



State of Health in the EU Ireland

Country Health Profile 2017

The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making

The Country Health 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 Member States and the Health Systems and Policy Monitor network.

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Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 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.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:
<http://dx.doi.org/10.1787/888933593608>

Demographic and socioeconomic context in Ireland, 2015

	Ireland	EU
Demographic factors	Population size (thousands)	509 394
	Share of population over age 65 (%)	18.9
	Fertility rate ¹	1.6
Socioeconomic factors	GDP per capita (EUR PPP ²)	28 900
	Relative poverty rate ³ (%)	10.8
	Unemployment rate (%)	9.4

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 50% of median equivalised disposable income.

Source: Eurostat Database.

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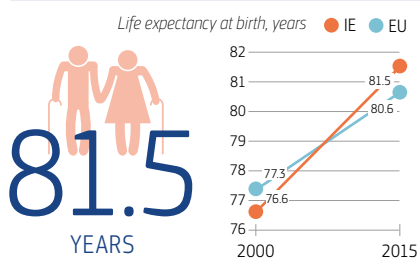
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1 Highlights

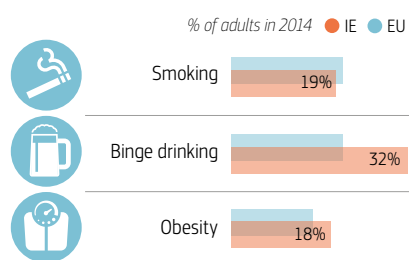
The health status of Irish people has improved and more rapidly than in many other EU countries. Yet, providing patients timely access to care remains a major challenge in Ireland. With the aim to achieve universal health coverage within the next years, Ireland is currently discussing far-reaching reform options in health care financing, delivery, entitlements and governance.

Health status



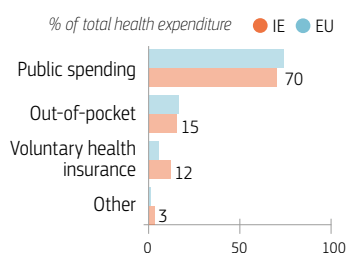
Life expectancy at birth in Ireland was 81.5 years in 2015, up from 76.6 years in 2000 and slightly above the EU average. Women still generally live longer than men but this gap has narrowed in the last 15 years. Life expectancy gains are mainly the result of a steady reduction of premature deaths from cardiovascular diseases. Yet, ischaemic heart diseases are still the leading cause of death, followed by lung cancer and dementia.

Risk factors



In 2015, 19% of adults in Ireland smoked tobacco every day, down from 24% in 2008. Excessive alcohol consumption was well above the EU average, with 32% of adults reporting having had at least six drinks in a single occasion each month in 2014. Obesity is an issue in Ireland: 18% of adults are obese based on self-reported data (and nearly one in four, 23%, based on actual measures of height and weight).

Health system

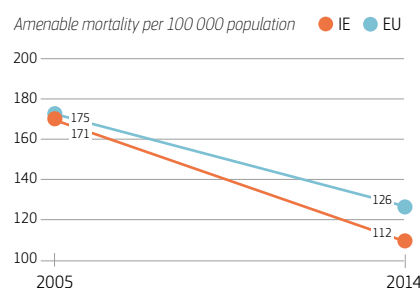


Health spending per capita in Ireland is higher than in most other EU countries. In 2015, Ireland spent EUR 3 939 per head on health care (7.8% of GDP), compared to the EU average of EUR 2 797. Around 70% of health spending is publicly-funded, which is well below the EU average. Out-of-pocket payments (15%) and voluntary health insurance (12%) also cover important parts of health spending.

Health system performance

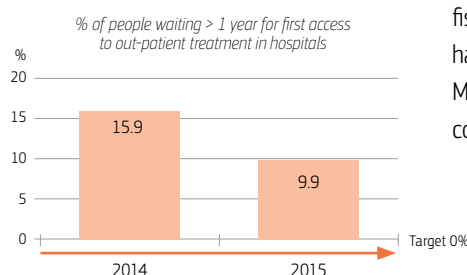
Effectiveness

Amenable mortality in Ireland is below the EU average, indicating that the health care system is relatively effective in treating people with life-threatening conditions.



Access

Ireland currently has no universal coverage for primary care representing a barrier to access for these services. Long waiting times for secondary care are also an important issue.



Resilience

Ireland struggled to maintain levels of health services throughout the financial crisis. Budget cuts and shortcomings in fiscal governance caused overruns, which have continued to grow in recent years. Moving care to its appropriate setting could assist in improving efficiency.



2 Health in Ireland

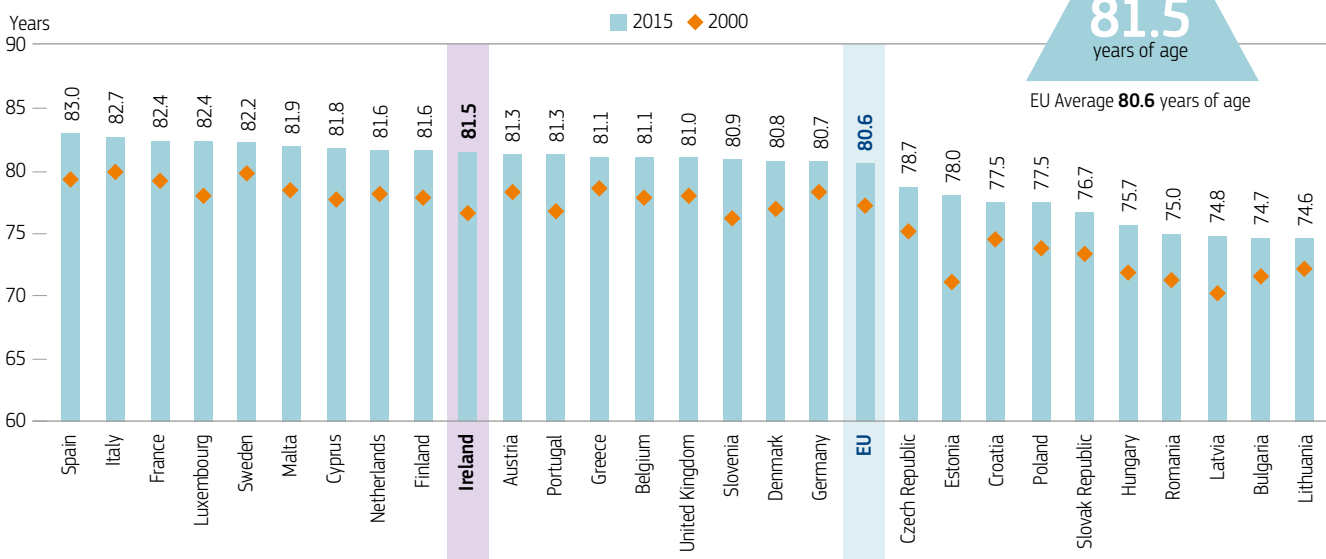
Life expectancy is increasing faster than the EU average

Life expectancy at birth in Ireland increased by nearly five years between 2000–15, to 81.5 years, much faster than in nearly all other EU countries (Figure 1). A substantial gap persists in life expectancy between men and women, with men living about four years less than women, but this gender gap has narrowed by one year since 2000.

Since 2000, most of the increase in longevity was the result of improved survival rates after the age of 65. The life expectancy of Irish women at age 65 reached 21.0 years in 2015 (up from 18.0 years in 2000) and that of men reached 18.4 years (up from 14.6 years in 2000). But not all of these additional years of life are lived in good health. At age 65, Irish men and women can expect to live only about 60% of their remaining years of life free of disability.¹

1. This is based on the indicator of 'healthy life years' which measures the number of years that people can expect to live free of disability at different ages.

Figure 1. Life expectancy in Ireland is increasing faster than the EU average



Source: Eurostat Database.

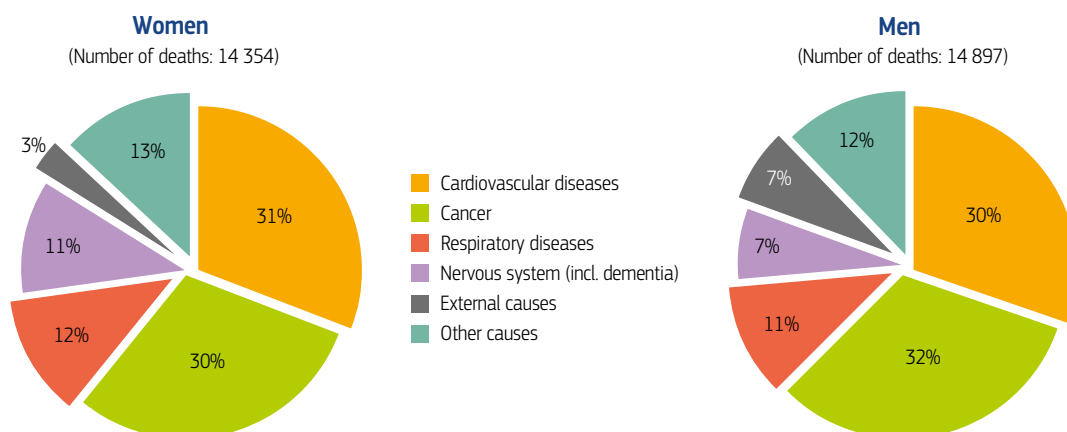
Cancer and cardiovascular diseases are the leading causes of death in Ireland

The gains in life expectancy in Ireland have been driven by a reduction in the mortality rate for cardiovascular diseases, which were nearly halved between 2000–14. As a result of this sharp reduction, cancer was the leading cause of death for men in 2014 (accounting for 32% of all deaths). For women, cardiovascular diseases remained the leading cause of death (31%) with cancer (30%) being very close (Figure 2). Respiratory diseases were the third leading cause of death for men and women (11% and 12%, respectively). For respiratory diseases, Ireland had the second highest mortality rate in the EU after the United Kingdom.

Looking at more specific causes of death, the top ten causes in Ireland have stayed mainly the same since 2000 with some changes in ranking and the notable emergence of deaths from Alzheimer's disease and other dementias as one of the leading causes of death (Figure 3). As in many other EU countries, the number of people dying from Alzheimer's and other dementias has gone up drastically, due to population ageing, but also better diagnosis, lack of effective treatments and changes in coding practices. The number of deaths due to lung cancer has also increased², making it the second leading cause of death after ischaemic heart diseases in 2014, reflecting a legacy of higher smoking rates in past decades.

2. Age-standardised death rates for lung cancer, however, have decreased since 2000.

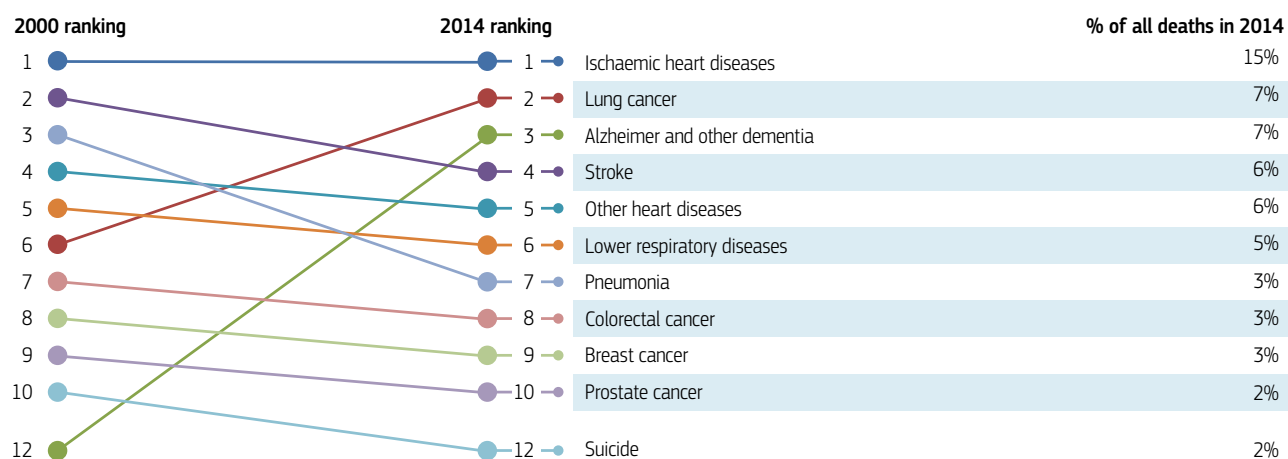
Figure 2. Cancer and cardiovascular diseases account for over 60% of all deaths in Ireland



Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: Eurostat Database (data refer to 2014).

Figure 3. Ischaemic heart diseases remain the leading cause of death in Ireland



Source: Eurostat Database.

Musculoskeletal problems are the leading determinant of disability-adjusted life years

After the burden of disease caused by fatal conditions, musculoskeletal problems (including low back and neck pain) and major depressive disorders are important determinants of disability-adjusted life years lost³ (DALYs) in Ireland (IHME, 2016). Even if not fatal, these health problems have serious consequences for health-related quality of life and can lead to various types of disabilities.

Based on self-reported data from the European Health Interview Survey (EHIS), one in eleven people in Ireland live with asthma, more than one in eight live with chronic depression, and nearly one in six live with hypertension. Wide inequalities exist in the prevalence of these chronic diseases by education level as in many other EU countries.⁴

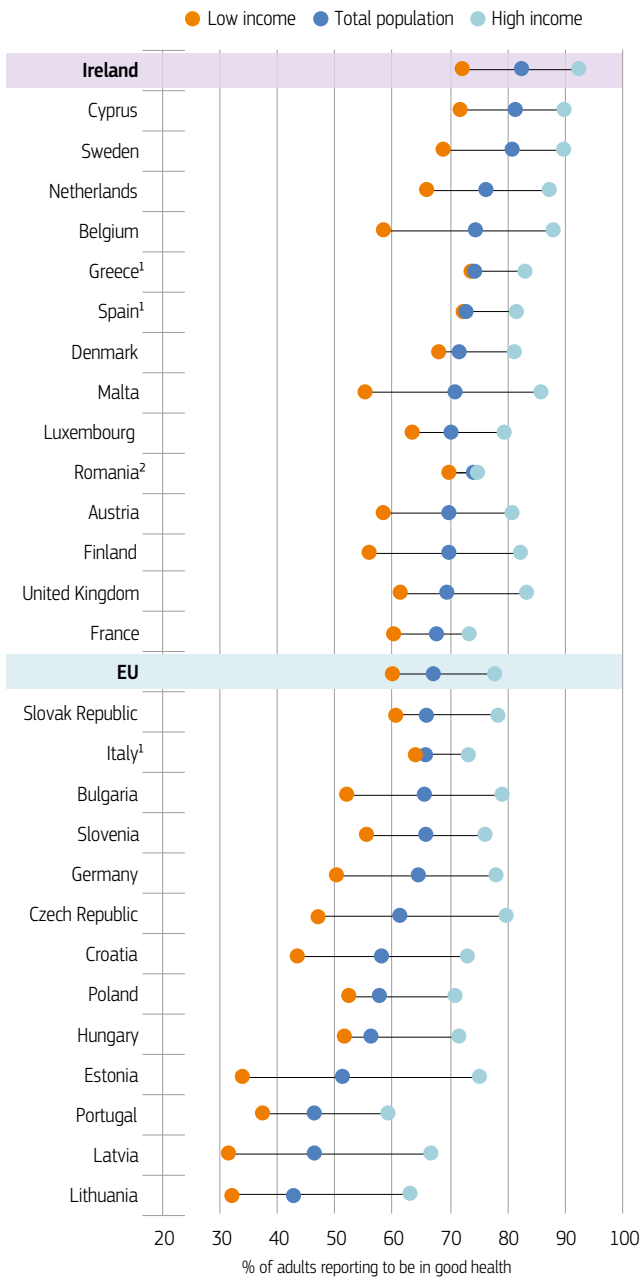
3. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

4. Inequalities by education may partially be attributed to the higher proportion of older people with lower education levels; however, this alone does not account for all socioeconomic disparities.

Most people in Ireland report being in good health

More than 80% of the population in Ireland report being in good health, a higher proportion than in all other EU countries (Figure 4). However, as in other EU countries, there is a gap in self-rated health by socioeconomic status, with more than 90% of people in the highest income quintile reporting to be in good health, compared with about 70% of people in the lowest income quintile.

Figure 4. Most Irish people report being in good health, although there are disparities by income group



1. The shares for the total population and the low-income population are roughly the same.
 2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

3 Risk factors

Behavioural risk factors are major public health issues in Ireland

The health status of the population in Ireland and health inequalities are linked to a number of health determinants, including living and working conditions of people (the physical environment in which people live) and a range of behavioural risk factors. Based on IHME estimations, in 2015 more than one quarter (27%) of the overall burden of disease (measured in terms of DALYs) could be attributed to behavioural risk factors – including smoking, alcohol use, diet and physical inactivity, with smoking and dietary risks contributing the most (IHME, 2016).

Smoking rates and alcohol consumption continue to decline, but binge drinking among adults remains a problem

The proportion of adults who smoke daily in Ireland has decreased sharply since 2000 (from 33% to 19% in 2015) and is now below the EU average. Even steeper declines in regular smoking have been reported among 15-year-old girls and boys, with the proportion coming down from about 20% in 2001–02 to only 8% in 2013–14, the second lowest rate among EU countries (after Sweden).



Progress was made in reducing alcohol consumption in Ireland in recent years. With 14.2 litres of alcohol per adult, Ireland led the EU countries in 2000, drinking over three litres more than on average across the EU. This consumption level has gone down to 10.9 litres per capita in 2015, now only one litre above the EU average. But there remains a major challenge in reducing binge drinking⁵ among adults. Nearly one-third (32%) of adults in Ireland reported in 2015 engaging regularly in heavy alcohol consumption, a higher proportion than in most other EU countries.

Obesity rates among adults and adolescents present a major public health challenge

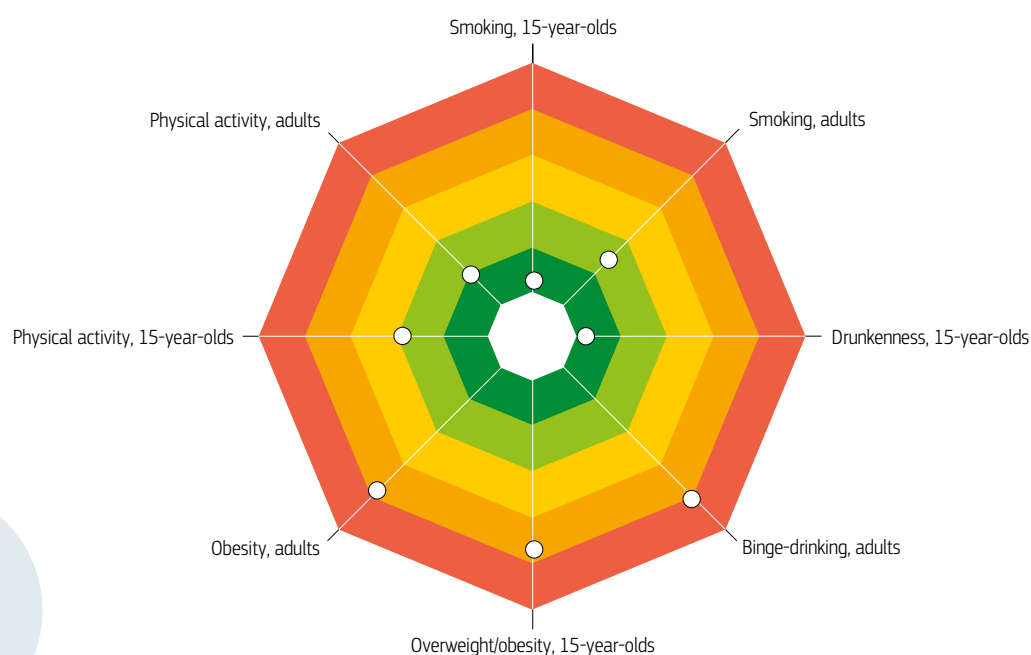
Based on self-reported data, 18% of adults in Ireland were obese in 2015, a higher rate than the EU average (15%). Measured obesity rates in Ireland are higher (23%), but have remained stable since 2007.⁶ Overweight and obesity problems of Irish adolescents are also of concern. Based on self-reported data, nearly one in five 15-year-olds (19%) were overweight or obese in 2013–14,

up from one in eight (12%) in 2001–02. Reducing obesity through increasing physical activity and promoting other healthy behaviours are included in the 'Healthy Ireland' agenda, which has recently been adopted and is starting to be implemented (see Section 5.1).

Behavioural risk factors are more prevalent among disadvantaged populations

As in other EU countries, many behavioural risk factors to health in Ireland are more common among people from groups with lower socioeconomic status. For example, people living in the most deprived areas of Ireland are more than twice (35%) as likely to smoke than those living in the least deprived areas (16%). The situation is similar for other risk factors such as binge drinking and obesity (IPSOS MRBI, 2016). This higher prevalence of risk factors among people with lower levels of education or income contributes to health inequalities.

Figure 5. Alcohol consumption, overweight and obesity are important public health issues 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 Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14 (Chart design: Laboratorio MeS).

5. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

6. Data for 2015 comes from the 'Healthy Ireland Survey 2015' (IPSOS MRBI, 2016).

4 The health system

The public health care system is tax-financed, though many people purchase voluntary insurance

The Irish health care system is largely a tax-financed national health service, although almost half of the population also buys voluntary health insurance. The Department of Health provides strategic leadership and allocates the health budget, which goes mainly to the Health Service Executive (HSE). The HSE has operational responsibility for care provision in public hospitals, health centres and a range of community and social care services.

There is no purchaser-provider split in those cases where HSE both finances and provides care. However, there are many other instances when the HSE purchases care from private providers (e.g. GPs) or voluntary insurers pay for care, thus operationalising such a split. Important reforms touching on service delivery and other dimensions of the health system are currently under discussion (Box 1).

Health spending per capita in Ireland is high but it was cut in the wake of the economic crisis

In 2015, health expenditure per capita in Ireland was EUR 3 939 (adjusted for differences in purchasing power), more than 40% above the EU average (Figure 6). This equates to 7.8% of GDP.⁷ The economic crisis, which began in 2008, led to a reduction of

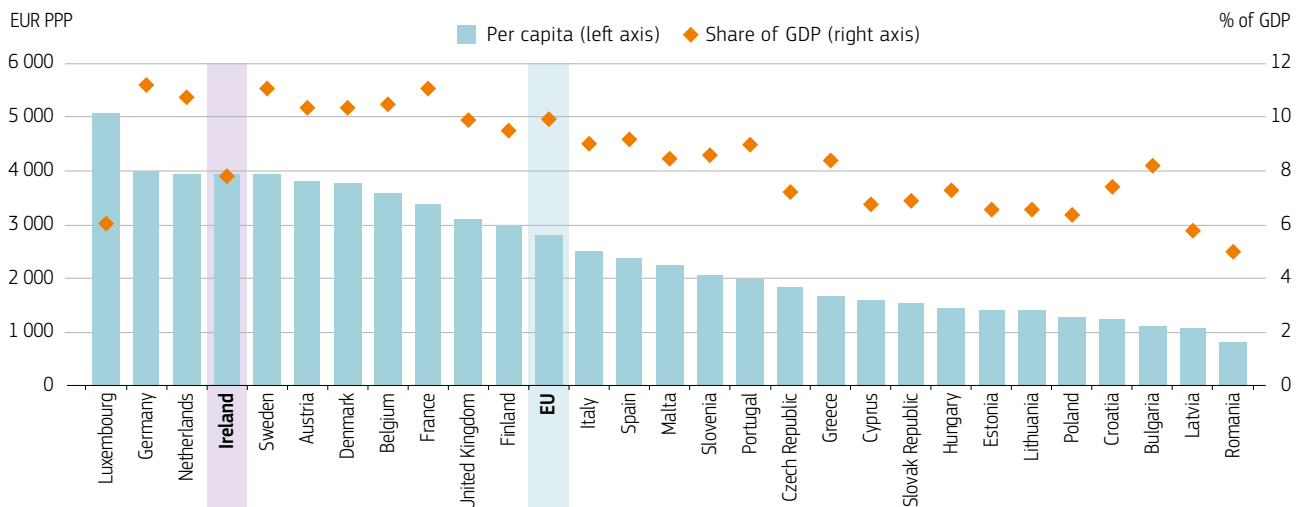
BOX 1. MAJOR REFORMS TO OVERHAUL THE HEALTH SYSTEM ARE UNDER DISCUSSION

Major reforms proposed in 2011 – including mandatory universal health insurance (UHI) and primary care free at the point of service – sought to expand coverage and to end the ‘two-tiered’ system where access to treatment is quicker for patients with private coverage than for those with public coverage. The plan to implement UHI was formally abandoned in 2015 after an independent evaluation found it too costly and essentially the wrong model for Ireland (Wren et al., 2015). A cross-party Oireachtas Committee on the Future of Healthcare has published a detailed proposal to move towards a person-centered health system with universal coverage within ten years in May 2017 (see Section 5.3).

public spending on health, causing the government share of health expenditure to fall. In 2015, this share stood at 70 percent. In more recent years, government budgets for health have started to grow again.

General taxation is the primary source of revenue for the public system. This is supplemented by a Universal Social Charge levied on self-employed people and employees. Voluntary health insurance and out-of-pocket payments (accounting for 12.3% and 15.2% of total expenditure respectively in 2015) make up a significant portion of health expenditure.

Figure 6. Health expenditure per capita in Ireland is substantially above the EU average



Sources: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

7. Health spending as a share of Gross National Income (GNI) is higher, at 9.7% in 2015, as GNI is substantially lower than GDP in Ireland. Because a significant proportion of the GDP in Ireland is made up of profits from foreign-owned companies that are exported, the GNI may be a more meaningful measure of the capacity to pay for health care in Ireland.

More than half the population lack coverage for GP visits

All residents are entitled to receive a range of health services in the public system, although there are notable variations in coverage. Visits to GPs are only covered for the 47% of the population who qualify either for Medical Cards or GP Visit Cards (see Section 5.2). In addition, Medical Card holders receive free of charge access to hospital services, as well as medicines at reduced cost. GP referral is needed to access most public specialists. The system is commonly referred to as ‘two-tiered’ because people with voluntary health insurance (or who are otherwise able to pay) obtain faster access to diagnostics and hospital treatments, even from public providers. Even though all residents are entitled to receive care, they may not in fact get it due to long waiting times or because services may not be available close to where they live (see Section 5.2).

Copayments are applied on a broad range of services including primary care

Cost-sharing plays a major role in paying for health services in Ireland, particularly for those who do not hold a Medical Card. Acute inpatient care requires copayment, capped at EUR 800 per

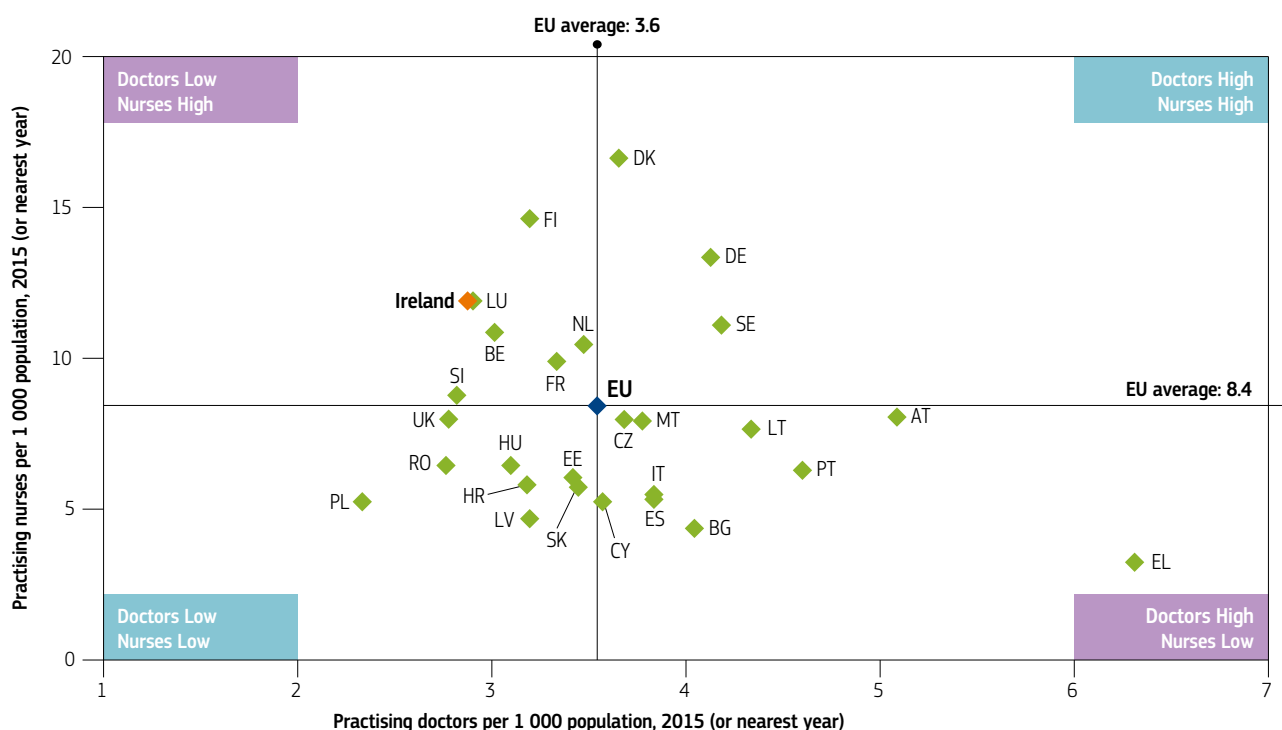
year, as do emergency department visits (EUR 100). Copayments on prescribed medicines are also applied with a ceiling of EUR 144 per household per month. While GPs set their own prices, a visit costs on average more than EUR 50 for those without Medical Card or GP Visit Card.

Ireland has a relatively low number of doctors and high number of nurses

Compared to other EU countries, Ireland has a relatively low number of doctors and high number of nurses (Figure 7). There were 2.9 practising physicians per 1 000 population in 2015, compared to an EU average of 3.6. Over one third of all doctors licensed to practise in Ireland in 2015 were trained abroad, reflecting a long-standing reliance on doctors from overseas. There were 11.9 nurses per 1 000 population in 2015, compared with an EU average of 8.4.⁸

Most hospitals are publicly owned. Public funding for capital projects is determined separately from current expenditure and fell considerably following the economic crisis, exacerbating capacity constraints. The number of hospital beds per capita in Ireland is half of the EU average at 2.6 per 1 000 population in 2015 (compared with an EU average of 5.1).⁹

Figure 7. Ireland has fewer doctors per capita than the EU average, but more 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. by 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.

8. The data on the number of nurses in Ireland is slightly overestimated (by around 10%) as it includes not only those providing direct care to patients but also other nurses working in the health system as managers, educators and researchers.

9. The number of hospital beds in Ireland only refers to public hospitals, thus underestimating the total available resources (by around 10% to 20%).

5 Performance of the health system

5.1 EFFECTIVENESS

Amenable mortality is lower than the EU average but far from best performing countries

Amenable mortality¹⁰ provides a first indication of the effectiveness of a health care system in saving the lives of people with life-threatening conditions. Ireland has lower amenable mortality rates than the EU average for both women and men alike (Figure 8), but still the rates are substantially above the best performing countries, such as France, Spain and Italy.

In 2014, around 3 800 deaths in Ireland were deemed to be amenable to health care (13% of all deaths).¹¹ Ischaemic heart diseases accounted for a large part (37%) of these amenable deaths, although this share has been declining. Other important causes of amenable deaths include colorectal cancer, breast cancer and stroke (all individually accounting for more than 10% of the total).

High numbers of avoidable hospitalisations suggest room for improvement in primary care

With an ageing population and a growing number of people living with chronic conditions, there is room for improving the management of chronic diseases in Ireland, so as to avoid a worsening of these health conditions and unnecessary hospitalisations. The rate of hospital admissions for chronic conditions such as Chronic Obstructive Pulmonary Disease (COPD) and diabetes remain relatively high in Ireland (OECD/EU, 2016), which cannot be explained by a higher prevalence of these conditions.¹²

The current fragmentation of the health system in Ireland creates substantial barriers to better care integration. Currently, five integrated care programmes are being developed to overcome these barriers. They refer to clinically-led, multi-disciplinary care models covering the areas of patient flow, targeting older people, the prevention and management of chronic diseases and children and maternity care. The implementation of these programmes is foreseen over the next two to five years.

In the area of chronic disease management, the Health Service Executive (HSE) is developing programmes focusing on diabetes, chronic pulmonary disease, asthma, heart failure and atrial fibrillation. Yet, the implementation of effective integrative care models in Ireland is hampered by the 'two-tier' financing system, the absence of universal health coverage as well as the lack of integration of different state agencies.

Enhancing patient safety and the development of clinical guidelines are important priorities

Enhancing patient safety is an important policy priority in Ireland. This will be the focus of the recently established National Patient Safety Office (NPSO) at the Department of Health. This new Office has been mandated to develop and start putting in place in 2017 a national patient safety surveillance system to better inform patient safety policy and leadership decisions.

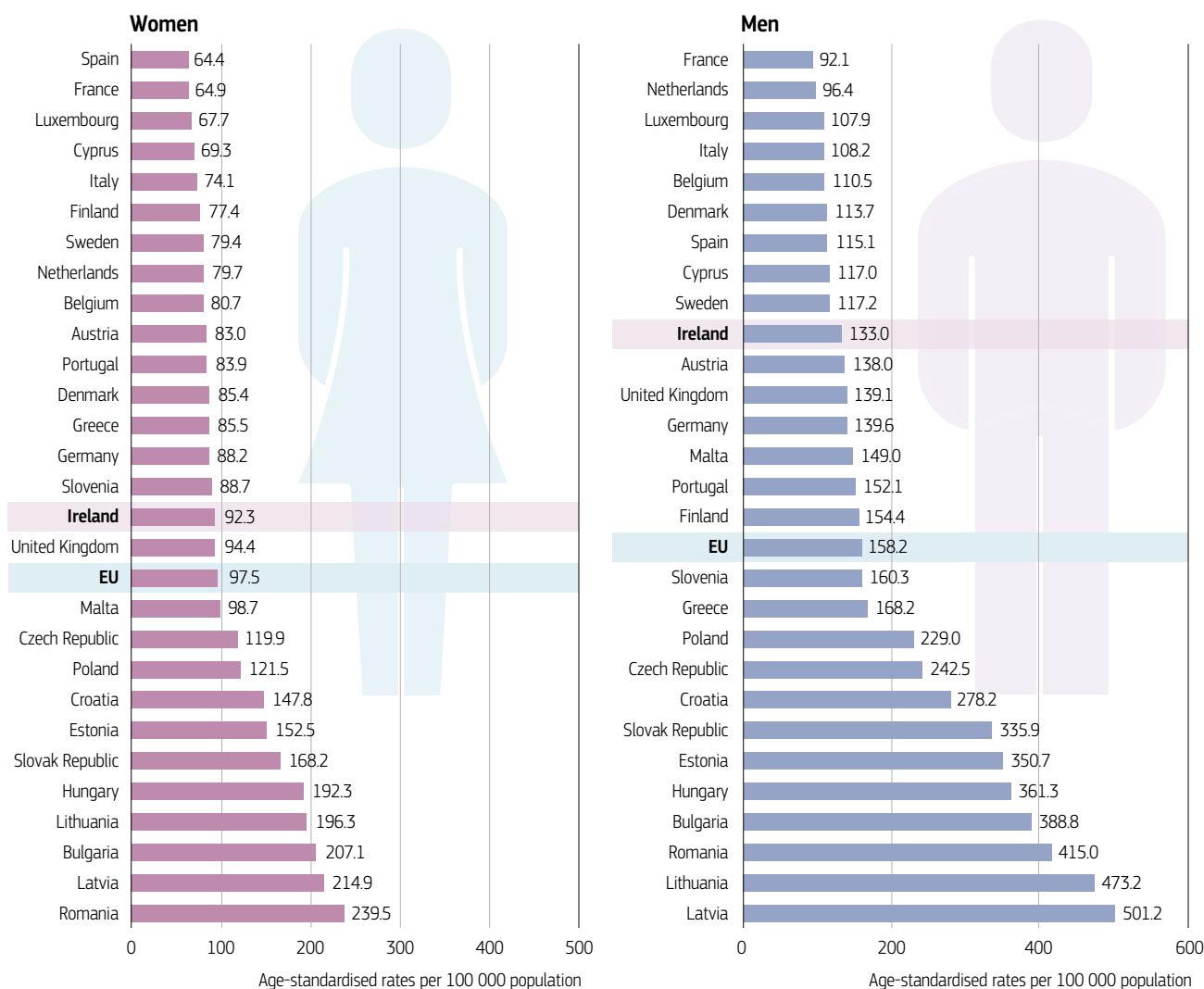
Moreover, the currently debated Health Information and Patient Safety Bill foresees an extension of the responsibilities of the Health Information and Quality Authority (HIQA) – an agency whose main functions include the setting and monitoring of care standards and health technology assessment – to cover private health providers as well.

A National Clinical Effectiveness Committee (NCEC) was established in 2010 to develop a framework for the endorsement of clinical guidelines to optimise patient care. Among its terms of references is the publication of standards for clinical practice guidelines, the publication of guidance for national clinical guidelines, the prioritisation and quality assurance of these guidelines and their commissioning. Once the guidelines have gone through the NCEC process and have been endorsed by the Minister of Health, they are mandated for implementation by Irish health care providers. By mid-2017, 15 National Clinical Guidelines covering a range of areas have been endorsed, including guidelines for sepsis management, treatment of patients with breast and prostate cancer and acute asthma attacks.

10. Amenable mortality refers to premature deaths that could have been avoided through timely and effective health care.

11. Excluding deaths due to injury, poisoning and certain other consequences of external causes.

12. According to data from the last wave of the European Health Interview Survey, the self-reported prevalence of these conditions in Ireland was lower than in most other EU countries.

Figure 8. Amenable mortality rates in Ireland are below the EU average

Source: Eurostat Database (data refer to 2014).

Preventable mortality is lower than the EU average, and new public health policies aim to reduce it further

Looking beyond the health care system, preventable mortality rates in Ireland are generally lower than in most other EU countries. For example, mortality rates from transport accidents are among the lowest in the EU (4.0 per 100 000 population in Ireland versus 5.8 for the EU average in 2014, based on age-standardised rates), and alcohol-related deaths are also lower than in many other EU countries. This partially reflects the progress in reducing overall alcohol consumption by more than 20% since 2000 (see Section 3). On the other hand, the mortality rate for lung cancer is above the EU average, although slightly reduced in recent years, reflecting the long-term consequences of previously higher smoking rates.

In 2013, the 'Healthy Ireland' agenda was adopted as a general framework to improve population health and wellbeing around four broad goals: a) increase the proportion of people who are healthy at all stages of life; b) reduce health inequalities; c) protect the public from threats to health and wellbeing; d) create an environment where every sector of society can play their part (Department of Health, 2013). Some of the key measures introduced by the government as part of the agenda include fixing some minimum unit prices for alcoholic beverages under the Public Health (Alcohol) Bill in 2015 to bring down alcohol consumption (the Bill has yet to be adopted by the Oireachtas) and introducing plain packaging for cigarettes in 2017 as part of the Public Health (Standardised Packaging of Tobacco) Act. Other areas addressed by the 'Healthy Ireland' agenda include measures to tackle obesity, promote physical activity and reduce drug use for which action plans and strategies have been developed and published. However,

the implementation of this very ambitious agenda, stretching across many government departments and agencies, has been delayed. The implementation plan and outcomes framework to measure the impact of these health promotion initiatives are expected to be published in late 2017 – four years after initially envisaged.

5.2 ACCESSIBILITY

Ireland is the only Western European country that does not offer universal coverage of primary care

The achievement of universal health coverage is a stated priority of the current government, but at the moment less than half of the population have public coverage for primary care (see Section 4). These are Medical Card holders (38%) and people with a GP Visit Card (9%). Eligibility to get a Medical Card is generally based on a means-test with different income thresholds mostly depending on age. A few exceptions include children diagnosed with cancer or with severe disabilities. They can also obtain a Medical Card.

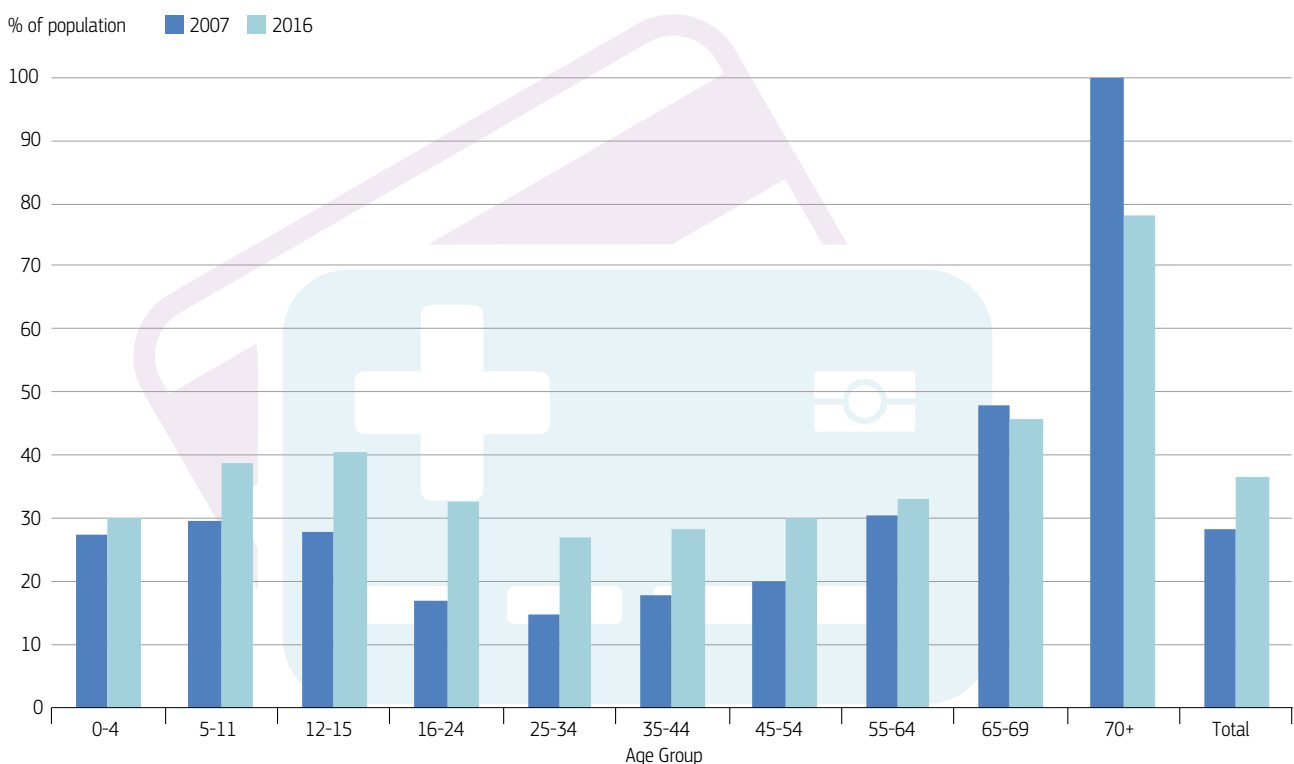
The eligibility criteria contribute to the high regional variation in its distribution ranging from 15% of the population in an urban district of Dublin to 54% in a rural region in the North of the country. They

are also the reason for an unequal age distribution for coverage – ranging from less than 30% for adults between the age of 25 and 44 to 80% for people above the age of 70 (Figure 9). People not qualifying for a Medical Card may qualify to obtain a GP Visit Card, which is also based on a means-test but has higher income thresholds. As of 2015, every child below the age of six and people over 70 can apply for a GP Visit card. Plans to extend eligibility for that card to children under 12 have currently been stalled until the successful negotiation of a new GP contract.

The number of people holding a Medical Card has gone up by over 40% over the last decade, despite changes to the entitlement criteria introduced in 2009 to limit access to it. Some of this rise can be related to the drop in employment and household income as a consequence of the financial crisis making a bigger portion of the population eligible for this scheme. As employment and income has started to grow again, the number of people holding a Medical Card has gone down slightly since reaching a peak in 2012.

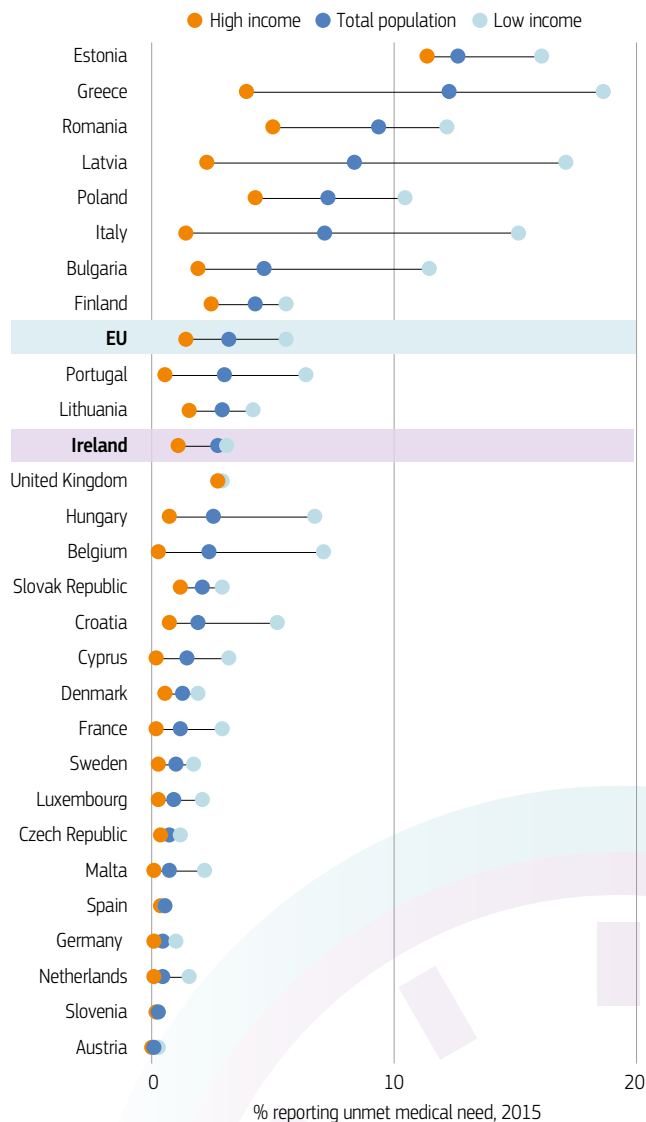
Although important gaps in coverage exist in Ireland, the proportion of people reporting some unmet need for a medical examination was around the EU average in 2015 (Figure 10). On average, 2.8% of the Irish population reported to have forgone medical care because of high costs, travel distances or waiting times, with high costs being the main reason (2.0%). Yet, the share is nearly one-third higher than 10 years before.

Figure 9. Wide variation in access to Medical Cards exists across age groups



Source: Primary Care Reimbursement Service. Irish Central Statistics Office, Census 2016.

Figure 10. Unmet needs for medical care in Ireland is around the EU average



Note: The data refer to unmet needs for a medical examination 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 2015).

Voluntary health insurance plays an important role to get faster access to care

Ireland has a number of different schemes covering a variety of services for different population groups. The package for Medical Card holders is the most comprehensive, including free GP care from a doctor contracted by the HSE. Due to important gaps and limitations in the public benefit basket – particularly for those without Medical Card – having voluntary private health insurance is important for many people in Ireland. Currently, around 44% of the population have predominantly duplicate coverage for private care in both public and private hospitals as well as for quicker access for hospital outpatient consultations.

Out-of-pocket payment is rising due to cost-containment measures taken during the financial crisis

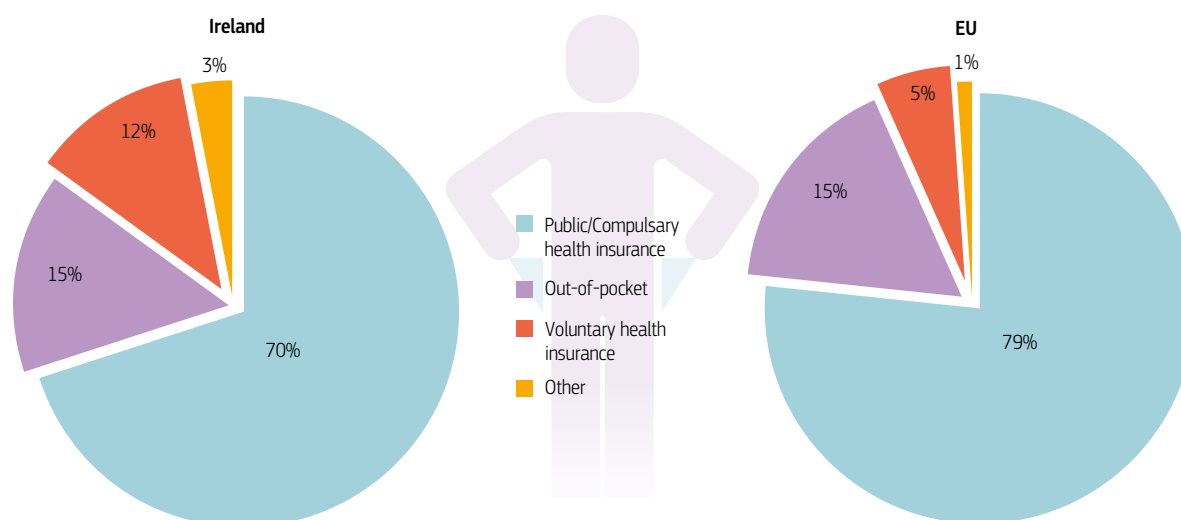
As already noted, for patients not entitled to Medical Cards, copayments and direct payments can be substantial (see Section 4). For Medical Card holders, these are much more constrained and are basically limited to a EUR 2.50 charge per pharmaceutical prescribed up to a ceiling of EUR 25 per month.

Copayments were increased following the financial crisis and the pressure on the Irish government to balance its budget. A pharmaceuticals prescription charge for Medical Card holders was introduced in 2010 (EUR 0.50) with a monthly ceiling of EUR 10, but both charge and ceiling have since been increased. For the rest of the population, the drug reimbursement deductible was raised in several steps from EUR 100 to currently EUR 144 per month. Outpatient and emergency department charges in hospitals were increased to EUR 100 in 2009, up from EUR 66. In the same year, daily inpatient charges were raised to EUR 80, also up from EUR 66.

As a consequence of the high copayments and limitations in the scope of coverage for specific groups, the private sector plays a much bigger role in financing health care than in most other EU countries (Figure 11). While the share of out-of-pocket payments in total health expenditure in Ireland was equal to the EU average in 2015, voluntary health insurance is more prevalent (12%) than in most other EU countries (5% on average). Interestingly, due to the fact that coverage via Medical Card is primarily available for the economically disadvantaged population, Ireland is the only EU country where unmet need due to costs for the people in the lowest income quintile is less than for the overall population (1.8% for the lowest income quintile versus 2.0% on average).

Relatively low capacity contributes to long waiting times

Although all citizens in Ireland are entitled to inpatient and outpatient care in public hospitals, they may not be able to get it because of capacity constraints. Waiting times have long been a major health policy concern and consecutive Irish governments have developed policies to try to address this issue over the past 25 years (Moran et al., 2013). Despite efforts under the 'Waiting Line Initiative', the introduction of the 'National Treatment Purchase Fund' and the 'Special Delivery Units', reducing extensive waiting times remains a challenge.

Figure 11. Public share of health spending is lower in Ireland than the EU average

Sources: OECD Health Statistics, Eurostat Database (data refer to 2015).

Figure 12. Long waiting times exist for outpatient treatment and surgery in Irish acute care hospitals

	Actual 2014	Actual 2015	Target 2015
Outpatients			
% of people waiting < 52 weeks for first access to OPD services	84.1%	90.1%	100%
Inpatient and Day Case Waiting Times			
% of adults waiting < 8 months for an elective procedure (inpatient)	73.5%	71.9%	100%
% of adults waiting < 8 months for an elective procedure (day case)	77.9%	76.5%	100%
% of children waiting < 20 weeks for an elective procedure (inpatient)	52.7%	53.0%	100%
% of children waiting < 20 weeks for an elective procedure (day case)	68.2%	58.3%	100%
Emergency Care			
% of all attendees at ED who are discharged or admitted within 6 hours of registration	67.6%	68.2%	95%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	81.3%	81.7%	100%
% of all attendees at ED who are in ED > 24 hours	new PI	3.9%	0%

Note: OPD = outpatient department; ED = emergency department; PI = performance indicator.

Source: Health Service Executive (2016).

In hospitals, waiting times are particularly high for outpatient services where 10% of patients had to wait more than a year to get first access to services in 2015 (Figure 12). But waiting times are also very high for elective surgical procedures, regardless of whether they are treated as inpatient or day cases. Therefore, getting faster access to hospital services is the prime motivation for people to buy voluntary health insurance.

The existence of waiting times can partly be explained by the relatively low bed capacity in Ireland. The low availability of beds, combined with the relatively high hospitalisation rates for conditions that should normally be treated in primary care settings, contribute to a very high occupancy rate: 95% of all hospital beds in acute care are occupied on average throughout the year. This is much higher than on EU average (77%) and leaves little capacity to handle emergency situations, except by postponing elective procedures.

5.3 RESILIENCE¹³

The Irish health system adapted to the financial crisis, but challenges remain

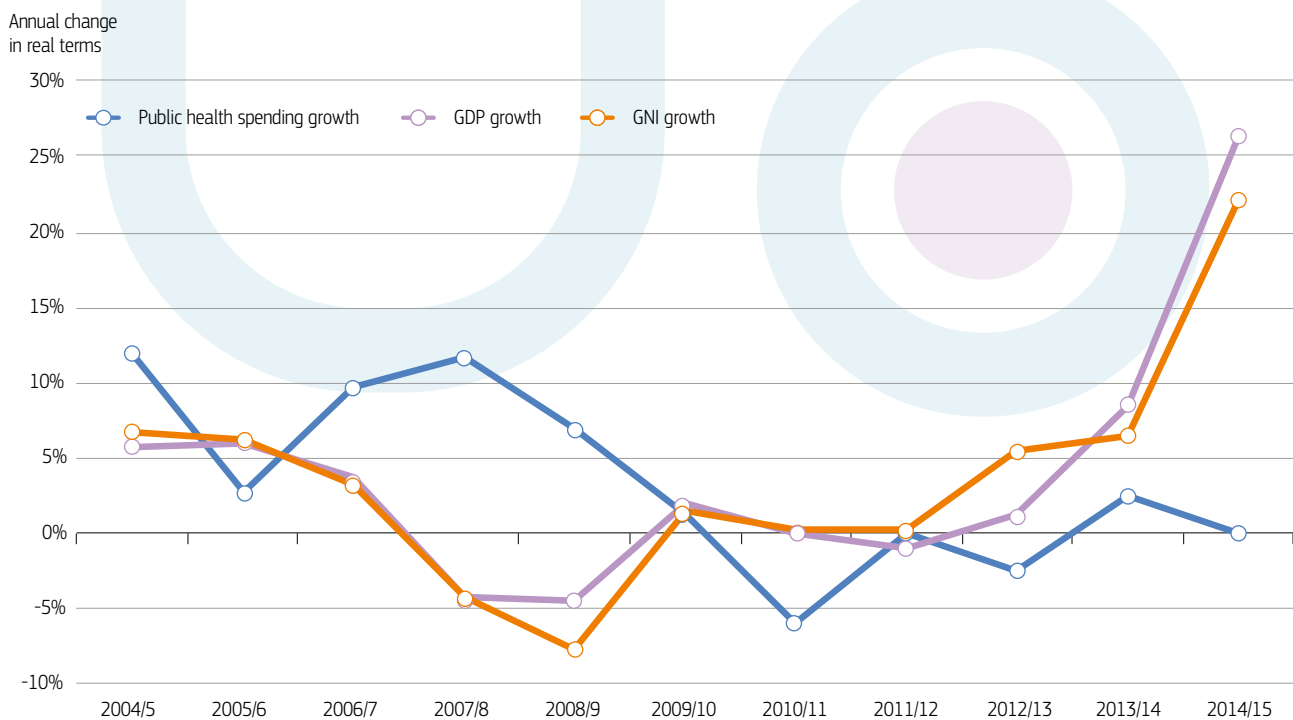
The resilience of the Irish health system was tested following the financial and economic crisis that began in 2008. At the beginning of the crisis, health spending was little affected from the economic downturn, but from 2010 onwards, public spending on health was either cut or remained flat (Figure 13).

Ireland has been struggling in recent years to keep spending within the health care budgets (Figure 14). To cover budget overruns, supplementary budgets had to be passed in Parliament. A number of factors are contributing to this over-spending problem: technical challenges in planning and budgeting, such as difficulties with financial management and governance, failures to fully implement the cost-savings measures, expectations that cost-savings measures would be eased during the year and unrealistic cost-reduction target setting (European Commission, 2016; Irish Fiscal Advisory Council, 2015). To cope better with these challenges a number of measures have been taken recently, such as the gradual implementation of the Finance Reform Programme and the publication of a revised Performance and Accountability Framework for health service managers.

To meet future growing health care needs in Ireland, one long-term challenge will be to increase the capacity of the system in terms of both human and physical resources. Ireland has raised the number of students entering medical education since 2010 which has already led to a strong increase in the number of new medical graduates. Nevertheless, retention appears to be a concern. Around one in two newly trained doctors do not plan to practise medicine in Ireland.¹⁴ Poor working conditions, such as understaffing of the workplace, or expectations to carry out too many non-core tasks as well as limited career prospects in Ireland were the top reasons for those planning to emigrate or pursue an alternative career.

As previously mentioned, hospitals operate constantly at near capacity limitations. While some of the pressure could be eased by strengthening primary care and promoting better care integration for the growing number of people living with chronic conditions, the issue remains that Ireland may have too few hospital beds and other equipment to provide timely and safe care for its population. To assess the magnitude of this problem, a national review of capacity including hospital beds and other important elements of capacity in primary and community care was commissioned in late 2016. The report is due in 2017.

Figure 13. Public health spending growth has been sharply reduced since 2008/2009

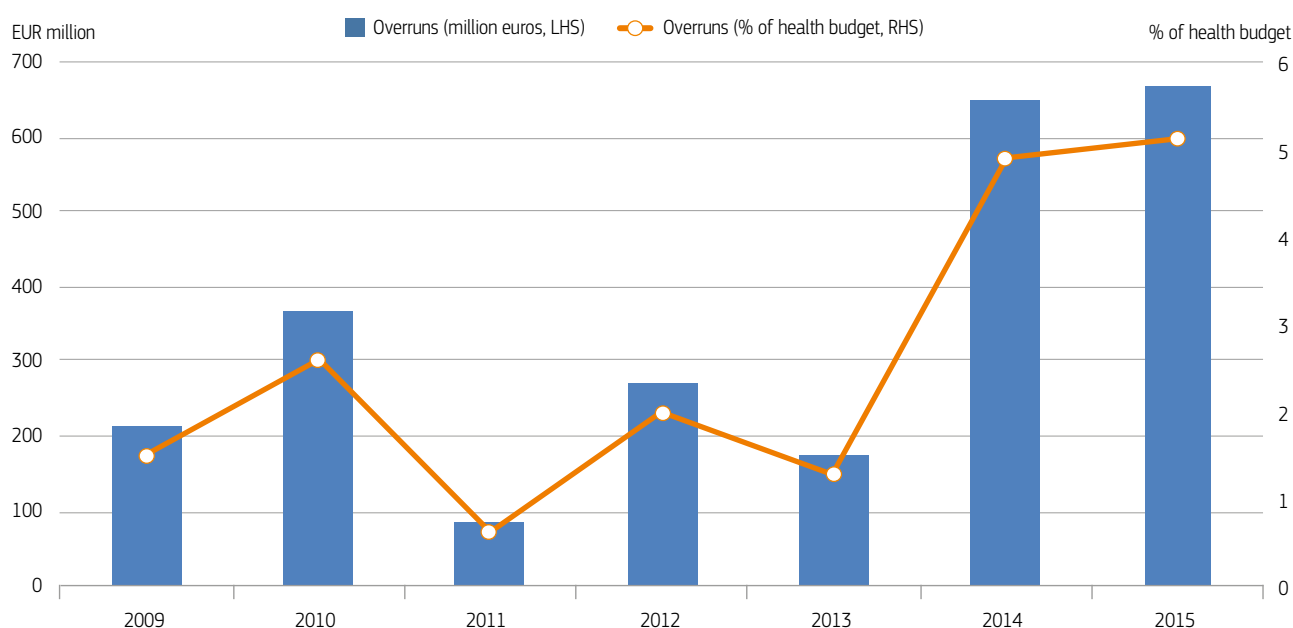


Note: GDP and GNI in Ireland increased significantly in 2015 as an effect of increasing globalisation and in particular due to the relocation to Ireland of some big economic operators.

Source: OECD Health Statistics, OECD National Accounts Database.

13. Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.

14. The estimates vary from only 40% of medical graduates planning to practice in Ireland according to information from the Irish Medical Organisation (IMO, 2017) to 58% of post-graduate trainees intending to practice in Ireland in the foreseeable future according to a 2015 survey from the Irish Medical Council (Irish Medical Council, 2016).

Figure 14. Health care budget overruns have been a growing issue in Ireland

Source: Department of Public Expenditure and Reforms.

Although progress has been made, potential for efficiency gains lies untapped

Some progress has been achieved in improving health system efficiency following the cost-containment measures after the financial crisis. The Irish health system was actually able to do more with less from 2008–13 as the number of Medical Card holders and hospital activity increased at a time when financial resources and nursing staff were cut (Burke et al., 2014). But it became increasingly difficult to achieve additional efficiency gains after 2013, and reduced inputs eventually resulted in a reduction in hospital discharges and day cases.

One of the main challenges for the Irish health system is to improve efficiency by moving care to the appropriate setting. Strengthening primary care access and capacity could avoid unnecessary visits to hospital emergency departments and hospitalisations for chronic conditions, such as COPD and asthma. There may also be room to perform more surgery as day cases in hospitals or in the ambulatory (outpatient) sector. While the share of cataract surgery performed as day care has increased greatly over the past decade, Ireland is lagging behind for other operations, such as tonsillectomy (OECD/EU, 2016).

There are questions to what extent earlier attempts to bring down waiting times through additional funding via the National Treatment Purchase Fund (NTPF) have been an efficient use of resources. Until its mandate was changed in 2012, the NTPF was organising and commissioning additional treatments for long-

waiting patients, in particular in private hospitals. As the prices for treatments in private hospitals were much higher than in public hospitals, the money spent on the NTPF might have been better invested to increase public hospital capacity and efficiency.

Improving referral practices and better coordination between primary and secondary care may also help to generate efficiency gains and reduce waiting times. Related to this are general problems with two-tier health systems as they can incentivise providers to give preference to patients who seek care outside of the public system. This can be a source of inefficient allocation of scarce resources if it diverts these resources away from those patients that need treatment most urgently.

Ireland has achieved some progress in reducing the average length of stay in hospitals in recent years. Further efficiency gains may be generated with the full rollout of activity-based financing in hospitals, which is replacing global budgets as the main financing mechanism.

In the pharmaceutical sector, a new deal to reduce pharmaceutical prices was reached between the Ministry of Health and manufacturers in 2016 by agreeing on more frequent price realignments and expanding the basket of countries used for reference pricing. There may be room for further improvement in the use of generics in Ireland. Generic penetration for pharmaceuticals is generally lower in Ireland than in many other countries in Europe, both in terms of volume and value of prescribed pharmaceuticals (OECD/EU, 2016).

Better governance and clearer accountability are likely to be central in new health reform agenda

Some fundamental questions remain about the capacity of the current Irish health system to implement the transformative changes needed to meet the overarching health policy goals of accessibility, responsiveness and efficiency. In an attempt to reach a broad consensus across political parties about the future directions of health care in Ireland, the aforementioned Parliamentary Committee was established in 2016.

The final report was published in May 2017 proposing a fundamental overhaul of the Irish health system within a decade (Box 2). The recommendations are expected to influence strongly the direction of health reforms, covering all health system domains including changes to entitlements, care models and service delivery, financing mechanisms and organisation.

Strengthening governance, including clinical governance and accountability also plays a major part in the recommendations for future health reforms. The Oireachtas report suggests a clearer separation of tasks between the Department of Health and the HSE in governing health care provision with the Minister of Health assuming the responsibility for service delivery and the health system as a whole. The role of the HSE should be re-oriented to a strategic 'national centre' with a bigger devolution of tasks to regional bodies in care provision. It remains to be seen to what

extent the proposal will be implemented. The high estimated costs will certainly be a crucial point for political discussion. Although many implementation challenges lie ahead, the proposal appears to have the potential to boost the performance of the Irish health system in the long-run.



BOX 2. KEY RECOMMENDATIONS OF THE PARLIAMENTARY COMMITTEE ON THE FUTURE OF HEALTH CARE

In its final report, the Parliamentary Committee suggests a re-orientation of the Irish health system towards a single-tier system with universal access based on need. Health care delivery should take place in primary care and social settings meeting patients' care needs in an integrated way across sectors. Providing a comprehensive reform and implementation plan, the report identifies measures structured around the domains of population health, entitlement and access, care integration, funding and governance.

Key recommendations include:

- Introduction of the *Carta Slainte* entitling all residents to access a comprehensive range of services based on need, at no or reduced cost
- Expansion of entitlements for services in primary care, social care, mental health, dental care and public hospitals – accompanied by an expansion of physical and human capacity

- Reduction and removal of copayments for pharmaceuticals and inpatient care
- Elimination of private care provided in public hospitals to reduce waiting times in the public sector accompanied by the introduction of waiting time guarantees
- Development of integrated workforce planning capacity at the HSE and the Department of Health
- Establishment of the 'National Health Fund' (NHF) as the single payer funded through a combination of general taxation revenues, earmarked taxes, levies and charges
- Limitation of private insurance to cover private care in private hospitals

The implementation costs are estimated to amount to EUR 5.8 billion over a ten-year period as a result of service expansion and required investment in infrastructure and eHealth.

Source: Oireachtas (2017).

6 Key findings

- Ireland has seen significant improvements in the health status of its population over the past decades. Life expectancy has increased more rapidly than in many other EU countries and is now above the EU average. Yet, almost one-third of adults report excessive alcohol drinking habits, a much greater proportion than in other EU countries, and obesity remains an important public health issue among adults and adolescents.
- On a per capita basis, Ireland spends around 40% more than the EU average. Approximately 70% of health spending in Ireland is publicly financed, a proportion well below the EU average. Instead, voluntary health insurance plays a much bigger role in financing health care than in most other EU countries.
- Comparably low rates of amenable mortality point to a relatively effective health care system in treating life-threatening conditions. However, high hospital admission rates for chronic conditions are largely avoidable and suggest problems with the coordination and continuity of care. More importantly, Ireland is the only Western European country without universal coverage at the primary care level, raising questions about the accessibility of these important first-line services. Less than half of the population are currently entitled to coverage for GP visits. Plans to roll out coverage to wider parts of the population are ongoing but face some resistance.
- Long waiting times for outpatient treatment and inpatient surgery continue to present a major challenge. A very low hospital capacity and a two-tier health financing system that gives patients with private health insurance preferential treatment contribute to this problem. Since hospitals operate at nearly full capacity year-round, this suggests that Ireland may not have sufficiently invested in infrastructure. In addition, low workforce levels also present a challenge for timely access to care. Ireland raised the number of students entering into medical education since 2010, yet retention of medical graduates remains a concern.
- Although some efficiency gains have been generated following the financial crisis, more could be done in pharmaceutical spending by increasing the share of generics prescribed. In terms of hospital activities, progress was achieved in implementing day surgery for many interventions, although experiences in some leading EU countries show that there is still room to avoid hospitalisation for an even larger number of surgeries. Large budget overruns were commonplace in recent years, pointing to the need to strengthen financial governance and accountability.
- A broad consensus across political party lines affirms that the Irish health system needs a transformation to respond better to the needs of the population and to put a stronger focus on prevention and primary care. The inevitable increase in the demand for services in years to come due to population growth and ageing (when capacity constraints already exist today) makes it even more important to find a long-term solution. The recently published report of the Parliamentary Committee describes far-reaching reform options to move towards universal health coverage within a single-tier health system. It is expected that its recommendations will form the basis for the next generation of health reforms in Ireland.



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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		



State of Health in the EU

Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and 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. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

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