European Commission

State of Health in the EU

Ireland

Country Health Profile 2019

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European Observatory on Health Systems and Policies
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The Country Health Profile series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Information.

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: http://www.oecd.org/health/Country-Health-Profiles-2019-Ireland.xls

Demographic and socioeconomic context in Ireland, 2017

Demographic factors	Ireland	EU
Population size (mid-year estimates)	4 807 000	511 876 000
Share of population over age 65 (%)	13.5	19.4
Fertility rate[1]	1.8	1.6
Socioeconomic factors		
GDP per capita (EUR PPP[2])	54 300	30 000
Relative poverty rate[3] (%)	15.6	16.9
Unemployment rate (%)	6.7	7.6

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income.
Source: Eurostat Database.

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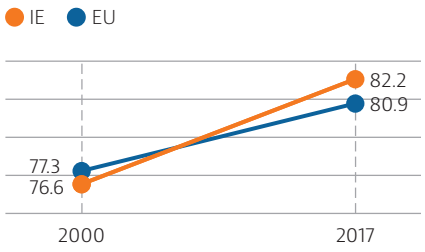
1 Highlights

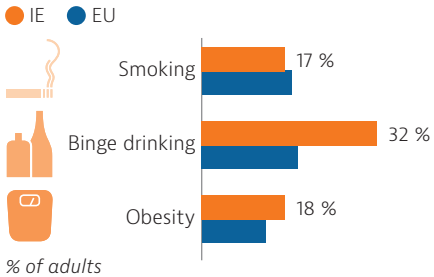
The health status of Irish people has improved substantially since 2000, with life expectancy registering huge gains and most people reporting being in good health. Despite this progress, there is consensus in Ireland that the health system is underperforming and that a fundamental transformation is needed to make it fit to meet future demands associated with an ageing society. Key areas to be tackled include introducing a universal health system, building up the health system to improve access and adequately meet health care needs, more consistent workforce planning and better budget management at all levels of the system.



Life expectancy at birth, years

Health status

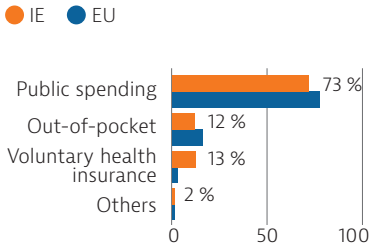
The life expectancy of the Irish population has increased by nearly six years since 2000, the strongest gains among western European countries, and is now above the EU average. The increase was driven by sharp reductions in mortality from cardiovascular diseases, due in part to reductions in some risk factors like smoking but also to improvements in treatments.



% of adults

Risk factors

In 2018, 17 % of adults in Ireland smoked tobacco every day, down from 27 % in 2002, and now slightly below the EU average. Nearly one-third of adults reported regular heavy alcohol intake in 2014, a rate well above the EU average. The obesity rate increased to 18 % in 2015, up from 15 % in 2007, and is now higher than the EU average.



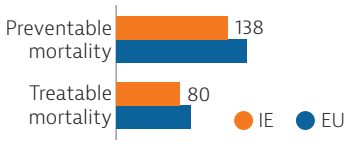
% of total health expenditure, 2017

Health system

Health spending in Ireland has increased at a moderate rate in recent years. At EUR 3 406 per person in 2017, it is around one-fifth higher than the EU average. Public funding accounts for 73 % of all health spending in Ireland, a lower share than the EU average (79 %). The remaining part is paid directly out of pocket by households (12 %) or through voluntary health insurance (13 %), which plays a much bigger role than in most other EU countries.

Effectiveness

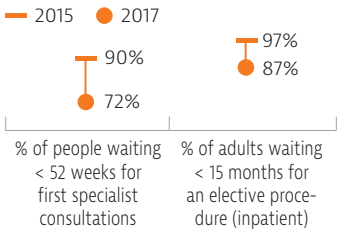
Mortality from preventable and treatable causes in Ireland is lower than the EU average, signalling that public health policies and health care interventions are generally effective. Yet many other western European countries are more successful in avoiding premature deaths.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

Ireland remains the only western European country without universal coverage for primary care. For those relying on the public system, long waiting times for specialist appointments and elective surgery in hospitals remain an important source of patient dissatisfaction.



Resilience

The Sláintecare Report of 2017 highlighted the importance of some fundamental changes in the Irish health system and the conviction that the system is not performing as well as it could. With the establishment of the Sláintecare Implementation Office in September 2018, the implementation of its recommendations is gaining some traction.

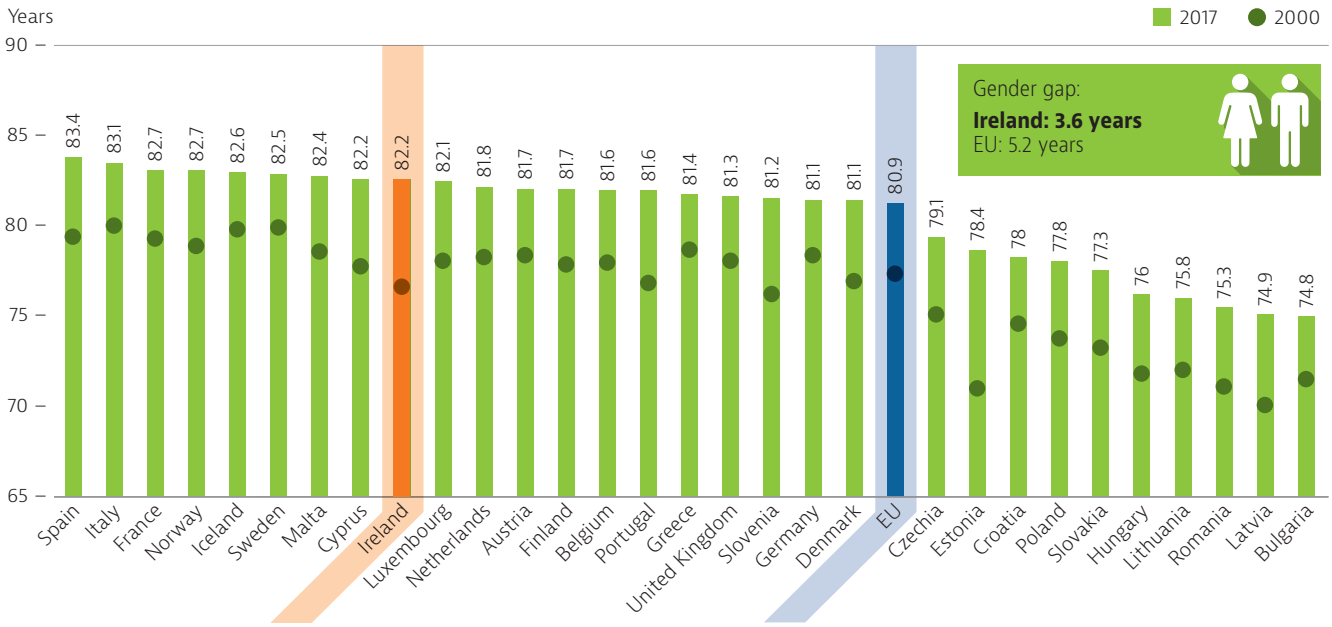
2 Health in Ireland

Life expectancy in Ireland has increased by nearly six years since 2000

Life expectancy at birth reached 82.2 years in Ireland in 2017, up from 76.6 years in 2000 (Figure 1). Since life expectancy in Ireland has grown more rapidly than in most other EU countries, it is now more than one year above the EU average (80.9 years) while it was still below the average in 2000.

Although the gender gap in life expectancy in Ireland is narrowing, Irish men could still expect to live almost four years less than women (80.4 years compared to 84.0 years) in 2017. This gap is, however, less pronounced than in many EU countries.

Figure 1. Life expectancy in Ireland has increased rapidly and is now above most EU countries



Source: Eurostat Database.

The main causes of death remain circulatory diseases and cancer

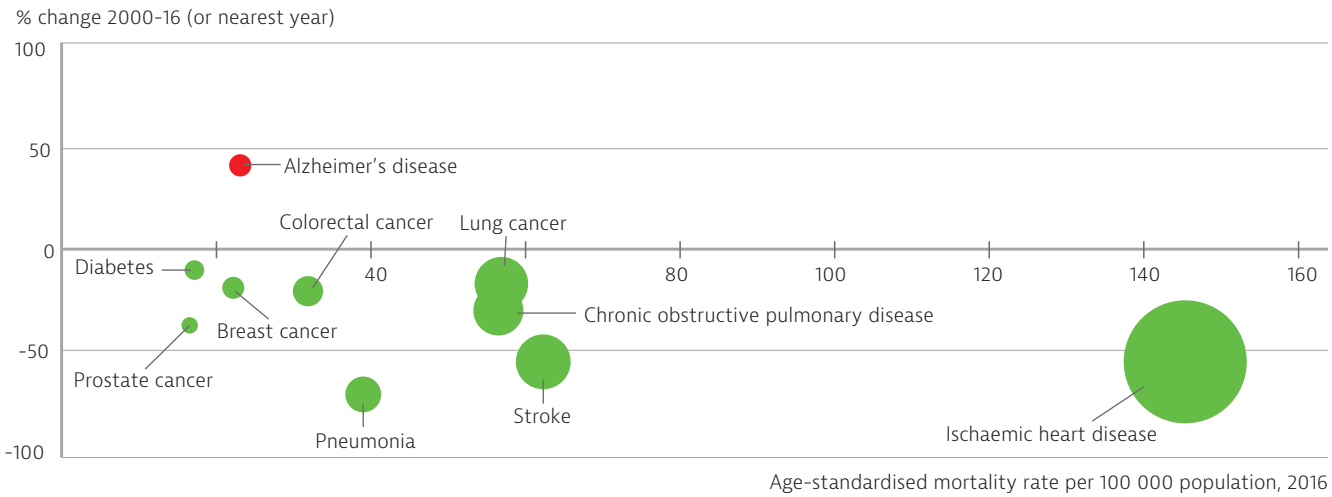
The increase in life expectancy in Ireland since 2000 has mainly been driven by reductions in mortality rates from circulatory diseases, notably ischaemic heart disease (Figure 2). Despite this progress, circulatory diseases remain the leading cause of death in Ireland (30.1 % of all deaths) followed by cancer (29.9 %). Among the different types of cancer, lung, colorectal and breast cancer are the most frequent causes of death in Ireland.

Deaths from respiratory diseases have decreased starkly since 2000, reflecting in part recent drops in tobacco consumption, although mortality rates remain well above the EU average. On the other hand, mortality rates from Alzheimer's disease have increased greatly since 2000. This strong increase is partly due to improvements in diagnostics and changes in death registration practices, but is also related to population ageing.

Most adults report being in good health, but the proportion is smaller among low-income groups

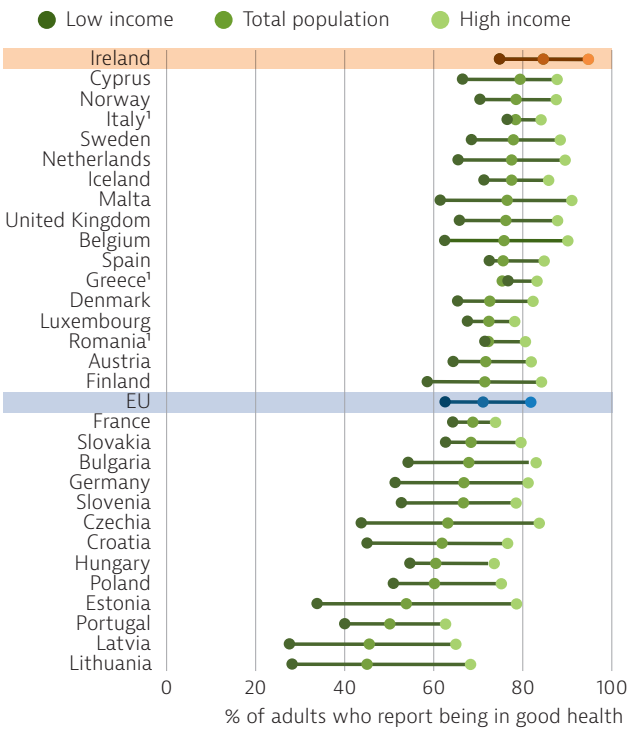
About 83 % of Irish adults reported being in good health in 2017, the highest share among all EU countries and substantially above the EU average of 70 % (Figure 3). As in other countries, there are some disparities in self-rated health across income groups. Only 73 % of people in the lowest income quintile assess their health as good, compared to 93 % in the highest. These disparities already exist in children's health: children from well-off parents are more likely to be in good health than those growing up in low-income households.

Figure 2. Circulatory diseases and cancer are still the leading causes of death



Note: The size of the bubbles is proportional to the mortality rates in 2016. The increase in mortality rates from Alzheimer's disease is largely due to changes in diagnostic and death registration practices.
Source: Eurostat Database.

Figure 3. Ireland has the highest share of the population that reports being in good health in the EU



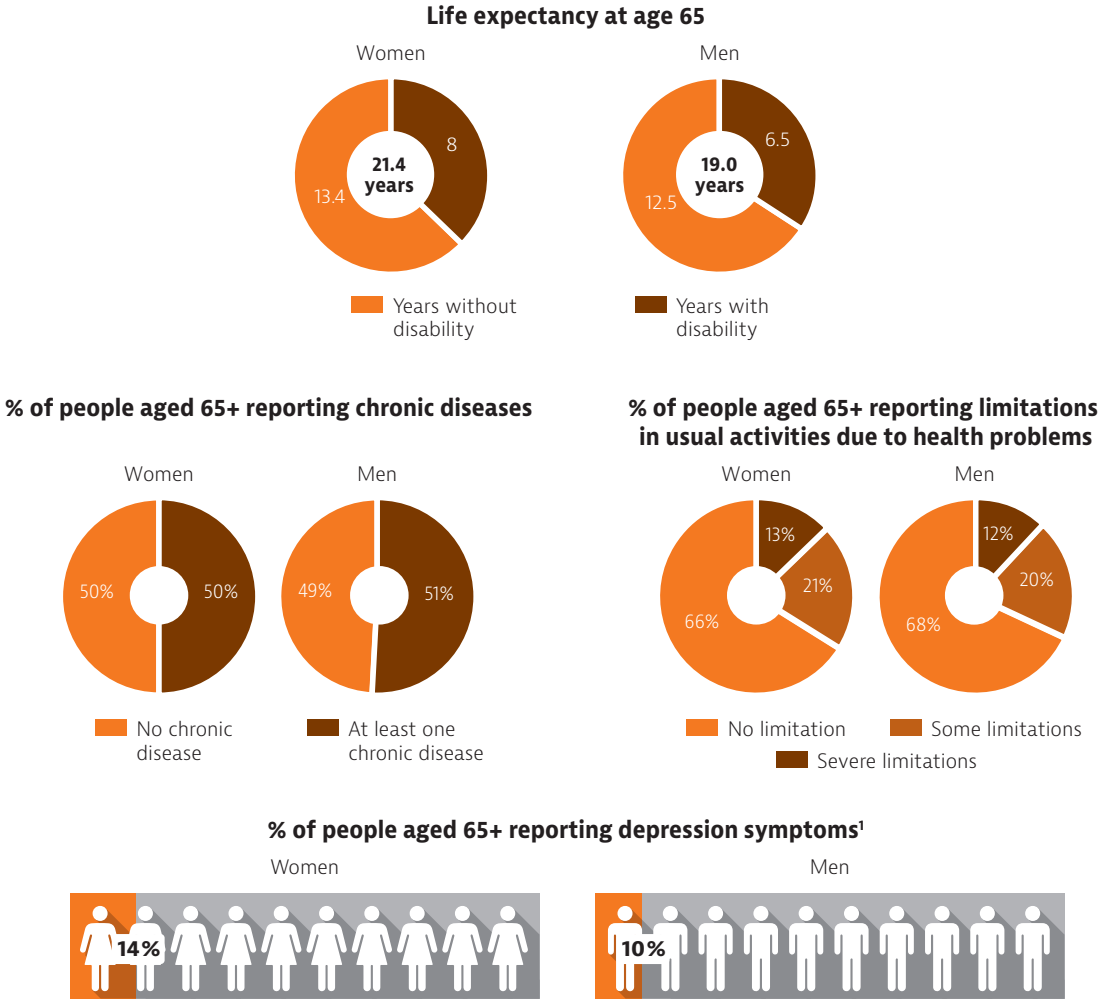
Note: 1. The shares for the total population and the population on low incomes are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2017).

The Irish are living longer than before, but not all remain healthy as they age

The proportion of people aged over 65 in Ireland is currently relatively low, accounting for 13 % of the population. However, due to rising life expectancy and declining fertility rates, this share is projected to double to 26 % by 2050, which will lead to growing demands on health and long-term care systems.

In 2017, Irish people aged 65 could expect to live another 20 years, with a 2.5-year gap between women and men (Figure 4). However, many years of life in old age are lived with some chronic diseases and disabilities. Around 50 % of Irish men and women aged 65 and over reported having at least one chronic condition, and around one in three reported some or severe limitations in carrying out usual activities because of health problems.

Figure 4. Many years of life after age 65 are lived with some chronic conditions and disabilities



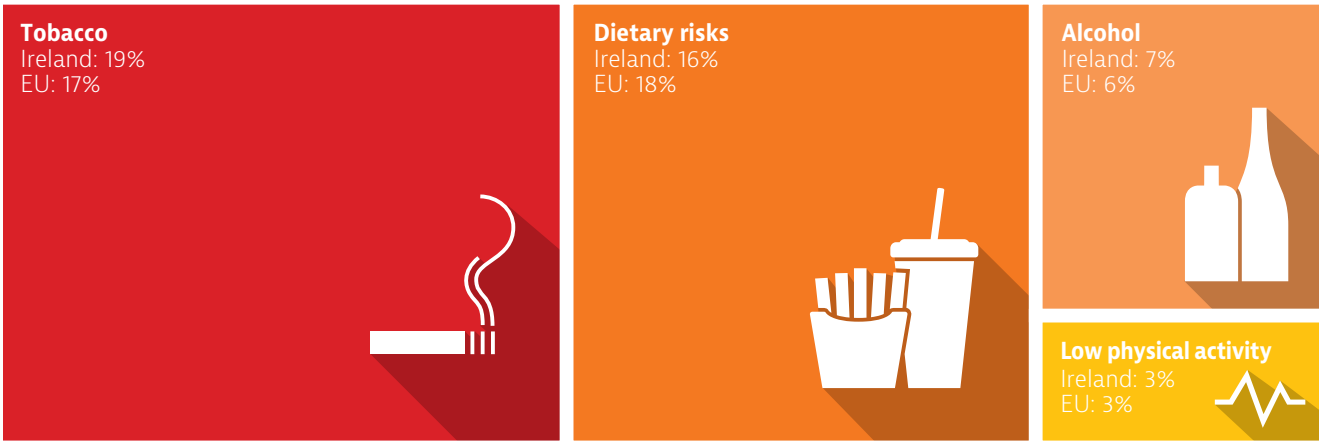
Note: 1. People are considered to have depression symptoms if they report more than three depression symptoms (out of eight possible variables).
Source: Eurostat Database (data refer to 2017).

3 Risk factors

Behavioural risk factors have important impact on mortality

Around 40 % of all deaths in Ireland in 2017 can be attributed to behavioural risk factors, a share close to the average across the EU (39 %). About one-fifth of all deaths in 2017 (6 000 deaths) are due to tobacco consumption. Dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption) are estimated to account for about 16 % of all deaths in Ireland. Alcohol consumption is associated with roughly 7 % of all deaths, while 3 % of deaths can be attributed to low physical activity (Figure 5).

Figure 5. About two-fifths of all deaths can be attributed to modifiable lifestyle risk factors



Note: The overall number of deaths related to these risk factors (12 000) is lower than the sum of each one taken individually (14 000) because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable consumption, and high sugar-sweetened beverages and salt consumption.
Source: IHME (2018), Global Health Data Exchange (estimates refer to 2017).

Despite reductions over the past decade, smoking rates among adults remain close to the EU average

Although progress has been made in reducing smoking rates, more than one in six Irish adults (17 %) smoked daily in 2018, a rate close to the EU average but still higher than in the best performing countries such as Sweden and Norway, where smoking rates are only 10-12 %. Smoking has become less popular among adolescents, especially among girls. Only about 13 % of 15- to 16-year-olds in Ireland reported that they had smoked cigarettes in the past month in 2015, one of the lowest rates in the EU. Initiatives are ongoing to further reduce tobacco consumption (see Section 5.1).

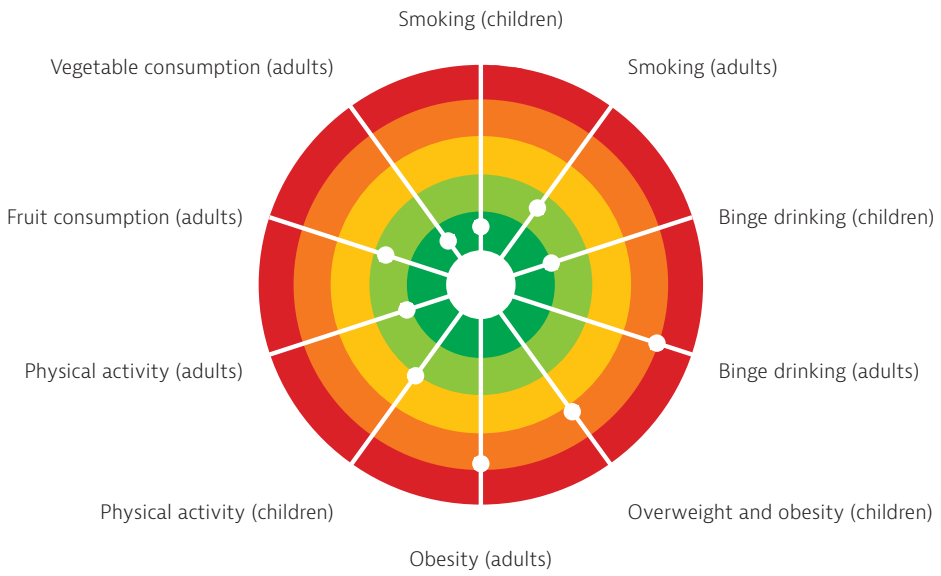
Overweight and obesity represent growing public health issues in Ireland

Overweight and obesity rates have increased among adults and teenagers. Among adults, the rate of obesity increased from 15 % in 2002 to 18 % in 2015[1] (Figure 6). Among 15-year-olds, the rate of overweight and obesity also rose to reach 19 % in 2013-14. As a result, overweight and obesity rates in Ireland are higher than in most other EU countries.

However, even though around one-third of Irish adults consume unhealthy foods at least once a day, a high proportion of Irish adults consume vegetables daily and they are also are among the most physically active in the EU. Implementing fiscal measures to support healthy eating and acknowledging the role of physical activity in the prevention of obesity are key steps identified in the country's Obesity and Policy Action Plan (Department of Health, 2016) (see Section 5.1).

1: Based on measured data of the actual weight and height of people, which is a more reliable measure, the obesity rate is even higher in Ireland but has remained stable at 23 % from 2007 to 2017.

Figure 6. Overweight and obesity, and alcohol consumption, are major public health concerns in Ireland



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.
Source: OECD calculations based on ESPAD survey 2015 and HBSC survey 2013-14 for children indicators; and EU-SILC 2017 and EHIS 2014 for adults indicators.

Heavy alcohol consumption is an important risk factor in Ireland

About one-third of adults in Ireland reported regular heavy alcohol consumption (binge drinking[2]) in 2015, a higher proportion than in most other EU countries. Regular binge drinking is twice as frequent among men than women.

Binge drinking among adolescents is, however, less widespread in Ireland than across the EU. The share of 15- to 16-year-olds who reported binge drinking at least once over the past month stood at 28 % compared to 38 % across the EU in 2015. While recording a comparably low rate is good news for Ireland, it should still be a reason for concern, since early drinking initiation can lead to harmful alcohol consumption habits later in life.

Social inequalities in risk factors contribute to inequalities in health

As in most other EU countries, many behavioural risk factors in Ireland are more common among people with lower education or income. Smoking rates among adults who have not completed secondary education are more than twice as high as among those with a university degree. This disparity is more pronounced in Ireland than in many other EU countries. Social differences also exist for obesity, as those with lower educational attainment display higher rates – but here the difference in Ireland is smaller than on average across the EU. The higher prevalence of risk factors among socially disadvantaged groups is an important driver of inequalities in health and life expectancy. Reducing health inequalities is one of the four key objectives of the Healthy Ireland agenda (Department of Health, 2013).

2: Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more alcoholic drinks for adolescents.

4 The health system

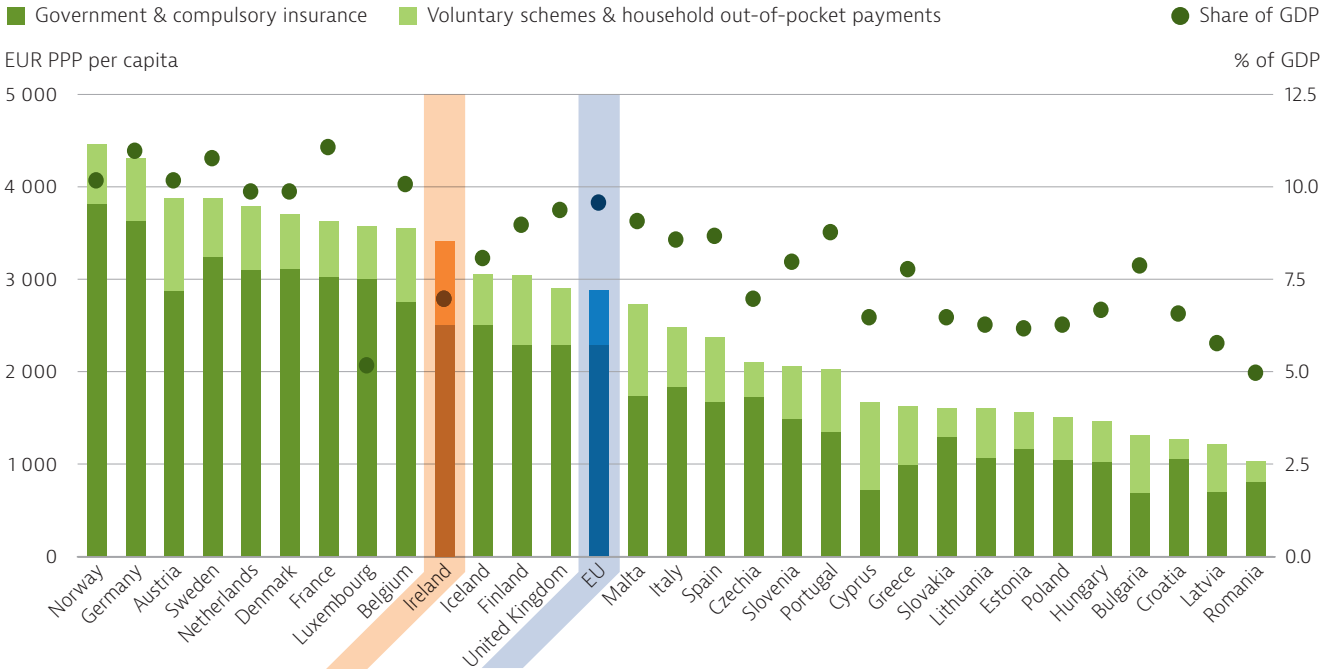
Comprehensive reforms to Ireland's health system are underway

Ireland's health system is a national health service funded predominantly through general taxation. In addition, more than two in five people purchase voluntary health insurance, mainly for quicker access to care. Leadership, policy direction, governance and performance oversight for the health sector is provided by the Department of Health. The Health Service Executive (HSE), a government agency under the aegis of the Department of Health, is responsible for the management and delivery of health and social care services. In many instances, the HSE is both purchaser and provider of services, although a purchaser–provider split exists in cases where the public sector purchases care from private general practitioners (GPs) or not-for-profit public hospitals. Fundamental reforms to the Irish health sector are currently being initiated following political consensus from a cross-party Parliamentary Committee on the future of health care in 2017 (Box 1).

Health spending per capita in Ireland is above the EU average

In 2017, health spending per capita in Ireland stood at EUR 3 406 (adjusted for differences in purchasing power), around one-fifth above the EU average (Figure 7). This surprisingly high level – given the comparably young demographic – is mainly due to high health prices. The use of both primary care services (measured in terms of number of doctor consultations per person) and hospital care (measured in terms of number of admissions and discharges) is lower in Ireland than the EU average (Figure 8). Salaries in the health sector, in particular for specialists and for senior doctors and nurses, are above those of many other countries in western Europe.

Figure 7. Health expenditure is above the EU average on a per capita basis

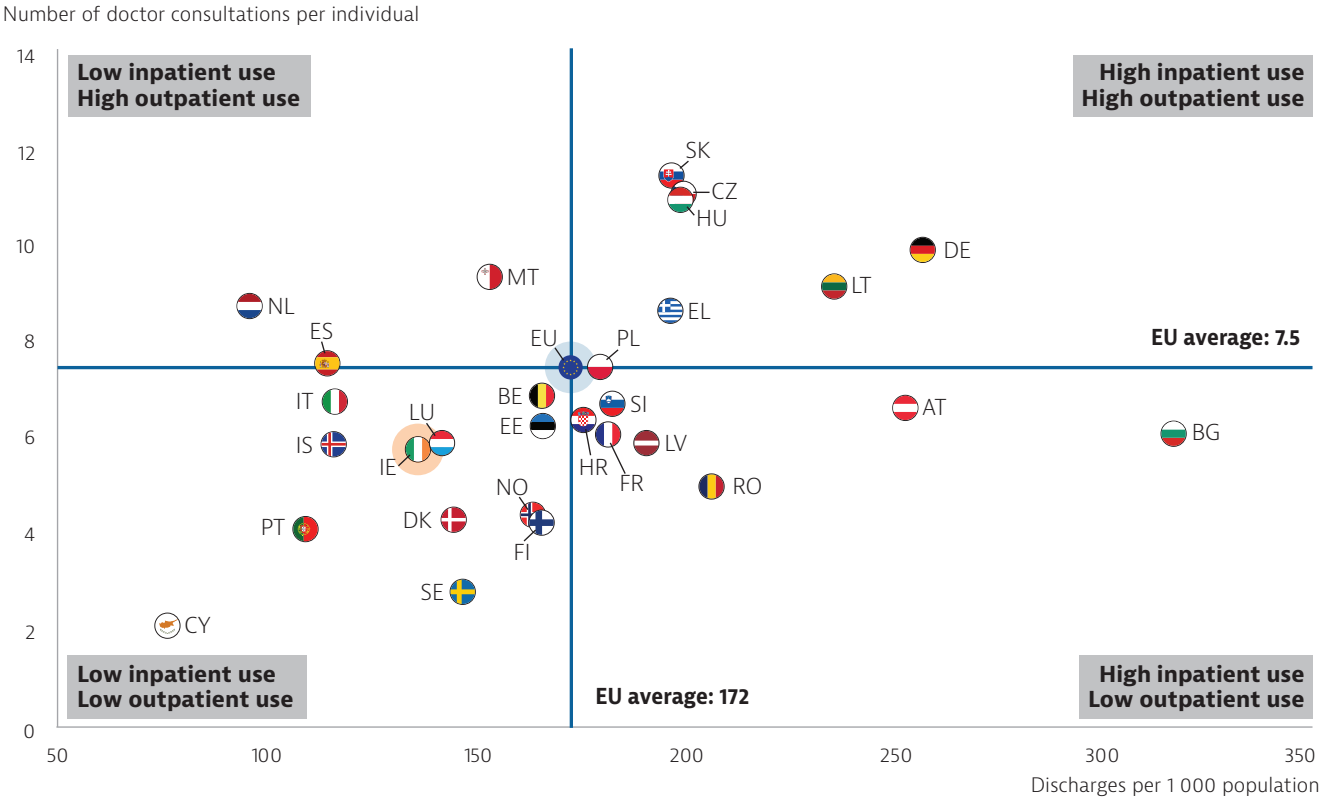


Note: Health spending as a share of GNI (9.0 %) in Ireland is substantially higher than as a share of GDP (7.2 %).[3]
Source: OECD Health Statistics 2019 (data refer to 2017).

Most health expenditure is financed through general taxation and a Universal Social Charge levied on employees and the self-employed. In 2017, the share of government financing in total health expenditure stood at 73 %. This share, however, is relatively low for a predominantly tax-based health system and below the EU average of 79 %. The proportion of overall health spending from out-of-pocket (OOP) payments[4] in 2017 was modest (12 %), while voluntary health insurance contributed 13 %, the second highest share in the EU after Slovenia (Section 5.2).

3: Given that a significant proportion of the GDP in Ireland consists of profits from foreign-owned companies that are repatriated, gross national income (GNI) is a more meaningful measure of the capacity to pay for health care in Ireland, but even GNI is not a true measure of the productive capacity of the domestic economy.
4: OOP payments include direct payments, cost-sharing for services outside the benefit package and informal payments.

Figure 8. The use of both primary care and inpatient care is lower in Ireland than the EU average



Note: Data for doctor consultations are estimated for Greece and Malta.
Source: Eurostat Database; OECD Health Statistics (data refer to 2016 or the nearest year).

Spending on inpatient care in Ireland is higher than in most other EU countries

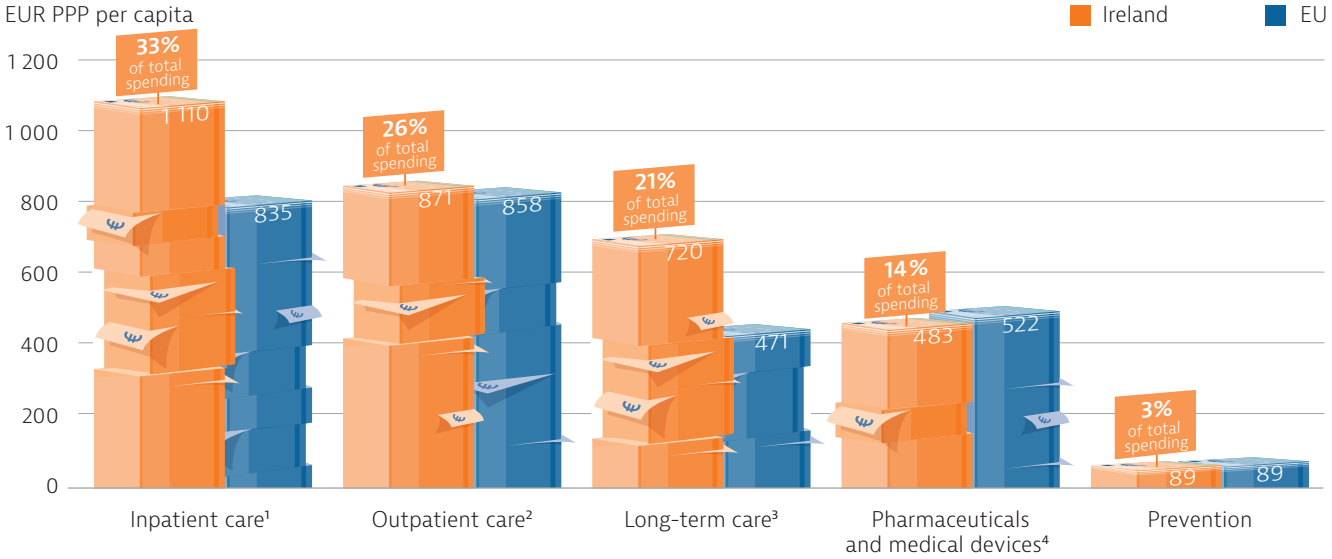
For many health spending components, Ireland spends more than the EU average per capita (Figure 9). Spending on inpatient care is the fifth highest in the EU, around one-third above the EU average. For long-term care, per capita spending is more than 50 % above the EU average. On the other hand, per capita spending on pharmaceuticals and medical devices was below the EU average in 2017. That being said, new initiatives are on the way to enhance the availability of newer and cheaper medicines (see Section 5.3).

Box 1. The Sláintecare Report provided a roadmap to deliver comprehensive system reforms but the Department of Health has been selective so far in implementing its recommendations

The final report of the cross-party Parliamentary Committee on the future of health care, commonly known as the 'Sláintecare Report' (Houses of the Oireachtas, 2017), provides a vision for a new health system in Ireland that would provide a universal, single-tier health service where patients are treated based solely on need, reorienting services towards primary care settings.

The Sláintecare Implementation Strategy, published by the government in 2018, outlines specific actions for the next three years and a ten-year strategic direction. Among other things, it details actions to strengthen primary care and deliver integrated care through alignment of community services and hospital services on a population basis within clear geographical areas, to allocate resources through regional health areas, and to develop a sustainable workforce and modern eHealth infrastructure. These actions are developed further in the Sláintecare Action Plan, published in March 2019. However, while the Strategy and Action Plan commit to expanding eligibility for health care on a phased basis, they do not wholly commit to legislating for entitlement to care and the expansion of services required to deliver universal health coverage, as laid out in the Sláintecare Report (see Section 5.3).

Figure 9. For most health services per capita spending in Ireland is above the average EU



Note: Administration costs are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care; 3. Includes only the health component; 4. Includes only the outpatient market.
Source: OECD Health Statistics 2019, Eurostat Database (data refer to 2017).

Ireland has a two-tier health system, with eligibility dependent on socioeconomic status

There is no universal entitlement to public health care in Ireland, with eligibility varying according to residency, age and socioeconomic status. All residents are entitled to receive care in public hospitals free of charge or at a reduced cost. However, a 'two-tier' system exists, as many individuals buy private insurance to bypass long waiting lists in the public system and gain faster access to hospital care and diagnostics.

Residents with an income below a defined threshold or with certain medical conditions (32 % of the population in March 2019) are eligible for a Medical Card, which provides access to primary care and hospital services free of charge and medicines with limited co-payments. Some other population groups (10 % of the population) have access to a GP Visit Card that covers GP charges but does not cover the costs of medicines or hospital fees. The remaining population (58 %), who hold neither a Medical Card nor a GP Visit Card, must cover the costs of accessing GP services themselves (see Section 5.2).

Co-payments are applied extensively for those without a Medical Card

Co-payments are an important component of health care funding in Ireland. For people without a Medical Card, a charge of EUR 80 per day – up to a maximum of EUR 800 – is levied for inpatient services, and EUR 100 for an emergency department visit for those without a referral from a GP. Costs per GP visit are about EUR 40-65. For pharmaceuticals, people with a Medical Card must pay prescription charges of EUR 2 per item dispensed, up to a maximum of EUR 20 per month per person or family. Those without Medical Card can, however, enrol in the Drugs Payment Scheme, which caps co-payments at EUR 124 per month for an individual or a family (see Section 5.2).

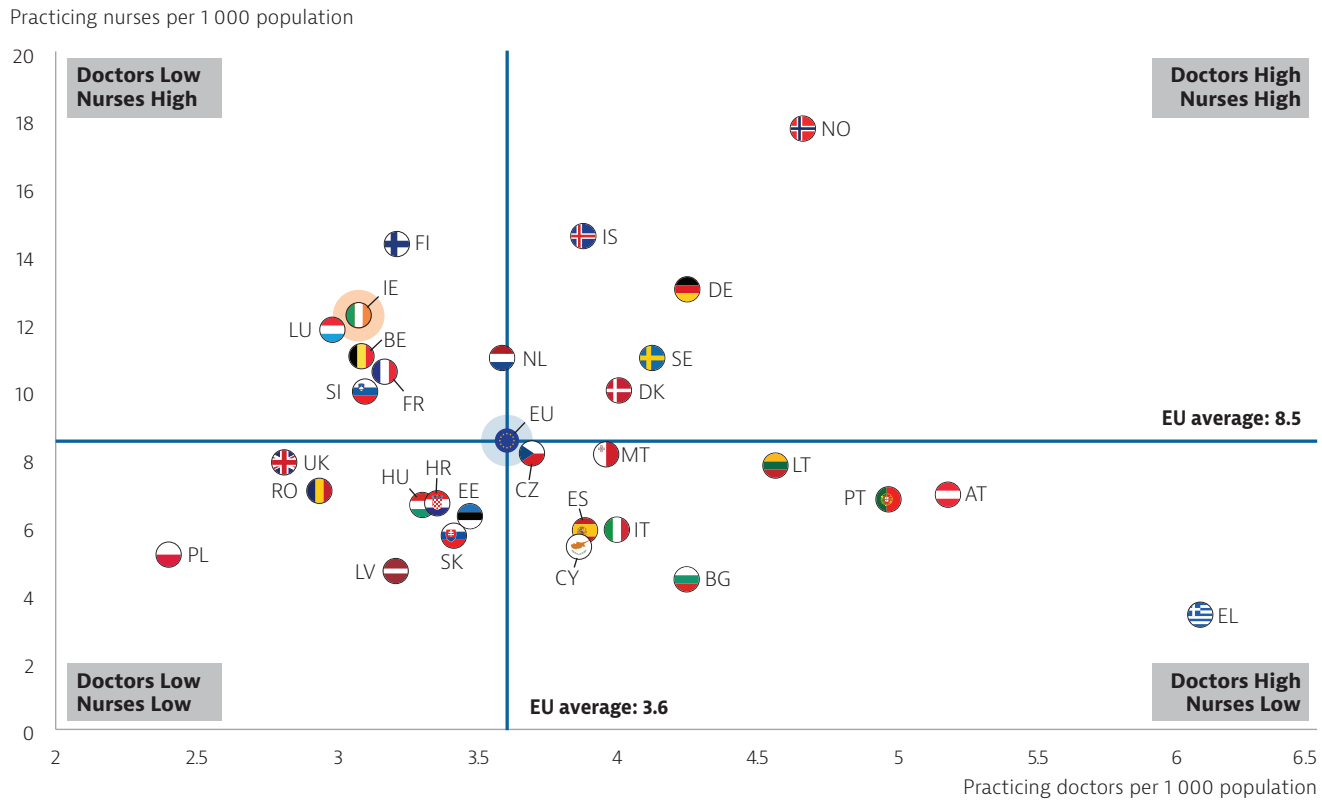
The Irish health sector is facing challenges in recruiting and retaining health professionals

The number of doctors in Ireland has increased in recent years but remains relatively low, at 3.1 per 1 000 population in 2017 compared to the EU average of 3.6 (Figure 10)[5]. This is related partly to restrictions in the training capacity of new doctors. Despite having the highest number of medical graduates per capita in Europe, the limited internship opportunities for new graduates create a bottleneck for many of them to complete their training, and the country is increasingly dependent on foreign-trained doctors to respond to its needs (see Section 5.3).

Conversely, the number of nurses is comparatively high, at 12.2 per 1 000 population in 2017 compared to the EU average of 8.5, but the number has decreased since 2010 and many nurses only work part time[5]. There are growing issues over recruitment and retention that have led to severe shortages within the nursing workforce.

5: Data on the number of nurses and doctors in Ireland is slightly overestimated (by 5-10 %) as it includes not only those providing direct care to patients but also those working in the health system as managers, educators and researchers.

Figure 10. Ireland has a low number of doctors but a relatively high number of nurses



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: Eurostat Database (data refer to 2017 or the nearest year).

Reforms are underway to strengthen primary care and address capacity issues in hospitals

The majority of GPs in Ireland are private practitioners who provide private care for paying patients but are also contracted by the government to provide free care for public patients with Medical Cards or GP Visit Cards. Secondary and tertiary care is predominantly provided in public hospitals. Although GPs act as gatekeepers to secondary care, Ireland's health system is hospital-centric and primary care infrastructure remains underdeveloped.

Capacity constraints persist in both primary and secondary care. There are long waiting lists in both settings for some services, and occupancy rates in hospitals are the highest in the EU and above recommended levels (see Section 5.2). Despite increasing since 2012, the number of hospital beds remains low, at 2.9 per 1 000 population (compared to an EU average of 5.1). Sláintecare reform proposals aim to improve service provision and meet future demand by reorienting services from hospital to primary care settings (see Box 1). The new GP contract signed between the government and GPs in April 2019 paves the way for further primary care reforms.

5 Performance of the health system

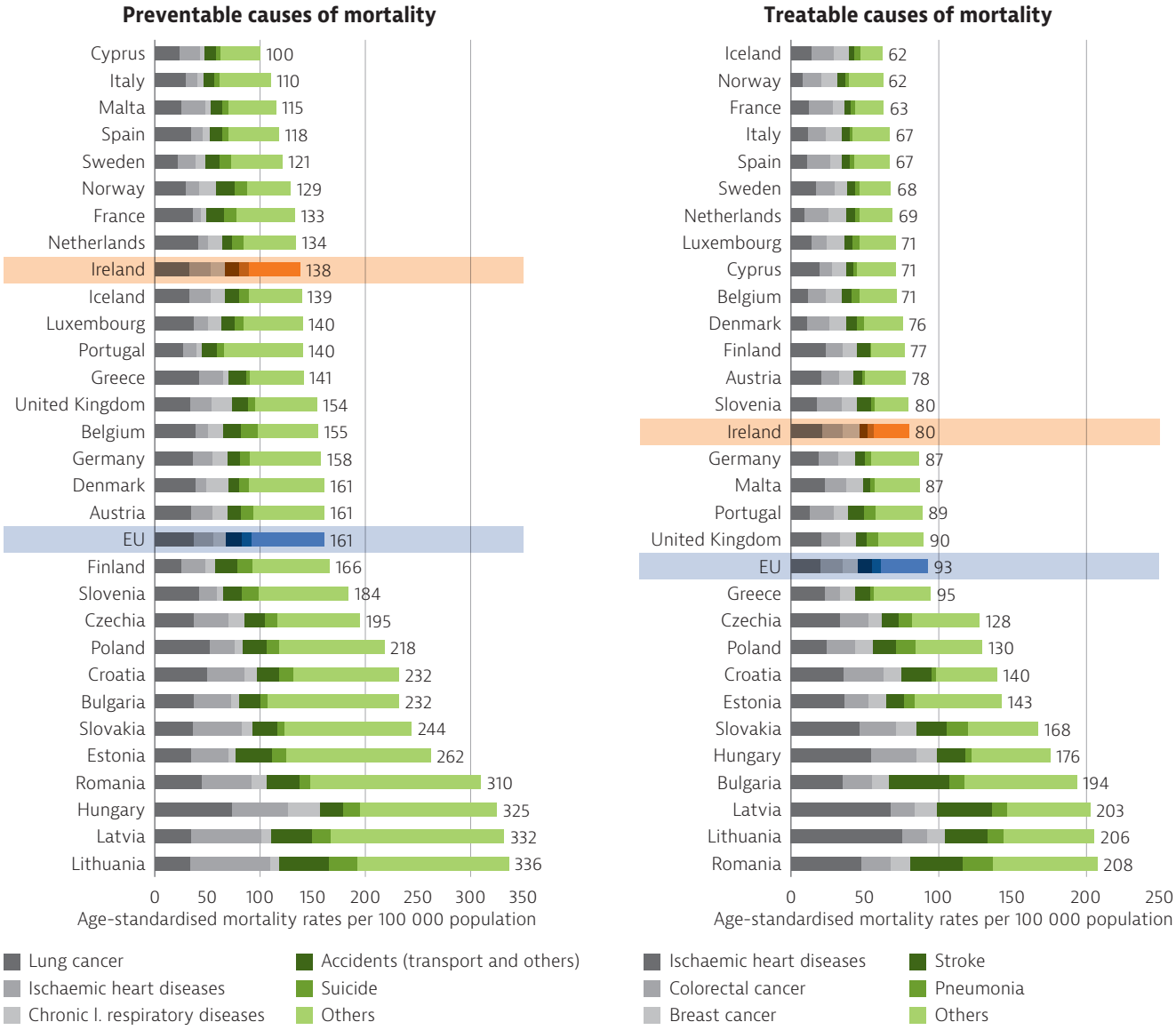
5.1 Effectiveness

Public health and health care in Ireland are comparatively effective

A first indication of how the Irish health system fares in terms of effectiveness is to look at mortality from preventable and treatable causes (Figure 11). Ireland is doing better than many other EU countries when it comes to preventable mortality, while mortality from treatable causes falls outside the top third of EU countries.

The main causes of premature death that could be avoided through a range of public health and prevention measures in Ireland include ischaemic heart disease, lung cancer and accidents (transport accidents and others). For mortality from treatable causes, the main causes are ischaemic heart disease, colorectal cancer, breast cancer and stroke.

Figure 11. Preventable and treatable causes of mortality in Ireland are below the EU average



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The data is based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2016).

Full implementation of the Healthy Ireland agenda could further reduce preventable deaths

A number of public health initiatives in recent years have aimed to reduce preventable deaths. Adopted in 2013, the Healthy Ireland initiative currently provides the national framework to improve health and wellbeing of the population. The importance of public health interventions is reiterated in the Sláintecare Implementation Strategy and Action Plan.

To further reduce smoking rates, plain packaging for all tobacco products became mandatory for all products sold as of October 2018, as foreseen in the Public Health Act of 2015. The law requires all forms of branding to be removed from tobacco products.

Addressing high obesity rates – in particular among children – is the main objective of the sugar-sweetened drinks tax, which was part of the law passed in 2017 that became effective in May 2018. This tax applies to water and juice-based drinks with an added sugar content of over 5 g per 100 ml.

After many years of discussion, the Public Health Alcohol Act came into law in October 2018 with the objective of reducing alcohol consumption. The law includes minimum unit pricing on alcohol, restrictions on advertising and warning labels on alcohol products, and the separation and reduced visibility of alcohol products in mixed trading outlets.

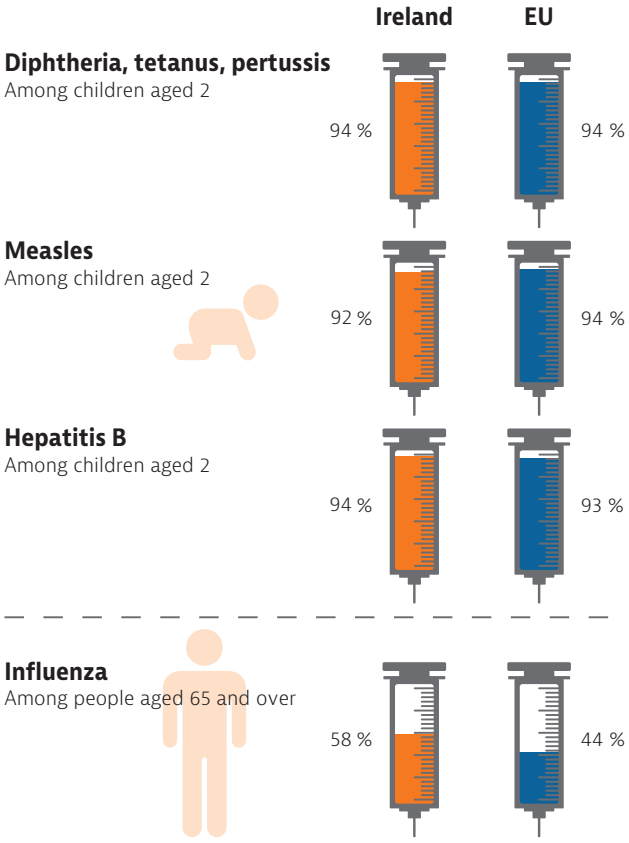
Vaccination rates in Ireland are around the EU average, but hesitancy has been growing

While childhood vaccination rates against many major infectious diseases are around the EU average and close to the WHO recommended target of 95 % (Figure 12), there has been a slow but notable decline in recent years. In 2017, vaccination rates against diphtheria, pertussis and tetanus, as well as measles, mumps and rubella, were all one percentage point below the rates seen in 2014 (Department of Health, 2018a). The decrease was even higher for influenza vaccination among older people (down by three percentage points compared with 2014).

Even more worrying was a sudden drop in the vaccination rate against the human papillomavirus (HPV)[6] among girls in secondary schools. Within two years, the uptake dropped from 87 % to 51 % in school year 2016/2017 – far below the national target rate of 85 % – following the spread of disinformation about the safety of this vaccination, mainly through social media.

A concerted effort by the HSE, the Irish Cancer Society and many non-governmental organisations and women's advocacy groups with strong government support appears to have reversed this trend. Data from March 2019 suggest that 70 % of girls in the target group have received the first vaccine dose in the last school year. Moreover, HPV vaccination will be rolled out to boys from September 2019.

Figure 12. Vaccination rates in Ireland are around the EU average but vaccination hesitancy is growing



Note: Data refer to the third dose for diphtheria, tetanus, pertussis and hepatitis B, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository for children (data refer to 2018); OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or nearest year).

6: HPV vaccination reduces greatly the risk for women to develop cervical cancer. The current vaccination schedule in Ireland recommends two vaccine doses within six months for girls younger than 15 years.

Many hospital admissions are avoidable, which suggests room for improvement in primary care

Hospital admissions for diseases such as diabetes, congestive heart failure or asthma and chronic obstructive pulmonary disease (COPD) are largely avoidable as patients with these conditions can be effectively treated in the community. Overall, hospitalisation rates in Ireland are around the EU average for these conditions (Figure 13). However, while there are fewer admissions for diabetes and chronic heart failure, Ireland records the second highest hospitalisation rate for asthma and COPD across EU countries after Hungary – around 50 % above the EU average. This signals untapped potential to improve the management of these chronic diseases in primary care. The reformed GP contract signed in 2019 includes a structured disease management contract commencing in 2020, which will potentially benefit Medical Card and GP Card holders.

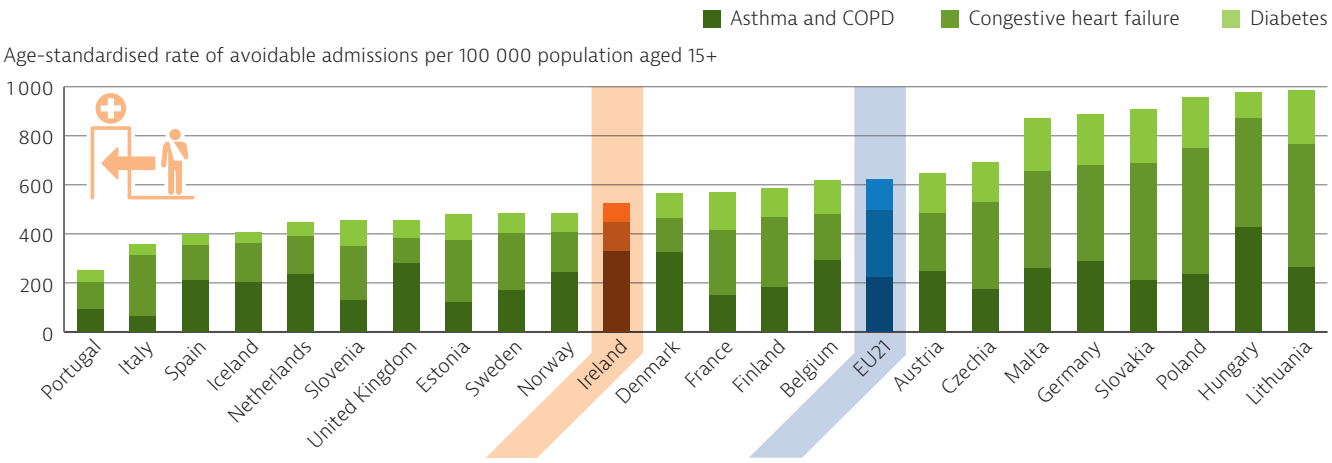
Moving away from a hospital-centred care model towards one where care is predominantly provided in the community is a cornerstone of the Sláintecare reform proposal, the Implementation Strategy and Action Plan. To achieve this objective, more task-sharing between nurses and primary care doctors is crucial. Initiatives to expand the scope of practice of nurses are underway but are still very limited (Box 2).

Box 2. Advanced Nurse Practitioners have enhanced access to care and improved patient outcomes, but their deployment is still limited

The scope of practice of nurses in Ireland has been expanded over the past decade with the introduction of Advanced Nurse Practitioners (ANPs), who can take over many tasks that were previously exclusively performed by doctors. Such tasks include the prescription of certain medicines and diagnostics and the provision of autonomous patient care. The first accredited ANPs were introduced in 2002 with the aim of improving patient care and offering better career opportunities for nurses. Evidence shows that ANPs contribute to improved patient outcomes and satisfaction, as well as continuity of care.

However, the number of registered ANPs remains low, with only 328 ANPs and midwives registered in February 2019. This only represents 0.6 % of the nursing and midwifery workforce. Expanding the number of registered ANPs is the focus of ongoing reforms. Funding has been allocated to deliver 700 new ANP posts by 2021. This development is also supported by a new educational programme for advanced nursing practice launched in 2017.

Figure 13. Hospitalisation rates for ambulatory care-sensitive conditions are around the EU average



Source: OECD Health Statistics 2019 (data refer to 2017 or nearest year).

5.2 Accessibility

Ireland remains the only western European country without universal coverage for primary care

Despite being one of the central recommendations of the Sláintecare Report of 2017, the rollout of universal access to primary care has not yet made much progress. In fact, the Sláintecare Implementation Strategy published by the government in July 2018 proposes a phased approach and only commits to the development of a roadmap of how and when universal coverage can be achieved by the end of 2021. Hence, in the immediate future, coverage for primary care will most likely not increase much, although the recent GP contract agreed between the Irish Medical Organisation and the Department of Health was conditional on agreement to the expansion of free care[7].

In 2017, only 42 % of the population had free access to GP and practice nurse care, down from 44 % in 2012. The largest group covered in 2017 were Medical Card holders, who account for 32 % of the population. An additional 10 % have access to free GP care with their GP Visit Card. While access to the Medical Card has been drastically reduced since 2012 as a result of the economic recovery and associated rise in income, an increasing number of people have access to a GP Visit Card. In recent years, it has been universally rolled out to all children under 6 and people aged 70 and over.

Due to the criteria of entitlement, access to a Medical Card is very unevenly distributed throughout the population. Only around 20 % of the population in the age group 25-34 had access to it in 2017, while coverage for people over 70 stood at 75 %.

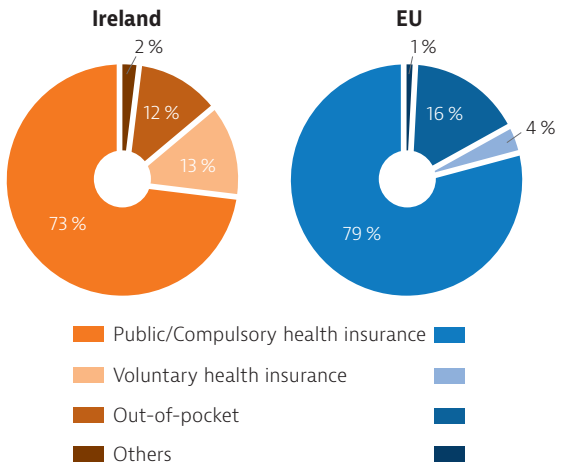
Private health insurance in Ireland is widespread and contributes to inequalities in access to care

Despite the lack of comprehensive coverage for a substantial part of the population, the share of OOP spending in total health spending (12.3 %) was 3.5 percentage points below the EU average of 15.8 % in 2017 (Figure 14). This is because private health insurance (PHI) plays a more important role than in all other EU countries except Slovenia.

At 13 % of total spending, PHI in Ireland is around three times the share observed across the EU (4 %). The design of PHI coverage also has an impact on the structure of OOP spending in Ireland. For example, the share of inpatient spending in all OOP expenditure is relatively low in Ireland, as in most cases people will use their PHI coverage for these services.

After a reduction during the financial crisis, the number of people with PHI coverage has grown again in recent years to about 45 % in 2017. The government subsidises the uptake of private insurance with a tax credit, which may further explain why private insurance is generally concentrated in higher socioeconomic groups. Since patients with private coverage have quicker access to care, the way PHI coverage is subsidised exacerbates inequalities in access to care.

Figure 14. The share of out-of-pocket spending in Ireland is below the EU average, but voluntary health insurance plays a bigger role



Source: OECD Health Statistics 2019 (data refer to 2017).

Long waiting times remain a substantial problem in Ireland

Waiting times for diagnostics and medical treatments have historically been high in Ireland, and a number of different initiatives have tried to reduce them in the past (Siciliani, Borowitz and Moran, 2013). While in some cases improvements were achieved initially, a long-term solution to this issue has not yet been found. Long waiting times for services exist throughout the system (HSE, 2018). Within the community, for example, 23 % of people in need of occupational therapy had to wait for more than a year for assessment in 2017. For ophthalmological treatment, waiting times were longer than one year for nearly 40 % of patients.

In hospitals, nearly 14 % of adults waited longer than 15 months for an elective inpatient surgery; for children the share was 12 %. Some 28 % of all patients had to wait longer than a year for first access

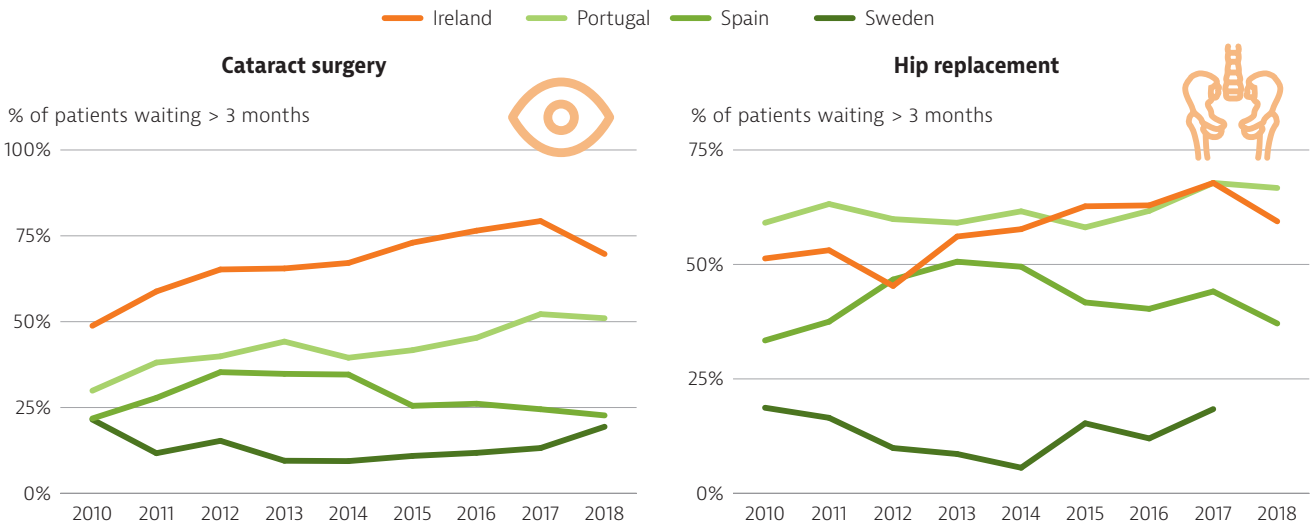
7: This includes a government commitment to extend free GP care to all children between 7 and 12 years of age by 2022.

to outpatient services in hospitals. However, there are some indications that the situation has started to improve following the introduction of new measures in 2018, such as the Inpatient/Day Case Action Plan.

While international comparison of waiting times is challenging, given that countries measure waiting times in different ways, the existing data suggest that, despite the recent improvements, the situation in Ireland in 2018 was still worse than in some comparable western and northern European countries for cataract surgery or hip replacement (Figure 15).

Capacity constraints in hospitals and the fact that private patients can be treated using public hospital infrastructure and workforce appear to be a key determinant of waiting times for public patients. Ireland records the highest bed occupancy rate among all EU countries. Nearly 95 % of all hospital beds are occupied at any given time. While some of these hospitalisations could be avoided (see Section 5.1), a recent health service capacity report found that the current infrastructure is simply not adequate for current demand and is unable to cope with the projected increases due to population ageing (Department of Health, 2018b). Tackling long waiting times has also been identified as a key priority in the Sláintecare Report and included in the high-impact actions of its Implementation Strategy.

Figure 15. Many Irish people wait a long time for cataract surgery and hip replacement



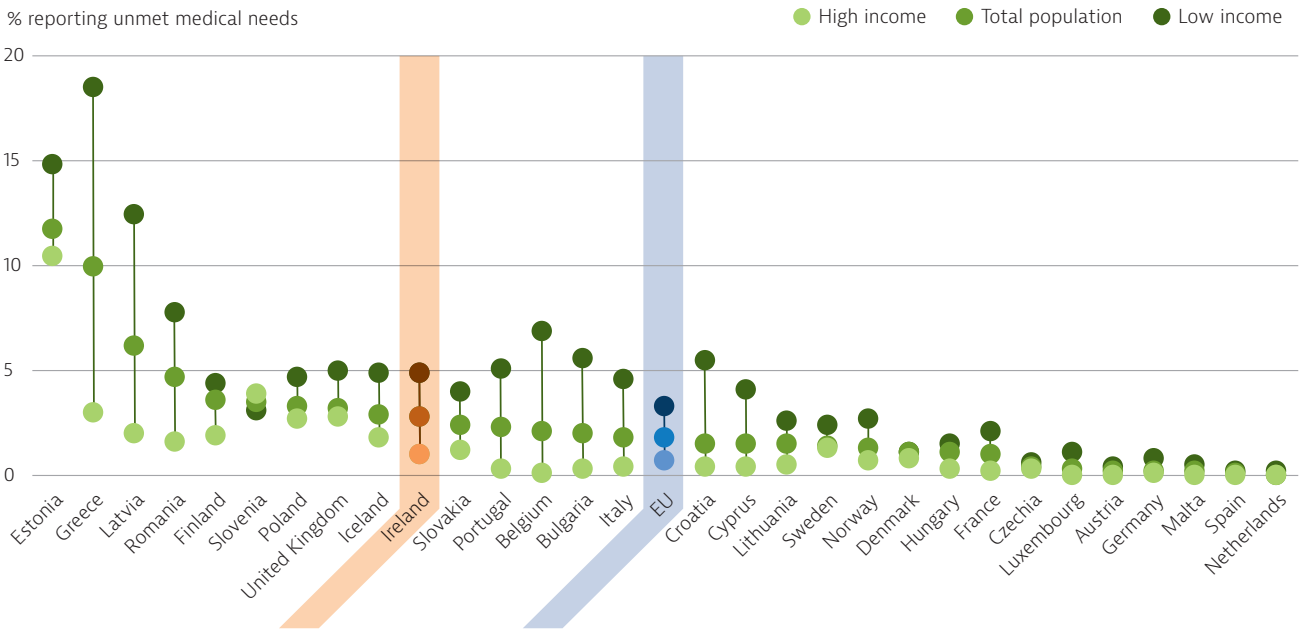
Source: OECD Health Statistics 2019.

Unmet needs for medical care in Ireland are above the EU average

As a consequence of non-universal coverage and long waiting times for treatment, unmet needs for medical care in Ireland are above the EU average (Figure 16). In 2017, 2.8 % of the Irish adult population had foregone medical care due to costs, long waiting times or distance. As in other countries, people on low income in Ireland encounter greater barriers to access health services (4.9 % report unmet needs) than those on high income (1 %). Interestingly, because of the way public coverage is organised, the share of the population that report unmet needs because of costs is slightly lower for low-income groups than for middle-income groups. The largest income-related inequality in unmet needs is due to waiting times. While those on low incomes primarily rely on public care provision, those who can afford private health insurance may use private insurance coverage for quicker access.

The Irish government is currently investigating ways to address inequalities in access to care and is considering how to remove private practice from public hospitals. This practice is widespread in Ireland and refers to the fact that senior doctors in public hospitals are allowed to see 'private' patients (whose costs are typically covered by private health insurance) alongside their work commitments for public patients on the same premises. While many doctors profit from this practice as they earn additional income on top of their public salary, and public hospitals rely on the income in order to provide the activity, the practice reduces access for public patients, since they have to compete for the availability of doctors and infrastructure with private patients. The fact that Ireland has the biggest duplicate insurance market in Europe contributes to this dilemma. So far, Ireland has not been able to confront the powerful stakes involved in the insurance market (European Commission, 2019).

Figure 16. Unmet needs for medical care in Ireland are slightly above the EU average



Note: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2017).

5.3 Resilience[8]

Far-reaching changes are required to make the Irish health system sustainable

The Irish health system had to prove its resilience when public health spending was cut and staff reduced in the wake of the economic downturn at the end of the last decade. Initially, efficiency gains could be achieved fairly easily to maintain service levels with fewer resources, but after 2013 reduced inputs finally resulted in fewer outputs. Since then, Ireland has moved on: public health budgets have again seen some strong growth in recent years and the number of health workers has increased.

Yet the cross-party political support for the Sláintecare Report of 2017 among members of the Oireachtas (Irish parliament) highlighted the desire for some fundamental changes and the conviction that the Irish health system is not performing as well as it could. Its findings also indicated that without transformative changes the current system would not be able to cope with further increases in demand for health care associated with population ageing[9].

According to the latest projections, public spending on health as a share of GDP is expected to increase by one percentage point between 2016 and 2070, and by two percentage points for public spending on long-term care (European Commission-EPC, 2018). This projected increase for Ireland is more pronounced than in many other EU countries and raises some fiscal sustainability risks in the long term.

The scope of the Sláintecare Implementation Strategy is limited so far

Unlike many other countries, Ireland has managed to achieve a broad political consensus of what a new and transformed health system should look like. The current government appears committed to supporting the general vision of the Sláintecare Report and has started to implement some aspects of the ambitious reform proposals (see Section 4). It published its Sláintecare Implementation Strategy for the next three years in August 2018 around four key strategic goals and ten high-level strategic actions. In March 2019, the newly established Sláintecare Implementation Office presented an ambitious Sláintecare Action Plan, which details further 239 deliverables to be actioned in 2019 in the context of this Implementation Strategy.

The actions taken so far include the establishment of a HSE board to improve accountability, the commissioning of an independent review on removing private practice from public hospitals

8: Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.
9: Addressing the expected increase of age-related expenditure by making the health care system more cost-effective was one of the country-specific recommendations issued by the Council of the European Union to Ireland in the context of the 2019 European Semester (Council of the European Union, 2019).

(see Section 5.2), a government decision on geographic alignment of Hospital Groups and Community Healthcare Organisations and a EUR 20 million Sláintecare Integration Fund.

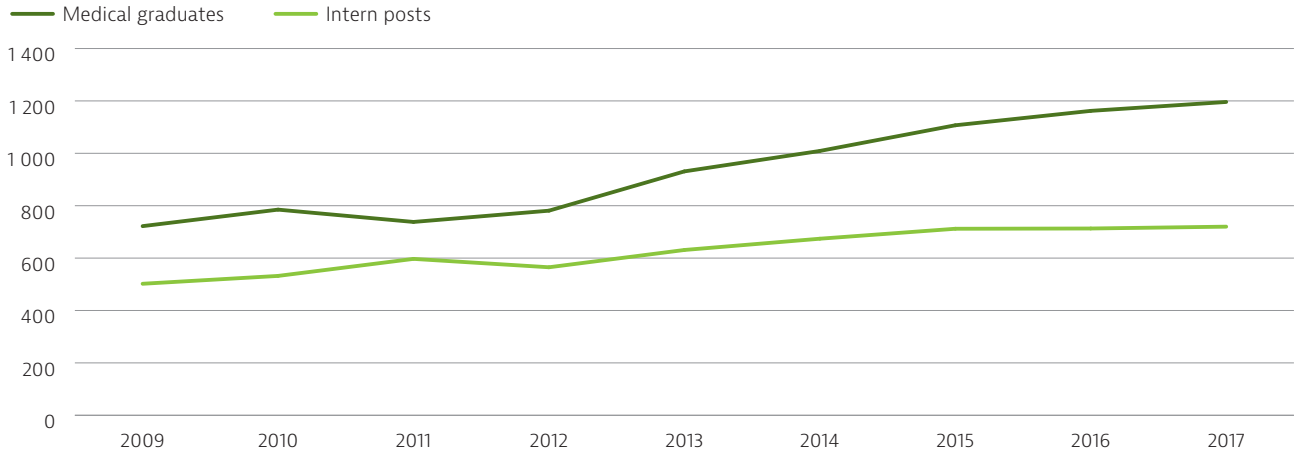
Despite these important reform steps, some concerns have been expressed that the implementation process so far has been too slow and too limited in scope. In some areas, the Implementation Strategy currently falls short of some key aspects of the Sláintecare Report. For example, while the Strategy commits to expanding eligibility for health care on a phased basis, it does not wholly commit to providing universal health coverage through legislating for entitlement to care. There are also concerns that it dials down commitments to reduce waiting lists, does not adequately address the staffing and skill mix reforms necessary to strengthen primary care, and does not commit to financial resourcing as specified in the original Report.

Health workforce planning needs to be strengthened and more coherent

A key recommendation of the Sláintecare Report to ensure a sustainable provision of health services is to reform health workforce planning. Given its strategic importance in bringing about many of the Sláintecare objectives and the desire to move towards integrated care models, improved workforce planning should be a high priority in the reform agenda and conceived across professions. Yet vital information for effective workforce planning, such as on staffing costs and skill mix, has thus far been missing[10].

Addressing issues of training, recruitment and retention are also important, since demand for services will increase with ageing societies and the proposed rollout of universal GP care. In this context, it is paradoxical that Ireland has the highest number of medical graduates per capita among all EU Member States, while at the same time relying more heavily on immigration of medical staff than any other EU country. Among the possible explanations is the fact that Irish medical schools have become a popular destination for many international students (since they are not subject to numerus clausus policies), yet they do not match the expansion in the number of international medical students with a corresponding increase in the number of internship opportunities to allow these students to complete their postgraduate training (Figure 17). As a result, many non-Irish medical students are unlikely to enter the Irish medical labour supply after graduation (OECD, 2019).

Figure 17. The creation of intern posts lags behind the growth in medical graduates



Source: OECD Health Statistics 2019; Department of Health, Key Facts 2018.

A high number of young Irish-trained doctors emigrate (or at least consider it), partly in response to working conditions that are characterised by long working hours in an understaffed and overworked health system, with insufficient training and career progression opportunities. Moreover, due to language skills and networks, they are in a very advantageous position to find adequate jobs in medical labour markets such as the United States, the United Kingdom or Australia.

Hence, more coherent education, training and employment policies would help to train and retain a sufficient number of doctors in Ireland. This would require greater cooperation between the Department of Health, the HSE and professional medical bodies.

10: The development of an integrated workforce plan is, however, a key action included in the Sláintecare Action Plan of 2019.

eHealth solutions will be an important element in the future service delivery model

While Ireland is lagging behind other European countries in the adoption of information technology in the health sector, the potential of eHealth to support the delivery of an efficient, modern and responsive health system is well recognised. The eHealth priorities in the Sláintecare Implementation Strategy include the implementation of a national electronic health record (EHR) in the acute hospital sector, design and rollout of a community-based EHR and design and rollout of a range of primary and community-based ICT services, including ePrescriptions and telehealth solutions.

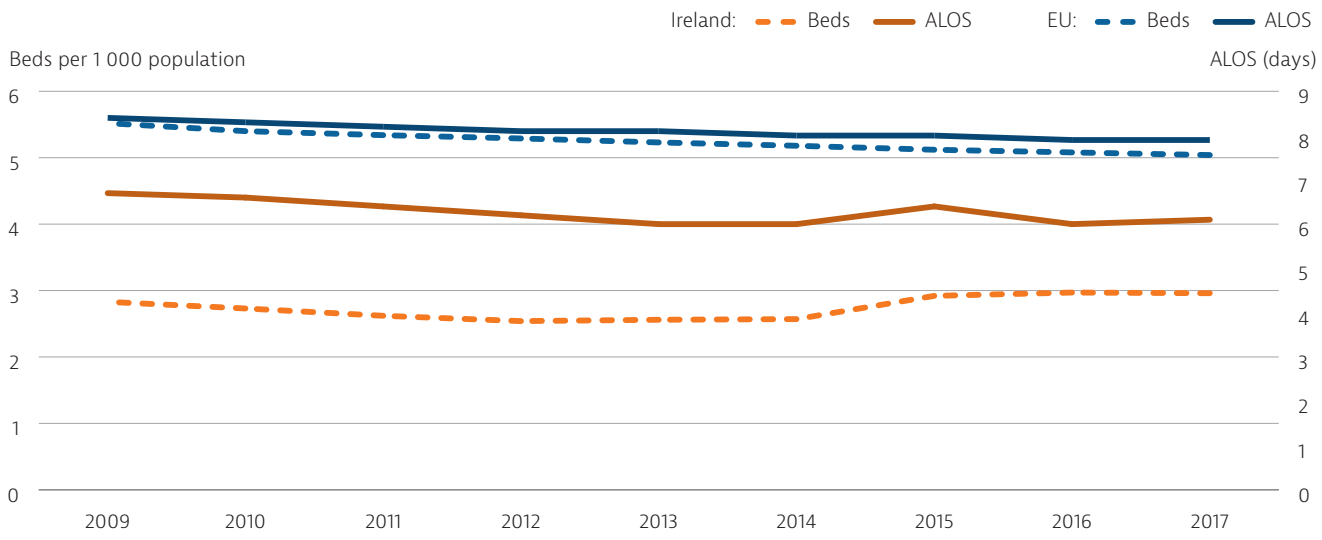
These investments will be partly financed by a 20-year loan from the European Investment Bank (EIB). In 2018, the EIB agreed to provide EUR 225 million to support the rollout of Ireland's transformational eHealth programme, making it the first eHealth project ever supported by the EIB.

More efficient use of hospital resources can be achieved

As noted in Section 4, about one-third of health spending in Ireland is allocated to inpatient care in hospitals. Some initiatives are underway to improve the efficient use of hospital resources; indeed, the average length of stay (ALOS) of patients has decreased over the past decade and is now about 25 % lower than across the EU (Figure 18).

Still, there is further potential to get more value for money. A recent report prepared by the Irish Government Economic and Evaluation Service observed that the latest increase in hospital funding did not lead to any increase in hospital activity, even though staffing numbers went up (Lawless, 2018). While activity-based funding (ABF) was introduced in 2016 to replace block grants, it is currently limited to inpatient and day cases in around three-quarters of acute care hospitals. Some 30 % of hospital budgets are still financed by block grants. The Sláintecare Implementation Strategy sets out an increase in the number of acute care hospitals using ABF and an expansion of the proportion of hospital budgets financed by ABF.

Figure 18. The average length of stay in hospital has decreased and is lower than the EU average



Source: Eurostat Database.

The Irish health system is also characterised by shortcomings in care coordination between hospital and follow-up care. As shown in Table 1, the number of bed days related to delayed discharges for patients who no longer need to stay in acute care hospitals is much higher in Ireland than in Denmark and Norway. Hospital bed occupancy rates could be reduced if post-discharge planning and care arrangements for the elderly were improved (OECD/EU, 2018).

As noted in Section 5.1, strengthening access to primary care and community care could also help avoid many hospitalisations for ambulatory care-sensitive conditions. However, for this to happen, the lack of capacity and resources at the community level will need to be addressed.

Table 1. Hospital bed days related to delayed discharges are higher than in other countries

	Number of bed days	Bed days/1 000 population
Denmark	30 844	5
Ireland	201 977	43
Norway	82 411	16
Sweden	393 124	40
United Kingdom (England)	2 254 821	34

Source: Suzuki (forthcoming), "Reducing delays in hospital discharge", OECD Health Working Papers (data refer to 2016).

Recent initiative in cross-border collaboration may help reign in pharmaceutical spending

Ireland has taken a number of measures to control pharmaceutical spending during the past decade, including agreements between the Department of Health and manufacturers in 2012 and 2016 to realign prices and expand the basket of countries used for reference pricing more frequently. After signing the Valletta Declaration in May 2017, where Ireland and a number of mainly southern European countries agreed to collaborate in exploring possible ways to guarantee access to new medicines for patients, Ireland joined Austria, Belgium, the Netherlands and Luxembourg in June 2018 in the so-called 'BeNeLuxA' collaboration to enhance patients' access to high-quality and affordable treatment. In addition to information and policy exchanges, one of the areas of cooperation includes joint price negotiations to improve the payer's position in the market (Box 3).

Budget management remains an issue at all health care levels

Staying within allocated health budgets continues to be an issue at all levels of the Irish health system. In recent years the HSE has repeatedly struggled to remain within its budget, despite substantial increases in its original budget allocations from the Department of Health (Connors, 2018). These problems are partly triggered by consistent overspending at the hospital level, which is also a consequence of a lack of capacity for non-acute care at the community level. A recent report by the Irish Government Economic and Evaluation Service (Lawless, 2018) found that only two out of 49 hospitals stayed within their budgets in 2017, with an average budget overrun of 7 % per hospital.[11] Overall, this suggests that budget management is weak, partly due to a lack of comprehensive planning and data limitations (European Commission, 2019).

Box 3. Ireland seeks to develop its horizon-scanning capacity through the BeNeLuxA initiative

The BeNeLuxA initiative was started in 2015, initially formed of Belgium, the Netherlands, Luxembourg and Austria, with Ireland joining in 2018. It aims to increase the efficiency of assessment, pricing and reimbursement processes to improve payer's position in the market.

In 2018, the BeNeLuxA countries launched the International Horizon Scanning Initiative. This would assess upcoming products based on their predicted impact on patient health, the organisation of health systems and potential costs to public finances.

More than ten countries (in addition to the BeNeLuxA members) have now joined this project. Given the potential impact of new high-cost medicines on long-term access and fiscal sustainability of health systems, more detailed predictive information is becoming increasingly important.

11: This is similar to the situation in 2012, despite the introduction of the Performance and Accountability Framework by the HSE in 2015, raising questions about the effectiveness of this tool.

6 Key findings

- Life expectancy in Ireland has increased more rapidly than in nearly all EU countries since 2000 and is now more than one year above the EU average, but not all additional years are lived in good health. Around one-third of years after age 65 are lived with some chronic diseases and disabilities, increasing demands on health and long-term care systems.

- The health system is generally effective in avoiding deaths from preventable causes. As part of further efforts to reduce smoking, plain packaging for all tobacco products became mandatory in October 2018. Overweight and obesity among adults and children are growing public health issues in Ireland. To tackle this problem, a tax on sugar-sweetened drinks was adopted in 2017.

- Ireland spends around one-fifth more on health per capita than the EU average, but the share of public spending is below the EU average. This can be explained by the important role of private health insurance: Ireland has the largest market for duplicate insurance in Europe. Consequently, the financing share of private health insurance is three times higher than the EU average.

- Ireland remains the only western European country without universal access to primary care. More than 50 % of the population have to pay out of pocket for a general practitioner visit. For those without coverage this can lead to delayed and more expensive treatment in hospitals. While addressing this problem stands at the heart of the recent Sláintecare reform proposal, the measures taken thus far do not wholly commit to providing universal health coverage through legislating for entitlement to care.

- Waiting times for treatment are widespread in the Irish health system, be it in the community or for specialist visits or elective surgery in hospitals. A two-tier health system, where those with the ability to pay for treatment privately get faster access to care, combined with low levels of hospital capacity and the inappropriate use of some hospital resources, contribute to this problem. Initiatives taken in 2018 appear to have been somewhat effective in reducing waiting times in some areas, but it remains to be seen whether this trend will continue.

- The high reliance on foreign-trained doctors and the fact that a high number of medical graduates in Ireland will never work in Ireland raise serious questions about coherence between the education, training and employment policies of doctors. Increasing internship and postgraduate training places for new medical graduates would go a long way in addressing the current bottleneck and increasing the number of fully trained doctors.

- Managing to stay within allocated health budgets continues to be an issue at all levels of the Irish health system. This refers to the Health Service Executive at large, but consistent overspending at the hospital level is a particular challenge.

- The Sláintecare Report of 2017 laid out the ten-year vision for a modern patient-centred single-tier health care system with universal access for everyone. The publication of the very detailed Action Plan in 2019 is an important step and shows the commitment of the current government to implementing this vision. However, there are questions over whether sufficient financial resources will be made available to implement all central elements of the reform as envisaged in the original Sláintecare Report.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT	United Kingdom	UK

European Commission

State of Health in the EU
Country Health Profile 2019

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

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