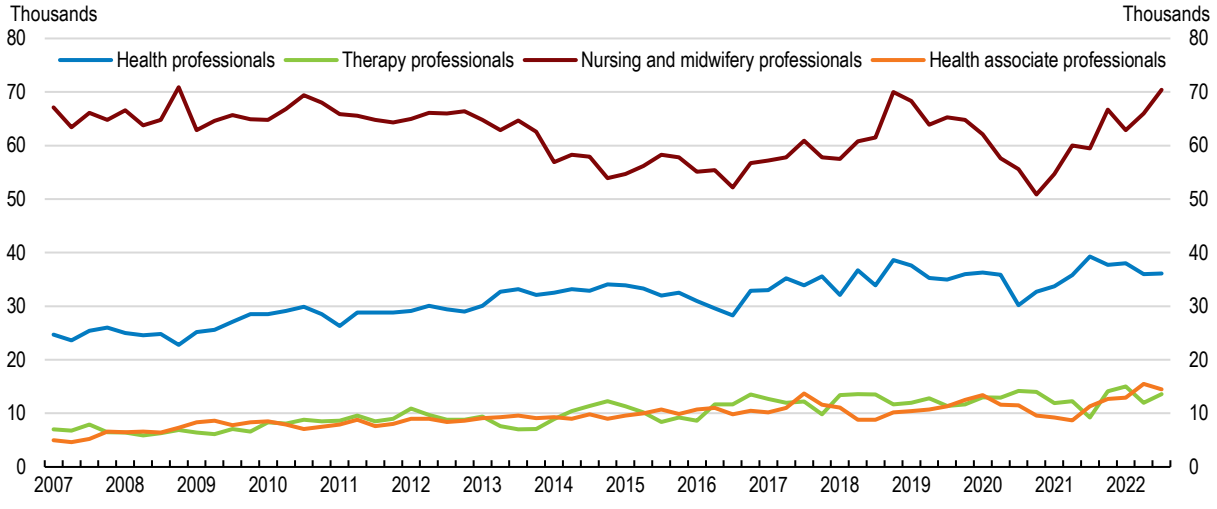
Figure 2.9. Staffing moratoria mainly affected nurses

Persons aged 15-89 in employment



Source: Central Statistics Office, Labour Force Survey.

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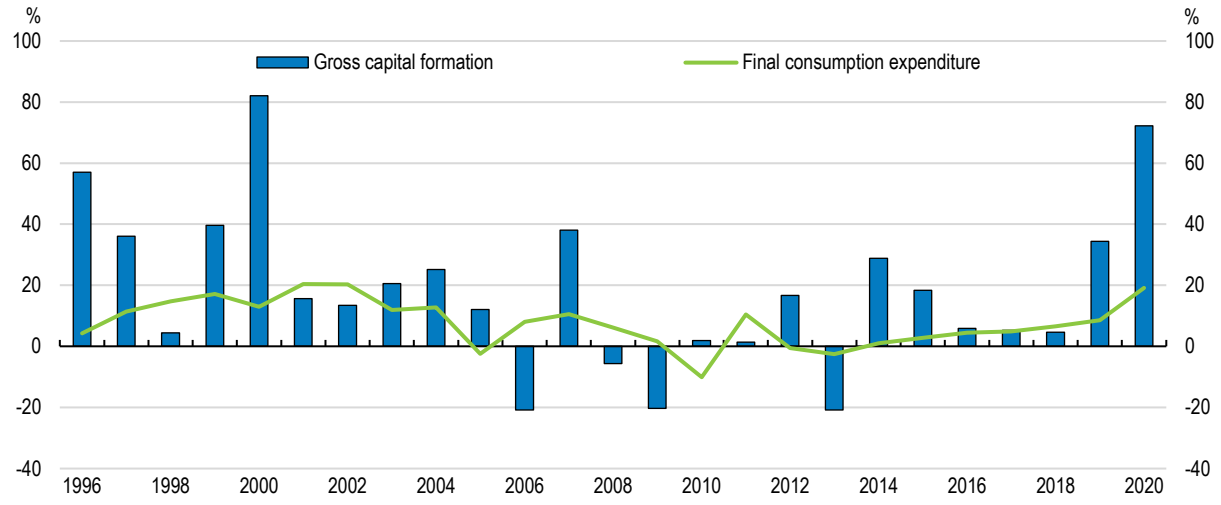
Figure 2.10. Capital spending growth has picked up only recently

Growth rate of government health expenditure



Source: OECD, Government expenditure by function (COFOG) database.

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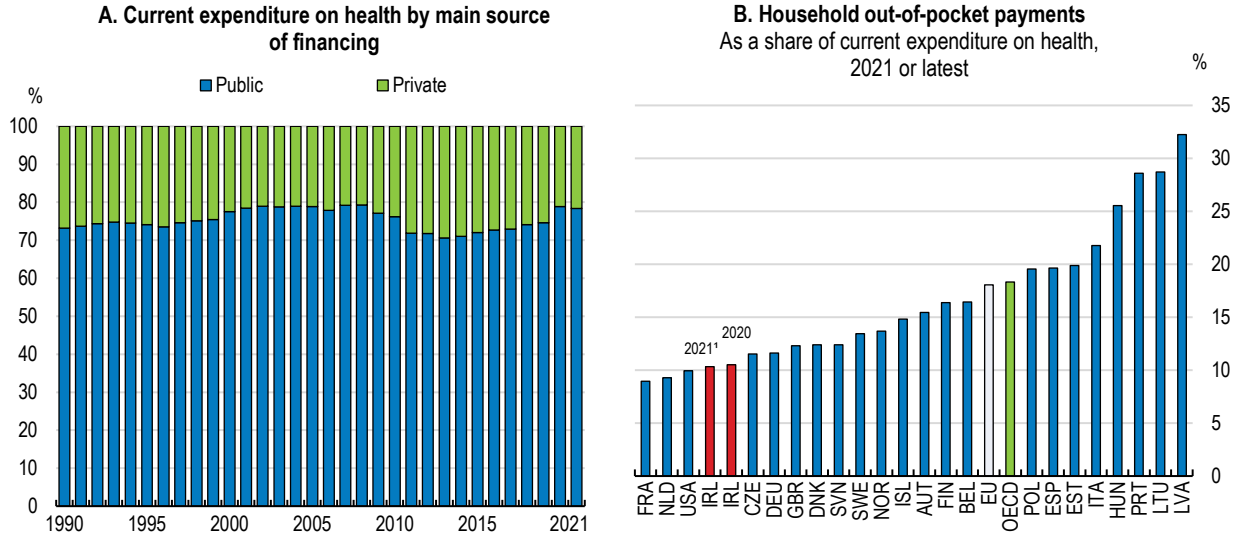
Figure 2.11. Private sources are a relatively limited part of health care financing



Note: In Panel A, private health care financing includes voluntary health care payment schemes and household out-of-pocket payments, while Panel B includes only household out-of-pocket payments. 1. Provisional estimate.
Source: OECD, Health Statistics database.

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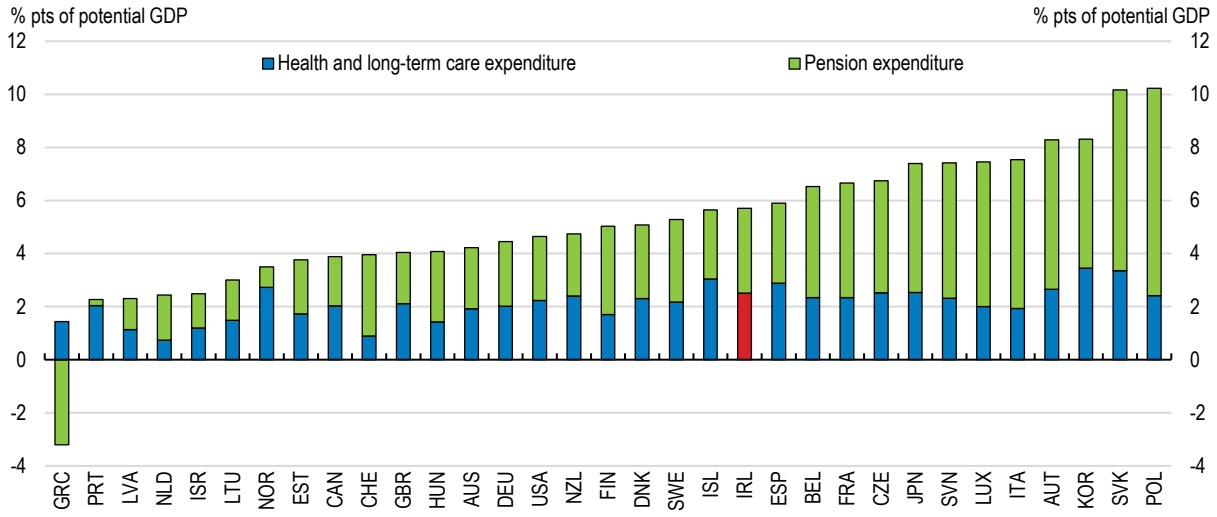
Past projections of health spending growth in Ireland, from even just about a decade ago, have erred on the downside, even though they used GDP rather than gross national income as the denominator. More recent projections suggest higher health spending levels than earlier ones (de Biase et al., 2022), notably due to the rise in long-term care costs (European Commission, 2021). Given Ireland's current youthful population, rapid expected ageing and relatively high long-term care costs, the projected increases in spending are substantial. Incorporating health spending projections alongside pension projections into the OECD's long-term model reveals that Ireland is facing some of the largest pressures on public spending to 2060 (Figure 2.12).

Figure 2.12. Population ageing will increase pressures on the government budget
Projected change in expenditures from 2021 to 2060



Source: Simulations based on the OECD Economics Department Long-term Model.

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Reforms underway suggest a movement of resources from acute towards non-acute care. However, so far, staff recruitment at primary- and community-level has not yet picked up markedly, in contrast with the larger staff gains in acute settings since 2014 (Fleming et al., 2022). As such, the locus of spending growth will change. More granular recent projections to 2035 suggest that spending growth outside the hospital sector will be pronounced, particularly in long-term residential care, home support and the high-tech community pharmaceutical scheme (Walsh et al., 2021). Earlier interventions outside the hospital setting can reduce overall costs. For example, some evidence suggests that primary care interventions to detect and treat frailty can delay or reverse it (Travers et al., 2019). As frailty is associated with heightened risks of illness, falls, disability, poorer outcomes after surgery and dependency and institutionalisation, effective primary care interventions are likely to reduce pressure on acute hospitals and long-term care facilities, reducing both health care use and spending (OECD, 2020a). Likewise, effective promotion and prevention programmes have the potential to contain the long-term costs of mental ill-health. In particular, the adoption of e-health solutions, combined with parenting and educational interventions (to help prevent anxiety disorders in young people) and well-being programmes in the workplace have generated significant savings in Australia and England (OECD, 2021b).

While spending projections are an important tool to assess pressures on public spending, they rely on a number of simplifying assumptions. Countries have been pursuing a number of options to slow spending growth. Public per capita spending growth on health had been slowing in a number of other OECD countries (including Ireland) before the pandemic, particularly following the 2008 global financial crisis. This was notable in curative and rehabilitative care and, to a lesser extent, medical goods (Lorenzoni et al., 2017). In many countries, including Ireland, the pandemic has spurred greater use of telemedicine, which offers potential to raise efficiency in the delivery of some services. Greater use of digitalisation, backed by the scaling-up of the needed digital infrastructure, can support health care workers and reduce pressure. For example, in Japan, the use of robots and remote sensors in long-term residential care settings allows medical staff to prioritise the patients most in need of interventions. Similarly, larger use of generics may help contain rapidly increasing spending on pharmaceuticals (see below). Against this background, efforts to boost efficiency could help offset spending pressures.

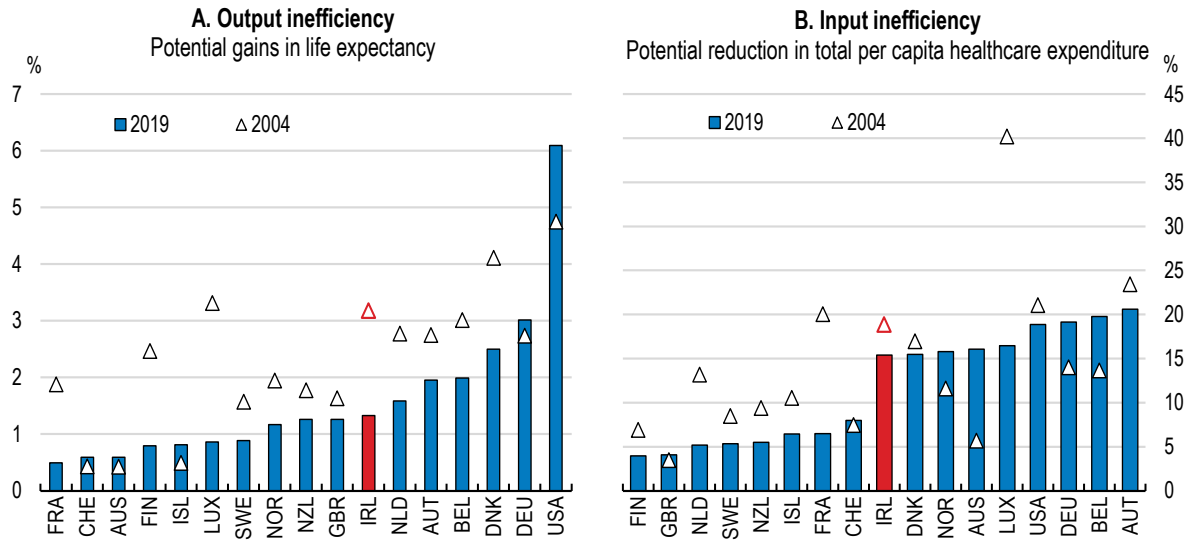
2.3. Benchmarking performance

Significant gains in life expectancy, combined with a larger incidence of chronic conditions, partly because of rapid population ageing, exert significant pressures on health spending. At the same time, technological and treatment development translate into higher demand for new services, which are usually more expensive. In light of these and other structural fiscal challenges (pensions, housing, green and digital transitions), enhancing the efficiency of public spending will be key in ensuring adequate access to healthcare for all whilst preserving fiscal sustainability.

Recent OECD calculations, following Dutu and Sicari (2020) – and updating results from the OECD Economic Surveys of Switzerland and the Slovak Republic (OECD, 2015a and OECD, 2017a) – use a non-parametric approach to measure the efficiency of healthcare expenditures (Box 2.1). Based on a restricted sample of OECD countries whose health systems are relevant benchmarks for Ireland, and subject to the caveats highlighted in Box 2.1, the results point to potential efficiency gains in healthcare spending between 2004 and 2019, which would have moved Ireland from the "least efficient" group towards the middle of the distribution (Figure 2.13). Estimated potential efficiency gains are larger across the input dimensions, suggesting that Ireland could in theory save up to 15% of its current expenditure on health, while maintaining the life expectancy of the population unchanged, if it were able to fully exploit the efficiency gains of frontier countries – again subject to the caveats in Box 2.1. The potential for similar gains along the output dimension seem more limited. Adjusting the composition of healthcare spending to OECD best practice, while keeping its level constant, may increase life expectancy by around 1%.

Figure 2.13. Potential input efficiency gains in health care are considerable

Restricted sample



Note: The restricted sample is obtained by excluding Eastern and Southern European OECD countries from the sample, as well as all non-European ones, with the exception of Australia, New Zealand and the United States.
Source: OECD Secretariat calculations using R's FEAR package, as made available in Wilson (2008).

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Box 2.1. Updated OECD estimates of healthcare spending efficiency

Data envelopment analysis (DEA) is a nonparametric statistical technique which uses linear programming of input-output data combinations to construct a frontier of best practice countries. It then interprets each deviation from the latter as an inefficient input-output pair (Charnes et al., 1978), without requiring the specification of any underlying functional form. The DEA-estimated frontier thus 'envelops' all available observations and a country's vertical (horizontal) distance along the Y-axis (X-axis) represents the measure of achievable output (input) efficiency gains while keeping input (output) constant. To limit the bias which occurs when a large number of inputs and/or outputs are used relative to a limited number of decision units (small sample), estimates are based on a "two input – one output" model structure.

The model uses life expectancy at birth as a proxy of the health system's outcomes. Life expectancy is used due to its high levels of reliability and international comparability. As for inputs, the monetary value variable (average 5-year total per capita health expenditure) is complemented by a composite indicator capturing the effects of socio-economic environment and life-style factors. The purpose of the composite variable is to control for factors that influence the outcome variable but are not directly related to the health system. As such, it includes GDP per capita, adult educational attainment, nitrogen oxide emissions and, finally, consumption of fruit and vegetables, as well as of alcohol and tobacco (all lagged by ten years). The results are broadly confirmed by a sensitivity check using GNI* per capita for Ireland.

Life expectancy is influenced by health spending and a large set of non-health determinants whose full effects are hard to control for. Hence, its use as outcome variable comes with some caveats, including largely overlooking the effects of spending on the quality-of-life dimension of care. Furthermore, DEA estimates of relative efficiency are sensitive to the choice of indicators. Therefore, these estimates should not be taken at face value, but rather as measures providing a ranking of how countries' health systems perform in terms of broad input and output efficiency.

To limit potential issues of the frontier being defined by health systems that are not relevant for Ireland, the sample includes 17 relevant OECD benchmark countries, i.e., northern European countries, Australia, New Zealand and the United States. Estimates assume non-increasing returns to scale and apply bootstrapping to DEA efficiency scores, following Simar and Wilson (2005), in order to obtain unbiased confidence intervals around the point estimates.

To shed more light on the exact nature of the estimated potential efficiency gains, Malmquist productivity indices are computed across the 17 countries, with reference to the input efficiency dimension. By identifying changes in the frontier of best currently known input-output combinations over a specific period of time, the Malmquist index allows a decomposition of overall productivity growth (efficiency gains) into technical efficiency gains and technological improvements (Färe et al., 1993). The former captures the catching-up of each health system towards the corresponding efficiency frontier and the latter takes into account the upward shift of the efficiency frontier itself, due to technological improvements during the period considered.

Source: OECD Secretariat calculations based on Dutu and Sicari (2020).

Efficiency gains are largely driven by technological change. The Malmquist productivity index, computed with reference to the input dimension, suggests that the Irish health system registered (macro-level) productivity growth of 40% over the period from 2004 to 2019, second only to Australia's 44% growth and more than double the average productivity growth across the other 16 countries in the sample (18%). When looking at the decomposition components, though, productivity gains in the Irish health sector result almost entirely from technological change, rather than outright technical efficiency gains. This, however, is far from being a condition peculiar to Ireland, as upward shifts in the frontier are the main driver of efficiency improvements in all the sample countries.

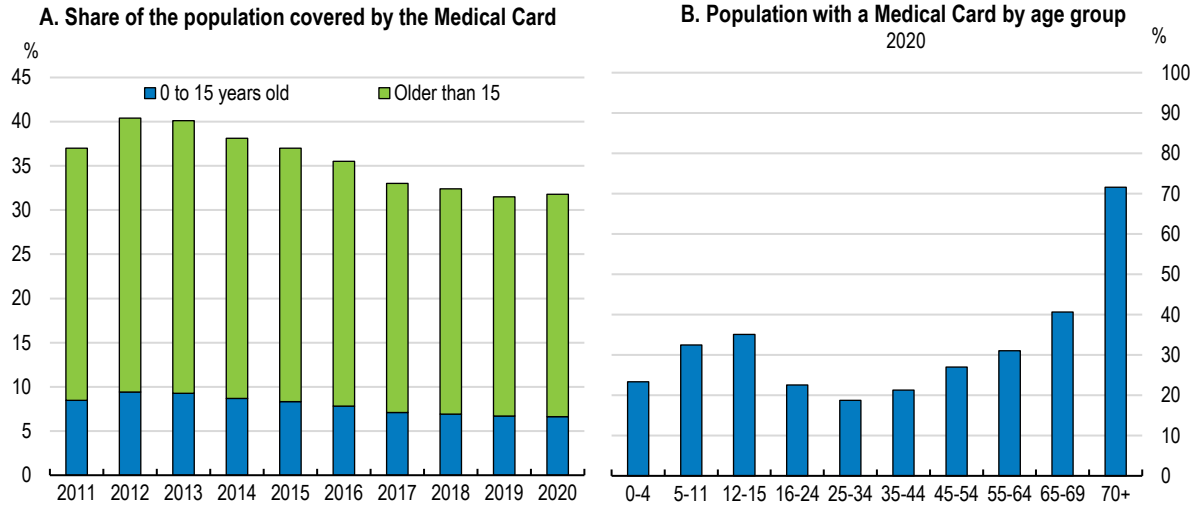
2.4. The structure of the health sector

2.4.1. Full eligibility to public health services is limited to part of the population

In contrast with other EU countries, Ireland's population does not benefit from universal coverage of primary care. Access to public health services, on the contrary, is differentiated across groups of individuals. Families with lower incomes are eligible for the Medical Card, which entitles them to largely free primary, community and public hospital care and examinations, as well as to lower prescription charges. Medical cardholders are generally identified as "Category I" users of publicly financed health services. Enrolment in the Medical Card system, which is largely not automatic, also ensures a relatively more generous coverage of dental, optical and aural services, as well as access to an array of ancillary services (maternity and infant care, public health nursing and social work services). In addition, the package also includes some relevant non-health related benefits, including a reduced rate of the Universal Social Charge income tax, plus an exemption from school transport charges and state exam fees in public second-level schools (Citizen Information, 2021).

Entitlement to the medical card is means-tested. This explains the peak in the number of Medical Card holders at 40% of the population in 2012, when the unemployment rate surged above 14%, and the gradual decrease thereafter as the economy recovered. Medical Card holders accounted for 31.8% of the population at the end of 2020 (Department of Health, 2021a), with the highest degree of coverage concentrated at the extremes of the age distribution (Figure 2.14). Means-testing thresholds depend on age, with higher levels of allowable income applied to applicants older than 70. Duly completed on-line applications for Medical Cards are normally treated within 15 days, while a longer wait might apply for forms filed through GPs or local health offices. So-called discretionary cards may be granted to applicants with income levels above the eligibility threshold, provided their circumstances would result in financial hardship without it. They account for around 11% of the total. Overall, the Medical Card constitutes the closest approach to the application of universal health coverage principles in Ireland, albeit restricted to lower income groups and individuals with the highest healthcare needs (Keane et al., 2021). In addition, Medical Card holders are more likely to use preventive care services, such as cancer screening (Connolly and White, 2019).

Figure 2.14. Take-up of the Medical Card is influenced by the economic cycle



Source: DOH (2021a), Health in Ireland: Key Trends 2021, Department of Health.

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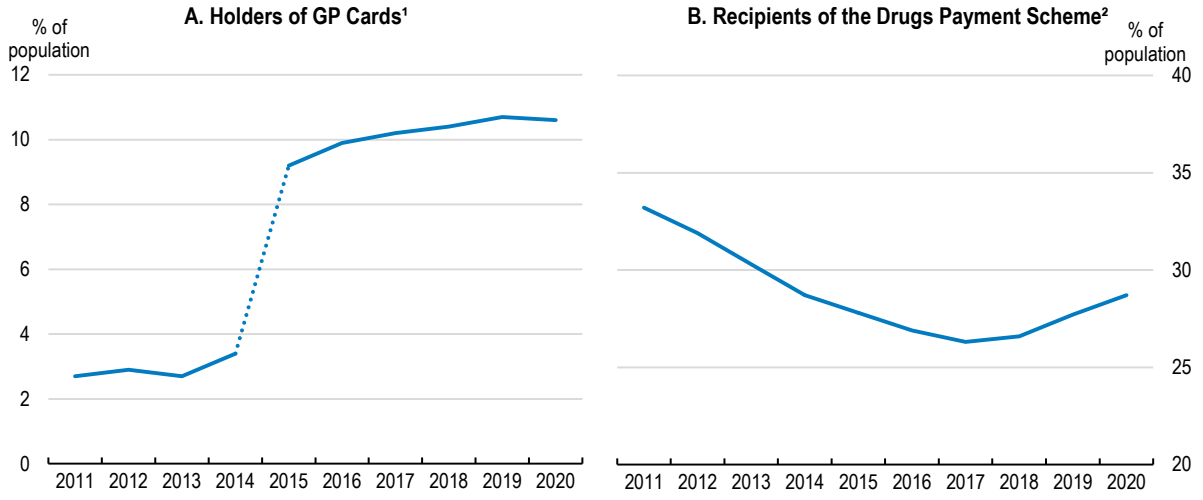
GP Visit Cards, established in 2005 and entitling holders to most GP visits for free, including through the GP Out of Hours Service, add to the system's complexity. Extended free of charge, since 2015, to children under the age of six, as well as to people aged 70 and over, eligibility for GP Visit Cards is means-tested for all other categories, with an income threshold more than 60% higher than for Medical Cards, in the case of people aged under 70 (Nolan, 2017). Moreover, assessment of the entitlement to GP Visit Cards is automatic for applicants who were found ineligible to the Medical Card. About 10.6% of the population held a GP Visit Card at the end of 2020 (Figure 2.15, Panel A; HSE, 2021a), with around 7.4% of existing cards being discretionary. The extension of eligibility to the GP Visit Card to children aged six and seven, already announced in previous budgets, was restated in Budget 2023, with a commitment to implement it by end-2022. Budget 2023 also committed to extend the GP Visit Card to individuals with earnings at or below the median income by early 2023. These measures are set to increase the population eligible for GP Visit Cards by about 420 000 individuals. Were 80% of the latter to actually take up a GP Visit Card, the benefit's coverage rate would be pushed up to about 17% of the population. Budget 2023 also committed funding to support GP capacity.

Figure 2.15. GP Cards and the Drug Payment Scheme are important supports to households

As a percentage of the population



1. In 2015, eligibility was extended automatically to children under the age of six and adults aged 70 and over.
2. Under the Drug Payment Scheme, households may cap monthly out-of-pocket payments for prescribed medicines.
Source: DOH (2021a), Health in Ireland: Key Trends 2021, Department of Health.

StatLink https://stat.link/fxu8os

The remainder of the population have so far been entitled to subsidised in-patient services in public hospitals (Category II users), subject to a maximum co-payment of €800 in 12 consecutive months (the standard charge for in-patient/day public services being currently at €80), although charges are not applied to maternity services and treatments involving children younger than 17 or related to infectious diseases. However, in compliance with Sláintecare's objective to expand universal care, Budget 2023 includes the abolition of all in-patient hospital charges from 1st April 2023, which will support access to affordable acute services. Moreover, under the Drugs Payment Scheme, individuals or households regularly residing in Ireland may cap out-of-pocket monthly payments for prescribed medicines at a defined threshold (Figure 2.15, Panel B), recently lowered to €80 per household, from €114 at the beginning of 2021. At the same time, whilst non-medical cardholders enjoy access to out-patient specialist and diagnostic assessments in public hospitals without fees, provided they are backed by a GP referral, they are mostly required to pay the full cost of GP consultations – usually in the €45-65 range, as well as dental and ophthalmic treatments. Only a small fraction of these costs are covered by private health insurance,

though, as the bulk of insurance plans are focused on in-patient (mainly semi-private) treatments (Health Insurance Authority, 2022). Finally, about one fifth of persons aged 15 and over did not hold any medical or GP visit card, nor any private insurance in 2021 (DOH, 2021a), and are thus subject to heavy user charges for many health care services.

2.4.2. The institutional landscape

In recent decades, several reforms have made way for organisational changes in the Irish healthcare system. At present, the governance of public healthcare services involves three main bodies: the Department of Health (DOH), the Health Service Executive (HSE) and the Health Information and Quality Authority (HIQA).

- The key mission of the DOH is to improve the health and well-being of Ireland's population by ensuring the required delivery of high-quality health services and the best effective use of the system's resources. Consequently, the DOH advises the Minister and the Government on the health system's strategic development.
- Established in 2005, the HSE is tasked with the delivery of health and social care services. These services are provided either directly or by third parties under contract with the HSE (private healthcare providers, community organisations or self-employed health professionals) (Nolan, 2017; Government of Ireland, 2021; Citizens Information, 2021).
- HIQA is an independent authority established in 2007 with the aim to define higher standards for health and social care services and ensure their monitoring. It is also responsible for inspecting residential services for children, older persons and people with disabilities, as well as for health technology assessments. Notwithstanding recent law proposals, and with the only exception of regulations on medical exposures to ionising radiations, HIQA does not currently have the legal remit to regulate or monitor providers of private healthcare services (Nolan, 2017; HIQA, 2021).

2.4.3. The legacy of the financial crisis on healthcare spending and resources

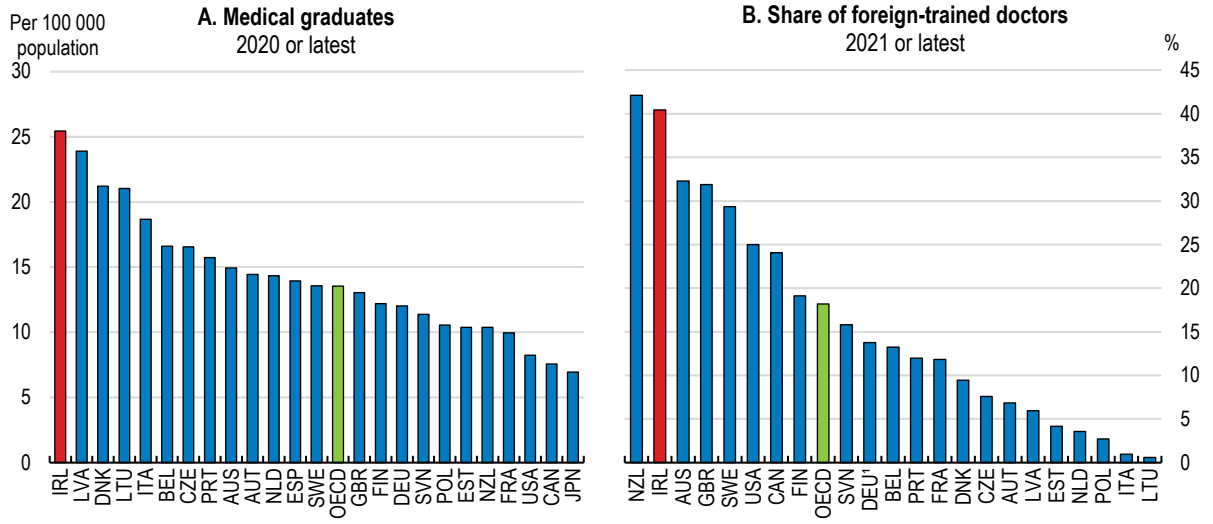
Current health system imbalances largely stem from spending cuts in the wake of the 2008 global financial crisis. In order to rapidly shore up public finances, the government reduced HSE's financial envelope by 22% between 2009 and 2013 (Thomas et al., 2014), with the objective of cutting hospital beds and staff levels by more than 10%. As a result, Ireland's health sector delivered 43% of total public sector staff cuts. Between 2008 and 2014, job reductions affected mostly support, administrative and management staff (-18.5%). Frontline staff numbers decreased by 3%, largely driven by a contraction in the number of non-specialised nurses (Williams and Thomas, 2017). In addition to staff reductions, the Government legislated across-the-board public sector pay cuts in both 2009 and 2010, via the Financial Emergency Measures in the Public Interest. At the same time, it introduced a public service moratorium on recruitment and promotions, with some exceptions, to be lifted only in 2015. Furthermore, the salaries and benefits of new entrants were reduced.

The public sector pay cuts and staff freezes have reduced the relative attractiveness of health professions in public hospitals. Due to the combined effect of the Pension Related Deduction and outright pay cuts, for instance, nurses faced salary reductions in the range of 5% to 20%, depending on their qualifications and income, as well as increased working hours since 2013 (Wells and White, 2014), which were reversed only recently. Similarly, the starting and top points of the salary scale of consultants – the most senior grade of hospital doctors – dropped by about 20% (IMO, 2017). At the same time, significant salary reductions were legislated for new hirings - from October 2012, accompanied by the lengthening of career progression scales (Public Service Pay Commission, 2018).

Although partly reversed in the recovery phase, cutbacks weighed on the system. The combined effect led to a deterioration in working conditions and mounting dissatisfaction with job quality. Salary and working conditions perceived as less favourable than in other healthcare systems have hindered recruitment and retention in the sector and contributed to outward migration among health care workers (IMO, 2017; IGEES, 2019). Unfilled consultant posts have emerged as a recurrent feature of recruitment drives, although some appear to be sector- and location-specific (HSE, 2016).

The shortage of specialists/consultants is in stark contrast to medical education in universities. In 2019, Ireland had close to 25 medical graduates per 100 000 population, 10 more than in the mid-2000s and almost twice the OECD average – the area's record high (Figure 2.16, Panel A). In addition, Irish medical schools attract a large number of international students, who face no numerus clausus policy and accounted for about 45% of students in recent years (OECD, 2021a). However, only a limited share of these international students remain in Ireland after graduation, partly due to constrained access to postgraduate specialty training places, mostly reserved to domestic and EU students (Heffron and Socha-Dietrich, 2019). Hence, international recruitment was needed to meet domestic demand, with foreign-trained doctors making up about 41% of doctors in 2019 (Panel B), suggesting limited inflows from the large intakes of medical students in Irish medical schools. Similarly, the relative lack of postgraduate education opportunities may also help explain the system's difficulty in retaining domestically-trained nurses (INMO, 2021), who accounted for 53% of all nurses in 2021. Recent regulatory reforms providing Irish trained non-EU doctors an equal footing as their EU peers, when applying for specialised training, and easing conditions for foreign-trained doctors' access to visas are welcome.

Figure 2.16. Notwithstanding record high numbers of medical graduates, foreign-trained doctors make up a large share of the medical workforce



1. For Germany, data are based on nationality rather than on the place of training.
Source: OECD, Health Statistics database.

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2.5. The reform agenda towards a system centred on care needs

Persistent inefficiencies and unequal access to care services, in the face of relatively high spending, cemented consensus around the need for significant structural reforms in the health system. In particular, policymakers converged on the desirability of a system centred on care needs rather than on patients' ability to pay. In 2011, the government committed to end two-tier access to hospital care and introduce universal free GP care at the point of use, which involved a shift towards compulsory universal health insurance. The proposal was abandoned in 2015 on the grounds of cost, as the system of price competition

between insurers, adopted by the Netherlands in 2006 and taken as reference by the authorities, was deemed unsuitable for Ireland's low-density and dispersed population (Connolly and Wren, 2019). However, the idea of universal health care remained central in the context of the 2016 elections. This led the ensuing coalition government to establish an all-party parliamentary committee with the aim of agreeing on a ten-year strategic plan for health reforms. The committee published its final report (Sláintecare) in May 2017, which stressed the need to establish a universal, single-tier and high-quality health system, in which patients are treated solely based on health need, while also reorienting emphasis towards primary and social care (Burke et al., 2018).

The strategy relied on a gradual expansion of health care entitlements, backed by organisational reforms and capacity building aimed at gradually shifting away from a hospital-based care model towards community-based services integrating health and social care. At the same time, emphasis was laid on fostering prevention and health promotion, as well as on e-health as a key tool to ensure more timely access to care (Box 2.2).

To ensure access to care is based on clinical need, rather than ability to pay, the Sláintecare Report also recommended dropping all user charges for GP, primary and public hospital care and reducing prescription charges for outpatients. In addition, phasing private care out of public hospitals, while empowering public-only consultants and attracting them with a newly agreed contract, was identified as a key step to achieving streamlined care services. This was seen as a way to reduce waiting lists for inpatient diagnostics and treatments. In addition, the proposed introduction of waiting time guarantees would further reinforce timely access to healthcare. On the funding side, the Report recommended anchoring financing of the targeted single-tier health system in a newly established National Health Fund, combining general taxation revenues and receipts from earmarked taxes, levies and charges – an approach broadly consistent with recent OECD analysis (Dougherty et al., 2022). This funding would support multi-year financial stability, integration of services and accountability. The multi-party Committee on the Future of Healthcare estimated the additional cost triggered by the proposed reforms at about €2.8 billion by year ten, plus €3 billion of transitional funding arrangements, over six years, aimed at making up for the country's historical under-investment in health.

The Government launched its Sláintecare Implementation Strategy in 2018. Since then, improvements have been mainly concentrated on the organisational side, e.g., with the establishment of the Sláintecare Implementation Office, converted into a senior leadership team led by the Department of Health at end-2021, and a new independent Board for the HSE. Furthermore, a new contract enabled GPs to refer patients directly to community diagnostic services and extended their responsibility to chronic disease management, while a Sláintecare Integration Fund was set up to fund pilot projects in the area of integrated services. Progress on extending entitlements and lowering access costs, though, has been relatively limited.

The strategy adopted careful sequencing of reforms, involving the frontloading of reforms that were easier to implement and delaying more costly and contentious measures, e.g., universal access to GP/primary care or the removal of private care from public hospitals. Phasing in a set of entitlement expansions, especially when accompanied by reductions in cost barriers, could entail risks to the system's integrity, were perverse incentives to build up and lead patients to seek care at the wrong entry point (Thomas et al., 2021). In addition, Sláintecare's rights-based approach might represent an important step towards stronger accountability in the system. By establishing a legal entitlement to free care, as opposed to the current focus on eligibility (which depends on individual characteristics like age, means and residency), patients could appeal against those responsible for non-delivery and require corrective actions (Thomas et al., 2021).

Box 2.2. The Sláintecare Report on the Future of Healthcare in Ireland

The Oireachtas Committee on the Future of Healthcare published its final report, known as Sláintecare, in May 2017. It set out a ten-year, costed, policy roadmap to deliver systemic reform and achieve universal healthcare in Ireland. The report rested on eight fundamental principles (Table 2.1).

Table 2.1. The fundamental principles in the Sláintecare Report

Engagement	Create a modern, responsive, integrated public health system, comparable to other European countries, through building long-term public and political confidence in the delivery and implementation of this plan
Nature of integrated care	All care planned and provided so that the patient is paramount (ensuring appropriate care pathways and seamless transition backed-up by full patient record and information)
	Timely access to all health and social care according to medical need
	Care provided free at point of delivery, based entirely on clinical need
	Patients accessing care at the most appropriate, cost-effective service level with a strong focus on prevention and public health
Enabling environment	The health service workforce is appropriate, accountable, flexible, well-resourced, supported and valued
	Public money is only spent in the public interest/for the public good (ensuring value for money, integration, oversight, accountability and correct incentives)
	Accountability, effective organisational alignment and good governance are central to the organisation and functioning of the health system

The Sláintecare Report laid out an agreed definition of universal healthcare and explicitly identified the set of healthcare entitlements that should be covered under it. It stipulated that a universal healthcare system should provide preventive, primary, curative, rehabilitative and palliative health and social care services to Ireland's entire population, ensuring timely access to quality, effective, integrated services on the basis of clinical need. Accordingly, a range of services from health promotion, self-management and screening to rehabilitation, social, palliative and long-term care would come under the remit of universal healthcare. According to the Sláintecare report, the latter would also cover dental, ophthalmic and aural care, as well as drugs, mental healthcare and counselling. Moreover, special emphasis is laid on enhancing public health and prevention, as well as on the shift from hospital delivered care to primary and social care delivered in the community, especially with reference to the management of chronic diseases and the delivering of integrated care.

The Sláintecare Report included five main sections:

I – Population health profile

Despite significant improvements in life expectancy over the last decades, health outcomes continue to vary considerably between social, economic, regional and age groups. At the same time, a growing but rapidly ageing population would trigger increased demand for chronic disease management and other care services. The Report acknowledged that, in order to cope effectively with these challenges, health services should be delivered in an efficient, integrated manner at the lowest level of complexity, while the role of health prevention should be enhanced. Likewise, specific whole-of-government policy actions would need to address the social determinants of health, in order to reduce the inequality of health outcomes.

II – Entitlements and access to healthcare

A significant phased expansion – backed by legislation – in the entitlements to primary and social care services, was envisaged, through the similarly phased introduction of a health card (the Cárta Sláinte), providing all residents with access to a comprehensive range of services based on need. Within a preferred model delivering the vast majority of healthcare at community level, the expansion in entitlements must be accompanied by the strengthening of the system's capacity to deliver better and fairer access to primary, general practice and public hospital care services. To this end, the Report

foresaw the gradual elimination of private care in public hospitals, alongside the removal or reduction of out-of-pocket payments from households, which may be a considerable barrier to equitable access to healthcare. The Committee estimated the additional cost triggered by the expansion in entitlements and capacity at about € 2.8 billion over ten years, excluding other likely increases due to demographic pressures and medical inflation.

III – Integrated care

Ireland's rapid population ageing heightens the demand for a more complex set of clinical and social care services, especially in light of the growing prevalence of chronic diseases. In order to meet these needs, a new model integrating health and social care is required, in which the person is put at the centre of system design, and delivery occurs at the appropriate level of clinical complexity, within a reasonable period of time, with little if any charge at the point of access. This will be backed by newly established regional executive bodies, responsible for resource allocation and tasked with implementing integrated care services at the subnational level via enhanced coordination across the territorially relevant Hospital Groups and Community Health Organisations. Achieving effective integrated care, though, will depend on the system's capacity to channel significant investments towards expanding diagnostic services out of hospitals. This, coupled with the imposition of time guarantees, would also help address exceedingly long waiting lists for access to essential diagnosis, treatment and elective care.

IV – New funding model

After having appraised various possible options, based also on lessons from international experience, the Sláintecare Report proposed to fund the desired single-tier health system through general taxation revenues and the earmarking of some taxes, levies or charges, all combined into a newly established single National Health Fund. The latter, as opposed to several purchasing mechanisms, would help incentivise integration of services and accountability. Over time, this would imply a diminishing role for private sector payments, as a larger share of the overall health budget would come from public, pooled resources. Moreover, in addition to the €2.8 billion expansion of the health budget over ten years, to meet the increase in spending led by the expansion in entitlements, the Report recommended the implementation of transitional funding arrangements totalling €3 billion over six years, in order to make up for the country's historical under-investment in health. In the Committee's proposal, these funds were meant to be deployed to enhance capital expenditure, training capacity and reinvestment into one-off system changing measures, as well as to enable a full roll-out of the eHealth strategy.

V – Implementation

The Report's final section included a series of provisions aimed at ensuring that the high level of political consensus attained in the Committee, concerning the need to pursue an ambitious programme to reform Ireland's health system, is effectively carried over into implementation of its recommendations. These provisions included the request for a rapid establishment of an Implementation Office reporting directly to the Minister of Health, but placed under the authority of the Taoiseach. Adequately resourced and staffed, the Implementation Office should also set up a cabinet sub-committee tasked with the ongoing and effective monitoring and evaluation of the implementation programme.

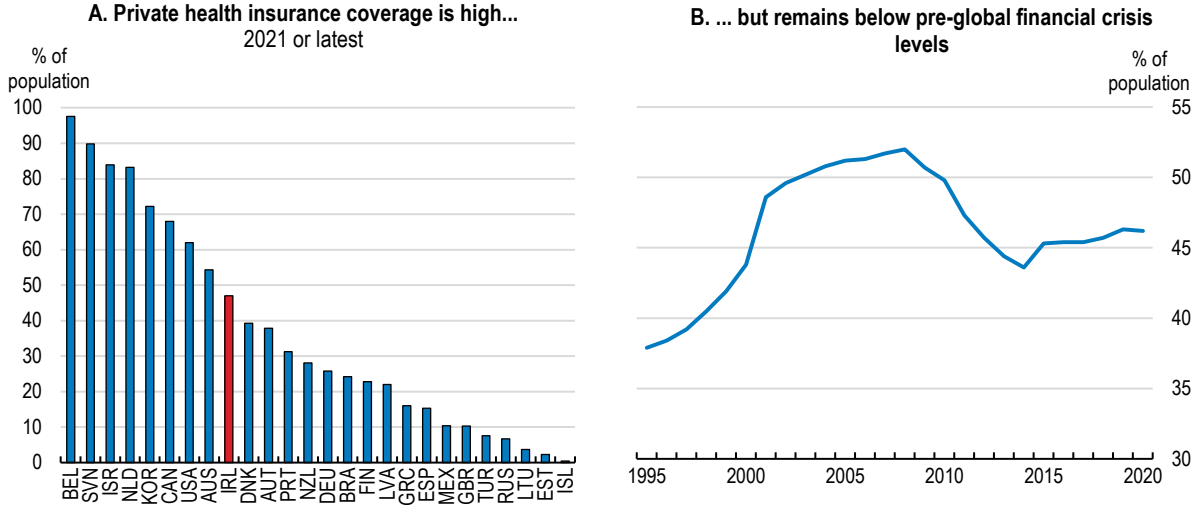
Source: Committee on the Future of Healthcare (2017), *Sláintecare Report*, Houses of the Oireachtas, Dublin; Burke et al. (2018), "Sláintecare – A ten-year plan to achieve universal healthcare in Ireland", *Health Policy*, Vol. 122.

2.5.1. Adjusting the public and private sector mix

Ireland's healthcare consists of a publicly funded system, run by the HSE, and a private system that operates alongside it. Take-up of private health insurance is supported by public subsidies, in the form of a relatively sizeable tax relief. With about 46% of the population covered in 2020, private health insurance plays a prominent role in Ireland's healthcare (Figure 2.17, Panel A). Overall, the share of the population covered by private health insurance rose only moderately from its 2014 trough, with the trend increase in take-up more evident across groups younger than 40 and older than 70 (Department of Health, 2021a). However, the coverage rate remained well below its levels in the mid-2000s, when it had peaked above 50% (Panel B; HIA, 2021).

At its core, the country's health system is designed to provide comprehensive publicly-funded health services to low-income groups, coupled with universal public hospital coverage. Whilst open to medical and GP visit cardholders, private health insurance is thereby mainly taken out by individuals excluded from a significant part of public coverage, essentially to finance private or semi-private care provided in both public and private hospitals (Connolly and Wren, 2019; Nolan, 2017). As a consequence, over recent decades, policy-makers have supported the development of private health insurance as a way to provide greater choice over providers, while funding cost-sharing and services not covered by the public system (Colombo and Tapay, 2004). In particular, to shore up plummeting private health insurance coverage in the wake of the financial crisis (Figure 2.17, Panel B), the government introduced a tax relief equal to 20% of the cost of insurance premiums, which, in 2013, was capped at €1 000 per adult and €500 per children under 21 years of age. While the limited gains in private insurance coverage after the 2014 trough – despite the subsequent economic recovery– may justify the government's decision to keep the tax relief in place, some form of means-testing would lower equity concerns. In 2015, a financial penalty on new policies subscribed by the over-35s was put in place, with the aim to incentivise early take-up of health insurance by younger generations.

Figure 2.17. The private health insurance market is large



Note: Panel A only refers to voluntary private health insurance.
Source: OECD, Health Statistics database.

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The peculiar role of private health insurance in the country's health system raises equity concerns. Irish private health insurance subscribers, to a large extent, do so to acquire coverage for services that are essentially already made available in the public sector, either for free or in a highly subsidised form, but whose timely delivery is constrained by excess demand. Private health insurance ensures faster access to scheduled hospital treatments or services to people who can afford to pay for it (Turner and Smith,

2020). Besides, the duplicative nature of private insurance in Ireland is further emphasised by major private health insurers increasingly offering some limited coverage for primary care expenses. This contrasts with many other EU countries, where the role of private health insurance is largely to cover any cost sharing left after basic coverage (complementary, as in Belgium, Germany or Slovenia), or to ensure access to additional services (strictly supplementary, as in Austria and the Netherlands).

Private health insurance is thus at the core of a two-tier system in which public hospitals also provide beds and care services of a purely private nature to patients who can afford voluntary insurance coverage, thereby entailing the risk of differentiating quality in access to care based on patients' ability to pay, rather than on their actual needs. Increased evidence of mounting barriers, affecting specific categories' timely access to health care services, corroborates such concerns. Longer waiting lists for hospital-based and key diagnostic services weigh, in particular, on Medical Card holders (The Irish Times, 2021), while reduced take-up of primary health care, due to cost, emerged even among households in income groups well above the Medical Card's eligibility threshold (Schneider and Devitt, 2018), and this may have deteriorated further during the pandemic. In addition, the adopted mixture of a universal public health service and a fee-based private system may lead people legitimately eligible to the benefits granted by the Medical Card to forego entitlement (Keane et al., 2021).

Rules managing entitlement to publicly-financed health services are extremely complex and limit the system's transparency. In principle, eligibility is based on residence, but entitlement to several public health benefits is actually dependent on meeting additional criteria, including income, age and – to a more limited extent – payment of social contributions. At the same time, co-payments by Medical Card holders (for medical prescriptions), as well as some by non-medical cardholders (hospital in-patient services and the use of emergency departments if not referred there by a GP) are capped at monthly or annual amounts that vary across services. Not means-tested and with varying units of reference, either single individuals or households, these caps have often been set at lower levels for older people. In the wake of the 2008 global financial crisis, in particular, rapidly increasing user fees, imposed on non-medical cardholders for most inpatient and outpatient services, led to substantial upward revisions of annual caps on payments in 2013, which, once the economy recovered and fiscal consolidation concerns eased, were only partly reversed. Similarly, individuals aged over 70, who enjoyed automatic eligibility to the medical card since 2001, saw means testing reinstated in 2009 and a lowering of the relative income threshold four years later. Moreover, fees for some specific services (i.e., dental care or GP visits without a GP Visit Card) are not capped, which may weigh on low-income patients' access to care. The variety of entitlement requirements and their relatively frequent adjustments create uncertainty for recipients whose income hovers around legislated eligibility thresholds, as even modest adjustments in one of the required parameters can affect their entitlement to public health benefits. At the same time, cuts in health spending and personnel lengthened waiting lists for many essential consultations and treatments, especially for Medical Card holders.

2.5.2. Reforming dual practice

The public health system features widespread consultant involvement in private care. The characteristics of this involvement, however, depend on the type of contract held by consultants (Box 2.3). As of 2020, more than 80% of consultants held contracts allowing for some form of private practice (HSE/NDTP, 2021; Figure 2.18), a share found to be higher in public acute hospitals (IRG, 2019).

In this context, in December 2019, the Government proposed a new Sláintecare consultant contract as a key pillar to attract and retain staff via enhanced job satisfaction in the public health sector. Reserved for specialists working exclusively in the public health system, in line with current Type-A contracts, the proposed instrument is an integral part of the Sláintecare strategy to improve working conditions in public hospitals by removing private care services from their premises (HSE, 2021b). In a context of limited capacity, public hospital involvement in private care has resulted in long waiting lists for many services,

creating equity concerns of access by poorer households entirely dependent on public care services. By freeing up public capacity and staffing, gradually reduced engagement in private care is expected to help move towards a need-based public health system (Independent Review Group, 2019). The restored resources, for instance, could lower bed occupancy rates or shorten waiting lists. However, the move would result in a limitation of patients' right to choose the preferred service provider, not to mention the revenue losses faced by public hospitals.

Box 2.3. Typology of currently available consultant contracts

The 2008 Consultant Contract granted public hospital consultants pay increases in exchange for higher restrictions to their private practice, with the objective – largely unattained – of increasing the number of consultants treating public patients only. While introducing a 39-hour working week, the 2008 agreement established three different types of contracts varying according to the extent of private practice allowed:

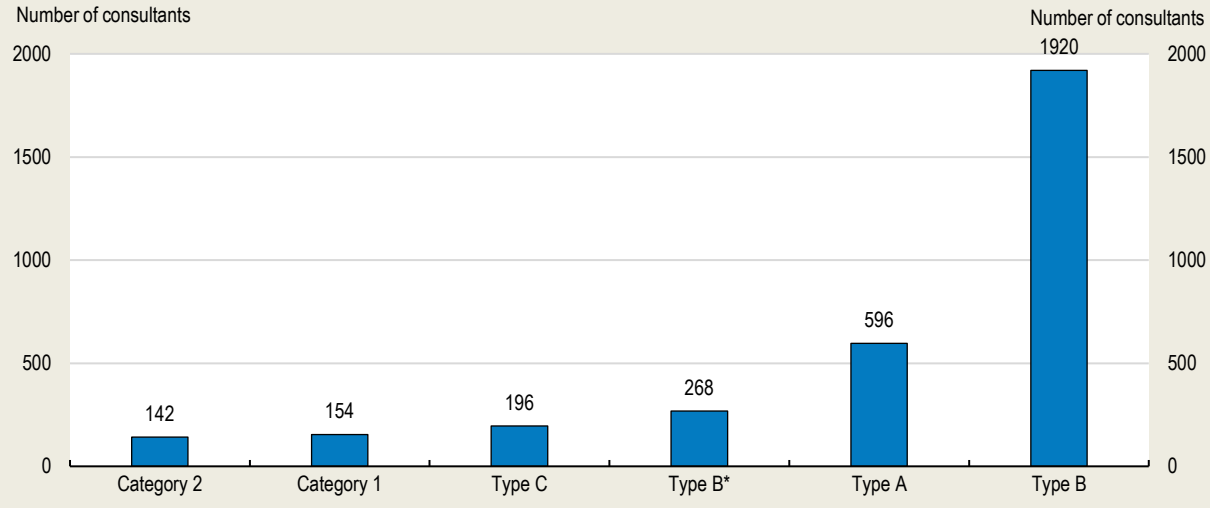
- Type-A: public-only contract (consultants practising exclusively in public health services).
- Type-B: consultants are free to engage in private practice on the public site or in a co-located site, but only up to 20% of their total clinical or patient output.
- Type-C: consultants can also engage in off-site private practice, but private patient treatment should not exceed 20% of the consultant's clinical workload.

These contracts have so far coexisted with more flexible alternatives, still linked to the previous 1997 Consultant Contract that allowed freer in- and off-site private practice in the context of a 37-hour working week. They include:

- Type-B* contracts: extended to holders of the 1997 Consultant Contract whose public-to-private practice ratio was greater than 20%; they could retain a higher ratio under the 2008 Contract, subject to an overriding maximum of 70:30.
- Old 1997 Category 1 and Category 2 contracts, with the former entitling holders only to limited off-site private practice, relative to more flexible Category 2 contracts.

Figure 2.18. Dual practice largely prevails among specialists employed in the public system

Number of active consultants by type of contract, 2020



Source: Health Service Executive.

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According to the Government's first proposal, incumbent consultants will be offered the opportunity to opt into the new contractual framework, which, instead, will automatically apply to newly hired consultants. Even so, in a bid to lure more experienced health professionals into a fully public health system, the Government enhanced the new contract's attractiveness by committing to raise pay levels to between €210 000 and €252 000 over a six-point scale. This implies a return to pre-2012 pay rates, i.e., before the wage cuts of about 30% imposed on higher-earning public sector staff in the aftermath of the 2008 crisis. Efforts have also been made in other OECD countries to improve the attractiveness of working conditions (Box 2.4).

Box 2.4. Recent reforms to improve conditions for hospital practitioners in France

The French authorities have recently introduced new reforms for public hospital practitioners and specialists, as a means to foster the attractiveness of public hospital medical careers. The measures built on the 2018 "Ma Santé 2022" plan, which, following long consultations involving the French Hospitals Federation, trade unions and various associations of healthcare professionals, set out a strategy to improve practitioners' working conditions in public health venues.

The authorities merged three pre-existing categories of fixed-term contracts into the single status of contract practitioner, thereby simplifying human resource management. This was also accompanied by measures improving career support mechanisms and ensuring a better recognition of non-clinical activities within the framework of practitioners' service obligations and their working time.

In order to respond to increased requests for new ways to deliver care, the new measures eased the conditions limiting dual practice among public hospital practitioners. This occurred in the context of public hospital doctors' modest involvement in private practice and the absence of significant concerns over waiting lists. In particular, the minimum amount of working time for a public hospital practitioner was set at five half-days. The possibility to combine hospital employment with an off-site private activity was extended to all physicians whose public practice covers between 50% and 90% of their working time, with the only condition being to declare this activity – and its relative terms – to the employing institution. This was previously only granted to part-time practitioners with 40% to 60% public hospital time.

Similarly, while on-site private activity was formerly reserved to full-time hospital practitioners, the new rules open such opportunity to every physician with at least 80% public practice, including practitioners still in their probationary period. On-site private activities may be carried out on two separate sites within the same territorial hospital group.

Source: Ministère des Solidarités et de la Santé (2022), "Attractivités des carrières médicales à l'hôpital : l'exercice et les statuts de tous les praticiens sont réformés".

Notwithstanding the proposed salary hikes, the new contract has so far failed to be agreed by medical representative bodies. Although in line with the policy objective to rebalance the health system towards public patients' care by removing private care services from public hospitals, the contract's ban on dual practice for new public sector specialists, even if partly compensated by higher pay, will add to existing contractual fragmentation during the foreseen transition phase. Additionally, the overall proposal appears to be perceived as including a strong top-down component with limited scope for flexible arrangements that are key to attract and nurture talent. In this regard, anecdotal evidence about the emigration of Irish-trained doctors to Australia in recent years suggests that their decision to leave is driven in part by the possibility over there to more easily combine clinical hours with research or management tasks, based on personal skills and interests (thejournal.ie, 2022; Humphries et al., 2019). Recent survey data suggest doctors in specialist training and fellowships – thereby still barred from private practice – have serious concerns about the proposed contract's rigid approach with respect to patient advocacy, mobility policies,

intellectual property rights and the implementation of future contract changes, which would result in reduced professional autonomy and stifled incentives for innovation (Croghan et al., 2021).

Dual practice of inpatient specialists is relatively common, but its regulation and organisation vary considerably across OECD countries. Canada is the only country not allowing public staff specialists to practice privately, whereas they are entitled to do so only outside of public hospital premises in Spain and Portugal. Dual practice is instead allowed within public hospitals – as well as outside – in Australia, France, Ireland, Italy and the United Kingdom, although with differences in the type of services provided to private patients, which may include treatments that are part of public benefit packages (Müller and Socha-Dietrich, 2020). In Ireland, as in the United Kingdom, private patients can in fact be treated alongside public patients but pay all related charges and fees themselves, either out-of-pocket or through private health insurance. Australia and France, instead, allow the public purse to partially cover the costs of private treatment. The high incidence of dual practice among Irish specialists, second only to Austria's (Garrattini and Padula, 2018), has also had a significant impact on the financial management of public hospitals. Revenues from private practice, excluding consultant fees, have in fact grown to account for about 10% of public hospitals' income, which helped stabilise health care provision in periods of volatile public spending (Müller and Socha-Dietrich, 2020).

The net effects from reducing dual practice in public hospitals depend on various country-specific factors, but institutional quality is likely to play a key role. On the one hand, dual practice within public care settings is often associated with conflicts of interests and competition for time, which reduce care responsiveness for public patients, distort the use of public resources and erode public trust in the health system (Ferrinho et al., 2004; Müller and Socha-Dietrich, 2020). The adoption of specific institutional arrangements and public sector governance frameworks, though, may help curtail these risks. Clearly outlined and effectively enforced public employment terms and conditions, combined with regulation enabling equal access to care for equal needs, could go a long way in balancing health workers' incentives with the right to quality and timely care for all (Araujo et al., 2016).

On the other hand, if not accompanied by effective complementary measures to improve health professionals' working environment, reducing dual practice opportunities in public hospitals would likely weigh on their capacity to attract more qualified physicians. The latter may thus look for jobs in the private sector or opt for practising abroad (Müller and Socha-Dietrich, 2020). The ensuing staff reductions would end up frustrating the objective to redirect freed resources towards tackling lengthy waiting lists and improving public patients' access to care, unless the recruitment of new specialists is adequately stepped up. On the positive side, ceasing any involvement in private care services should simplify public hospitals' administrative processes. At the same time, public hospitals might require higher public transfers to neutralise the income losses from reduced activity and preserve their financial stability.

Policy changes aimed at restricting dual practice opportunities should avoid accentuating the system's rigidities. In light of this, close consultation with hospital practitioners and other relevant stakeholders, in both design and implementation stages, would help smooth the policy's introduction. Moreover, approaches foreseeing the complete separation of public and private specialist practice should be complemented by regulatory changes aimed at removing any significant constraint on inter-sectoral mobility. Routine elective surgery currently represents the main operational focus of private hospitals, whereas more complex acute care is provided within public hospitals. As private practice in public settings is phased out, as planned, private hospitals may have stronger incentives to widen their range of services by investing in more advanced clinical and technological capacity. In this context, ensuring specialists can easily alternate public- and private-sector professional spells, along their entire careers would help support the enhancement of skills across the whole system.

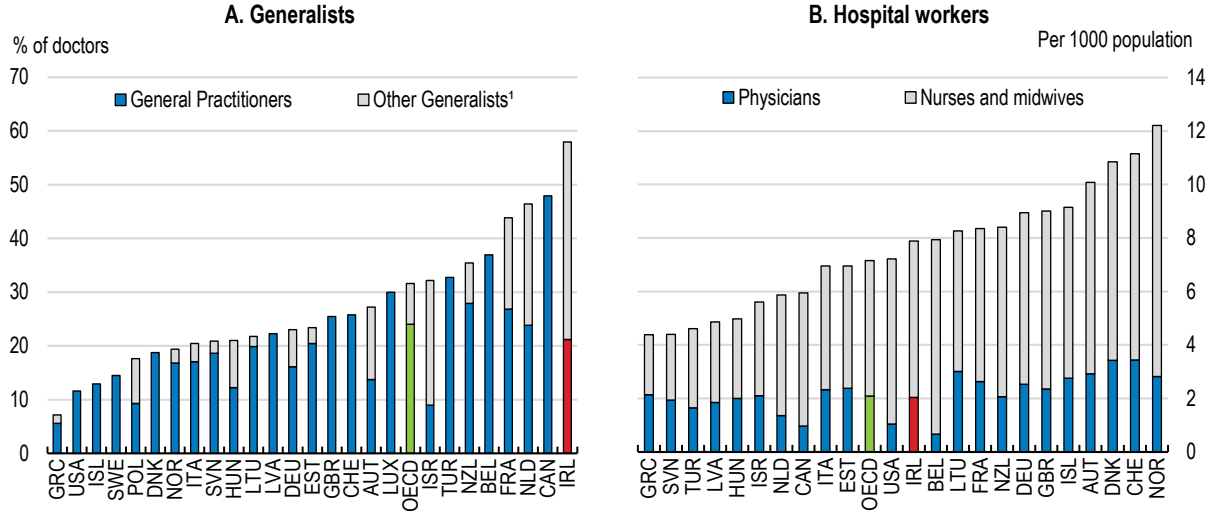
2.5.3. Getting to grips with waiting lists

Pressures contributing to waiting lists stem from a lack of specialists and past under-investment including in specialist diagnostic equipment. The share of generalists in the health system is comparatively large and there is room to expand hospitals' clinical staff (Figure 2.19). In this regard, plans to expand the cadre of specialists are welcome. Similarly, ensuring Advanced Practice nurses and other specific clinical professionals may, under a consultant's supervision or independently, assess patients that are deemed non-urgent based on referral information, could help streamline waiting lists for specialist appointments (Delamaire and Lafortune, 2010; Fennelly et al., 2018). The long period of under-investment in the health sector until recently has also resulted in a somewhat lower than average availability of some diagnostic technologies (CT scanners, MRI units and PET scanners) in comparison with other OECD countries (OECD, 2021a). However, this is being addressed and current plans include expanding elective capacity in a number of specialist units in Cork, Galway and Dublin (HSE, 2022c). These should expand the capacity for outpatient consultations to perform diagnostic procedures and some minor operations.

Some pressure stems from insufficient bed availability. Bed occupancy rates are elevated and amongst the highest in the OECD (Figure 2.5 above). Such rates are difficult to sustain and generally greater safety margins are advisable (the pressure on beds contributed to the limited capacity of the system to respond to the COVID-19 pandemic). However, elevated bed occupancy rates have been a chronic feature of acute hospitals in Ireland for some time. In part, this reflects the pressure on hospitals due to limited community care and long-term care provision providing alternative healthcare options (see below). For example, admissions of patients suffering from asthma and chronic obstructive pulmonary disorders are elevated when compared with other health systems (Figure 2.20). The pressure on beds also leads to pre-emptive blocking for patients who may have treatments scheduled after their admission date.

Figure 2.19. There is room to expand the cadre of specialists

2021 or latest available year



1. Includes non-specialist doctors working in hospitals and recent medical graduates who have not yet started post-graduate specialty training.
Source: OECD, Health Statistics database.

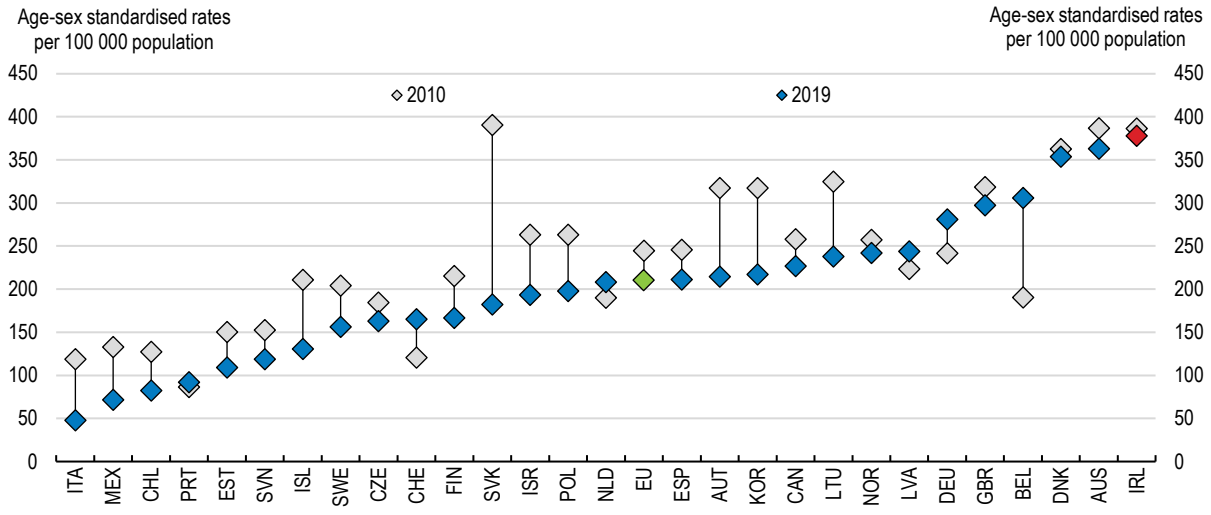
StatLink 2 https://stat.link https://stat.link/cxsioe

Around 400 000 outpatient appointments annually are missed due to people not attending. This is about 12% of all appointments and more than 30% above the corresponding rate in England, where more than 5 million hospital appointments annually are classified as 'did not attend' (NHS Quarterly Hospital Activity Data). This hinders the efforts to reduce waiting lists and complicates resource management. In some cases, it also leads to greater subsequent use of hospitals and increased mortality risk (Williamson et al.,

2021). Improving existing methods of communication can reduce did not attends (DNAs). For instance, the use of behavioural science to redesign existing communications with the Better Letter Initiative had a positive impact in randomised control trials. A redesign of inpatient appointment offer letters increased confirmed intention to attend rates from 66% to 75%, and reduced DNA rates by 50% in one hospital (Murphy et al., 2020). Modifying, as intended, the technology developed during COVID-19 for vaccination and test and trace to improve bi-directional communication with patients and care givers could help reduce non-attendance. Sending SMS reminders to patients before an appointment or using electronic records to predict those patients most likely to miss appointments and contacting them in advance, appears to be effective in reducing non-attendance (Murphy and Taaffe, 2019; Valero-Bover et al., 2022). A national DNA Strategy is planned as part of the Action Plan for Waiting Lists.

Figure 2.20. Avoidable hospital admissions are high for some conditions

Asthma and COPD hospital admissions in adults, 2010 and 2019



Note: The EU average is unweighted. COPD refer to chronic obstructive pulmonary disorders.
Source: OECD, Health at a Glance 2021.

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Hospital overcrowding with patients spending time on trolleys has also developed alongside waiting lists. Overcrowding in emergency departments is a phenomenon in many countries. At an average of 12 hours, the waiting times in emergency departments (EDs) from registration to admission appear very long in Ireland, particularly for older patients, with hundreds each day spending time on trolleys waiting for beds to become available. Prolonged durations of stay in EDs (above six hours) are associated with poorer patient outcomes and increased mortality, while longer waiting times have adverse outcomes for discharged patients. In part, the relative underdevelopment of primary and long-term care has put pressure on hospitals (INMO, 2022). However, at 6.2 days, the average length of stay in hospital was among the lowest in the European Union in 2019 and well below the OECD average of 7.6 days, although the average time spent in hospital was comparably longer in case of diseases of the digestive and genitourinary system or neoplasms (OECD, 2021a). Pressure on emergency rooms also arises from under-provision of step-down beds, which would allow patients to move out of emergency rooms but still receive a higher level of care than in a general ward.

Previous expansions of the health sector did reduce waiting lists for a number of procedures prior to the onset of the global financial crisis in 2008 (Siciliani, Moran and Borowitz, 2014). However, expanding supply to address waiting lists can be expensive and, in some cases, induce higher demand (OECD, 2020b). OECD countries have tended to address waiting lists with a multi-pronged approach. These include setting maximum waiting times, which nonetheless need to be set in relation to what is feasible,

and guarantees for patients, which may include the option to use different providers if waiting times exceed the maximum. In the United Kingdom, the waiting list maxima were gradually tightened, met partly by greater activity but also better demand management.

Ensuring adequate supply to meet demand cannot be achieved through a short-term boost to spending. Rather care is needed to identify priorities and ensure that efficiency is maximised. In some cases, a second layer of gatekeeping is helpful in preventing inappropriate or misdirected referrals clogging the system. For example, policies in Costa Rica, Finland and Poland coordinate primary and secondary care to use resources efficiently and minimise waiting lists. Finland plans specialist consultations in a primary care setting to reduce the need for unnecessary hospital referrals, particularly for patients with chronic conditions. An alternative approach, such as in Australia, New Zealand and Norway, uses clinical prioritisation to ensure that those most in need of care encounter shorter waiting lists (OECD, 2020b). Countries tend to prioritise treatments for life-threatening conditions (Siciliani, Moran and Borowitz, 2014). This is the case in Ireland, where cancer patients have fast-track pathways to care, given that delay is potentially life threatening.

A number of waiting list time targets have been set in Ireland, which are long in comparison with other OECD countries (OECD, 2020b). These include that 90% of patients wait less than 15 months for an elective procedure and that 85% of patients will be seen for their first outpatient appointment within 52 weeks. The Sláintecare implementation strategy also set waiting time targets, such as ten weeks for an outpatient appointment and 12 weeks for day and inpatient treatments. The first Waiting List Action Plan in 2021 saw some success in reducing numbers. The 2022 plan attempts to achieve further gains, allocating €350 million to increase activity, particularly initially for a number of procedures. For example, the National Treatment Purchase Fund will organise care for these procedures in the public or private sector, where prices are reasonable. Further work in the forthcoming multi-annual Waiting List Reform Programme will need to build a proper information base to monitor progress.

There is room to move some diagnosis and care from hospitals to primary and community care. The Waiting List Plan, besides funding for increased activity, also includes changes to cut waiting times in the future (HSE, 2022c). One initiative is Modernised Scheduled Care Pathways that are consistent with Sláintecare ambitions to move care out of the hospitals and into the community setting and should be implemented immediately. For example, not all patients use the most appropriate health pathways, either being referred to specialists that are not the correct ones or presenting themselves to emergency rooms to get diagnostic tests. Allowing diagnosis and care to be delivered in primary care and community care settings when appropriate (such as for minor operations) can reduce some of the pressures on waiting lists. Providing support and advice to medical professionals outside the acute hospital sector can help them direct patients to appropriate primary or community care instead of hospitals.

2.5.4. Meeting growing demand for long-term home care

The COVID-19 pandemic had a severe impact on the long-term residential care sector. Nursing homes became an epicentre of contagion at the beginning of the pandemic, leading to marked increases in mortality among their residents. Nursing home deaths accounted for about 56% of Ireland's total COVID-19-related deaths in mid-2020, one of the highest shares in Europe. However, the rate decreased to 36% in early 2022, a level below the average of European Union countries with available data (ECDC, 2022), thanks to improved infection prevention and control protocols and prioritised vaccinations (DOH, 2021b; Comas-Herrera et al., 2021). Outbreaks in residential facilities, though, led to disruptions of non-essential care and stringent visit restrictions (Rocard et al., 2021).

Overall disruptions in home care services because of COVID-19 were relatively limited, like in many other OECD countries (Rocard et al., 2021). In April 2020, the HSE temporarily suspended the provision of low-priority personal care services and referred recipients to alternative voluntary and community support. The HSE introduced detailed guidelines on infection prevention and control measures in home care settings,

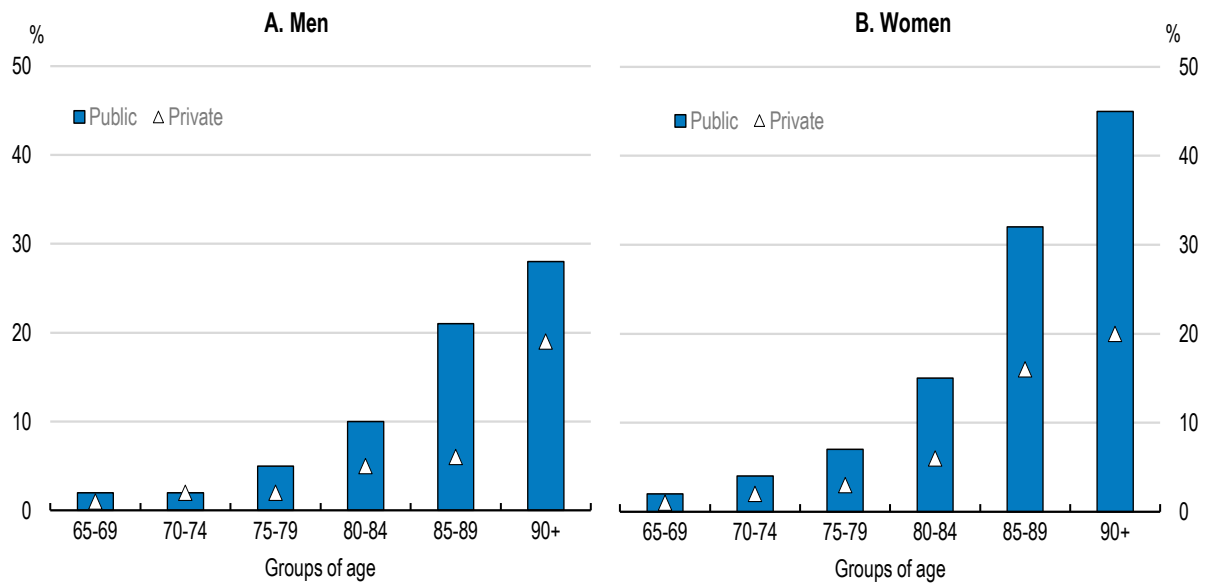
as well as an array of related training opportunities for home care providers, while ensuring the latter had continued access to facemasks and other appropriate PPE material. This resulted in extremely limited numbers of registered COVID-19 outbreaks in home care settings (DOH/HSE, 2021a). At the same time, a relatively low number of home care workers were redeployed to residential care services, when the policy emphasis was on preserving their essential staff capacity during pandemic peaks (DOH/HSE, 2021a).

Demand for home care support is rising. In 2019, publicly funded home-care, which is provided free of charge – up to the level of funded services, considerably exceeded the corresponding supply of services, resulting in long waiting lists (Smith et al., 2019). Mismatches between supply and demand led to untimely delivery, which, in turn, discouraged potential recipients from seeking home support and may have diverted part of demand from public towards private care provision, particularly at older ages (Figure 2.21). In addition, constrained access to home care favoured the use of residential care (Walsh and Lyons, 2021). At the regional level, lower supply of home care support correlates with longer hospital inpatient stays (Walsh et al., 2020).

In recent years, the government has increased the financing of home care services, to enhance community-based support and improve quality of life among the frail elderly (Table 2.2). In 2021, the authorities pledged to increase home support for people aged 65 or over by five million hours and committed to finalise the establishment of a new statutory scheme for the financing and regulation of home support services (Walsh and Lyons, 2021). Open to seniors who are unable to continue to live at home without support, due to illness, disability or, temporarily, following a hospital stay, the scheme – which is still under development by the Department of Health – will seek to ensure that, according to their needs, recipients can live in their own homes for as long as possible, and, thereby, reduce the number of those entering long-term residential care.

Figure 2.21. Estimated use of home care is considerable at older ages, particularly among women

Home support receipt rates among the elderly by sex, age and type of provider; share of the population, 2019



Note: Includes recipients of Home Help, Home Care Packages and Personal Care Attendant schemes; analysis based on data from TILDA Waves 2-4 Research Microdata File, collected between 2012 and 2016.
Source: Walsh and Lyons (2021), "Demand for the Statutory Home Support Scheme", Research Series, No. 122, Economic and Social Research Institute, Dublin.

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Table 2.2. Budget allocations for home support increased considerably during the pandemic

	Budget (€ million)	Home support hours (target, million hours)	Budget (annual % increase)	Home support hours (annual % increase)
2017	380.4	16.7		
2018	416.9	17.5	+9.6	+4.5
2019	445.7	18.3	+6.9	+4.6
2020	487.0	19.3	+9.3	+5.1
2021	632.0	24.3	+29.8	+26.0
Δ 2021-2017	+251.6	+7.6	+66.1	+45.0

Source: Department of Health and Health Service Executive (2021).

International studies tend to associate home care with lower societal costs, when compared with residential care (Kok et al., 2014; VanderBent and Kuchta, 2010). While home care is generally cheaper than residential care, its appropriateness and cost-effectiveness might be questioned for users requiring round the clock care and supervision or who reside in remote areas with limited access to caregiving services (Colombo et al., 2011). Evidence from a quasi-experimental study among a population of 65 years and over, eligible for permanent nursing home admission in the Netherlands, for instance, suggests that substituting nursing home care with home care might actually not save costs for patients with relatively severe medical needs. Nursing home care is expensive in the Netherlands but paid for by mandatory social insurance, which usually covers room and board costs as well. Albeit still relatively generous, social insurance coverage of home care is less pervasive because of its less structured nature. This, together with the more limited scope for economies of scale, might explain why individuals giving up nursing home care may end up using an almost equally expensive amount of home care (Bakx et al., 2020). These context-specific results, which do not consider the positive impact of home care on the individual's well-being, echo recent OECD estimates of the average cost of long-term home care for over-65s with different levels of needs, across 24 OECD jurisdictions (OECD, 2022a). The latter highlighted that, independently from personal income levels, the total costs of long-term home care for over-65s with severe needs, measured as a share of their disposable income, were significantly higher than in the case of institutional long-term care (LTC). This is despite the overestimation of nursing home costs, which include food and accommodation, in contrast to home care costs (Figure 2.22, Panel A). Such results, however, do not seem to hold for Ireland, where the total costs associated with home care, in case of severe care needs, are well below those of institutional alternatives (Panel B), which are the sample's second highest, after Finland's. A review of funding for home support and its sustainability is currently in progress, which can help guide ongoing reforms.

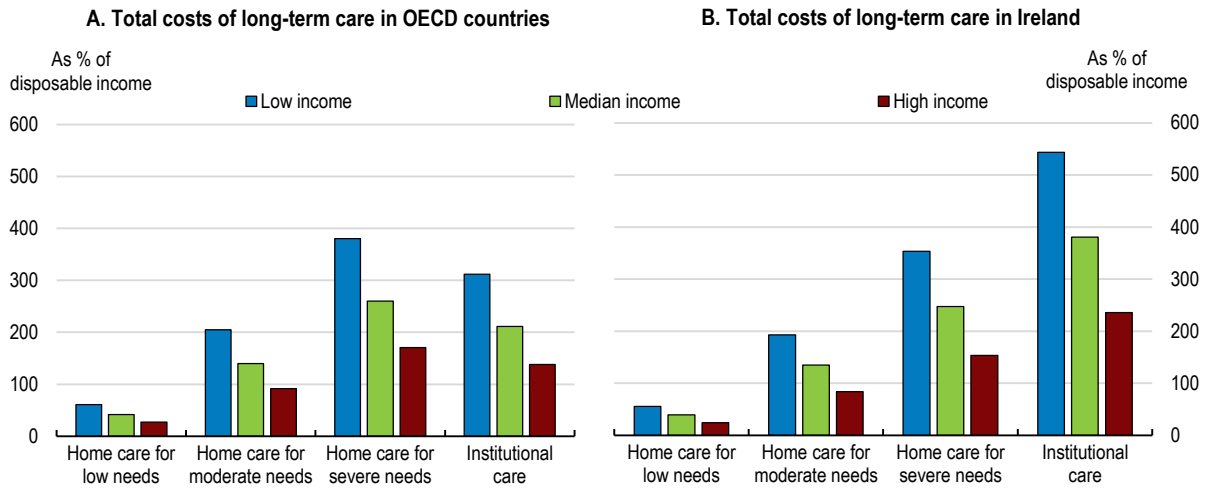
Due to their qualitative nature, many benefits ensuing from expanded home support services are difficult to capture with standard quality-of-life metrics, which makes performing meaningful cost-effectiveness analysis more complicated (Moran and Halpin, 2021). In this context, identifying specific cost thresholds – resulting from a comprehensive assessment of the patient's medical needs and well-being – above which a shift from home to institutional care settings may be considered could help enhance the cost effectiveness of long-term care spending (Bakx et al., 2020). Ideally, the quantification of the optimal provision of home care services should also build on a clear understanding of their implications for the health, well-being and labour supply of informal caregivers, who usually complement formal providers. In practice, however, these costs are hard to determine due to limited data availability.

Home care schemes' cost-effectiveness partly depends on an adequate identification of needs. This would require effective integration of home care with other community-based health, long-term care and social services. Integrated funding and delivery of services, on the backdrop of combined management and information systems, would help ensure a service user moves through a continuum of care, eventually culminating with admission to long-term residential care.

The implementation of the Single Assessment Tool (SAT) at the national level would support better planning and allocation of LTC and strengthen integration across providers. SAT is a digital standardised assessment – based on the international interRAI framework – of the health and social care needs of frail older persons or people with disabilities applying for either home or nursing home support schemes (HSE, 2022d). The comprehensive assessment, which is set to replace a paper-based procedure, takes into account a broad set of information across several dimensions. These range from the individual's (physical and mental) health status, functional performance and well-being to more detailed aspects of daily life, like medication management, physical activities, dietary habits and social interactions. Progress is already underway. The evaluation of the outcomes of four pilot projects of a reformed model of home support services – based on the use of SAT – is expected to inform the design of the new statutory home support scheme. Recruitment for 128 Care Needs Facilitator posts has commenced.

Figure 2.22. Home care for frail elderly is considerably cheaper than institutional long-term care

Total costs of LTC as a share of over-65s' disposable income for different levels of needs



Note: OECD aggregate shows averages for 24 jurisdictions in the OECD in Panel A. Low income refers to the upper boundary of the 20th percentile, and high income to the upper boundary of the 80th percentile. Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. The costs of institutional care include the provision of food and accommodation, so are overestimated relative to home care. The OECD average is computed across jurisdictions' latest available observations (from 2016 to 2020). The reference year is 2016 for Ireland.

Source: OECD analyses based on the Long-Term Care Social Protection questionnaire and the OECD Income Distribution Database.

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The implementation of the SAT at the national level should be accelerated and prioritised. Better identification of individual needs can enable better planning, effective and tailored person-centred care, improved clinical decisions, and less duplication of records. At the same time, the standardised nature of the assessment would make access to LTC support more equitable, by avoiding assessor bias (Walsh and Lyons, 2021). Moreover, when integrated with other relevant healthcare datasets or aggregated, SAT individual data could also support decision-making at the population level through more effective benchmarking and monitoring, for instance by improving screening of target priority groups.

The government has also committed to overhaul home-support regulations. Ongoing work to establish a professional licensing framework for public and private home-support providers, outline minimum license requirements and define national standards for home-support services is welcome. These regulations can also help address the sector's skill shortages (The Irish Examiner, 2022; Houses of the Oireachtas, 2022a) by strengthening the professional status of formal home carers. The Strategic Work Advisory Group, an interdepartmental body established in March 2022 to identify challenges affecting the workforce in home-support and nursing home sectors – from recruitment and training to pay, career progression and retention – can also help.

2.6. Improving planning to ensure equitable and cost-effective care

2.6.1. Budgeting and the use of performance budgeting

Health care is largely funded by the public purse. Public spending for health is a "voted" expenditure in the budgetary framework that sets a ministerial ceiling as part of Ireland's medium-term expenditure framework. In comparison with other OECD countries, spending has been relatively centralised (Beazley et al., 2019). Other revenue sources include out-of-pocket payments to general practitioners that the majority of the population face. In addition, public hospitals have been able to charge private patients.

The Irish Fiscal Advisory Council noted persistent overshooting of spending allocations in the past (IFAC, 2015). The overruns were pronounced for hospitals and primary care reimbursement services. In part, unrealistic budgetary allocations contributed to this outcome. For example, maintaining spending at existing service and staffing levels given expected inflation would cost more than budgetary allocations by some margins. As a result, inability to meet spending objectives softened the intended spending discipline of maintaining tight spending limits.

Some assessments have noted poor planning and a lack of modelling (European Commission, 2019). Furthermore, the Comptroller and Auditor General has identified problems in public procurement in the health sector, in particular non-competitive allocation of contracts. To some extent, the data needed to make better projections of health expenditure exist. For example, the Primary Care Reimbursement Service has collected pharmacy prescription claims since 1998 to track pharmaceutical spending and use. These, particularly following the recent centralisation of data processes, could feed into making better forecasts of likely spending evolutions (OECD, 2019a). Putting in place systems to prevent adverse outcomes includes establishing rules to identify malpractice and using analytical techniques to identify anomalies and predict where problems may emerge (OECD, 2017b).

In other cases, effective decision making is undermined by limitations in the governance of healthcare information systems. For example, so-called section 38 hospitals, which are funded by the HSE, have resisted providing more than aggregated data for their activities. Therefore, cost comparisons across hospitals are complicated. Furthermore, the limited take-up of digitalisation in the sector, combined with the lack of direct linkages across the existing key health-relevant datasets, make following-up of patient interventions difficult. Hence, fragmented governance frameworks, as well as lack of sufficient resources and technical capacity to process data and make them accessible across the system (Oderkirk, 2021), hamper authorities' capability to reap the information potential of anonymised patients' data. Finally, updated costing of Sláintecare implementation has not been fully released, making it difficult to assess progress (Casey and Carroll, 2021).

Besides financial reporting, performance budgeting can help ensure better service delivery but also creates challenges. Putting too much emphasis on financing can have adverse consequences for health care delivery. The authorities are sensitive to this risk and the HSE has implemented a Balanced Scorecard Approach to performance management since 2008 (Mesabbah and Arisha, 2016). This approach takes into account a wider set of indicators than relying solely on a financial perspective. Similarly, since 2020, a Balanced Scorecard Approach is used by the Department of Health to monitor the implementation of HSE's national service plan and other reform measures. Overall, the national scorecard establishes key performance indicators and associated targets grouped in four sections: quality and safety; access and integration; finance, governance and compliance; and workforce (HSE, 2020). The use of available patient-level datasets to regularly report on health system performance or health care quality, however, remains limited (Oderkirk, 2021). Performance on the eve of the pandemic reveals a mixed picture with targets being met or approached in a number of areas, such as mental health services, whereas progress in meeting targets was uneven in others (industrial action affected some, such as outpatient waiting times). A lack of spending control can lead to outcomes where funds are allocated to other purposes than anticipated. In 2019, the Health Budget Oversight Group was created to monitor health spending and

staffing, provide early warnings for any emerging deviation from annual budget allocations and help bring spending under control.

With the implementation of the Sláintecare reforms and the rebalancing of health care provision from hospitals to general practitioners and home care, budgets may come under pressure from unanticipated sources. As such, maintaining budgetary discipline will require strengthening oversight (see below). Learning from the recent experience will be important in that regard, but lessons from other countries may also help. Other OECD countries use performance management systems to facilitate the monitoring of the quality of service delivery, the extent to which national standards are being met, and of productivity and efficiency within the sector (Beazley et al., 2019). As reforms are implemented, they should be rigorously evaluated to ensure value for money, including through a formal spending review of all health spending.

2.6.2. Reigning in pharmaceutical spending

Total public pharmaceutical spending is estimated to have amounted to €2.6 billion in 2021, up by 47% since 2014. A large majority of this spending is covered or subsidised through State pharmaceuticals arrangements administered by the DOH and the HSE. The bulk of State pharmaceuticals expenditure occurs centrally via the HSE Primary Care Reimbursement Service, which runs four separate reimbursement schemes that depend on the illness or type of drug. A remaining part is procured and paid for by hospitals and other health services. In addition, a small fraction (€80 million, according to 2020 estimates) is channelled through remaining health areas (for instance mental health). The complexity and the fact that payments are spread across different possible actors make the actual tracking of total pharmaceuticals spending complicated.

Spending performance diverged considerably across State pharmaceutical arrangements. Expenditure savings were only registered in the General Medical Scheme (GMS), which covers pharmaceutical spending of Medical Card holders, and the Drugs Payment Scheme (DPS), reimbursing households whose expenditure on drugs exceeds a given threshold. The former saw spending decreasing by 4% per annum on average between 2012 and 2020, largely driven by the fall-off in Medical Card numbers in the latter part of the 2010s, versus a 2% average decline for the latter, as a consequence of gradual increases in the expenditure threshold following the financial crisis. In contrast, the Long-Term Illness and the High-Tech Drug schemes are the arrangements registering the strongest average annual expansion in spending during that period (around 10% for both).

High-Tech Drug arrangement spending increased by 2.1 times from 2012 to 2020, from €380 million to €790 million (just under €1 billion in 2021, according to estimates). This is largely because this arrangement covers categories of medicines that treat serious, complex or chronic conditions and are associated with the larger cost increases. The rising patient headcount is an additional explanation, as it has grown at an annual average rate of 6.5% between 2012 and 2019. Moreover, the scheme is devoted to advanced medicines, which are based on technologies that are likely to remain under patent longer, resulting in higher prices due to the lack of competition.

Incentives to lower pharmaceutical prices could be strengthened. As pricing arrangements in place with industry prohibit upward adjustments, producers have incentives to set higher prices for new medicines coming to market to achieve a desired return to investment. This implies that cost pressures result from changes over time in the basket of pharmaceuticals purchased towards more expensive ones. Each medicinal product, though, is potentially subject to a downward annual price realignment based on the evolution of average ex-factory prices across 14 European comparator countries, for the same product. However, these benchmark prices are likely to be overestimated, as they may not take into account the “actual” price paid based on more favourable, but confidential, agreements. Whilst External Reference Pricing based on average pharmaceutical prices is quite common in the European Union, Italy, Spain and Hungary have moved their reference unit to the lowest price, whereas Greece, the Czech Republic and

Slovakia consider an average of the lowest prices in their country baskets (Holtorf et al., 2019). Considering a similar move may help ease the price pressures weighing on Ireland's pharmaceutical bill.

Recognizing the trade-off between ensuring fair access to healthcare and preserving the system's sustainability, many countries have set up systems of Health Technology Assessment to determine what medical interventions should be funded through state expenditure (OECD, 2015b). In Ireland, this is carried out by the National Centre for Pharmacoeconomics (NCPE) in collaboration with the HSE Corporate Pharmaceutical Unit. While the benefits of new medications can be diverse, the NCPE establishes a standardised assessment of any new drug application based on an Incremental Cost-Effectiveness Ratio. This summary measure of cost-utility divides the incremental costs implied by the new drug, net of the estimated potential savings provided due to reduced use of healthcare resources – i.e., costly existing treatments avoided or reduced odds of hospitalisation, by a measure of the health improvement offered (incremental health effect) in terms of Quality Adjusted Life Years ("QALY"). A QALY incorporates both the additional years of life provided by a drug, and the quality of life provided during those extra years. For example, one QALY constitutes one year of life at perfect health, or two or more years of life at less than perfect health. The obtained measure of cost per QALY gained, thus, enables a comparison of the cost effectiveness of all drugs independent of the specific illness they treat (Prior et al., 2021). The NCPE recommendations are based around a threshold for cost effectiveness, in general recommending for reimburseable drugs that offer benefits of one QALY per €45 000 of spending or less (HIQA, 2020).

With the 2013 Health Act, Ireland adopted a system of reference pricing – applying common reimbursement prices to branded and generic medicines considered interchangeable – and enabled pharmacists to provide clients with a generic alternative whenever a more expensive (interchangeable) branded product was prescribed. As a result, the share of generics in the total pharmaceutical market rose to 40% in volume terms. This remains much lower than in other OECD countries (Figure 2.23), which is surprising given that part of domestic pharmaceuticals production is precisely in this segment of the market.

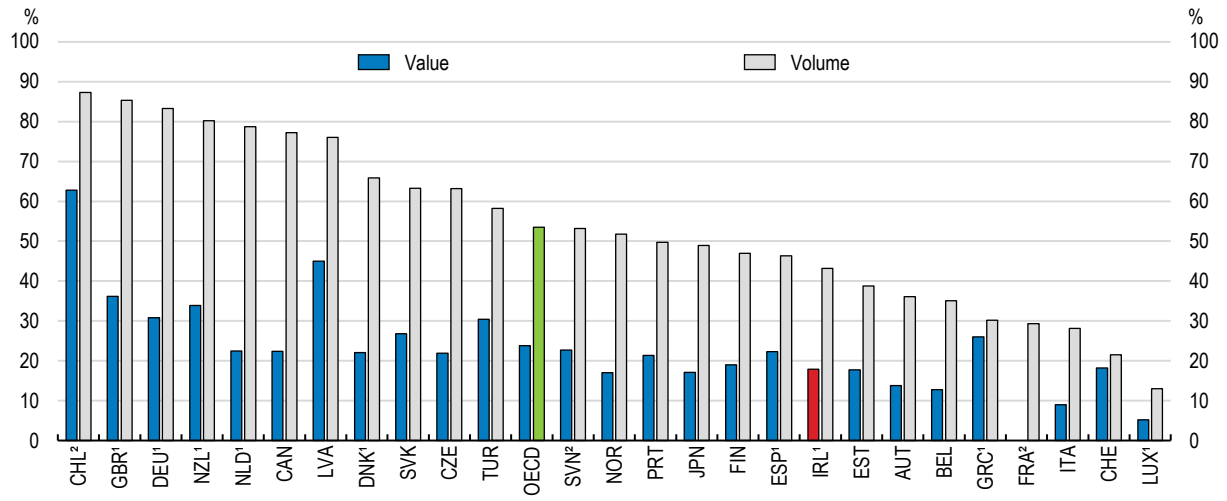
Enhanced competition in the off-patent drug market could increase the penetration of generics and ensure greater savings (OECD, 2020c). Currently, loss of exclusivity clauses, included in the existing industry agreement between the government and pharmaceutical producers, imposes mandatory price reductions on originator medicines (once their patent is expired) upon the launch of a non-generator alternative (Prior et al., 2021). These reductions amount to 40% of the generator's price upon the launch of an alternative generic – 63% for the launch of a biosimilar one (IPHA, 2021), which suggests the generator drug may still remain less costly than the alternative and dominate the market despite the loss of exclusivity. The economic incentive to invest in the introduction of a new generic or biosimilar is thus significantly reduced, with negative effects on the system's competition and productivity. However, the authorities' capability of assessing the extent to which mandatory price reductions in generator drugs crowd out generic alternatives is hindered by limited information. Drug-level data comparing the utilisation and prices of branded medications and their generic alternatives are lacking and increased policy efforts to remedy such information gaps should be considered.

Action is being taken to strengthen the take-up of biosimilar medicines. The Department of Health has stepped up efforts in public consultation and awareness-enhancing activities to support greater biosimilar utilisation. In 2017, as part of its Acute Hospitals Drug Management Programme, the HSE adopted an operational biosimilar strategy aimed at making inroads in prescribing practices, via the introduction of targeted minimum prescribing rates and a collaborative approach with hospital pharmacists and clinical teams. This was accompanied by strong information support on the benefits of biosimilar medications, through targeted presentations to clinicians and hospitals (Prior et al., 2021). Overall, the programme led to marked increases in the prescribing rates of specific biosimilar drugs, particularly those treating rheumatoid and psoriatic arthritis, which, in their originator version, account among the costlier. The trend was further reinforced by the HSE in 2019, through the introduction of a gain-sharing system to incentivise the prescribing of identified best-value biological medicines. By the end of 2020, the new scheme had successfully widened access to biosimilar treatments for the most disabling forms of arthritis, yielding large

savings relative to HSE's corresponding spending on branded alternatives. Following official confirmation that biosimilar medicines approved in the European Union are interchangeable with their reference drug, recently released by the European Medicines Agency, the authorities could envisage legislative changes to bring the interchangeability of biosimilars on par with the current one on generics. More frequent updates of the list of interchangeable medicines managed by the Health Products Regulatory Authority can also support competition and increase the utilisation of lower cost non-originator products.

Figure 2.23. The use of generics is underdeveloped

Share of generics in total pharmaceutical market, 2020 or latest available, %



1. Reimbursed pharmaceutical market refers to the sub-market in which a third-party payer reimburses medicines.
2. Community pharmacy market.
Source: OECD, Health Statistics database.

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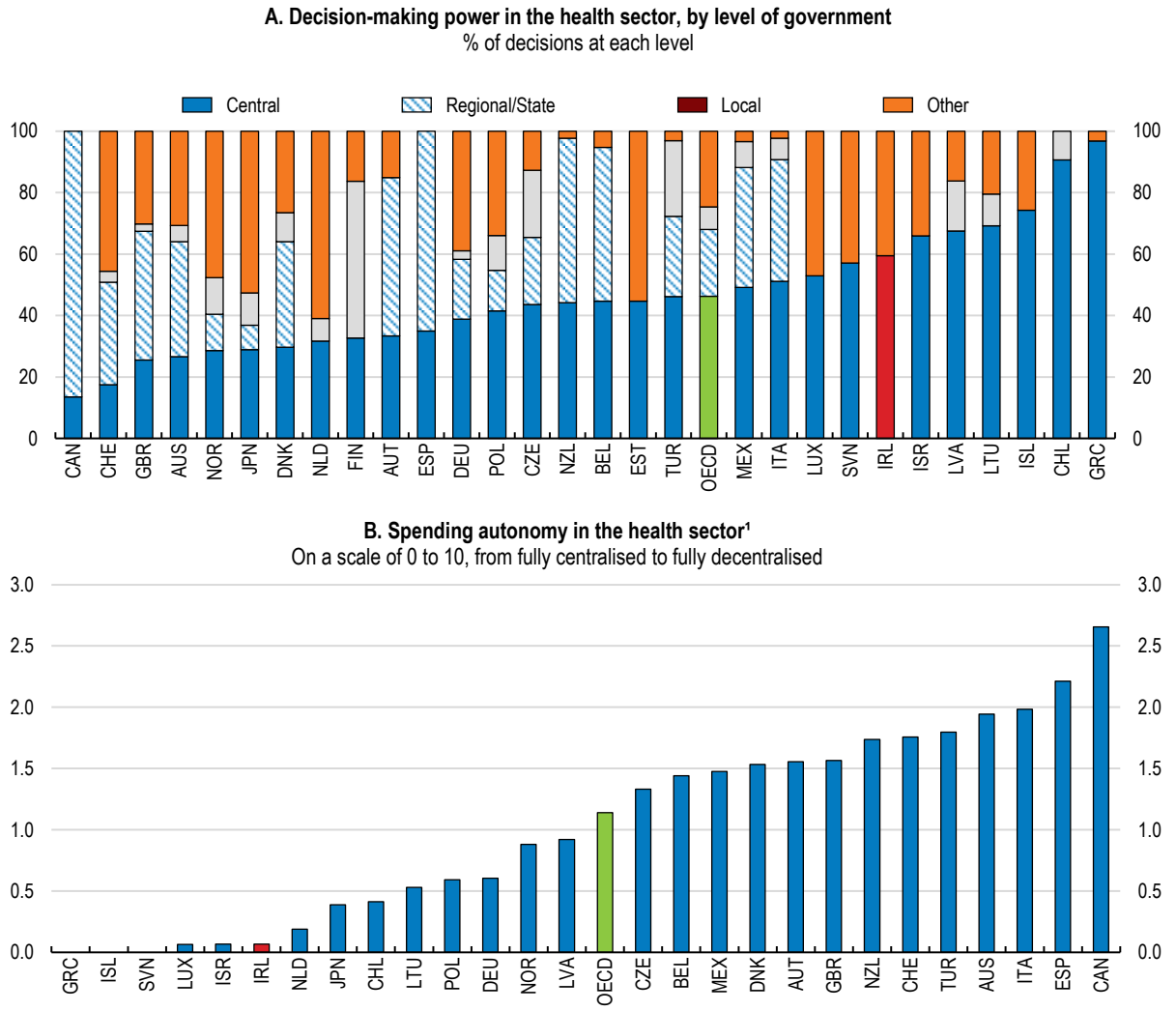
Available international data on biosimilar alternatives for tumour necrosis factor inhibitors or erythropoietins (used, respectively, to treat a range of autoimmune disorders and anaemia) reveal a mixed picture. Biosimilars' share in the Irish accessible market for these two types of medicines, on average, is below 25%, which is low compared to the majority of European countries and results from the relatively dominant presence of originator products with market exclusivity. Consequently, savings in drug prices following biosimilar market entry are limited, although not negligeable. Focusing on erythropoietins, Ireland achieved price reductions of 36%, well below the 76% price reductions in Portugal and Spain, obtained, respectively from biosimilar market shares of 29% and 75%, or Poland's -61% with a 90% share of biosimilars in its accessible market (OECD, 2021a).

2.6.3. Decentralising provision

Ireland's health system, as a result of the 2005 reform establishing the HSE as a single national body managing healthcare, counts among the most heavily centralised in the OECD. According to recent OECD estimates, the country's central government accounted for about 60% of decision-making power (Figure 2.24, Panel A). The remaining 40% were accounted for by private health insurance funds and public and private service providers. Ireland's health system stands out for its marginalisation of the country's local authorities in decision-making processes (Panel B), although this reflects the small scale of the country and the uneven territorial distribution of its population. According to recent OECD work, across a sample of 26 member countries, a moderate degree of decentralisation is generally associated with lower public spending on health care and gains in life expectancy, but the direction of these relationships reverts when the degree of decentralisation becomes high (Dougherty et al., 2019).

Figure 2.24. Decision-making power in the health sector is highly centralised



1. The spending autonomy of subnational governments measures the extent to which subnational entities exert influence over rules and regulations in different policy areas and whether they are free from constraints imposed by upper-level governments. Spending autonomy is considered across four different categories of rules and regulations: policy, budget, inputs and output and monitoring autonomy.
Source: OECD (2022), *Fiscal Federalism 2022: Making Decentralisation Work*, OECD Publishing, Paris; OECD (2022), OECD Fiscal Decentralisation Statistics (database).

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Notwithstanding the centralised nature of the system, governance structures are fragmented and hamper the strategic planning of healthcare service delivery. There are 16 delivery structures operating independently (six Hospital Groups, nine Community Health Organisations plus Children's Health Ireland) with no overlap in management and clinical oversight. Furthermore, Hospital Groups and Community Health Organisations serve different populations and are not geographically aligned, while there is no management structure that oversees the budget process at a specific territorial area. In addition, the funding system is siloed across particular care settings, which reduces the system's transparency and limits the traceability of spending.

The current system of service delivery has addressed governance and funding in acute and community care separately. This led to multiple management layers, differentiated corporate, accounting and IT systems and, thereby, diluted accountability settings and fragmented care for patients when they move between primary, community and acute care venues (HSE, 2022a). Moreover, rather than being linked to

key outcomes for defined populations, the type and level of health and social care services, as well as the relative budgetary allocations, were decided by the HSE based on service providers' proposals. Such institutional settings were unfit to deliver on the key Sláintecare objective of putting in place a patient-centric, community-first model of integrated health and social care service delivery.

The creation of six new Regional Health Areas (RHAs) is a key step to deliver decentralised integrated care. Having approved RHAs' geography in 2019, the Government recently agreed on a preferred geographically-based model to regionalise service delivery (DOH, 2022). Set to be operational by early 2024, each RHA will be endowed with an annual budget via a Population-Based Resource Allocation (PBRA) funding model, with an executive manager directly accountable to the HSE board. These new regional units will take on responsibility for delivering integrated (physical and mental) health and social care services, gradually replacing the current network (HSE, 2022a). Tasked with planning, funding, managing and delivering integrated and patient-centred care based on local population needs, RHAs will empower community-level decision making and local ownership. They should also facilitate more cost-effective access to health and social care services closer to patients' home (DOH, 2022).

Linking the creation of Regional Health Areas to the adoption of a PBRA funding model could significantly enhance the efficiency of public healthcare spending. By distributing healthcare resources in ways that reflect the specific needs of varying population profiles, rather than based on the requests from different categories of providers as is currently the case, PBRA will enable better service planning, while promoting equity in health outcomes and more effective resource allocation (McCarthy et al., 2022). Moreover, on the back of RHAs' clearly defined responsibility for delivering integrated care services to their citizens, PBRA will support enhanced accountability. This will pave the way for stronger incentives to improve corporate governance and the system's transparency, allowing for better spending traceability and more meaningful assessments of its effectiveness.

The adoption of a PBRA funding model in Ireland is currently hampered by the limited coverage of the unique health identifier and by the technical difficulty – due to data unavailability – to match the utilisation of health services, as well as their costs, to specific characteristics of the population, i.e. individual socioeconomic status (McCarthy et al., 2022). Hence, the adoption of a unique health identifier should be prioritised, while greater linkages between national healthcare datasets are pursued. However, custodians of Irish personal health datasets make limited use of treatments for variables that pose a risk of re-identification, nor is systematic de-identification of datasets before analysis reported (Oderkirk, 2021). This poses risks to data confidentiality and may erode patients' trust in digital solutions, which is needed for them to agree with the processing of their personal data. This should be complemented by a legislated national data governance framework, as is currently under discussion in the Health Information Bill.

Centralising the governance and appropriate national health information functions in a single, independent body could ensure greater data protection and support confidence. The new institution could be responsible for linkage and de-identification services across available health data collections and act as their single custodian (HIQA, 2022). The new entity should take a lead role in the implementation of a national data governance framework, outlining the conditions for data collection, secondary use and secured sharing in an anonymised form. Extending the possibility of sharing health information with eligible private and not-for-profit research services, currently precluded, would be welcome, as it may enhance the potential to utilise data for evidence-based policy-making.

Devolved responsibilities to the newly established regional bodies will take place within a highly centralised national governance framework. HSE's annual National Service Plans (NSP), which set service priorities, will continue to drive healthcare planning and resource allocation across the system. Though the ways in which new NSP drafts will take account of the reformed governance framework is currently under discussion, it is expected that each RHA will assume responsibility for their implementation at the regional level. Based on information currently available, to ensure economies of scale and effective resource utilisation, the national HSE is expected to centralise the main corporate functions, such as finance control,

human resources and IT support. HSE will also remain the contracting body for the procurement of all goods, services and capital inputs required by the national delivery of health services, as RHAs' legal status will not allow them to enter into contracts in their own right. Clinical models of care and clinical pathways, to be applied across the country, will continue to be set at the national level. The government pledged to test a shadow budget cycle in 2023 (Houses of the Oireachtas, 2022b).

2.6.4. A network of community-based healthcare providers

Through the Enhanced Community Care programme, the Government has provided a framework involving all service providers delivering care within communities. The programme, funded with more than €200 million over 2020-22, aims to foster the provision of decentralised primary care. This will help to reduce the risks of hospital admission and relieve the pressure on acute hospitals (DOH, 2021c). The build-up of local care capacity, in particular, was pursued by breaking down the newly established RHAs into 96 Community Healthcare Networks (CHN), in line with the approach previously adopted with Community Health Organisations (Committee on the Future of Healthcare, 2017). Defined, as much as possible, according to county boundaries, each network is set to deliver primary care services to an average population of about 50 000. These usually include professional services by occupational, speech and language therapists, physiotherapists, podiatrists, and dieticians, as well as social workers. In addition, since service delivery must occur in strict cooperation with GPs, a leading general practitioner is designated in each Community Healthcare Network, with the task of coordinating and representing GPs at the network level. This approach, based on multi-disciplinary teams, helps bring decision-making closer to the point of care. Moreover, it makes the networks key institutional structures enabling more integrated end-to-end care pathways (HSE, 2022a). Out of the total 96, as of end-2021, among pandemic-related disruptions, only 39 CHNs have been properly established and possess an appointed manager, with about 25% of staff already recruited, as full roll-out is set to be completed by end 2022.

Other initiatives, such as the Community Interventions Teams and Community Specialist Hubs, tailor appropriate care for patients with acute or chronic conditions with the aim of reducing visits to emergency departments and hospital admissions, as well as facilitating easier discharge from hospitals. In acute cases, interventions would occur mainly at home, while for chronic conditions, emphasis would be given to preventative measures. These initiatives are being supported by the planned creation of 3 500 new job positions over the 2021-22 biennium (HSE, 2022a).

Reforms have put GPs at the centre of community-based primary care. A 2019 joint agreement assigned to GPs who opted in an active role in chronic disease management for eligible patients aged 75 and over, which was later extended to patients older than 70 in response to the COVID-19 pandemic (HSE, 2022e). Since January 2022, these GPs may also develop a care plan for adult patients diagnosed with a chronic condition and who hold a Medical or a GP Visit Card. In addition, GPs can refer eligible patients, aged at least 65, to chronic disease management treatment or prevention programmes, based on specific risk criteria. This referral is based on a suite of tests offered to 'at risk' patients to identify those with an undiagnosed chronic disease or at high risk of developing it (HSE, 2022e).

GPs can also refer patients to community-level mental health counselling services and specialists. Although about one fifth of GP consultations pertain to mental ill-health symptoms (ICGP, 2021), they mostly consist of mild-to-moderate anxiety and depression. These can usually be alleviated through lifestyle advice and follow-up at practice level, based on the GPs' stronger knowledge of the patients' background, reducing overreliance on mental health medication services. However, continued provision of training is key to ensure that GPs possess the mental health competencies required to accurately evaluate and diagnose patients (OECD, 2021c).

GPs' role in Ireland's health system, as both gatekeepers and central actors in preventive care, has been further strengthened by new measures enhancing their direct and timely access to diagnostics. At the height of the pandemic, GP direct referral to diagnostics was extended to the whole population, but is

currently limited to adult patients with a medical or GP card. Direct access to diagnostics allows GPs to treat patients who would otherwise have been referred to outpatient hospital departments and, at the same time, reduces waiting times from testing to treatment (Roland et al., 2006; Sibbald, 2009). While this potentially risks increased incidence of inappropriate referrals, international evidence suggests the risk is relatively low and no significant differences in the use of diagnostics between GPs and hospital specialists are observed (O'Riordan et al., 2013). Moreover, a significant proportion of GP investigations were found on the whole to reduce outpatient referrals (Winpenny et al., 2016). Nonetheless, easier access to diagnostics may boost demand. Evidence suggests that protocols to regulate the use of tests and onward referral procedures strongly influences the effectiveness of care pathways (Williams et al., 2007). Systematic use of locally agreed protocols, to be followed by GPs and other actors in order to decide whether specific tests are required and how to access them, would help rationalise the use of existing diagnostic facilities, limit the risk of excessive take up and support effective planning.

Effectively integrated care services at the point of delivery will require successful coordination across different care providers. The new governance should ensure RHAs have an adequate degree of autonomy to fine tune service delivery, as well as its operational organisation, based on their specific population needs. The new Health System Performance Assessment will improve measurement, monitoring and reporting processes. It will thus enable a better understanding of health policy performance. Shifting towards a measurable and quantifiable outcome-based model, and away from the current activity-based indicators, the new tool will significantly support better evidence-based health policy decisions, particularly if increasingly underpinned by more coherently linked datasets. At the same time, policy-makers should avoid 'locking' RHAs strictly into common performance patterns. Namely, the outcome-based indicators should not be turned into specific, quantitative policy objectives to be met by all regional bodies, as this would stifle local policy innovation.

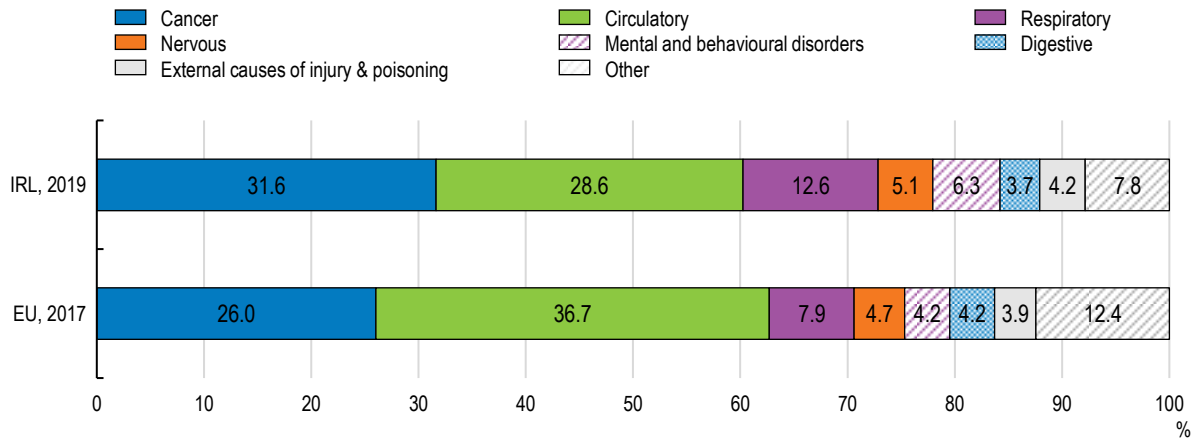
2.7. Ensuring healthier lives

2.7.1. Reducing the burden of cancer

Cancer is a leading cause of deaths in Ireland, accounting for around 32% of the total in 2019. This was three percentage points higher than mortality due to circulatory diseases and 6 percentage points above the corresponding EU average in 2017 (Figure 2.25). Due to greater prevalence of risk factors, e.g., smoking and alcohol consumption, men were slightly overrepresented in cancer-related casualties (53%), while individuals older than 65 accounted for close to 80% of the total. Gastrointestinal, as well as respiratory and thoracic, represented the types of cancer associated with the highest number of deaths, accounting for 9% and 6% of total deaths, respectively (Matthews et al., 2021). While the number of deaths caused by cancer has increased by 6% since 2013, the standardised mortality rate, which adjusts for population increase and ageing, decreased over the same period. This occurred on the backdrop of significant improvements, over the past 20 years, in age-standardised five-year net survival rates across almost all types of cancer (Figure 2.26). This reflected more effective treatment for specific cancers but, to some extent, also increased predominance of those with more favourable prognoses (NCRI, 2021).

Figure 2.25. Cancer is the leading cause of mortality

Main causes of mortality as a percentage of all deaths

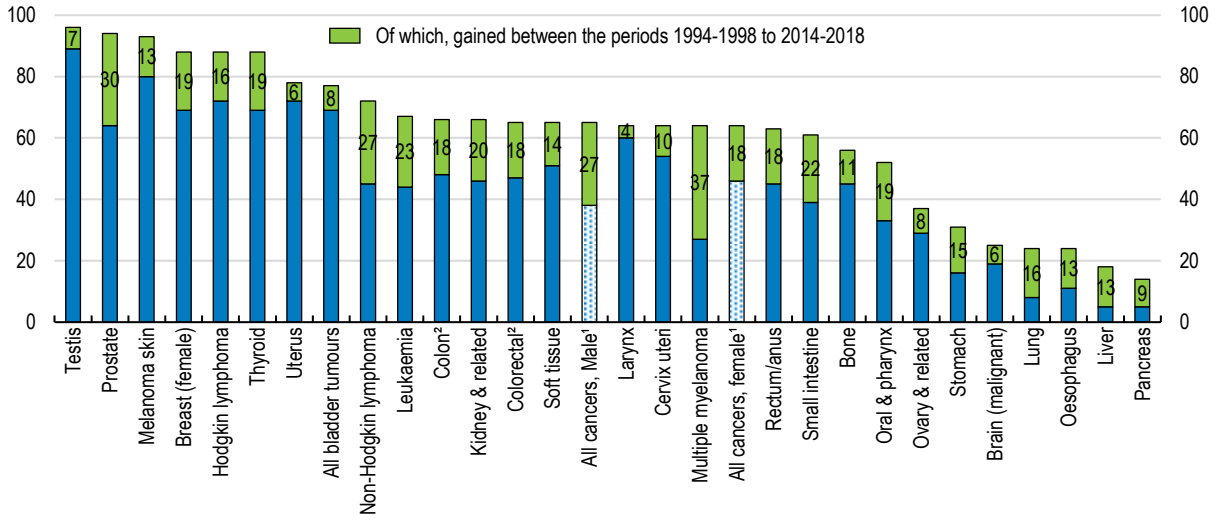


Source: Eurostat (2022), "Causes of death - Deaths by country of residence and occurrence - Table HLTH_CD_ARO", Eurostat database.

StatLink https://stat.link/yivzco

Figure 2.26. Survival rates have risen across all types of cancer in recent decades

Age-standardised 5-year net survival, 2014-2018 diagnosis period



1. Excluding non-melanoma skin cancer.
2. Excluding carcinoid tumours of appendix.
Source: National Cancer Registry Ireland, Annual Report 2021.

StatLink https://stat.link/r9xyku

Cancer prevention and care will be important priority areas. Projections produced shortly before the COVID-19 pandemic implied the country's age-standardised cancer incidence rate would become one of the highest in the European Union by 2020 (OECD, 2021a; OECD/EU, 2021). Calculations made in 2019 by the National Cancer Registry and applying the average rates of cancer by age cohort during the 2011-15 period to official national population projections, suggested that, based on demographics alone (population growth and ageing), the annual number of diagnosed invasive cancers would double between 2015 and 2045. Gains in treatment efficiency in line with historical trends, however, could limit the projected demographic-driven surge to 50% by reducing the individual relative risk of morbidity (NCRI, 2019).

The indirect effects of COVID-19 on cancer diagnosis and treatment could worsen the trend. Cancer services struggled to meet demand already prior to the pandemic, due to underfunding. The Government, though, reacted promptly to the outbreak of COVID-19 by allocating €92 million to cancer services in 2020-21, partly to support the continued implementation of the National Cancer Strategy 2017-2026, as well as by prioritising continued delivery of cancer care throughout the pandemic. Moreover, it temporarily relocated some cancer services to private facilities. Even so, the number of patients referred by GPs to Cancer Rapid Access Clinics decreased markedly following the first introduction of sanitary restrictions, while national cancer screening programmes were all paused in March 2020 and only resumed in the second half of the year, on a phased basis (DoH/HSE/NCCP, 2020). At the same time, physical distancing requirements and infection prevention and control measures limited diagnostic and treatment capacity, even though organisational changes and adaptive behaviour helped smooth these effects over successive waves of COVID-19.

Population growth, together with more effective diagnostics and treatments, also resulted in a growing number of cancer survivors. The latter, including all individuals living through or after cancer treatment, accounted for about 4% of the Irish population as of end 2019 (NCRI, 2021; NCRI, 2019). While early diagnostics and better treatments have increasingly enabled a part of cancer survivors to resume work (Kennedy et al., 2007), longer cancer survivorships may nonetheless pose serious challenges to the sustainability of health systems. Needs for cancer treatment, financial support and ongoing diagnostics will consequently expand over time and further add to ageing-related fiscal pressures. In this context, calculations made in Mariotto et al. (2020), with reference to the United States, might help illustrate the possible magnitude of the fiscal costs related to improved and prolonged cancer survivorship, with the overall outlays for medical services and prescription drugs, delivered to cancer survivors, accounting for over 5% of national health spending in 2015 (slightly above 1% of GDP).

Adequate planning should ensure rising demand for long-term support and follow-up solutions to the specific needs of cancer survivors is met in a cost-effective way. The complex and multidimensional nature of survivors' needs, which may involve physical, psychological, social and financial issues, makes establishing effective cancer survivorship programmes particularly cumbersome (O'Connor et al., 2019). Flexible but comprehensive policy approaches are thus required to enable rapid tailored support based on cancer and treatment type, while enhanced integration between health and social services would ensure significant efficiency gains. Developing and promoting effective survivorship care patterns has become an official government objective in 2017, with the launch of the ten-year National Cancer Strategy. In line with the Sláintecare health strategy, the plan outlined a greater role for primary care in the delivery of survivorship care, which heretofore was mainly concentrated in public hospitals (DOH, 2017a). In addition, in 2020, the National Cancer Control Programme developed a set of guidelines to support hospital and community-based care centres in the delivery of psychosocial care to patients with cancer and their families (NCCP, 2020).

While many cancer survivors gradually renew with normal living conditions after successful treatment, a good number of them are faced with physical and psychological impairments limiting their quality of life and ability to engage in working or other activities. The latter are estimated to account for about one quarter of cancer survivors in Ireland, with poorer and older individuals, especially those living alone, among the most heavily affected (DOH, 2017a). Side effects of cancer may emerge several months or even years after treatment. They vary in prevalence and severity, depending on the type of cancer, stage of the disease, treatment received and other factors related to patient profiles (ACS, 2021). In a similar context, further complicated by the risk of recurrence, adequate survivorship programmes should provide tailored and integrated assistance along both the short- and long-term effects of cancer and its treatments (O'Connor et al., 2019). In order to ensure the best possible quality of life for cancer survivors and their families, these programmes should effectively combine health care with psychosocial and financial support, especially when cancer is treated as a chronic disease. Enhanced efforts to link population-based cancer registry data with health relevant information on patients' quality of life, or patient-reported

outcomes (Smith et al., 2016), would help improve monitoring and surveillance of the long-term and late effects of cancer while strengthening the effectiveness of survivorship programmes.

When working-age cancer survivors resume employment, they are likely to work fewer hours than at the time of diagnosis, face higher risks of unemployment and weaker career prospects (Hanley et al., 2013; Rottenberg et al., 2016; de Boer et al., 2020). Recent survey evidence suggested that, over a sample of Irish cancer survivors having returned to formal employment in the past ten years following a cancer diagnosis (with a median 26 weeks of related leave), about 40% judged their leave period too short. Among these, half indicated financial need as the main driver of their return to work (Connolly et al., 2021), consistent with evidence of sizeable out-of-pocket payments and financial stress among cancer survivors in Ireland (O'Ceilleachair et al., 2017; Hanley et al., 2018). Premature reinsertion in the working environment, though, could result in undue stress to perform for cancer survivors. Possible difficulties encountered in accomplishing working tasks could affect their psychological balance and strengthen incentives to leave the labour market, heightening the risk of higher social costs.

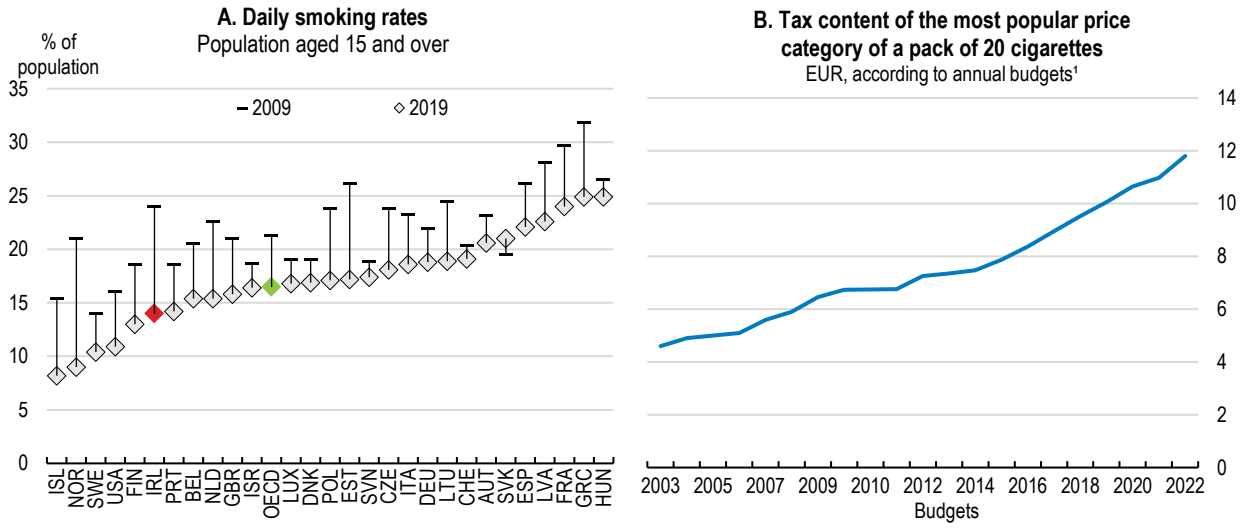
Measures facilitating a more gradual and flexible return to full-time employment could help limit the risk of cancer survivors' permanent detachment from the labour market. In line with Irish Cancer Society's proposals, the establishment of occupational health support programmes for SMEs and the self-employed could complement these measures. While the introduction of a new statutory sick pay scheme by January 2023 will be an important improvement, coverage of sick pay leave will likely remain relatively weak among employees of SMEs and self-employed workers, for whom pressures to (re)take up work are stronger. In such a context, cancer patients could face undue financial hardship upon diagnosis and until the end of their treatment, which could be eased by extending eligibility to Medical Cards/GP Visit Cards on a discretionary basis. To increase uptake, transparency should be increased and complexity in the awarding of cards should be reduced. This would help those belonging to the population groups and cancer types covered by public free care programmes to avoid foregoing screening and diagnostics that may enable early treatment in the case of cancer recurrence, due to prohibitive costs, and thereby ensure higher survival.

2.7.2. Modifying risky behaviours

Behavioural risk factors, such as smoking and alcohol consumption, were linked to more than 35% of all deaths in Ireland in 2019. Limiting the incidence of these risk factors would help improve societal welfare, by enabling larger savings on public spending and stronger productivity outturns, thanks to reduced chronic diseases. Though smoking continued to represent a major contributor to mortality (OECD/EU, 2021), Ireland halved adult smoking rates to levels well below the OECD average by 2019 (Figure 2.27), on the back of a comprehensive policy strategy supported by strong tobacco taxation and pricing policies, aimed at reducing smoking rates to less than 5% by 2025 (HSE, 2018). Moreover, the incidence of smoking among people aged 15 became relatively limited in recent years, though it increased somewhat in 2019, following the diffusion of e-cigarettes (OECD, 2021a).

High levels of alcohol consumption in the population pose serious policy challenges. In 2019, Ireland's adults aged 15 and over, on average, consumed 10.8 litres of pure alcohol per capita, an amount matching the series' long-term average since 1970 and 2.1 litres above the average OECD country. Besides, over one fifth of Irish adults reported regular heavy alcohol consumption (one half among men), while episodes of drunkenness appeared more limited among 15-year-olds relative to their European peers (OECD/EU, 2021; OECD, 2021b). Harmful alcohol consumption contributes to chronic diseases like cirrhosis, diabetes, cardiovascular disease (CVD) and cancer, and causes injuries and premature deaths. Such alcohol-related diseases have wider detrimental societal consequences that emerge through four main channels: higher health spending, shortened life expectancy, reduced labour market participation and lower productivity.

Figure 2.27. Strong tobacco taxation helped reduce high smoking rates



1. Including the April 2009 emergency budget.
Source: OECD, Health Statistics database; HSE (2018), "The State of Tobacco Control in Ireland: HSE Tobacco Free Ireland Programme 2018", Health Service Executive, Dublin.

StatLink https://stat.link/uzcyiw

Recent OECD research based on the OECD Strategic Planning for Public Health for NCDs model and the OECD long-term economic model tried to shed light on the combined long-term impact of diseases caused by alcohol consumption. Based on simulations for the period 2020-50 across a sample of 52 countries, OECD (2021d) estimated that daily alcohol per capita consumption of 12 grammes for women and 18 grammes for men, respectively equivalent to 1 and 1.5 standard drinks, accounted for 88% of all cases of dependence and 37% of all cases of cirrhosis over the period considered. The results also highlighted that daily alcohol consumption above the identified caps could result in a significant deterioration of population health at the end of the period, amounting to a 1.1 year loss of Healthy Life Expectancy (HALE) for an average individual in OECD countries, versus a 1.2 year loss for an Irish individual on average. The ensuing higher morbidity would result in lower labour market participation and increased public spending on health care. At the same time, the financing requirements to cover the higher spending on medical treatments for alcohol related diseases, over the reference period, were projected to raise the overall annual tax rate, measured as the increase in government primary revenue (as a percentage of GDP) needed to stabilise the public debt ratio, by 0.6 percentage points in Ireland at the end of the projection horizon, against 0.4 percentage points for the OECD. Although affected by considerable limitations and uncertainties, these estimates suggest significant scope for scaling up efforts aimed at curbing the damaging consequences of alcohol consumption.

Earlier OECD work concluded that the most effective and cost-efficient response to harmful alcohol consumption consisted into a multi-pronged strategy combining measures around four main dimensions: regulating alcohol advertising – in a bid to prevent underage drinking; tackling alcohol related violence and traffic injuries; providing primary care counselling and treatment for alcohol dependence; and taxing and pricing to reduce the affordability of alcohol (OECD, 2015b). Simulations in OECD (2021d) suggested how a similar package, augmented with more innovative measures like minimum unit pricing and tighter statutory bans on alcohol advertising targeting children, could ensure large gains in life years in Ireland (and most other OECD countries), as well as significant savings in health expenditure and labour market costs, owing to reduced incidence of chronic diseases. While involving sizeable costs, such measures were projected to yield the highest returns on investment, relative to alternative packages focused mainly on restricting alcohol availability.

Ireland enacted its national alcohol prevention strategy, the Public Health Alcohol Act, in October 2018, with the aim of drastically reducing the damage deriving from society's excessive exposure to harmful alcohol consumption, especially among children and younger people. The Act included a set of policy measures broadly in line with OECD recommendations, as they provided for the introduction of a minimum unit price and labelling requirements on alcohol products, as well as for tightened structural separation of alcohol sale in mixed retail outlets and restrictive regulations of alcohol marketing. New rules, gradually phased in in recent years, prohibited advertising of alcohol products near schools or, among others, in public parks, transport and stations, as well as in sports events involving a large participation of children (DOH/HES, 2019). Promotions involving the sale or supply of alcohol at a reduced price or free of charge were banned, as was the possibility, for retailers, to award loyalty card points on purchases of alcohol. At the same time, alcohol companies' opportunities to sponsorship events were significantly restricted (DOH/HES, 2021b).

Tightening of the laws against alcohol-impaired driving complemented the set of prevention policies outlined in the Alcohol Act. This included mandatory disqualification and a significant increase in the fine for a first drink-driving offence, were the motorist to have blood alcohol concentration above 50 mg/100 ml (O'Dwyer et al., 2021). The move should help reduce the negative externalities of drunk-driving, in a context in which driving under the influence of alcohol is a relatively common practice, especially among younger male individuals (RSA, 2021). Intoxicated driving is a major factor in serious road injury and fatal collisions. Evidence based on data from closed coronial cases revealed that between 2013 and 2017, about 37% of road user fatalities were related to alcohol use, with over half of the fatalities in the 15-34 year group (RSA, 2020).

Increased alcohol affordability gave price regulation a key role in the authorities' toolkit to reduce the burden of alcohol-related harm. Over recent decades, Ireland saw alcohol consumption moving away from the on-trade sector, with the number of pub licenses declining by more than one fifth between 1998 and 2018, while off-premise wine and spirit licenses increased fourfold (O'Dwyer et al., 2021). This contributed, since 2000, to a marked surge in alcohol affordability in the off-premise sector, relative to the OECD average, driven by rising real incomes as well as cheaper alcohol prices (OECD, 2021d). In addition, alcohol became particularly affordable for Irish young people after 2013, once the economic recovery led to renewed gains in household income. Under such circumstances, the government prioritised increases in the price of cheaper alcohol products, the ones more likely to be consumed by heavy and younger drinkers and, thereby, associated with larger negative externalities. With limited room for further tax increases, because of excise and VAT rates on alcohol beverages already among the highest in the EU (OECD, 2020d), the 2018 Alcohol Act opted for setting a €0.1 minimum price per gramme of alcohol, in order to make the cheapest alcoholic beverages significantly less affordable. The measure, however, became effective only at the beginning of 2022.

Empirical evidence on minimum unit pricing adoption in OECD countries seems to confirm rapid reductions in the consumption of targeted alcohol beverages after the measure's introduction (Table 2.3). As for Ireland, simulations commissioned by the Department of Health, early in the process, to model the impact on alcohol consumption of a €1 minimum price per standard drink, estimated an 8.8% reduction for the total population, against a 15.1% drop in alcohol consumption in the case of high-risk drinkers (Angus et al., 2014). International evidence also found the adoption to be accompanied by reductions in emergency department admissions (Sherk et al., 2018), alcohol-related assault offences, protective custody episodes and road traffic crashes resulting in fatalities or injuries (Coomber et al., 2020). Moreover, policy-induced increases in the price of alcoholic beverages have been associated with lower rates of alcohol dependence (Henderson et al., 2004) and reduced alcohol-related morbidity and mortality (Wagenaar et al., 2010; Zhao et al., 2013; Anderson et al., 2009), though health gains from the policy are unequally distributed among socioeconomic groups (Holmes et al., 2014).

Table 2.3. Effects of minimum unit pricing on alcohol consumption
Selected studies

Studies	Country of introduction	Date of introduction	Minimum unit price	Variation in off-trade alcohol consumption since date of introduction
Anderson et al. (2021)	Scotland	May 2018	0.5 GBP per standard unit of pure alcohol (8g)	-7.6%[1] (after seven months)
Anderson et al. (2021)	Wales	March 2020	0.5 GBP per standard unit of pure alcohol (8g)	-8.6% (after ten months)
Taylor et al. (2021)	Northern Territory, Australia	October 2018	AUD 1.30 per standard unit of pure alcohol (10g)	-51% for cheap cask wine -21% for total wine (after 12 months)
Stockwell et al. (2012)	Saskatchewan Province, Canada[2]	April 2010[3]	Ranging from CAD 1.16 to 1.89 by beverage type and alcohol strength Per standard unit of alcohol (17.05 ml ethanol)	-9.2% (for a 10% increase in the minimum price of all beverages, after 24 months)

1. Estimates from Anderson et al. (2021) revealed that similar reductions were maintained in 2020, relative to 2018.
2. MUPs on alcohol are set by the Saskatchewan Liquor and Gaming Authority (SLGA), which has a monopoly on alcohol distribution and a partial monopoly on the sale of alcohol in liquor stores. Minimum prices apply directly to liquor store retail prices and also to the prices at which SLGA sells alcohol to bar and restaurants, hence, they indirectly on-trade retail prices, although to a smaller degree.
3. Date at which SLGA introduced a comprehensive set of new and increased minimum prices. The latter were originally introduced for spirits other than brandy and cognac in 2003, beer in 2005, wine in 2008 and higher strength cooler, brandy and cocktails in April 2010.
Source: Anderson, A. et al. (2021), "Impact of minimum unit pricing on alcohol purchases in Scotland and Wales: controlled interrupted time series analyses", *Public Health*, Vol. 6, Lancet; Taylor, N. et al. (2021), "The impact of a minimum unit price on wholesale alcohol supply trends in the Northern Territory, Australia", *Substance Use*, *Australian and New Zealand Journal of Public Health*, Vol. 45, No. 1; Stockwell, T. et al. (2012), "The Raising of Minimum Alcohol Prices in Saskatchewan, Canada: Impacts on Consumption and Implications for Public Health", *American Journal of Public Health*, Vol. 102, No.12.

2.7.3. Addressing the risks of unhealthy diets

The number of overweight and obese adults is a growing concern. Measured overweight, including obesity, affected 61% of the Irish population as of 2019, slightly above the average of OECD countries with available data, with about one quarter of the population being obese. Both overweight and obesity rates were broadly stable over recent decades (OECD, 2021a). Overweight and obesity are major risk factors for various chronic diseases and individuals with an unhealthy weight are at higher risk of severe consequences from COVID-19 (Katz, 2021). Moreover, by putting people at a higher risk of sickness and disability, higher body mass is found to be associated with lower employment opportunities, earnings and productivity (Campbell et al., 2021; OECD, 2019b). These effects considered, overweight-related diseases are expected to reduce healthy life expectancy in Ireland by 2.9 years, on average, over the next 30 years, because of higher premature mortality (-3.2 years for the OECD average). Over the same period, average annual overweight-driven health expenditure would increase by 9.0% (+8.4% for the OECD), which, in turn, would add fiscal pressure and, therefore, increase the average annual government primary revenue needed to stabilise the debt-to-GDP ratio by 0.8 percentage points (+0.6 for the OECD).

Ireland is among the OECD countries taxing sugar-sweetened drinks. The excise duty, introduced in 2018, effectively reduced demand for popular soft drinks and, at the same time, incentivised manufacturers to reduce their sugar content, especially in those preferred by children. Exposure to economic vulnerability in early childhood, in particular, is significantly associated with being overweight and obese (Maître et al, 2021).

Supporting healthier diets, particularly among lower-income households, would complement measures to reduce sugar intake. Reliable labels on the front of pre-packaged foods are key to ensure consumers make informed food purchases in line with disease prevention policies. To facilitate this, the European Commission, as committed in its 2020 Farm to Fork strategy, is set to propose harmonised mandatory

front-of-pack labelling for food products by end-2022 (European Commission, 2020), Ireland is among the OECD countries allowing front-of-pack labels on a voluntary basis, but only to the extent they repeat the – mandatory or complementary – nutrition contents displayed in back-of-pack labels. Overall, increased use of food labelling has resulted in higher purchases of healthier food in many countries (Cecchini and Warin, 2016; Barreiro-Hurlé et al., 2010). Food labels' effectiveness in supporting healthy dietary choices, however, depends on certain consumer characteristics: higher levels of income and education are positively associated with greater use and understanding of nutritional information, which are less easily interpretable by more disadvantaged categories (Storcksdieck Bonsmann et al., 2020). As a result, simpler front-of-pack labels combining colour-coded information with, for instance, a graded indicator conveying immediate graphic information about the product's amount of key nutrients, as in the "Nutri-Score" recently launched in France, would help enable healthier food choices (OECD, 2022b).

Tackling the economic and social burden of obesity is a policy priority in Ireland. Under the framework of the Healthy Ireland Agenda, a ten-year Obesity Policy and Action Plan was launched in 2016 (Government of Ireland, 2016), followed by the establishment of a cross-departmental implementation advisory group in 2017. By identifying regulation as a priority policy tool towards enabling healthier dietary choices, the Plan gave way to the development of behavioural science-based research, particularly on the positive impact of portion size markings in reducing the excessive consumption of food high in fat, salt and sugars (Robertson et al., 2020). Moreover, the Department of Health launched a public consultation on front-of-pack nutrition labelling and scores in 2021. Recent OECD work suggests that the implementation of front-of-pack labelling, such as Nutri-Score, would have beneficial effects for Ireland's population and its economy, namely via long-term health expenditure savings and improved labour market participation (OECD, 2022b).

Supporting more balanced and healthier school meal programmes could strengthen children's food literacy and have long-term beneficial effects on their health. Dietary practices formed early in life tend to leave a lasting imprint (Murimi et al., 2018). The school free-meal programme, managed and funded by the Department of Social Protection (with the involvement of local authorities, in the case of primary schools), is currently benefitting 230 000 children belonging to over 1 500 schools featuring significant concentration of disadvantage, with students participating on a voluntary basis (Darmody, 2021). The scheme, in particular, had a key role in supporting struggling families during the COVID-19 crisis, following the decision to extend the provision of school meals beyond academic years, in order to cover for the summer breaks. Over the years, schools participating in the state meal programme have mainly used its cold lunch option. Only recently did the Department of Social Protection extend its pilot Hot School Meal Programme, initially tested in 37 schools, to over 55 000 primary school pupils in disadvantaged schools. Under current rules, funding for school meals is provided for food items only, excluding any expenditure on staff or equipment (Darmody, 2021). This, together with relatively low maximum rates of payment per meal, tilts the system towards purchases of pre-packed food resulting from larger-scale production. While such meals may meet basic nutritional standards, a large part of their components are often ultra-processed (Darmody, 2021).

By enabling increased consumption of freshly prepared food, particularly among more disadvantaged pupils who are less likely to have access to it, the establishment of in-school or community-level kitchens could enhance pupils' dietary resilience and food literacy, potentially resulting in long-lasting changes to daily dietary habits. This would be in line with considerable internal demand for higher quality food in Irish schools (Browne et al., 2019; EDC, 2020), as well as with international experiences in countries like Japan, Australia (the Kitchen Garden Programme) and England (The Food for Thought project, Box 2.5), where lunches are an integral part of the education curricula. Positive indirect economic effects would also spread to local communities through additional employment opportunities and increased sustainability of supply chains, by means of greater involvement with networks of local producers.

Relatively tight regulations apply to the advertising of energy-dense foods, including a ban on targeting children in radio and television ads (OECD, 2019b). Additionally, a voluntary code of conduct, agreed between the government, advertising and broadcasting authorities, as well as various industry associations, tightened the rules on non-broadcast media advertising and marketing of High Fat, Salt and Sugar (HFSS) food and (non-alcoholic) drink products in 2018 (DOH, 2017b). While detailed, these provisions failed to outline a regulatory body tasked to oversee compliance and able to investigate potential complaints. As a result, the Advertising Standards Authority for Ireland (ASAI) recently issued new rules restricting marketing communications for HFSS products targeting children younger than 15, broadly in line with the stance adopted in anti-alcohol regulations (ASAI, 2021). However, the new rules are not legally binding. Making compliance with rules on non-broadcast media advertising and marketing of these products mandatory, as in alcohol advertising, would limit the risks involved with children's exposure to aggressive promotion of unhealthy products. Moreover, the development of digital media and technology, together with increasingly sophisticated profiling techniques, make the detection and enforcement of harmful food advertising particularly complex, notwithstanding 2018 data regulations prohibiting online targeting of children by advertisers (DOJ, 2018). Implementing a system of fines, while outlining clear monitoring and enforcement responsibilities, as well as easily accessible complaint mechanisms, could enhance regulatory efficiency and foster reformulation incentives in food manufacturing.

Box 2.5. School food quality in England: The Food for Thought Project

The Food for Thought (FFT) school meal project was established in 2003 by six local head teachers in the Liverpool City region. They had grown unhappy with the quality and healthiness of meals that local authorities, either directly or through large private contractors, provided to children in their schools. As such, they established a not-for-profit company with the purpose of providing partner schools with daily meals freshly prepared on site and of greater variety. To ensure a broader positive return to local communities, schools employ their specific catering teams, while FFT's 30-persons staff support manage the system on their behalf and support them in the case of absentees. However, administratively, schools continue to deal with payments by families and pay FFT for its services thereafter. Costs, as well as all profits, are shared among participant schools pro-rata to the number of meals served. Decisions are taken by a Board whose members are the head teachers of the schools using the service. FFT's network has gradually expanded to include 86 schools in the Liverpool City region. In 2021, it served about two million meals.

Strong reliance on food products sourced from local providers helps FFT preserve its cost-competitiveness, relative to large private catering companies, while supporting community-level businesses. Moreover, the company's modus operandi allows it to flexibly adapt food provision to the tastes of children from different communities, which also helps them to become accustomed to dietary variety. Emphasis is laid on the educational value of food processes. This includes reviewing menus every six weeks to follow fruit and vegetable seasonality or the adoption of learning modules aimed at empowering children's knowledge on food's origins and on how to prepare it, as well as on related environmental issues.

Source: www.foodforthoughtschools.co.uk

Recommendations on the health sector

MAIN FINDINGS	RECOMMENDATIONS (key in bold)
Moving towards a system centred on care needs	
The capped tax relief on private health insurance premiums accentuates the two-tiered nature of the health system.	Remove the tax relief or consider making it conditional on means-testing.
Entitlement to publicly-financed care services depends on several criteria that have been adjusted over time, increasing uncertainty.	Streamline and harmonise eligibility criteria across publicly-funded health schemes and limit their adjustments over time.
A new Sláintecare consultant contract has been proposed to effectively reduce understaffing by improving working conditions in public hospitals. Full separation of public and private specialist practice may permanently weaken incentives for inter-sectoral professional mobility.	Further increase the number of consultant and medical training posts to effectively reduce understaffing. To attract talent, ensure the new contract enables flexible combinations of clinical hours with research and management tasks, according to specialists' skills, interests and propensities.
The challenge of long waiting lists needs to be addressed by policy action in a number of areas. There is room to move some diagnosis and care from hospitals to primary and community care. Not all patients use the most appropriate health pathways, either being referred to specialists that are not the correct ones or presenting themselves to emergency rooms to get diagnostic tests.	Keep the path of increases in public hospital capacity in line with planned objectives and improve waiting time management. Build a proper information base to monitor progress of the Waiting List Action Plan. Provide assistance to medical professionals outside the acute hospital sector to direct patients to primary or community care rather than hospitals when appropriate.
Pre-pandemic demand for home care support exceeded the corresponding supply of services, resulting in long waiting lists, which could further be exacerbated in the near future.	Support effective integration of home care with other community-based health, long-term care and social services. Set cost thresholds – linked to comprehensive assessments of patients' need – above which a user is shifted from home to institutional care settings.
Home care for the elderly involves lower societal costs, but when the patient becomes sicker, the costs rise and the quality of care diminishes.	**Establish integrated funding and service delivery to offer home care and admission to long-term residential care when needed.**
The Single Assessment Tool (SAT) is a key IT tool to support enhanced operational integration across all health and social long-term care providers, enabling large efficiency gains and the provision of more effective person-centred care services.	**Accelerate the implementation of the Single Assessment Tool across the country in order to move towards more effective person-centred care services.** Extend access to SAT data, at the individual and/or aggregate level, to acute and other community care providers.
Ensuring equitable and cost-effective healthcare	
Within the most expensive High-Tech Drug pharmaceutical spending arrangement, the price of patented originator medicines may be reduced based on the average price paid in 14 European countries.	Consider linking downward price adjustments to an average of the lowest prices among the chosen benchmark countries.
The use of generics and biosimilars remains modest. The European Medicines Agency has recently confirmed that biosimilar medicines approved in the European Union are interchangeable with their reference drug.	Enhance competition in the off-patent and biosimilar drug market, ensuring that market penetration of medications is not artificially suppressed by the existing system of mandatory price reductions. Regularly update the Health Products Regulatory Authority list of interchangeable medicines in order to increase utilisation of lower cost non-originator products. Encourage the increased use of biosimilars, including by considering making them as interchangeable as generics.
The Sláintecare reforms are overhauling the Irish healthcare system. The system is currently overly centralized and biased towards expensive hospital-based treatments.	**Implement the reforms to create Regional Health Areas and rebalance healthcare delivery across primary, community and long-term care and hospitals.** Improve value for money in health spending through a repeated use of spending reviews.
The success of Regional Health Areas will depend on a suitable funding system and data availability. The funding system is currently fragmented across care settings and lacks transparency, limiting the traceability of healthcare spending. Monitoring the health system is hindered by its complexity, lack of adequate information, fragmented data governance and underdeveloped digital infrastructure.	**Introduce a Population-Based Resource Allocation funding model, as planned, to improve financial reporting and management and strengthen equity in health outcomes.** **Prioritise reforms to enhance the take-up of a unique health identifier across health services and centralise governance and appropriate national health information functions within a single independent body.**
Effectively integrated care services at the point of delivery by Regional Health Areas (RHAs) will require successful coordination across different care providers and improved measurement, monitoring and reporting processes.	Ensure RHAs have the autonomy to effectively arrange the coordination of care providers and service delivery based on the needs of their population. Use the new Health System Performance Assessment to support better evidence-based decisions, but avoid locking RHAs into strict, common performance patterns.

Ensuring healthier lives	
Growing needs for cancer treatment, financial support and ongoing diagnostics over longer spells of time could add to ageing costs.	Establish effective and cost-efficient cancer survivorship programmes aimed at meeting survivors' needs along the physical, psychological, social and financial dimensions. In line with the 2017-2026 National Cancer Strategy, continue to expand the delivery of cancer survivorship care at the community and primary care level.
Many cancer survivors' return to formal work occurs prematurely and mainly based on financial need considerations, which could strengthen incentives to leave the labour market and result in higher social costs.	Introduce measures enabling a more gradual and flexible return to full-time employment for cancer survivors. Consider establishing occupational support programmes for SME employees and the self-employed, who may face pressures to resume work because of weaker coverage of sick pay leave.
A cancer diagnosis could represent a significant source of financial stress to the patient and her/his family, even at income levels well above the thresholds traditionally set for eligibility to the Medical Card.	Continue to expand means-tested eligibility to primary care to ensure financial protection of patients. Increase transparency and reduce complexity in the awarding of cards to increase uptake.
The move towards off-premise alcohol sales at cheaper prices increases consumption among younger people.	Continue to use minimum unit pricing of alcohol as a lever to reduce its affordability in the off-premise sector.
There is room to improve the use of food labelling, which is associated with higher purchases of healthier food, to make it more interpretable to more disadvantaged consumers.	Adopt a scheme conveying simpler graphic information on the amount of key nutrients in pre-packaged food products, in line with EU-level efforts towards harmonised mandatory front-of-pack labelling.
A voluntary and non-binding code of conduct restricts marketing and non-broadcast media advertising of High Fat, Salt and Sugar food and non-alcoholic drink products targeting children younger than 15. Technological development and sophisticated profiling technics make detection and enforcement of harmful food advertising more complex.	Make compliance with rules on non-broadcast media advertising and marketing of High Fat Salt and Sugar food and drink products mandatory, as in alcohol advertising. Introduce a regulatory body overseeing compliance and investigating potential complaints.
Supporting balanced and healthier school meal programmes could have long-term beneficial effects on children's health.	Consider extending the eligibility for funding from the state's school meal programmes to expenditures on equipment and staff.

References

ACS (2021), *Cancer Treatment and Survivorship – Facts & Figures 2019-2021*, American Cancer Society, Atlanta.

Anderson, P., D. Chisholm and D.C. Fuhr (2009), "Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol", *The Lancet*, Vol. 373, No. 9682, pp. 2234-2246.

Angus, C. et al. (2014), "Model-based appraisal of minimum unit pricing for alcohol in the Republic of Ireland", *ScHARR*, University of Sheffield.

Araujo, E.C., T. Grant Evans and A. Maeda (2016), "Using economic analysis in health workforce policy-making", *Oxford Review of Economic Policy*, Vol. 32, No. 1, pp. 41-63.

ASAI (2021), *Code of Standards for Advertising and Marketing Communications in Ireland: Section 8 – Food and Non-Alcoholic Beverages*, Advertising Standard Authority for Ireland, Dublin.

Bakx, P., B. Wouterse, E. van Doorslaer and A. Wong (2020), "Better off at home? Effects of nursing home eligibility on costs, hospitalizations and survival", *Journal of Health Economics*, Vol. 73.

Barreiro-Hurlé, J. et al. (2010), "Does nutrition information on food products lead to healthier food choices?", *Food Policy*, Vol. 35, No.3, pp. 221-229.

Beazley, I. et al. (2019), "Decentralisation and performance measurement systems in health care", *OECD Working Papers on Fiscal Federalism*, No. 28, OECD Publishing, Paris.

Brick, A. and S. Connolly (2021), "Waiting Times for Publicly Funded Hospital Treatment: How does Ireland Measure Up?", *The Economic and Social Review*, Vol. 52/1.

Browne, S. et al. (2019), "We Know What we Should Eat But we Don't…: A Qualitative Study in Irish Secondary Schools", *Health Promotion International*, Vol. 35, No. 35, pp. 984-993.

Burke, S., S. Parker, P. Fleming, S. Barry and S. Thomas (2021), "Building health system resilience through policy development in response to COVID-19 in Ireland: From shock to reform", *The Lancet Regional Health - Europe*, Vol. 9.

Burke, S., S. Barry, R. Siersbaek, B. Johnston and M. Ní Fhallúin (2018), "Sláintecare – A ten-year plan to achieve universal healthcare in Ireland", *Health Policy*, Vol. 122, pp. 1278-82.

Campbell, D.D. et al. (2021), "Effects of increased body mass index on employment status: a Mendelian randomisation study", *International Journal of Obesity*, Vol. 45, pp. 1790-1801.

Casey, E and K. Carroll (2021), "The Path for Ireland's Health Budget", *Analytical Note,* No. 14, Irish Fiscal Advisory Council.

Cecchini, M. and L. Warin (2015), "Impact of food labelling systems on food choices and eating behaviours: a systematic review and meta-analysis of randomised studies", *Obesity Reviews*, Vol. 17, No. 3, pp. 201-210.

Charnes, A., W.W. Cooper and E. Rhodes (1978), "Measuring the efficiency of decision making units", *European Journal of Operational Research*, Vol. 2, pp. 429-444.

Citizens Information (2021), *Health Services in Ireland*.

Colombo, F., A. Llena-Nozal, J. Mercier and F. Tjadens (2011), "Help Wanted? Providing and Paying for Long-Term Care", *OECD Health Policy Studies*, OECD Publishing, Paris.

Colombo, F. and N. Tapay (2004), "Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems", *OECD Health Working Papers*, No. 15, OECD Publishing, Paris.

Comas-Herrera, A. et al. (2021), "Mortality associated with COVID-19 in care homes: international evidence", International Long Term Care Policy Network.

Committee of Public Accounts (2021), *HSE Financial Statement 2020*, Houses of the Oireachtas, Dublin.

Committee on the Future of Healthcare (2017), *Sláintecare Report*, Houses of the Oireachtas, Dublin.

Connolly, S., H. Russell and E. Henry (2021), "Returning to Employment Following a Diagnosis of Cancer: An Irish Survey", *ESRI Survey and Statistical Report Series*, No. 103, Dublin.

Connolly, S. and R. White (2019), "Uptake of cancer screening services among middle and older ages in Ireland: The role of healthcare eligibility", *Public Health*, Vol. 173, pp. 42-47.

Connolly, S. and M.A. Wren (2019), "Universal care in Ireland: what are the prospects for reform?", *Health Systems & Reform*, Vol. 5(2), pp. 94-99.

Coomber, K. et al. (2020), "Investigating the introduction of the alcohol minimum unit price in the Northern Territory", Final Report, prepared for the Northern Territory Department of Health, Deakin University, Geelong Australia.

Croghan, S.M. et al. (2021), "Perceptions of higher specialist trainees and fellows of the proposed Sláintecare consultant contract and implications for workforce planning in Ireland", *Journal of Medical and Health Studies*, Vol. 2, No. 2.

Darmody, M. (2021), "A kitchen at the heart of a school: an investigation into school meals in the Republic of Ireland", *Irish Educational Studies*, Vol. 40, No. 4.

De Biase, P., S. Dougherty and L. Lorenzoni (2022), "Ageing and the long-run fiscal sustainability of health care across levels of government", *OECD Working Papers on Fiscal Federalism*, No. 38, OECD Publishing.

de Boer, A. et al. (2020), "Long-term work retention after treatment for cancer: a systematic review and meta-analysis", *Journal of Cancer Survivorship*, Vol. 14, No. 2, pp. 135-150.

Delamaire, M. L. and G. Lafortune (2010), "Nurses in advanced roles: A description and evaluation of experiences in 12 developed countries", *OECD Health Working Papers*, No. 54, OECD Publishing, Paris.

DOH (2022), *Business Case for the Implementation of Regional Health Areas (RHAs)*, Department of Health, Dublin.

DOH (2021a), *Health in Ireland: Key Trends 2021*, Department of Health, Dublin.

DOH (2021b), *COVID-19 Nursing Homes Expert Panel Recommendations - Third Progress Report*, Department of Health, September, Dublin.

DOH (2021c), *Sláintecare Implementation Strategy and Action Plan 2021-2023*, Department of Health, Dublin.

DOH (2017a), *National Cancer Strategy 2017-2026*, Department of Health, Dublin.

DOH (2017b), *Non-Broadcast Media Advertising and Marketing of Food and Non-Alcoholic Beverages, including Sponsorship and Retail Product Placement: Voluntary Code of Practice*, Department of Health, Dublin.

DOH/HSE (2021a), *Home Support Services: Preparedness and impact of COVID-19 on services*, Department of Health and Health Service Executive Joint Paper, Dublin.

DOH/HSE (2021b), *Public Health (Alcohol) Act 2018 – Guidance for Industry, Sections 15 and 16*, Department of Health and Health Service Executive, October.

DOH/HSE/NCCP (2020), *Cancer Services in Ireland in the Context of COVID-19*, Department of Health, Health Service Executive and National Cancer Control Programme, Dublin.

DOH/HSE (2019), *Public Health (Alcohol) Act 2018 – Guidance for Industry*, Department of Health and Health Service Executive, July.

DOJ (2018), *Data Protection Act 2018: Explanatory Memorandum*, Department of Justice, Dublin.

Dougherty, S., P. de Biase and L. Lorenzoni (2022), "Funding the future: The impact of population ageing on revenues across levels of government", *OECD Working Papers on Fiscal Federalism*, No. 39, OECD Publishing, Paris.

Dougherty, S. et al. (2019), "The impact of decentralisation on the performance of health care systems: A

non-linear relationship", *OECD Working Papers on Fiscal Federalism*, No. 27, March, OECD Publishing, Paris.

Dutu, R. and P. Sicari (2020), "Public spending efficiency in the OECD: benchmarking health care, education and general administration", *Review of Economic Perspectives*, Vol. 20, No. 3, pp. 253-280.

ECDC (2022), *Surveillance Data from Public Online National Reports on COVID-19 in Long-term Care Facilities*, European Centre for Disease Prevention and Control, Stockholm.

EDC (2020), *National Strategy Group for Hunger Prevention in Schools*, Educational Disadvantage Centre, Dublin City University.

European Commission (2021), *The 2021 Ageing Report. Economic and Budgetary Projections for the EU Member States (2019-2070)*, Brussels.

European Commission (2020), *Farm to Fork Strategy: For a fair, healthy and environmentally friendly food system*, Brussels.

European Commission (2019), *Country Report Ireland*, 2019 European Semester Country Report.

Färe, R., S. Grosskopf and C.A.K. Lovell (1993), *Production Frontiers*, Cambridge University Press.

Fennelly, O. et al. (2018), "Advanced practice physiotherapy-led triage in Irish orthopaedic and rheumatology services: national data audit", *BMC Musculoskeletal Disorders*, Vol. 19, No. 181.

Ferrinho, P. et al. (2004), "Dual practice in the health sector: review of the evidence", *Human Resources for Health*, Vol. 2, No. 14.

Fleming, P. et al. (2022), "Implications for health system reform, workforce recovery and rebuilding in the context of the Great Recession and COVID-19: a case study of workforce trends in Ireland 2008-2021", *Human Resources for Health*, Vol. 20, No. 48.

Garattini, L. and A. Padula (2018), "Dual practice of hospital staff doctors: Hippocratic or hypocritic?", *Journal of the Royal Society of Medicine*.

Government of Ireland (2023), *Budget 2023 Expenditure Report*, Dublin.

Government of Ireland (2021), *About the Department of Health*, Dublin.

Government of Ireland (2016), *A Healthy Weight for Ireland: Obesity Policy and Action Plan 2016-2025*, Dublin.

Hanley, P., R. Maguire, A. O'Ceilleachair and L. Sharp (2018), "Financial hardship associated with colorectal cancer survivorship: The role of asset depletion and debt accumulation", *Psycho-Oncology*, Vol. 27, No. 9, pp. 2165-2177.

Hanley, P. et al. (2013), "Work-related productivity losses in an era of ageing populations: the case of colorectal cancer", *Journal of Occupational and Environmental Medicine*, Vol. 55, No. 2, pp. 128-134.

Heffron, M. and K. Socha-Dietrich (2019), "The Irish paradox: Doctor shortages despite high numbers of domestic and foreign medical graduates", in *Recent Trends in International Migration of Doctors, Nurses and Medical Students*, OECD Publishing, Paris.

Henderson, C., X. Liu, A.V. Diez Roux, B.G. Link and D. Hasin (2004), "The effects of US state income inequality and alcohol policies on symptoms of depression and alcohol dependence", *Social Science and Medicine*, Vol. 58, No. 3, pp. 565-75.

Hennessy, M., C. Shine and E. Walker (2021), "Healthcare Capital Investment in Ireland", *Spending Review 2021*, Department of Health, Dublin.

HIA (2022), *Quarterly Report on Health Insurance - 2nd Quarter*, The Health Insurance Authority, Dublin.

HIA (2021), *Annual Report and Accounts 2020*, The Health Insurance Authority, Dublin.

HIQA (2021), *Acute and Community Healthcare Services*, Health Information and Quality Authority, Dublin.

HIQA (2020), *Guidelines for Economic Evaluation of Health Technologies in Ireland*, Health Information and Quality Authority, Dublin.

Holmes, J. et al. (2014), "Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study", *The Lancet*, Vol. 383, No. 9929, pp. 1655-1664.

Holtorf, A.P. et al., (2019), "External reference pricing for pharmaceuticals – A survey and literature review to describe best practices for countries with expanding healthcare coverage", *Value in Regional Health Issues*, Vol. 19, pp. 122-131.

Houses of the Oireachtas (2022a), *Debate of the Joint Committee on Health*, 9 February.

Houses of the Oireachtas (2022b), *Debate of the Joint Committee on Health*, 6 April.

Houses of the Oireachtas (2020), *Debate of the Special Committee on COVID-19 Response*, 2 June.

HSE (2022a), *National Service Plan 2022*, Health Service Executive, Dublin.

HSE (2022b), *Annual Report and Financial Statements 2021*, Health Service Executive, Dublin.

HSE (2022c), *2022 Waiting List Action Plan*, Government of Ireland.

HSE (2022d), Single Assessment Tool (InterRAI), Health Service Executive, Dublin.

HSE (2022e), *Structured Chronic Disease Management Programme Phase 2*, Health Service Executive, Dublin.

HSE (2021a), *Health Services Performance Profile October-December 2020*, Health Service Executive, Dublin.

HSE (2021b), *Medical Workforce Report 2020-21*, Health Service Executive, Dublin.

HSE (2020), *Performance and Accountability Framework*, Health Service Executive, Dublin.

HSE (2018), *The State of Tobacco Control in Ireland*, Health Service Executive, Dublin.

HSE (2016), *Towards Successful Consultant Recruitment, Appointment and Retention*, Health Service Executive, Dublin.

Humphries, N., J. Creese, J.P. Byrne and J. Connell (2021), "COVID-19 and doctor emigration: the case of Ireland", *Human Resources for Health*, Vol. 19, No. 29.

Humphries, N., J. Connell, J. Negin and J. Buchanan (2019), "Tracking the leavers: towards a better understanding of doctor migration from Ireland to Australia 2008-2018", *Human Resources for Health*, Vol. 17, No. 36.

ICGP (2021), *ICGP Response to Consultation on Review of the Mental Health Act*, Irish College of General Practitioners, Dublin.

IFAC (2015), "Controlling the health budget: Annual budget implementation in the public health area", *Analytical Note*, No. 8, Irish Fiscal Advisory Council, Dublin.

IGEES (2019), "Health Workforce Consultant Pay and Skills Mix, 2012-2017", *Spending Review 2019*, Irish Government Economic and Evaluation Service, Department of Public Expenditure and Reform, Dublin.

IMO (2017), *Irish Medical Organisation Submission to the Public Service Pay Commission*, Ireland Medical Organisation, Dublin.

Independent Review Group (2019), *Report of the Independent Review Group established to examine Private Activity in Public Hospitals*, February.

INMO (2022), *Submission to the Joint Committee on Health Emergency Department Overcrowding*, Irish Nurses and Midwives Organisation.

INMO (2021), *Pre-Budget Submission 2022*, Irish Nurses and Midwives Organisation.

IPHA (2021), *Framework Agreement on the Supply and Pricing of Medicines – Final Version*, Irish Pharmaceutical Healthcare Association, Dublin.

IRG (2019), *Report of the Independent Review Group Established to Examine Private Activity in Public*

Hospitals, Independent Review Group.

Katz, M. (2021), "Regardless of Age, Obesity and Hypertension increase risks with COVID-19", *JAMA Internal Medicine*, Editor's Note.

Keane, C., M. Regan and B. Walsh (2021), "Failure to take-up public healthcare entitlements: evidence from the Medical Card system in Ireland", *Social Science & Medicine*, Vol. 281, 114069.

Kennedy, F. et al. (2007), "Returning to work following cancer: a qualitative exploratory study into the experience of returning to work following cancer", *European Journal of Cancer Care*, Vol. 16, No. 1, pp. 17-25.

Kennelly, B. et al. (2020), "The COVID-19 pandemic in Ireland: an overview of the health service and economic policy response", *Health Policy and Technology*, Vol. 9, No. 4, pp. 419-429.

Kok, L., C. Berden and K. Sadiraj (2014), "Costs and benefits of home care for the elderly versus residential care: a comparison using propensity scores", *The European Journal of Health Economics*, Vol. 6, pp. 119-131.

Lorenzoni, L. and S. Dougherty (2022), "Understanding differences in health care spending: A comparative study of prices and volumes across OECD countries", *Health Services Insights*, Vol. 15.

Lorenzoni, L. et al. (2019), "Health Spending Projections to 2030: New results based on a revised OECD methodology", *OECD Health Working Papers*, No. 110, OECD Publishing, Paris.

Lorenzoni, L. et al. (2017), "Cyclical vs structural effects on health care expenditure trends in OECD countries", *OECD Health Working Papers*, No. 92, OECD Publishing, Paris.

Maître, B., H. Russell and E. Smyth (2021), "The Dynamics of Child Poverty in Ireland: Evidence from the Growing Up in Ireland Survey", *Research Series*, No. 121, Economic and Social Research Institute, Dublin.

Mariotto, A., L. Enewold, J. Zhao, C. Zeruto and K. Yabrof (2020), "Medical Care Costs Associated with Cancer Survivorship in the United States", *Cancer, Epidemiology, Biomarkers and Prevention*, Vol. 29/7, Philadelphia.

Matthews, S., M. Pierce, S. O'Brien Green, E. Hurley, B.M. Johnston, C. Normand and P. May (2021), "Dying and Death in Ireland: What do we routinely measure, how can we improve?", Irish Hospital Foundation, Dublin.

McCarthy, T., C. Lindberg and C. O'Malley (2022), "Towards Population-Based Funding for Health: Evidence Review and Regional Profiles", *Spending Review 2022*, Department of Health, Dublin.

Mercille, J., B. Turner and D.S. Lucey (2021), "Ireland's takeover of private hospitals during the COVID-19 pandemic", *Health Economics, Policy and Law*, Vol. 17, No. 2, pp. 232-237.

Mesabbah, M. and Arisha, A. (2016), "Performance management of public healthcare services in Ireland: a review", *International Journal of Health Care Quality Insurance*, 29(2).

Moran, P. a/nd E. Halpin (2021), *Spending Review 2021: Expanded Provision of Home Support and Total Costs of Long-Term Care for Older Persons – A Scoping Review and Explanatory Analysis*, Irish Government Economic and Evaluation Service, Government of Ireland, Dublin.

Müller, M. and K. Socha-Dietrich (2020), "Reassessing private practice in public hospitals in Ireland: an overview of OECD experiences", *OECD Health Working Papers,* No. 118, OECD Publishing, Paris.

Murimi, M.W., A.F. Moyeda-Carabaza, B. Nguyen, S. Saha, R. Amin and V. Njike (2018), "Factors that contribute to effective nutrition education interventions in children: a systematic review", *Nutrition Reviews*, Vol. 76, No. 8, pp. 553-580.

Murphy, R. et al. (2020), "The Better Letter Initiative: An Impact Evaluation of a Redesigned Inpatient and Day Case Appointment Letter", *Department of Health Research Paper*, Dublin.

Murphy, R. and C. Taaffe (2019), "Using SMS Reminders to Reduce Non-attendance at Hospitals Appointments: an Umbrella Review of Key Issues", *Department of Health Research Paper*, Dublin.

NCPP (2020), *Hospital and Community-based Psychosocial Care for Patients with Cancer and their Families: A Model of Care for Psycho-Oncology*, National Cancer Control Programme, Dublin.

NCRI (2021), *Cancer in Ireland 1994-2019 – Annual Report*, National Cancer Registry Ireland, Cork.

NCRI (2019), *Cancer Incidence Projections for Ireland 2020-2045*, National Cancer Registry Ireland, Cork.

Nolan, A. (2017), "Health: Funding, Access and Efficiency", in *The Economy of Ireland: Policy-Making in a Global Context*, edited by J. O'Hagan and F. Toole, Palgrave Editions, London.

Nolan, A. et al. (2014), *The Impact of the Financial Crisis on the Health System and Health in Ireland*, WHO.

O'Ceilleachair, O. et al. (2017), "Counting the cost of cancer: out-of-pocket payments made by colorectal cancer survivors", *Supportive Care in Cancer*, Vol. 25, No. 9, pp. 2733-2741.

O'Connor, M. et al. (2019), "The unmet needs of cancer survivors in Ireland: A scoping review 2019", *National Cancer Survivorship Needs Assessment*, Irish Cancer Society and National Cancer Registry Ireland.

Oderkirk, J. (2021), "Survey results: National health data infrastructure and governance", *OECD Health Working Papers*, No. 127, OECD Publishing, Paris.

O'Dwyer, C., D. Mongan, A. Doyle and B. Galvin (2021), "Alcohol Consumption, alcohol-related harm and alcohol Policy in Ireland", *HRB Overview*, Series 11, Health Review Board, Dublin.

OECD (2022a), *Social Protection for Long-Term Care in Old Age: Latest Estimates*, forthcoming.

OECD (2022b), *Healthy Eating and Active Lifestyles: Best Practices in Public Health*, OECD Publishing, Paris.

OECD (2021a), *Health at a Glance 2021: OECD Indicators*, OECD Publishing, Paris.

OECD (2021b), A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health, *OECD Health Policy Studies*, OECD Publishing, Paris.

OECD (2021c), *Fitter Minds, Fitter Jobs: From Awareness to Change in Integrated Mental Health, Skills and Work Policies, Mental Health and Work*, OECD Publishing, Paris.

OECD (2021d), Preventing Harmful Alcohol Use, *OECD Health Policy Studies*, OECD Publishing, Paris.

OECD (2020a), Realising the Potential of Primary Health Care, *OECD Health Policy Studies*, OECD Publishing, Paris.

OECD (2020b), Waiting Times for Health Services: Next in Line, *OECD Health Policy Studies*, OECD Publishing, Paris.

OECD (2020c), *OECD Economic Surveys: Ireland 2020*, OECD Publishing, Paris.

OECD (2020d), *Consumption Tax Trends 2020: VAT/GST and Excise Rates, Trends and Policy Issues*, OECD Publishing, Paris.

OECD (2019a), *OECD at a Glance 2019*, OECD Publishing, Paris.

OECD (2019b), The Heavy Burden of Obesity: The Economics of Prevention, *OECD Health Policy Studies*, OECD Publishing, Paris.

OECD (2018), *Accounting and Mapping of Long-Term Care Expenditure under SHA 2011*, OECD Publishing, Paris.

OECD (2017a), *OECD Economic Surveys: Slovak Republic 2017*, OECD Publishing, Paris.

OECD (2017b), *Budget Transparency Toolkit: Practical Steps for Supporting Openness, Integrity and Accountability in Public Financial Management*, OECD Publishing, Paris.

OECD (2015a), *OECD Economic Surveys: Switzerland 2015*, OECD Publishing, Paris.

OECD (2015b), *Fiscal Sustainability of Health Systems: Bridging Health and Finance Perspectives*, OECD Publishing, Paris.

OECD/EU (2021), *Ireland Country Health Profile 2021, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

O'Riordan, M., C. Collins and G. Doran (2013), *Access to Diagnostics – A Key Enabler for a Primary Care led Health Service*, Irish College of General Practitioners, Dublin.

Prior, S. et al. (2021), *Review of High-Tech Drug Expenditure – Spending Review 2021*, Irish Government Economic and Evaluation Service, Dublin.

Public Service Pay Commission (2012), *Recruitment and Retention Module 1 Report*, Dublin.

Rocard, E., P. Sillitti and A. Llena-Nozal (2021), "COVID-19 in long-term care: Impact, policy responses and challenges", *OECD Health Working Papers*, No. 31, OECD Publishing, Paris.

Roland, M. et al. (2006), "Outpatient services and primary care: A scoping review of research into strategies for improving outpatient effectiveness and efficiency", NCCSDO Department of Health, University of Manchester.

Rottenberg, Y., N.Z. Ratzon, M. Cohen, A. Hubert, B. Uziely and A.G.E.M. de Boer (2016), "Unemployment risk at 2 and 4 years following colorectal cancer diagnosis: a population-based study", *European Journal of Cancer*, Vol. 69, pp. 70-76.

RSA (2021), *Driver Attitudes and Behaviour Survey 2020*, Road Safety Authority, Ballina, Co. Mayo.

RSA (2020), *Road Deaths and Alcohol, 2013-2017*, Road Safety Authority, Ballina, Co. Mayo.

Schneider, S. and C. Devitt (2018), "Accessing health care in times of economic growth and economic downturn: Evidence from Ireland", *Journal of European Social Policy*, Vol. 28(4), pp. 357-369.

Sibbald B. (2009), "Direct Access to Diagnostic Services", *British Journal of General Practice*, Vol. 59, No. 562.

Siciliani, L., V. Moran and M. Borowitz (2014), "Measuring and comparing health care waiting times in OECD countries", *Health Policy*, Vol. 118/3, pp. 292-303.

Sherk, A., T. Stockwell and R.C. Callaghan (2018), "The effect on emergency department visits of raised alcohol minimum prices in Saskatchewan, Canada", *Drug and Alcohol Review*, Vol. 37, No. 51.

Shine, C. and M. Hennessy (2022), "Health Capital Investment in Ireland: An Analysis of Healthcare Infrastructure Capacity", *Spending Review 2022*, Irish Government Economic and Evaluation Service and Department of Health, Dublin.

Simar, L. and P.W. Wilson (2007), "Estimation and inference in two-stage, semi-parametric models of production processes", *Journal of Econometrics*, Vol. 136, No. 1.

Smith, S. et al. (2019), "Geographic profile of healthcare needs and non-acute healthcare supply in Ireland", *Research Series*, No. 90, Economic and Social Research Institute, Dublin.

Smith, T.G. et al. (2016), "The rationale for patient-reported outcomes surveillance in cancer and a reproducible method for achieving it", *Cancer*, Vol. 122-3, pp. 344-351.

Storcksdieck Bonsmann, S. et al. (2020), "Front-of-pack nutrition labelling schemes: a comprehensive review", *EUR 29811 EN – Publication Office of the European Union*, Luxembourg.

The Irish Examiner (2022), "Carer shortage leaves almost 1,000 people in Cork and Kerry without homecare", 29 September.

The Irish Times (2021), "Medical card holders' waiting three years for hearing tests", 3 March.

Thejournal.ie (2022), "44% increase in the number of Irish doctors emigrating to Australia since 2018", 22 April.

Thomas, S. et al. (2021), "Sláintecare implementation status in 2020: Limited progress with entitlement expansion", *Health Policy*, Vol. 125, No. 3, pp. 277-283.

Thomas, S., S. Burke and S. Barry (2014), "The Irish health-care system and austerity: sharing the pain", *The Lancet*, Vol. 383, No. 9928, pp. 1545-1546.

Travers, J. et al. (2019), "Delaying and reversing frailty: a systematic review of primary care interventions", *British Journal of General Practice.*

Turner, B. and S. Smith (2020), "Uncovering the complex role of private health insurance in Ireland", in *Private Health Insurance, History, Politics and Performance,* edited by Thomson et al., European Observatory on Health Systems and Policies, World Health Organisation - Europe.

Valero-Bover, D. et al. (2022), "Reducing non-attendance in outpatient appointments: predictive model development, validation, and clinical assessment", *BMC Health Services Research 2022 22:1*, Vol. 22/1, pp. 1-8.

VanderBent, S. and B. Kuchta (2010), *Valuing Home and Community Care*, Community Providers Association Committee, Ontario, Canada.

Wagenaar, A., A. Tobler and K. Komro (2010), "Effects of alcohol tax and price policies on morbidity and mortality: a systematic review", *American Journal of Public Health*, Vol. 100, No. 11, pp. 2270-2278.

Walsh, B. and S. Lyons (2021), "Demand for the statutory home support scheme", *Research Series*, No. 122, Economic and Social Research Institute, Dublin.

Walsh, B. et al. (2021), "Projections of expenditure for primary, community and long-term care in Ireland, 2019-2035, based on the Hippocrates model", *Research Series*, No. 126, Economic and Social Research Institute, Dublin.

Walsh, B., C. Mac Domhnaill and G. Mohan (2021), "Developments in healthcare information systems in Ireland and internationally", *ESRI Survey and Statistical Report Series*, No. 105, Economic and Social Research Institute, Dublin.

Walsh, B., S. Lyons, S. Smith, M.A. Wren and J. Eighan (2020), "Does formal home care reduce inpatient length of stay?", *ESRI Research Bulletin*, November Bulletin, Economic and Social Research Institute, Dublin.

Wells, J and M. White (2014), "The impact of the economic crisis and austerity on the nursing and midwifery professions in the Republic of Ireland: Boom, bust and retrenchment", *Journal of Research in Nursing*.

Williams, D. and S. Thomas (2017), "The impact of austerity on the health workforce and the achievement of human resources for health policies in Ireland (2008-2014)", *Human Resources for Health*, Vol. 15, No. 62.

Williams, S.C. et al. (2007), "Developing a robust and efficient pathway for the referral and investigation of women with post-menopausal bleeding using a cut-off of < or = 4 mm for normal thickness", *The British Journal of Radiology*, Vol. 80, No. 957.

Williamson, A. et al. (2021), "'Missingness' in health care: Associations between hospital utilization and missed appointments in general practice. A retrospective cohort study", *PLoS ONE*, Vol. 16/6.

Winpenny, E. et al. (2016), "Outpatient services and primary care: Scoping review, studies and international comparisons", *Health Services and Delivery Research*, National Institute for Health Research, London.

Wilson, P.W. (2008), "FEAR 1.0: A software package for frontier efficiency analysis with R", *Socio-Economic Planning Sciences*, Vol. 42, No. 4, pp. 247-254.

Wren, M.A. and A. Fitzpatrick (2020), "How does Irish healthcare expenditure compare internationally?", *Research Series,* Number 114, October, Economic and Social Research Institute, Dublin.

Zhao, J. et al. (2013), "The relationship between minimum alcohol prices, outlet densities and alcohol-attributable deaths in British Columbia, 2002-09", *Addiction*, Vol. 108, No. 6, pp. 1059-69.

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The Irish economy weathered the COVID-19 pandemic and is coping well with the repercussions from Russia's war of aggression against Ukraine. While the fiscal position is currently strong, with buoyant revenues, a number of pressures arising from ageing, housing, health, and climate change create fiscal risks in the longer term. Ongoing and planned investments to boost housing supply and affordability and lower greenhouse gas emissions should be accompanied by reforms to reduce regulatory and legal hurdles, uncertainty, and high transaction costs. The government has launched a major reform of the health sector, Sláintecare. Boosting spending efficiency, reducing waiting times and simplifying the interaction of different parts of the system are key to achieve improved health sector performance and sustainability. Moving towards a more integrated system of primary, community and hospital care should be prioritised to increase spending efficiency and the capacity to meet future challenges. Improving data availability and governance as well as financial reporting and management can help track spending and reform implementation.

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