European Commission

State of Health in the EU

Ireland

Country Health Profile 2021

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

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 Systems Performance Assessment (HSPA).

Contents

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 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

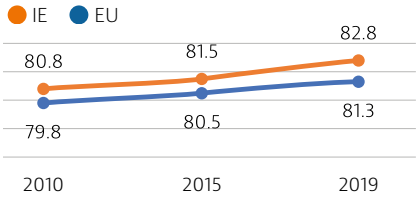
Demographic and socioeconomic context in Ireland, 2020

Demographic factors	Ireland	EU
Population size (mid-year estimates)	4 964 440	447 319 916
Share of population over age 65 (%)	14.4	20.6
Fertility rate[1] (2019)	1.7	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	63 811	29 801
Relative poverty rate[3] (%, 2019)	13.1	16.5
Unemployment rate (%)	5.7	7.1

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.

1 Highlights

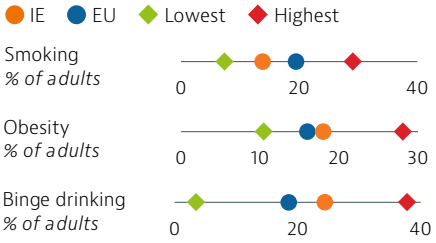
People in Ireland lead longer and healthier lives than most other Europeans, although behavioural risk factors, including smoking and obesity, remain important public health concerns. Quality of health care is generally good, but access to services is constrained by costs and waiting times. The COVID-19 pandemic exposed health system weaknesses – in particular a shortage of health workers in the public sector and low intensive care unit capacity in public hospitals. It also revealed some of Ireland's strengths in responding to crises, including the ability to develop technological solutions and to mobilise additional funding rapidly for health reform, health workforce and hospital resources.



Life expectancy at birth, years

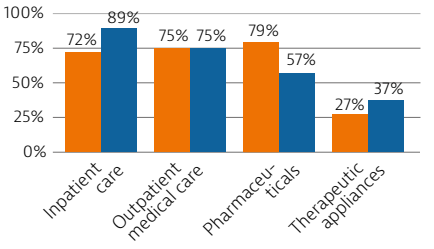
Health Status

Life expectancy in Ireland has increased rapidly since 2000, reaching 82.8 years in 2019, 1.5 years higher than the EU average. Circulatory diseases and cancers remain the leading causes of death, accounting for more than 30 % of all deaths.



Risk factors

Behavioural risk factors are a major driver of mortality in Ireland. While smoking rates among adults have reduced, obesity among adults is on the rise and is now slightly higher than the EU average. One quarter of adults in Ireland report regular heavy alcohol consumption, which is also above the EU average.



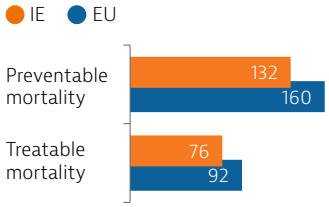
Public spending as a proportion of total health spending by type of service

Health system

Spending on health per capita in Ireland is close to the EU average. Public coverage of spending for inpatient care is more limited than in other EU countries, while it is greater for pharmaceuticals. The majority of the population pays the full cost of general practitioner visits, outpatient prescriptions up to monthly thresholds, outpatient medical supplies and dental care. Spending on prevention was below the EU average in 2019 but saw a substantial increase in response to COVID-19.

Effectiveness

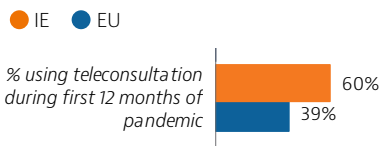
Mortality from preventable and treatable causes in Ireland is lower than in most EU countries. Still, there is room for further progress to reduce premature deaths through public health interventions and more timely diagnosis and treatment.



Age-standardised mortality rate per 100 000 population, 2018

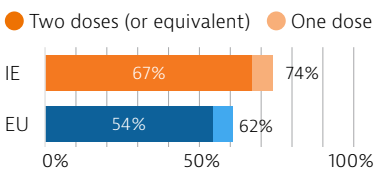
Accessibility

COVID-19 has affected access to care in Ireland: one fifth of the population reported unmet needs for medical care and treatment in 2020. Use of teleconsultations during the first wave of the pandemic aimed to improve access, and uptake was greater than the EU average.



Resilience

Ireland's successful management in the early phases of the COVID-19 pandemic was challenged in late 2020 a severe third wave was experienced. By the end of August 2021, Ireland's vaccination programme achieved above EU average results, with almost 70 % of the total population receiving two doses (or equivalent).



Share of total population vaccinated against COVID-19 up to the end of August 2021

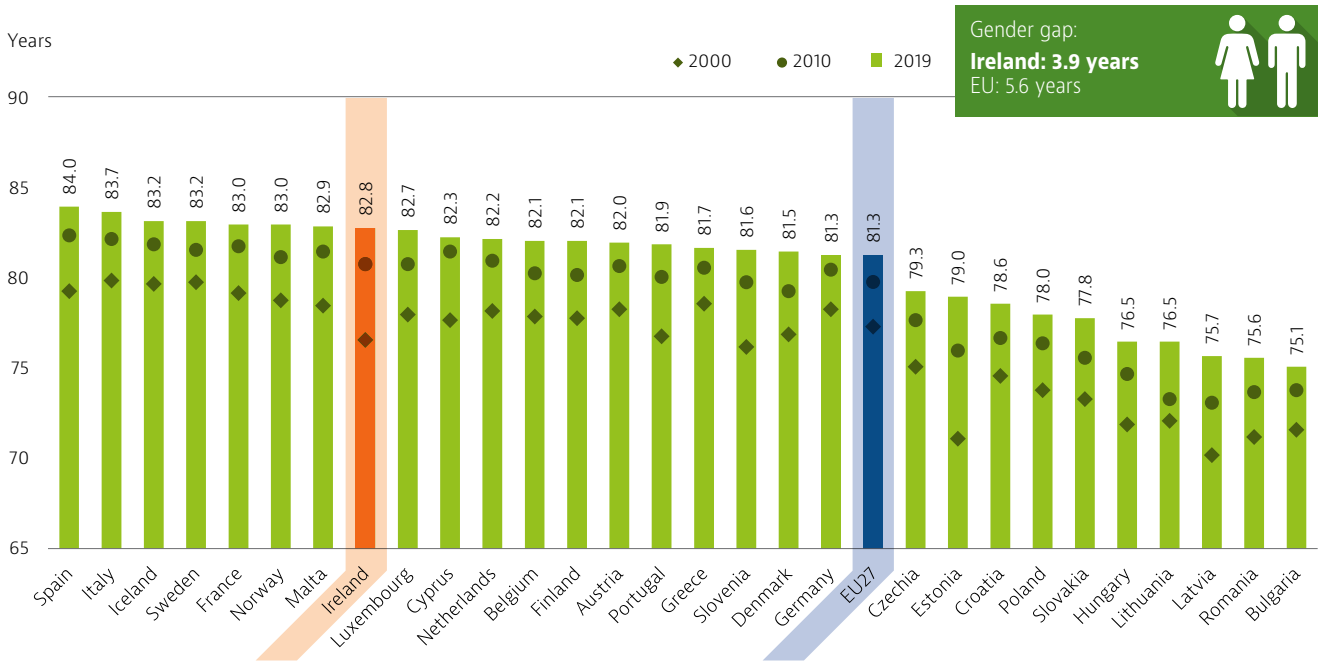
2 Health in Ireland

Life expectancy in Ireland has increased by more than six years since 2000

Life expectancy at birth in Ireland has increased rapidly since 2000 to reach 82.8 years in 2019, which is 1.5 years above the EU average (Figure 1). Most gains in life expectancy occurred between 2000 and 2010. These gains slowed following the economic crisis, as in other European countries, although life expectancy increased by 2 years between 2010 and 2019.

In 2019, the gap in life expectancy between men and women was nearly 4 years (80.8 years for men compared to 84.7 years for women), less than the EU average of 5.5 years.

Figure 1. Life expectancy in Ireland has increased rapidly and is among the highest in the EU



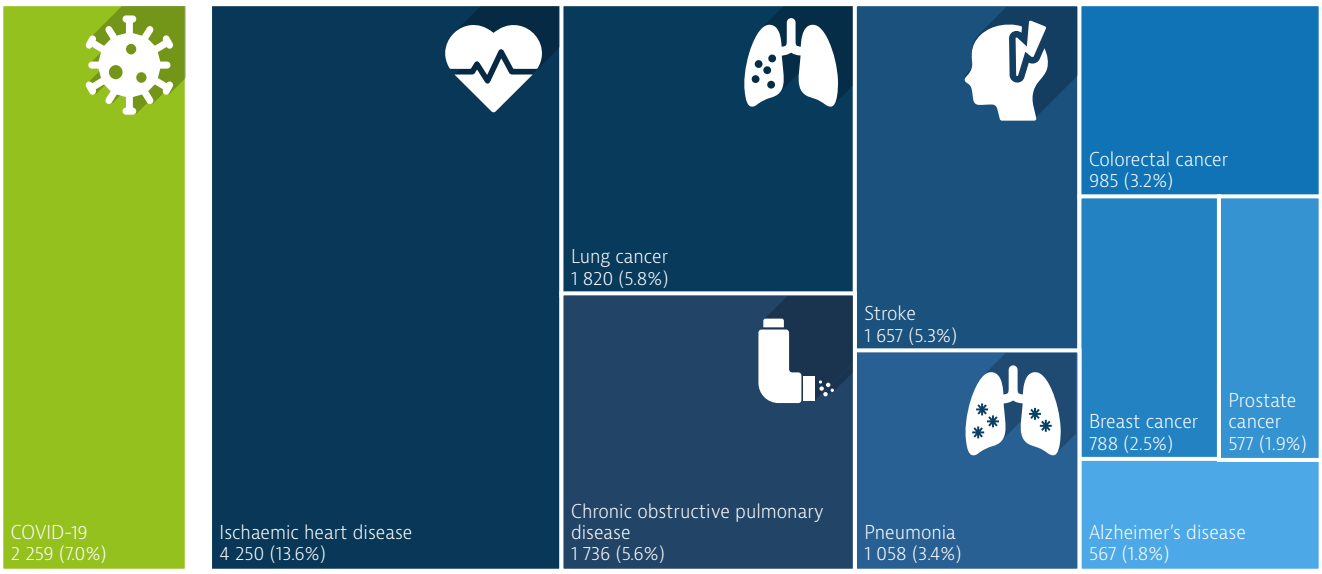
Note: The EU average is weighted.
Source: Eurostat Database.

Ischaemic heart disease remains the leading cause of death, but COVID-19 led to many deaths in 2020

In 2018, circulatory diseases and cancers accounted for more than 30 % of all deaths in Ireland. More specifically, ischaemic heart disease was the leading cause of mortality in 2018 (accounting for nearly 14 % of all deaths), followed by lung cancer (the most frequent cause of death by cancer), chronic obstructive pulmonary disease (COPD) and stroke (Figure 2).

In 2020, COVID-19 accounted for 2 259 deaths in Ireland (7.0 % of all deaths in 2018), mainly among older people. An additional 2 800 COVID-19 deaths were registered in the first eight months of 2021. By the end of August 2021, the mortality rate from COVID-19 was about one third lower in Ireland than the average across EU countries (about 1 025 deaths per million population compared to 1 590 for the EU average).

Figure 2. COVID-19 accounted for 7 % of deaths in 2020



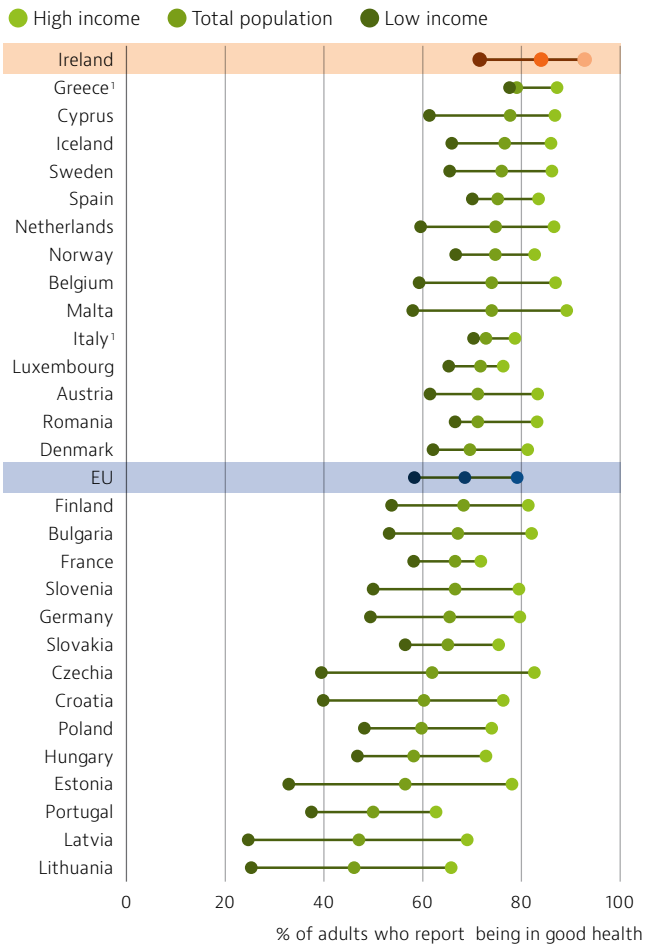
Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.
Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

Most Irish people report being in good health, but nearly three in ten have a chronic condition

In 2019, 84 % of the population reported being in good health – the highest proportion in the EU. However, as in other countries, disparities between income groups are clear: 93 % of the Irish population in the highest income quintile reported being in good health, compared with 72 % of those in the lowest (Figure 3).

Nearly three in ten Irish adults (28 %) reported having at least one chronic condition in 2019 – a proportion below the EU average (36 %), according to EU-SILC. This proportion increases with age: more than half of Irish people aged 65 and over reported having at least one chronic condition. Many of these conditions increase the risk of severe complications from COVID-19. As with self-reported health, there is a gap in the prevalence of chronic conditions by income group: 42 % of Irish adults in the lowest income group report having at least one chronic condition, compared with 17 % among those in the highest.

Figure 3. Ireland has the highest share of self-reported good health in the EU



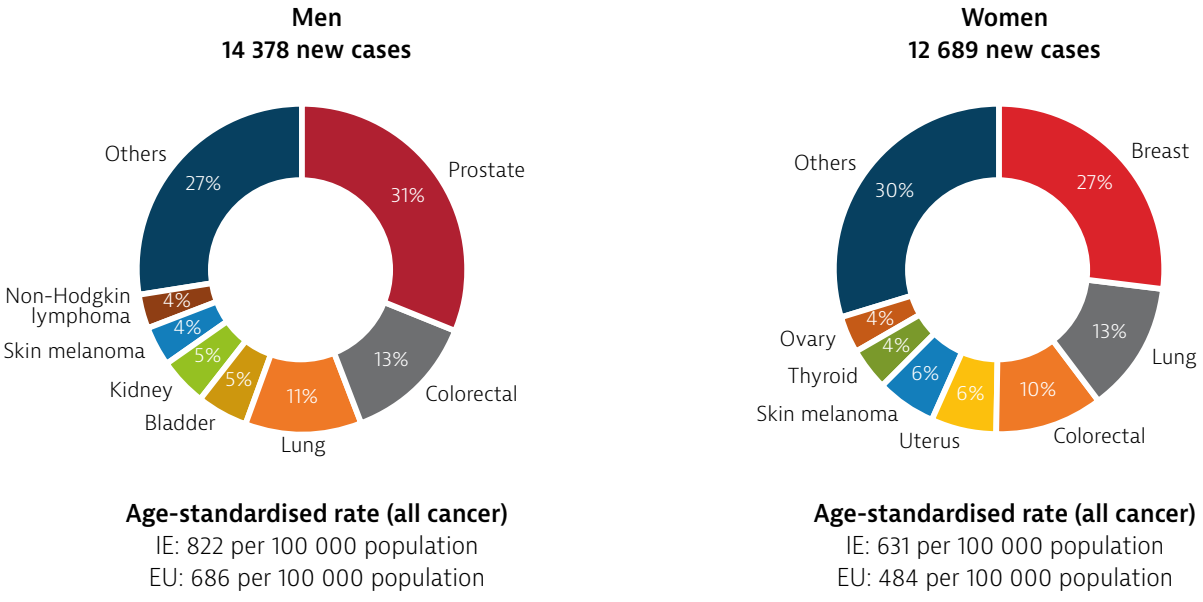
Note: 1. The shares for the total population and the low-income population are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2019).

The burden of cancer in Ireland is higher than the EU average

According to estimates by the Joint Research Centre based on incidence trends from previous years, an estimated 27 000 new cancers were expected in Ireland in 2020[1], and the age-standardised incidence rate was expected to be the highest in the EU for both men and women (Figure 4). The main cancer sites among men are prostate (31 %), colorectal (13 %) and lung (11 %), while among women these are breast (27 %), lung (13 %) and colorectal cancer (10 %). The high and increasing incidence of cancers is attributed in part to the ageing population and behavioural risk factors – in particular, smoking, alcohol consumption and low physical activity (see Section 3).

In 2018, over 31 000 people died from cancer. The age-standardised mortality rate from cancer was close to the EU average (270 per 100 000 population). Ireland's National Cancer Strategy 2017-26 identified cancer prevention and optimisation of care among priority improvement areas (see Section 5.1).

Figure 4. The most frequently diagnosed cancers in 2020 were expected to be prostate and breast cancers



Note: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

3 Risk factors

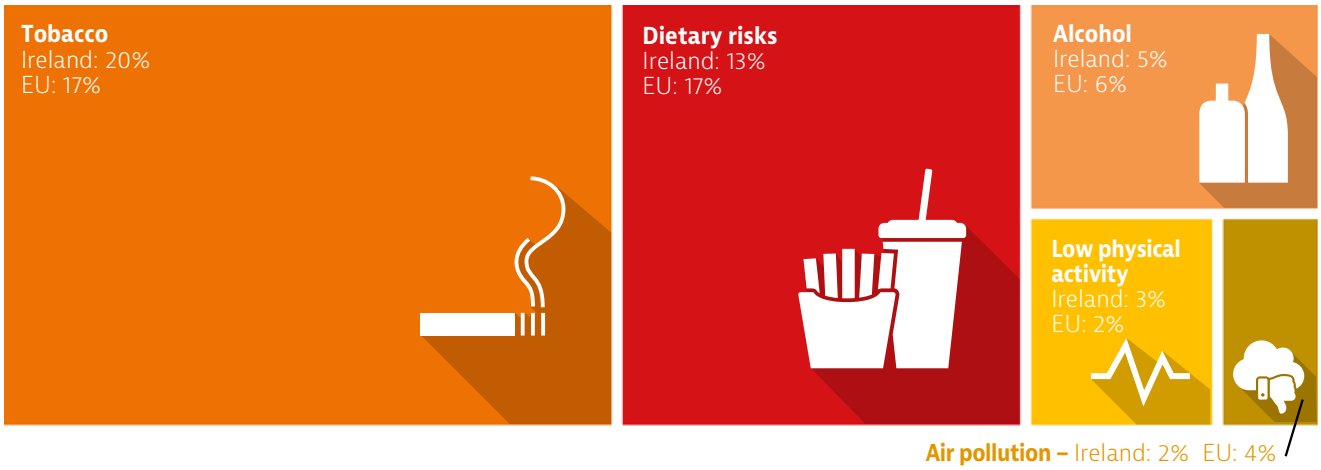
Behavioural risk factors are a major driver of mortality

Over 35 % of all deaths in Ireland in 2019 could be attributed to behavioural risk factors, such as tobacco smoking, dietary risks, alcohol consumption and low physical activity (Figure 5). Some 20 % were related to tobacco smoking (including direct and second-hand smoking) – a share larger than the EU average (17 %). Dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption) were estimated to account for about 13 % of all deaths in Ireland, which is lower than the EU average.

About 5 % of all deaths can be attributed to alcohol consumption, while about 3 % of all deaths are related to low physical activity. Albeit to a lower extent than in other EU countries, environmental issues in Ireland, such as air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure, also had a significant impact on mortality and were responsible for about 2 % of total deaths.

1. It should be noted that these estimates were made before the COVID-19 pandemic; this may have an effect on cancer incidence during 2020.

Figure 5. Tobacco and dietary risks are major contributors to mortality in Ireland



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution includes exposure to $PM_{2.5}$ and ozone alone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Smoking rates among adults in Ireland are below the EU average

Ireland made substantial progress over the past two decades in reducing smoking rates: one in seven Irish adults (14 %) smoked daily in 2019 compared to more than one in four (27 %) in 2002. The rate in 2019 was below the EU average, but still slightly higher than that registered in several Nordic countries (Figure 6). However, use of e-cigarettes has become more popular. In 2019, 5 % of the Irish population reported using e-cigarettes – up from 3 % in 2015 (Department of Health, 2019). Tobacco smoking has also become less popular among adolescents. Only about 10 % of 15-year-olds in Ireland reported that they had smoked cigarettes in the past month in 2018, which is one of the lowest rates in the EU.

Overweight and obesity among adults represent growing public health issues in Ireland

Based on self-reported data, overweight and obesity rates have increased in recent years among adults in Ireland. The rate of obesity increased from 15 % in 2007 to 18 % in 2015, and is above the EU average (16 %)[2]. Among adolescents, 14 % of 15-year-olds were overweight or obese in 2018 – a share lower than in most EU countries.

Low physical activity contributes to overweight and obesity. Only about one in six 15-year-olds reported doing at least moderate physical activity each day in 2018 – a proportion similar to many other EU countries. On a more positive note, adults in Ireland are more physically active than in most EU countries. In 2014, rates of physical inactivity among adults were 27 % in Ireland, compared to the EU average of 36 %. Fruit and vegetable consumption among adults and adolescents are also among the highest across EU countries.

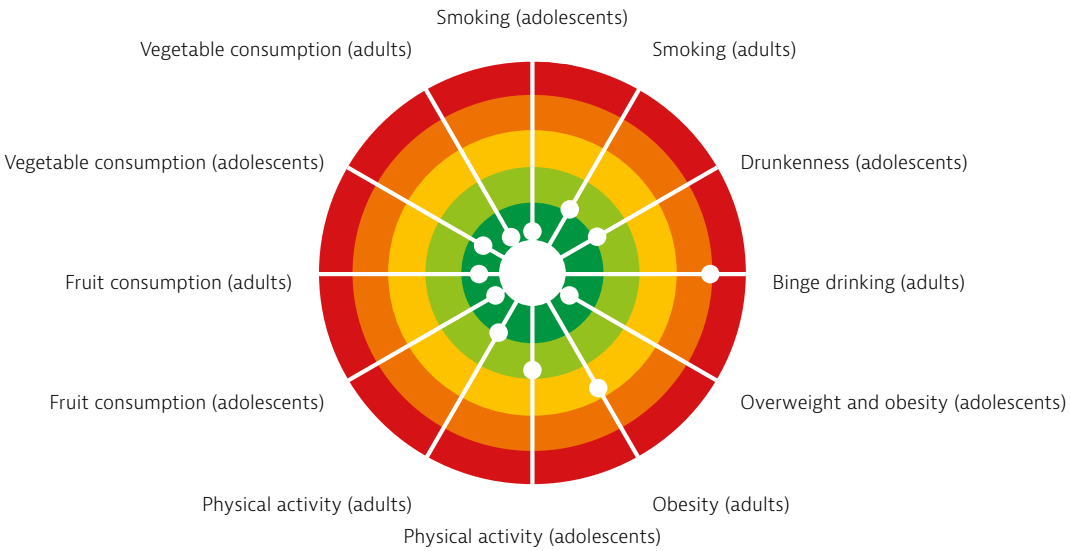
Heavy alcohol consumption is an important risk factor in Ireland

Nearly one quarter of adults (24 %) in Ireland reported regular heavy alcohol consumption (binge drinking[3]) in 2019 – a higher proportion than most EU countries. Rates of binge drinking are more than twice as high for men than women. Consumption per adult was 10.8 litres of pure alcohol in 2019, nearly 10 % higher than the EU average.

Heavy alcohol consumption among 15-year-olds is, however, less widespread in Ireland than across the EU. Only 15 % of 15-year-olds reported that they had been drunk at least twice in their life in 2018, compared with a 22 % EU average (Figure 6). Nonetheless, further progress could be achieved in reducing early drinking initiation and this is a core objective of Ireland's Public Health (Alcohol) Act introduced in 2018. The legislation was an important development in alcohol control policy to curb trends, introducing minimum unit pricing and structural separation of alcohol products in mixed retail outlets, among other provisions that target restricting access to alcohol products by children. However, key elements of this legislation are yet to be implemented as of mid-2021.

2. 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 % between 2007 and 2019.
3. Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.

Figure 6. Adult obesity and alcohol consumption are important 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.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; and EHIS 2014, EHIS 2019 and national source for adults indicators.

4 The health system

Ireland has a national health service, but many people also purchase voluntary health insurance

Ireland has a national health service, funded primarily through general taxation. Almost half the population nevertheless purchase private voluntary health insurance (VHI), primarily to obtain faster access to care for diagnostics, appointments with specialists and elective hospital treatment.

The Department of Health is responsible for providing leadership, policy direction, governance and performance oversight for the health sector, and for allocating the health budget. Management and delivery of publicly funded health and social care services are delegated to the Health Service Executive (HSE), a government agency under the oversight of the Department of Health. Both the Department of Health and the HSE played a central role in coordinating Ireland's COVID-19 pandemic response (Box 1).

The HSE provides health and social care through its own network of providers, including hospitals and community health organisations. A purchaser–provider split is operationalised when the HSE purchases care from private providers (including general practitioners (GPs) and nursing homes) and not-for-profit public hospitals, or when voluntary health insurers pay for care in public facilities.

Most health spending is financed through taxation, but voluntary health insurance also plays a large role

Per capita health spending in Ireland was EUR 3 513 in 2019 (adjusted for purchasing power), which is close to the EU average (Figure 7). Health spending as a share of GDP was 6.7 % in 2019, but reached 11.1 % when measured against gross national income[4] (CSO, 2019).

Revenues for health are predominantly raised through general taxation, supplemented by a universal social charge levied on employees and self-employed workers. Government financing accounted for 75 % of total health expenditure in 2019 – a relatively low share compared to the EU average of 80 %. The share of health spending from out-of-pocket (OOP) payments[5] in 2019 was 11.7 %, which is below the EU average of 15.4 %.

4. 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.
5. OOP payments include direct payments, cost-sharing for services outside the benefit package and informal payments.

The proportion of expenditure from VHI schemes was 14 %, which is the second highest in the EU after Slovenia, and almost three times higher than the EU average (4.9 %). In Slovenia, VHI is primarily used to cover co-payments and plays a complementary role, whereas in Ireland it is supplementary, providing people with faster access to care and some cover for co-payments.

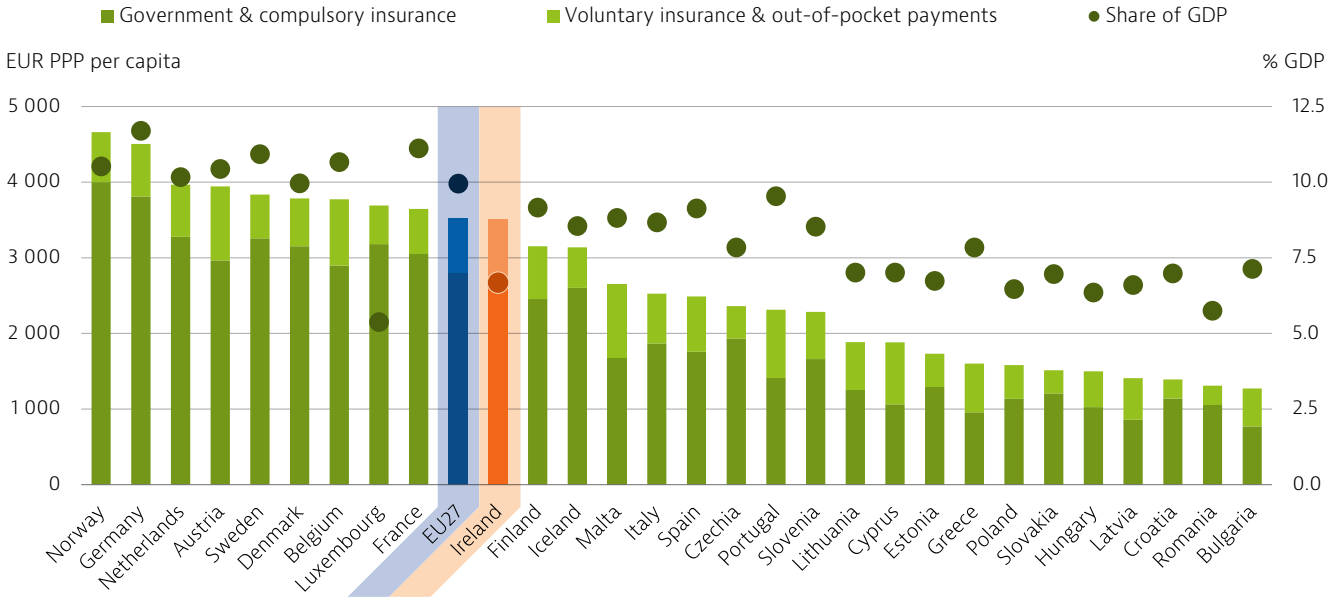
Box 1. Ireland responded to COVID-19 with a public health-led, whole-of-government approach

Ireland's response to COVID-19 was centrally coordinated, with national leadership provided by the Department of the Taoiseach (Prime Minister), in collaboration with the Department of Health and HSE. A National Public Health Emergency Team for COVID-19 was formed in January 2020, chaired by the Chief Medical Officer and comprising more than 30 medical, scientific and health service professionals and experts. The Team is supported by a multidisciplinary Coronavirus Expert Advisory Group and 10 subgroups that focus on areas including epidemiological modelling, vulnerable groups, acute hospital preparedness, medicines and health care workers (see Section 5.3).

The Team also works closely with the HSE National Crisis Management Team and Crisis Communications Group. A trans-partisan Special Cabinet Committee on COVID-19 chaired by the Taoiseach and supported by government officials from all departments and other agencies was also formed to ensure implementation of a whole-of-government response.

Sources: COVID-19 Health Systems Response Monitor; Kennelly et al. (2020); Government of Ireland (2020a).

Figure 7. Per capita health spending in Ireland is close to the EU average



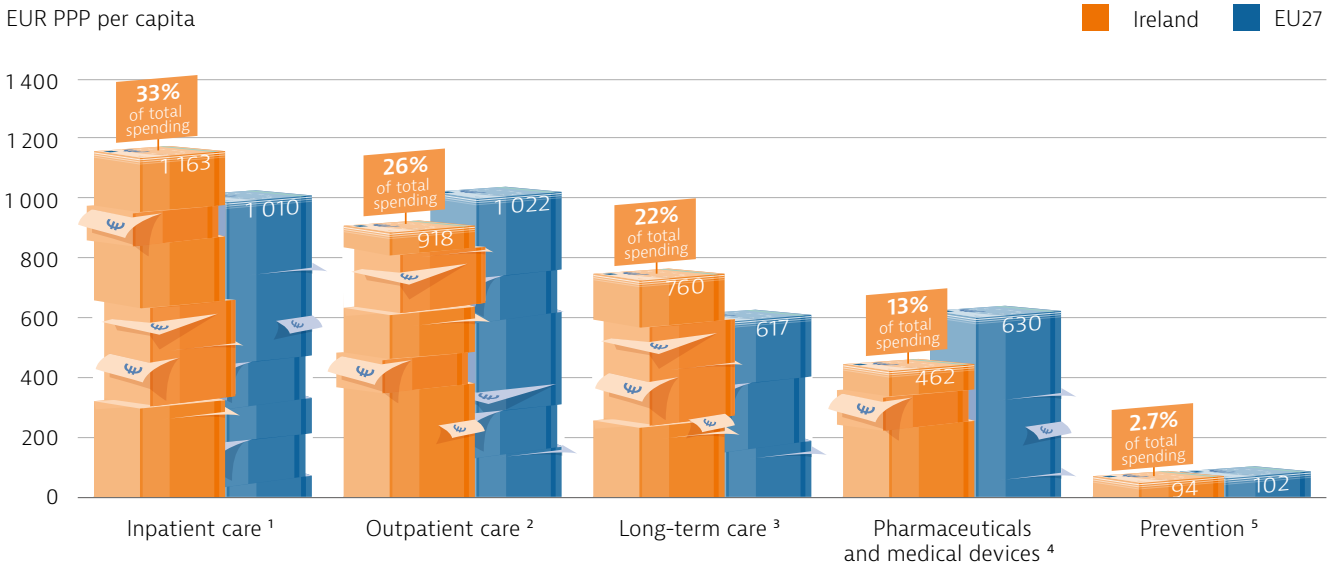
Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta and Iceland 2018).

Spending on inpatient care and long-term care in Ireland is relatively high

Inpatient care was the largest category of health spending in Ireland in 2019, accounting for one third of the total (Figure 8). A quarter of health spending was allocated to outpatient care – the fourth lowest share in the EU. Per capita spending on long-term care was 20 % higher than the EU average. In contrast, per capita spending on outpatient pharmaceuticals and medical devices was 27 % lower than the EU average.

Spending on prevention in 2019 was below the EU average, but Ireland increased funding allocated to prevention activities and other health sector functions during the COVID-19 pandemic (Box 2).

Figure 8. Spending on prevention and pharmaceuticals and medical devices is lower than EU averages



Note: The costs of health system administration are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes only the health component; 4. Includes only the outpatient market; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

Box 2. Ireland committed a record amount of funding to the health sector during the pandemic

Just under EUR 5 billion in additional funding was allocated to the health sector in Ireland during the COVID-19 crisis to support the pandemic response and to help address longstanding systemic issues. In March 2020, EUR 435 million was allocated to support the HSE in strengthening public capacity for testing and contact tracing; freeing up bed space in hospitals by purchasing additional bed space from private hospitals; increasing the health workforce and National Ambulance Service capacity; centralising procurement of medical technologies; and supporting remote monitoring of patients and remote consultations.

The Winter Initiative in September 2020 saw an additional EUR 600 million committed to the health service, to ensure it had the capacity and resources to continue responding effectively to COVID-19 during the winter months. EUR 4 billion was later committed in the 2021 budget (Department of Health, 2020). Approximately EUR 1.6 billion is for COVID-19 expenditure, with more than half allocated for substantial development of health and social care services, in line with Ireland's Sláintecare reform programme, which aims to deliver universal health coverage (see Section 5.2). This places emphasis on strengthening the public health workforce – including public health doctors, nurses, scientists and support staff – as an investment in the future development of public health in Ireland.

Coverage for publicly funded health care in Ireland is not universal

Ireland does not offer universal entitlement to public health care. The population is divided into two main entitlement categories: category I – those who qualify for medical cards (32 % of the population in 2021) and category II – those without medical cards (McGlacken-Byrne, Parker & Burke, 2021).

Category I medical cardholders are primarily determined on the basis of income through means-testing. A small number of people obtain discretionary medical cards on the basis of "undue hardship", no matter their income. People with medical cards have access to free primary and hospital care and minimum dental care without charge. They do, however, pay a prescription charge or levy of EUR 1.50 per item (EUR 1.00 for people over 70), up to a maximum of EUR 15 (EUR 10 for people over 70) per month per capita or family. Asylum seekers are entitled to the same range of health services as category I card holders.

Two other schemes provide additional benefits. One is a "GP visit card", which covers GP charges but not medicines for all children under 6, adults over 70 and some people on low incomes: the income threshold to obtain it is higher than the medical card threshold. As of 2021, around 10 % of the population had GP visit cards (McGlacken-Byrne, Parker & Burke, 2021). The second is the Long-Term Illness Scheme, which provides free medicines and appliances for people living with certain chronic conditions, regardless of income.

The majority of the population is not covered by a medical card, a GP visit card or the Long-Term Illness Scheme, and must pay the full cost of GP visits, outpatient prescriptions (up to monthly thresholds), outpatient medical supplies and dental care. Care in public hospitals in Ireland is provided free of charge or at reduced cost for all residents. However, extremely long waiting lists and waiting times in the public system and user charges mean that many people buy VHI to receive expedited access to hospital care and diagnostics, creating a de facto two-tier health care system (see Section 5.2). This context is partly responsible for many inequalities in the Irish health care system, which are addressed by the Sláintecare reform programme and its aim of universal health care.

People in category II are subject to co-payments for primary and hospital care (see Section 5.2). Primary care user charges include fees per GP visit (EUR 40-60 per visit) (Johnston, Thomas & Burke, 2020), with no annual cap – a situation that is exceptional in western Europe. For inpatient services, a charge of EUR 80 per day is applied, up to a maximum of EUR 800 per capita per year. Emergency department visits without a GP referral cost a fixed co-payment of EUR 100 per visit. People without a medical card pay a maximum of EUR 114 per month for prescription medicines per family. Individuals without a medical card can apply for a "drugs payment scheme card", which covers fees exceeding this amount. All COVID-19-related treatment, testing and remote GP assessments during the pandemic were available to all residents free of charge.

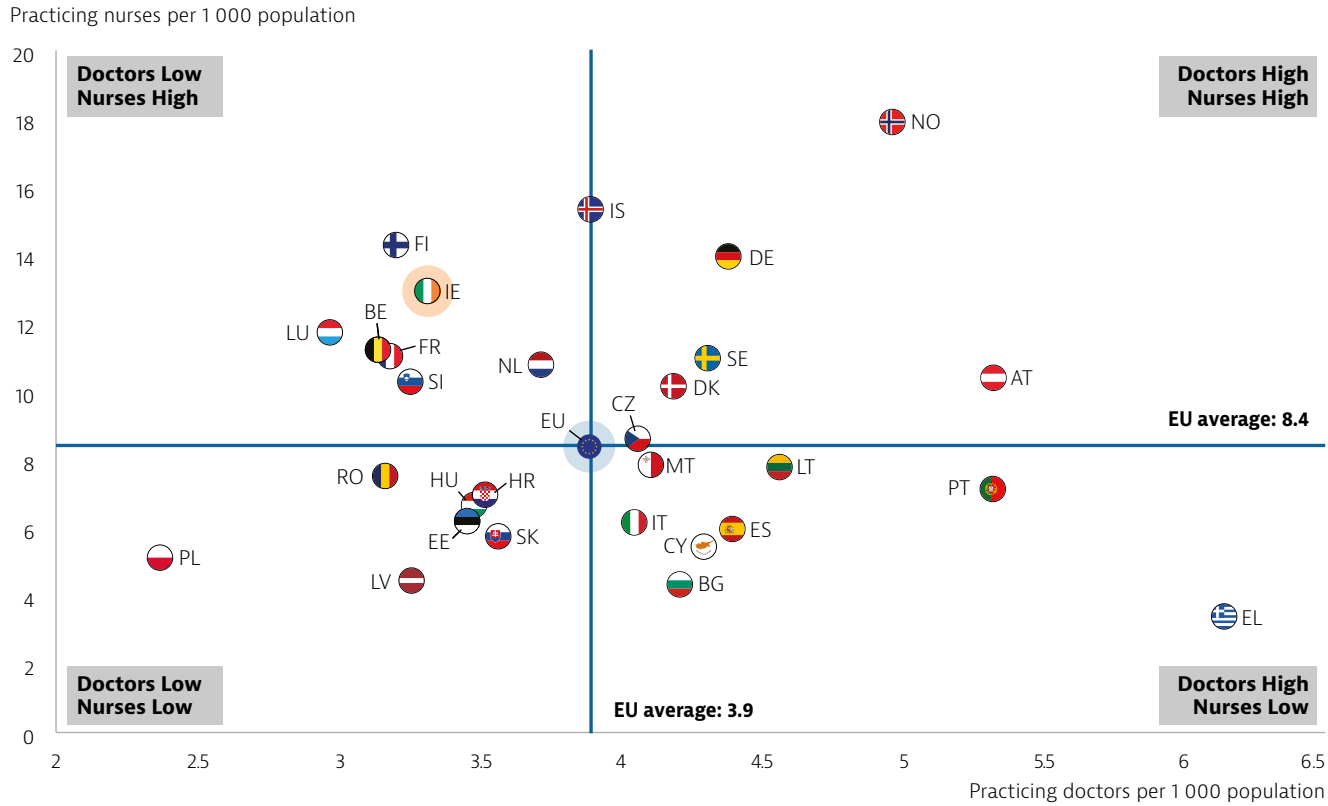
Although VHI provides some relief from user charges, this is dependent on the type of plan purchased. For example, some plans cover some GP visit user charges, but most do not cover the cost of medicines and long-term care. Premiums have increased substantially over time, rising by 7-12 % a year on average (from EUR 671 per policy on average in 2007 to EUR 1 048 in 2012 and EUR 1 177 in 2016). While 46 % of the population has VHI, about 20 % has neither VHI nor a medical card.

Ireland faces a shortage of doctors and nurses, but has plans to recruit substantial numbers

Ireland has a shortage of doctors and nurses. The number of doctors was 3.3 per 1 000 population in 2019 – the sixth lowest rate in the EU (Figure 9). While the number of nurses (12.9 per 1 000 population) was above the EU average (8.4), this number has declined in the past 10 years, and many nurses work part time. As a result, Ireland is increasingly reliant on recruiting foreign-trained doctors and nurses. Paradoxically, Ireland has had the highest number of medical graduates per capita among all EU countries in recent years, with about 25 new graduates per 100 000 population each year. However, many of these medical graduates are international students with limited opportunities to complete their postgraduate training and practice in Ireland.

The 2021 budget committed new funding to support the recruitment of up to 16 000 new staff across the health sector. Additionally, Sláintecare aims to increase the number of doctors in public hospitals through a public-only contracting scheme.

Figure 9. Ireland has a relatively high number of nurses, but a relatively low number of doctors



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2019 or the nearest year).

Reforms are under way to strengthen primary care and address capacity issues in hospitals and the community

Secondary and tertiary care in Ireland are predominantly provided in public hospitals. The majority of GPs are private practitioners who provide care for private fee-paying patients or public patients with medical cards or GP visit cards when contracted by the government. GPs act as initial gatekeepers to secondary care.

Public hospitals and primary care in Ireland face severe capacity constraints. The number of hospital beds in 2019 (2.9 per 1 000 population) was the third lowest in the EU. Pre-COVID-19, hospitals frequently ran at 95 % occupancy rates – above the capacity considered safe. The Sláintecare reform programme aims to strengthen primary care and address capacity issues in hospitals, with record funding in the 2021 budget committed to support this reform agenda (see Section 5.3).

5 Performance of the health system

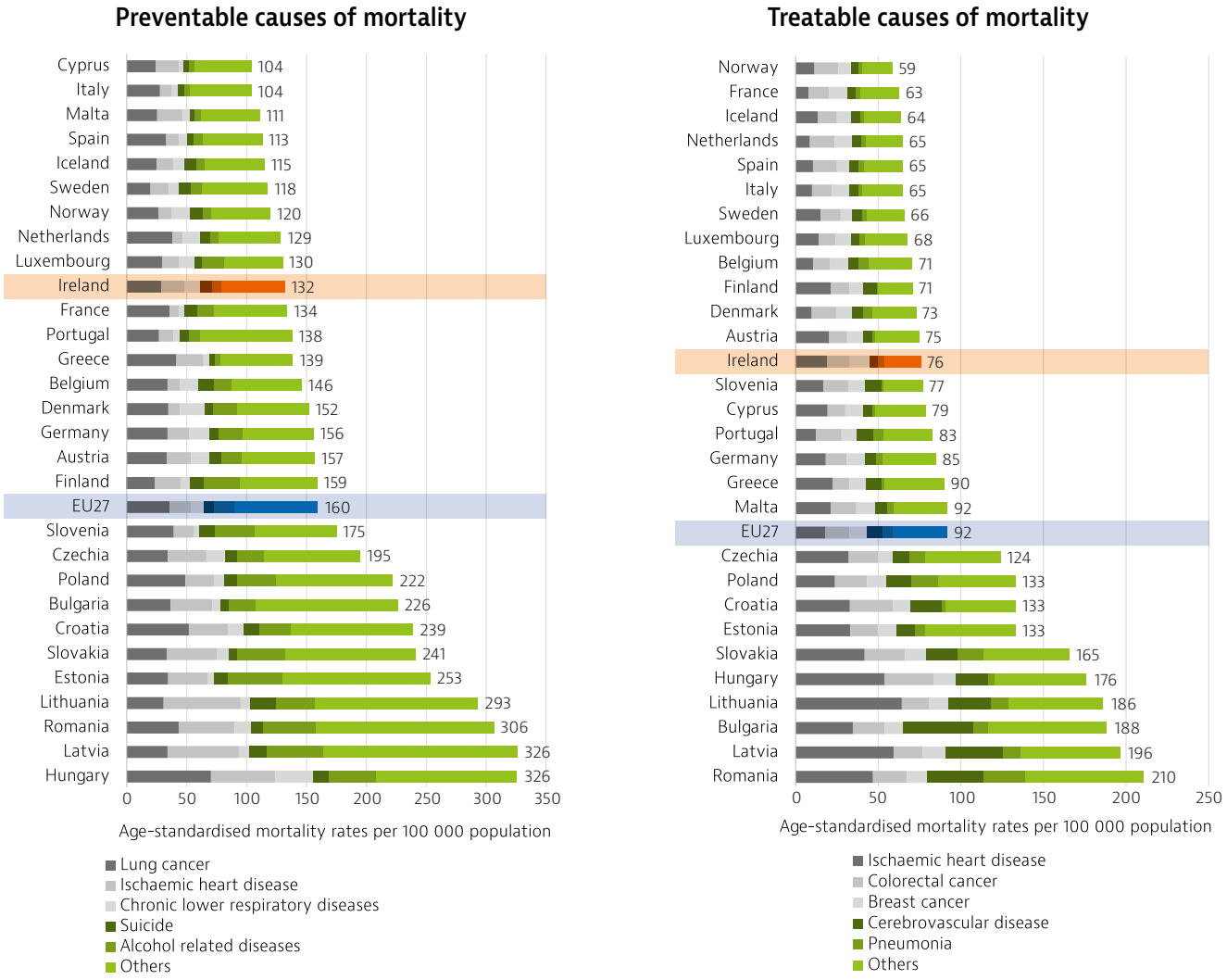
5.1 Effectiveness

Ireland performs well on treatable and preventable causes of mortality among EU countries

The Irish health system fares better than those of many other EU countries in avoiding mortality from preventable and treatable causes (Figure 10). In Ireland, the leading causes of death that could be avoided through public health and prevention interventions are lung cancer (29 deaths per 100 000 population, compared with 36 in the EU as a whole) and ischaemic heart disease (19 deaths, compared with 18 in the EU). The risk of developing both these conditions is in part related to smoking – the most prevalent behavioural risk factor in the country (see Section 3).

Mortality from treatable causes is also far below the EU average. The leading causes of death that could be avoided by timely health care interventions include ischaemic heart disease, colorectal cancer and breast cancer.

Figure 10. Mortality rates from preventable and treatable causes are lower than the EU averages



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2018, except for France 2016).

Robust rollout of Sláintecare could strengthen the effectiveness of the health care system

Ireland's Sláintecare reform programme (2019-28) aims to transform how health and social care services are delivered. It includes increased allocation of funds to support the Healthy Ireland initiative (running since 2013), which prioritises public health interventions to address the main drivers of preventable deaths, such as those set forth by the National Obesity Policy and Action Plan and Tobacco Free Ireland. In May 2021, the Sláintecare Implementation Strategy & Action Plan 2021-23 was published (Government of Ireland, 2021a). In September 2021, the two most senior people responsible for implementing Sláintecare resigned. The impact these resignations will have on Sláintecare's implementation is unknown.

To inform the decisions of policy makers and other key stakeholders, but also to improve the effectiveness of the health care system, Ireland has invested in developing an outcome-oriented health system performance assessment framework. This aims to enhance accountability and support monitoring of progress towards Sláintecare objectives.

Tobacco control policies have been contributing to reductions in smoking rates

Tobacco Free Ireland, the national tobacco control policy, was developed in 2013 with the aim of achieving a reduction in smoking prevalence to less than 5 % of the population by 2025. Within its scope, standardised (plain) packaging of all tobacco products was fully introduced in 2018, making Ireland one of the first European countries to do so (Department of Health, 2019).

Work on drafting a Public Health Bill is ongoing. The proposed legislation will introduce a licensing system for the retail sale of tobacco and nicotine inhaling products and prohibit the sale of tobacco products to people under 18, including those available from self-service vending machines and mobile units, and at events.

More influenza vaccines were ordered in 2020, but uptake among older people remains a challenge

The influenza vaccine is administered free of charge for children under 17, pregnant women, health care workers and people aged 18 and over who have a medical card or GP visit card. Historically, however, vaccination uptake falls below the WHO target of 75 % of people aged 65 and over, with 59 % coverage of this target group in the 2019/20 season. There were important variations in influenza vaccination uptake among older people across geographical regions (HSE, 2020a) (Figure 11). Uptake among medical card and GP visit card holders aged 65 and over also varied between 38 % and 82 % among local health offices.

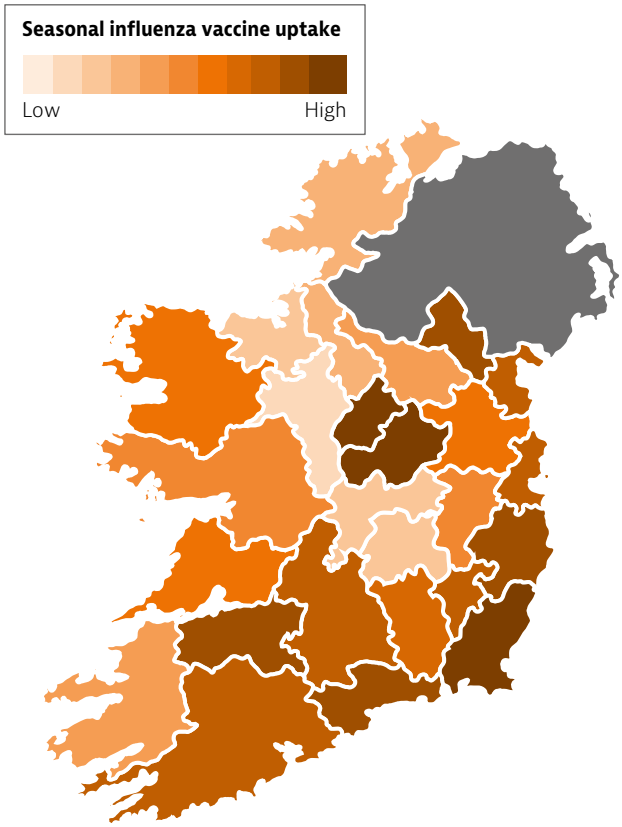
The COVID-19 pandemic increased the importance of vaccination against seasonal influenza, particularly for groups most at risk. For the 2020/21 influenza vaccination season, the HSE purchased nearly 2 million doses, doubling the number of vaccines administered during the previous season. To address potential shortages due to demand, priority tiers were established, with the highest priority given to people aged 65 and over and health care workers.

Sláintecare aims to strengthen integrated care and chronic disease management

In Ireland, hospital admission rates for some chronic conditions such as congestive heart failure and diabetes are lower than the EU average (Figure 12).

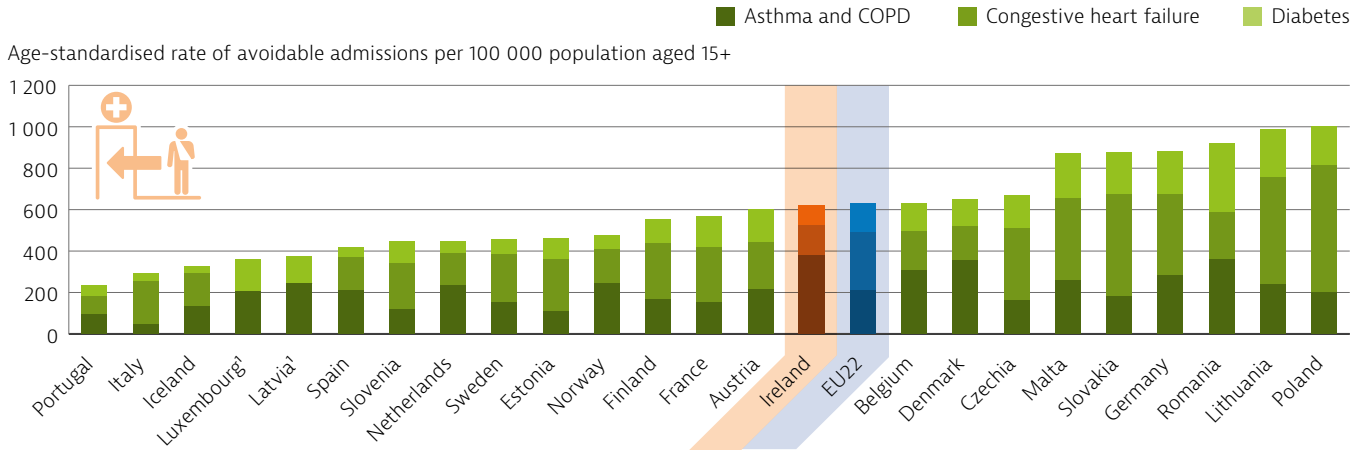
However, potentially avoidable hospital admission rates for asthma and COPD (378 admissions per 100 000 population aged 15 and over) are the highest among EU countries. The current Sláintecare reform programme aims to reorient the health care system towards a more integrated primary and community care approach, while striving to empower people to manage their own chronic condition and care needs better.

Figure 11. Seasonal influenza vaccine uptake shows some geographical variation



Note: Data are provisional and refer to the period of September 2019 to May 2020.
Source: HSE (2020a).

Figure 12. Avoidable hospital admissions for chronic conditions are greater than in many EU countries



Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Five-year cancer survival rates are at least as high as the EU average

In Ireland, the National Screening Service runs free population-based screening programmes for breast, cervical and colorectal cancers. These programmes are based on a call/recall system, where eligible people are invited to be screened and clinical services are provided for further investigation and treatment of people identified as at risk of having or developing the disease.

Ireland performs as well or better than the EU average for five-year cancer survival rates for common cancers (prostate, breast, cervical, colon and lung) and childhood leukaemia (Figure 13).

Figure 13. Ireland performs well compared to other EU countries for five-year cancer survival rates

Prostate cancer
Ireland: 91 %
EU23: 87 %

Childhood leukaemia
Ireland: 88 %
EU23: 85 %

Breast cancer
Ireland: 82 %
EU23: 82 %

Cervical cancer
Ireland: 64 %
EU23: 63 %

Colon cancer
Ireland: 61 %
EU23: 60 %

Lung cancer
Ireland: 18 %
EU23: 15 %

Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

Ireland has an ambitious cancer strategy that is aligned with other ongoing programmes

The National Cancer Strategy 2017-26 builds on lessons learned from the previous strategy for cancer control, where key gaps were flagged, such as limited capacity and resources, insufficient support for cancer patients after diagnosis – including survivorship programmes and psychosocial services – and need for greater coordination and integration across the health care system. The Strategy aims to strengthen prevention and survivorship care programmes, establish effective clinical pathways, involve patients in the planning and delivery of cancer care, and strengthen governance and accountability mechanisms. The National Cancer Strategy is aligned with the European Commission's Europe's Beating Cancer Plan (European Commission, 2021). At the national level, the Strategy links to other ongoing programmes, such as the Healthy Ireland initiative, which is designed to tackle key risk factors (see Section 3).

The COVID-19 pandemic strongly affected cancer screening and treatment in Ireland

The health system was overwhelmed and many patients were hesitant to seek non-COVID-19 care during the pandemic; this may have caused a large number of missed diagnoses and delayed treatments. During the initial phases of the pandemic, many screening programmes in Ireland were paused, affecting the number of cancers detected compared to the same period prior to COVID-19. For example, from January to September 2020, there were 371 (9.5 %) fewer lung, breast and prostate cancer detections compared to the same period in 2019 (Crowley & Hughes, 2021).

The effects of the pandemic were also observed on cancer treatments. In the first phase, a reduction of 12.5 % (668) of cancer resections occurred relative to 2019, and from January to April 2020, 67 % fewer patients attended chemotherapy sessions in Irish public hospitals compared to the same period in 2019. At the end of August 2020, activity was still at 85 % of 2019 levels.

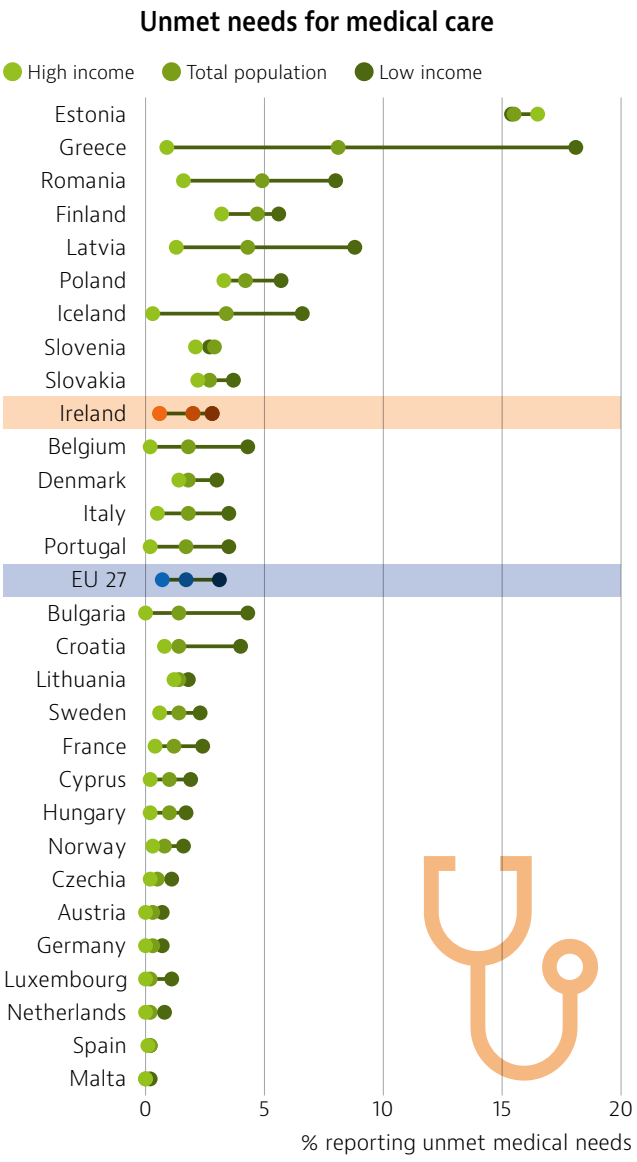
5.2 Accessibility

Unmet needs for medical care are similar to the EU average, but low-income groups are most affected

Unmet medical needs can be due to a variety of reasons, but in general the key drivers are those related to cost, waiting times or travel distance. In Ireland, unmet needs for medical care are low, according to EU-SILC survey data: 2 % of the population reported unmet needs for medical care in 2019 (Figure 14). There are gaps according to sex, with 2.4 % of women reporting unmet medical needs compared to 1.6 % of men. In addition, distribution of unmet care needs among income groups is unbalanced: the share is larger in the lowest income quintile (2.8 %) than the highest (0.6 %). The two main reasons for people in the lowest income quintile reporting unmet needs for medical examinations are waiting lists (1.6 %) and costs (1.2 %).

When considering other survey instruments such as the European Health Interview Survey, Ireland had the second highest rate of unmet needs for medical care due to cost, waiting times or travel distance among EU countries in 2014, at 40.6 %, which is substantially higher than the EU as a whole (26.5 %). These differences may be explained by differences in the methodologies used by each instrument.

Figure 14. Unmet needs for medical care are similar to the EU average, but the income gap is wider



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 2019, except Iceland 2018).

People in low-income groups reported lower unmet needs for dental care than the EU average

Unmet needs are greater for services that are less covered, such as dental care. The Department of Social Protection pays the full cost of one oral examination annually to supplement the limited provision of free dental treatment for medical card holders by the HSE. Those who do not qualify for a medical card need to visit a private dental provider and apply for tax relief on existing medical expenses via current tax return mechanisms, but these are only available for some specialised dental treatments.

The share of people reporting unmet needs for dental examinations was 2.4 % in 2019, which is slightly lower than the 2.8 % EU average. The lowest income group reported the largest share, at 3.7 %, compared to 0.4 % among the highest income group. . Improvements are expected in the coming years if the rollout of a new national oral health policy meets its targets. It seeks to provide free dental care to children up to the age of 16 and medical card holders.

One fourth of the population were unable to access care when needed due to COVID-19

The pandemic limited access to care for those with health conditions not related to COVID-19. Unmet needs for medical care because of delayed or missed consultations are likely to lead to poorer health outcomes in the future. A European-wide survey found that during the first 12 months of the pandemic, 26 % of the Irish population had forgone medical care, which is above the EU average of 21 % (Eurofound, 2021)[6].

Strong inequalities in access persist, but Sláintecare aims to provide universal health care

Ireland's category system to determine the package of entitlements is reflected in a slightly narrower share of public spending for several health services and goods relative to other EU countries. Nearly half of the population (46 %) has private health insurance, which allows timely access to aspects of care to those who can afford it. This supplementary use of VHI undermines equity and efficiency in the health system in several ways, including through the presence of substantial tax subsidies that benefit those who are able to spend more rather than targeting those with lower incomes (Johnston, Thomas & Burke, 2020). To address these inequalities, one of the aims of the Sláintecare reform programme is the establishment of a universal, single-tier health service, providing universal access to health services in Ireland.

6. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

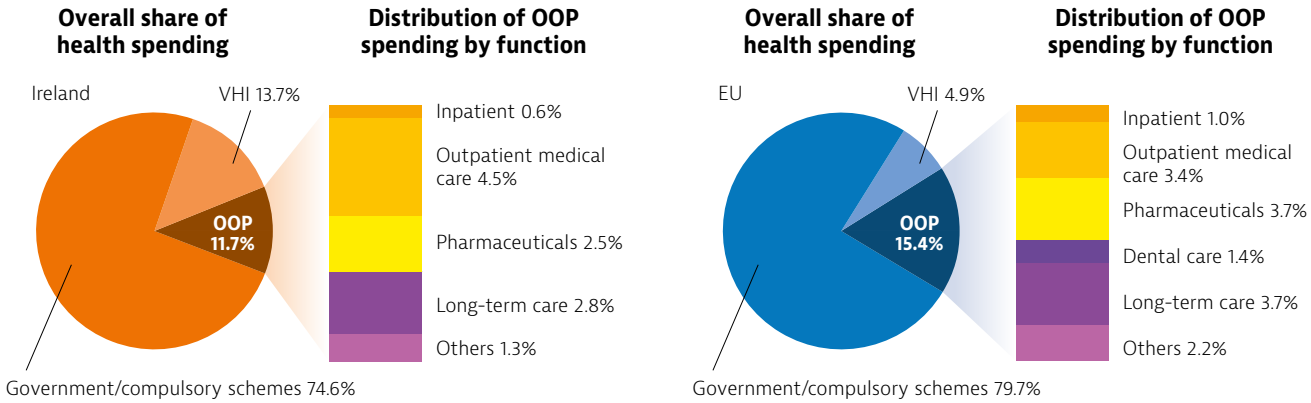
Out-of-pocket spending is mostly on primary care, despite initiatives to increase coverage

Ireland has a relatively low incidence of catastrophic[7] health spending: 1.2 % of Irish households experienced catastrophic OOP payments in 2015/16 (latest available data). The degree of protection for poor households is high relative to other EU countries and reflects the fact that the poorest 32 % of the population (medical card holders) have free access to most health services (Johnston, Thomas & Burke, 2020). The overall level of OOP expenditure as a share of total health spending is slightly lower than the EU average, at 11.7 % compared with 15.4 % in 2019 (Figure 15).

More than one third of OOP expenditure goes on outpatient medical care (38.5 % in 2019). OOP spending in this category is high because GP and other primary care services have to be paid for (except by expectant mothers and individuals who qualify for the GP visit card based on income eligibility criteria – see Section 4). Other important categories of OOP spending in Ireland are related to long-term care (24 %) and pharmaceuticals (22 %).

Ireland has one of the largest VHI markets in the EU, covering close to half of the population and accounting for 14 % of total spending on health. Despite its potential to reduce exposure to OOP spending, VHI represents a significant financial burden on households, accounting for around 3 % of household spending on average in 2015-16.

Figure 15. Outpatient medical care accounts for the largest share of out-of-pocket payments



Note: The EU average is weighted. VHI also includes other voluntary prepayment schemes.
Source: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

The COVID-19 pandemic supported increased uptake of telemedicine

The COVID-19 pandemic disrupted regular care delivery, presenting a challenge for providing care while meeting physical distancing measures. To overcome this, telemedicine services were increased, including the launch of a new secure communication portal (EireCare) by the HSE, linking GPs and other primary care providers with patients. In addition, as part of an emergency amendment to the Medicinal Products Regulation to respond to the COVID-19 pandemic, e-prescribing became universal in the early weeks of the pandemic.

According to the Eurofound survey, in the first 12 months of the pandemic in Ireland, 66 % of people received medicine prescriptions online or by telephone (compared with the EU average of 53 %), and 60 % received a medical consultation online or by telephone (versus 39 %). Patients were not charged for most telemedicine services during the pandemic, and all COVID-19-related teleconsultations with GPs for the whole population remained free at the point of use, which may partly explain the high adoption rates among patients.

7. Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).

Measures have been taken to address medicine shortages in Ireland

Medicine shortages put patients at increased risk. In 2018, the Health Products Regulatory Authority in Ireland published a medicines shortages framework for a multi-stakeholder approach to handle shortages of human medicinal products (HPRA, 2018). This aims to prevent shortages from occurring and to minimise the impact of shortages on the health of the population. Considering the importance of guaranteeing access to medicines to those who need it, the European Commission (2020) adopted a new pharmaceutical strategy for Europe. This is mirrored in Ireland's National Recovery and Resilience Plan, which supports the rollout of a nationwide e-pharmacy system that will, among other things, monitor hospital pharmacy inventories and costs (see Section 5.3).

5.3 Resilience

This section on resilience[8] focuses mainly on the impacts of and responses to the COVID-19 pandemic. As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Ireland in 2020 and first eight months of 2021, as in most other EU countries. , and the measures taken to contain the pandemic also affected the economy. Despite this, Irish GDP grew by 3.4 % in 2020 – mostly fuelled by the export sector (CSO, 2021).

Ireland responded to the COVID-19 pandemic with national and regional infection control measures

The first case of COVID-19 infection in Ireland was confirmed at the end of February 2020, and the first death on 11 March – the day WHO declared COVID-19 a pandemic. By the end of August 2021, 350 000 people (about 7.1 % of the population) had been diagnosed with COVID-19 (confirmed through a laboratory test) – a lower rate than the EU average (8.2 %). In the same period, 5 100 deaths occurred among confirmed cases, and the death rate was about one third lower than the EU average.

From mid-March 2020, Ireland introduced a series of containment measures, starting with closures of schools and restrictions on large gatherings, followed by closures of businesses and amenities. A first nationwide stay-at-home order was implemented on 27 March, requiring the public to remain within 2 km of home. A steady reduction in the number of COVID-19 cases followed (Figure 16).

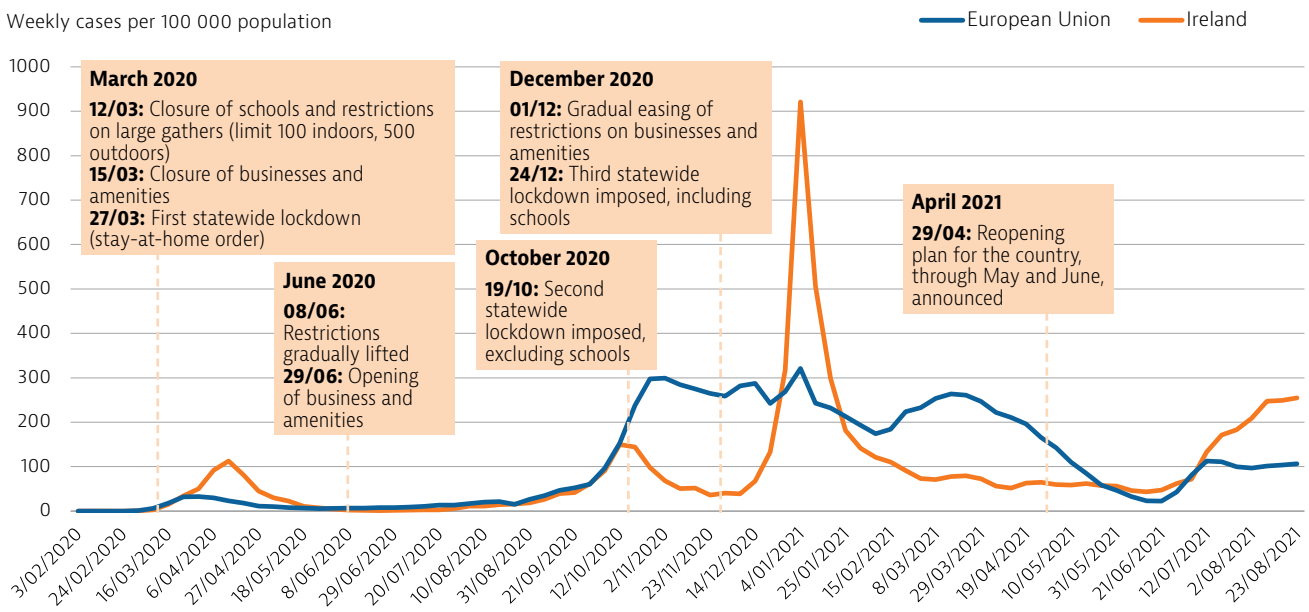
During summer 2020, the containment measures were gradually loosened, which led to a slow but steady rise in new cases in August 2020. Local outbreaks in settings such as meat processing plants and accommodation centres for asylum seekers led to geographically targeted containment measures. As the number of cases continued to grow, a second nationwide set of containment measures were introduced in October 2020. Measures did not include closing schools this time but achieved the desired effect of curbing COVID-19 transmission.

The relaxation of infection control measures in early December 2020, together with the higher prevalence of new variants, led to a third wave between December 2020 and February 2021. In the span of a few days, Ireland went from having one of the lowest COVID-19 cases per capita in the EU to the highest in the world, at 921 weekly cases per 100 000 people in early January 2021. An extension of strict stay-at-home orders and expanded testing capacity helped curb the third wave by early February 2021. On 29 April 2021, the government announced a reopening plan for the country throughout May and June.

During 2020 and 2021, the Irish government developed and made publicly available a series of COVID-19 resilience and recovery roadmap documents. These were influential to COVID-19 management plans in other European countries. During the first wave, they brought some clarity to help citizens, businesses and health care providers plan for the medium term. However, over time, the success of the plans was limited by their multiplicity and by many changes made to them, exacerbating fatigue and frustration among citizens.

8. *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

Figure 16. Ireland used three nationwide stay-at-home orders in 2020 to contain virus transmission



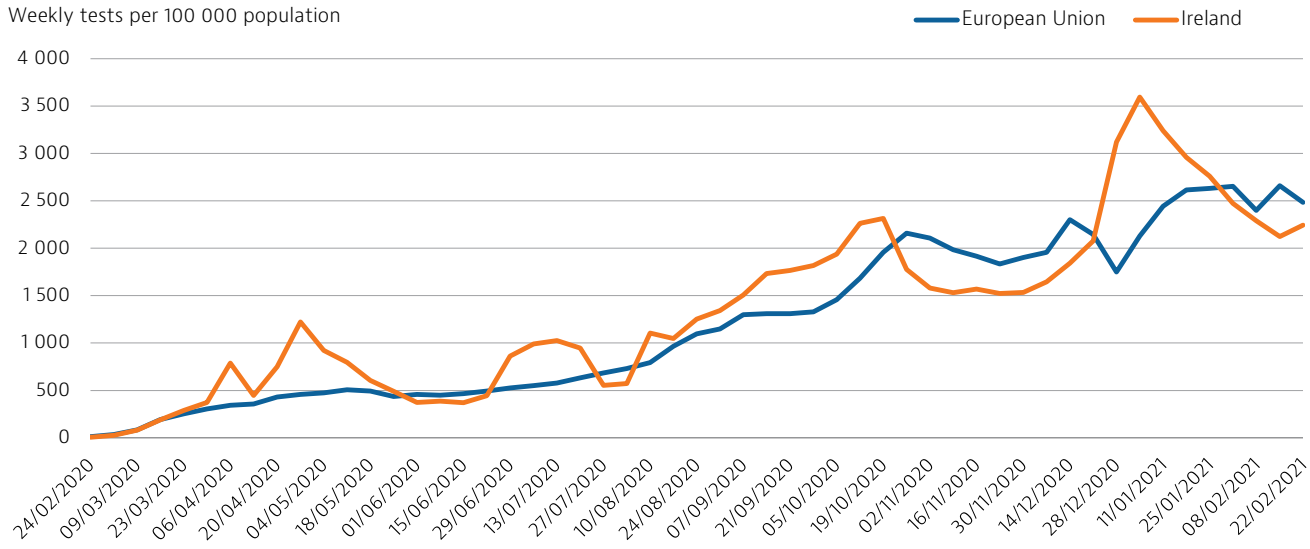
Notes: The EU average is unweighted (the number of countries included in the average varies depending on the week). The number of COVID-19 cases in EU countries was underestimated during the first wave in spring 2020 due to more limited testing. Ireland temporarily stopped testing close contacts in January 2021, as the system could not cope with the numbers being referred.
Sources: ECDC for COVID-19 data and authors for containment measures.

Testing capacity was scaled up, but keeping pace with infection rates proved challenging

Ireland successfully scaled up testing capacity and, by May 2020, surpassed the EU average of weekly number of tests performed (Figure 17). However, infection rates in the community during the first and third waves in 2020 placed the testing system under very significant strain to meet demand (Figure 18).

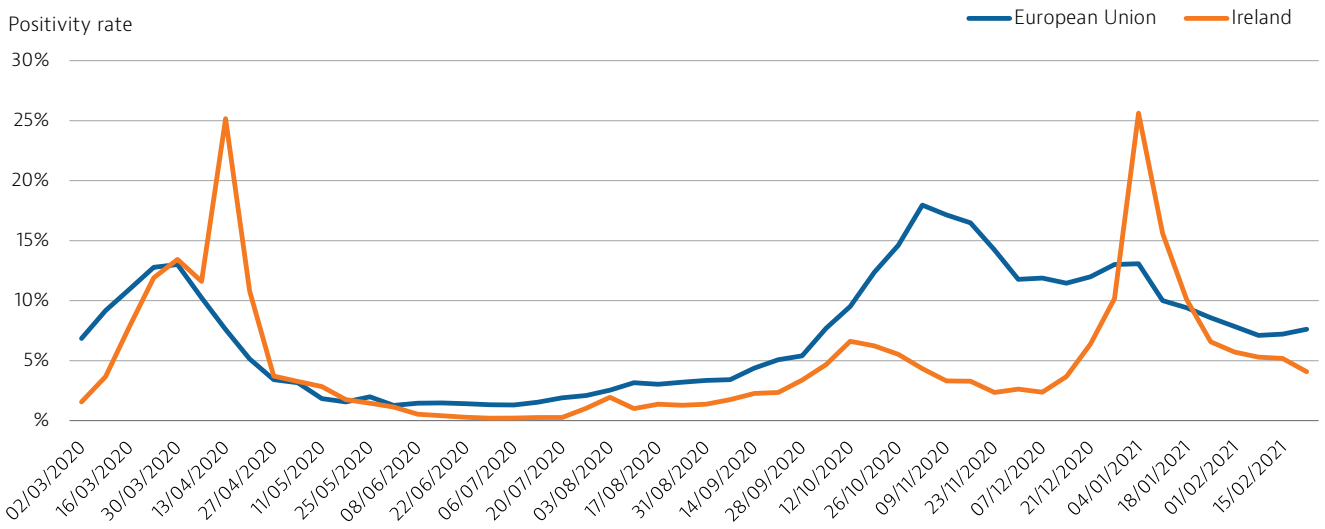
Positivity rates from testing occasionally reached one in four, including in April 2020 and January 2021. Multiple strategies were employed to prioritise testing, including scaling up testing capacity, outsourcing laboratory processing of tests to other countries and temporarily limiting community testing to symptomatic patients only.

Figure 17. Ireland scaled up its testing capacity in line with the EU average



Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

Figure 18. The first and third wave positivity rates show testing capacity shortcomings



Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

Ireland secured a high use of its national contact tracing application

The national contact tracing application "Ireland COVID Tracker" was launched on 7 July 2020 and reached 1 million users (25 % of the population over the age of 15) within 48 hours of launching (HSE, 2020b). By February 2021, half the Irish population had downloaded and were registered in the application. Ireland COVID Tracker also became one of the first national apps to be linked through the European interoperability gateway to apps from other countries (Italy and Germany), facilitating cross-border contact tracing functionality (Government of Ireland, 2020a). Following its successful implementation, the app's open source code was published, on a not-for-profit basis, for use in other countries.

While the successful rollout of the app provided a complementary addition to the contact tracing programme, follow-up of suspected contacts, contact management and arrangement of testing struggled to keep pace with demand during peaks of infection. The Irish public health workforce has traditionally been under-resourced, so a separate programme was set up to conduct routine contact tracing. This, at times, caused some difficulties in carrying out effective tracing of more complex cases.

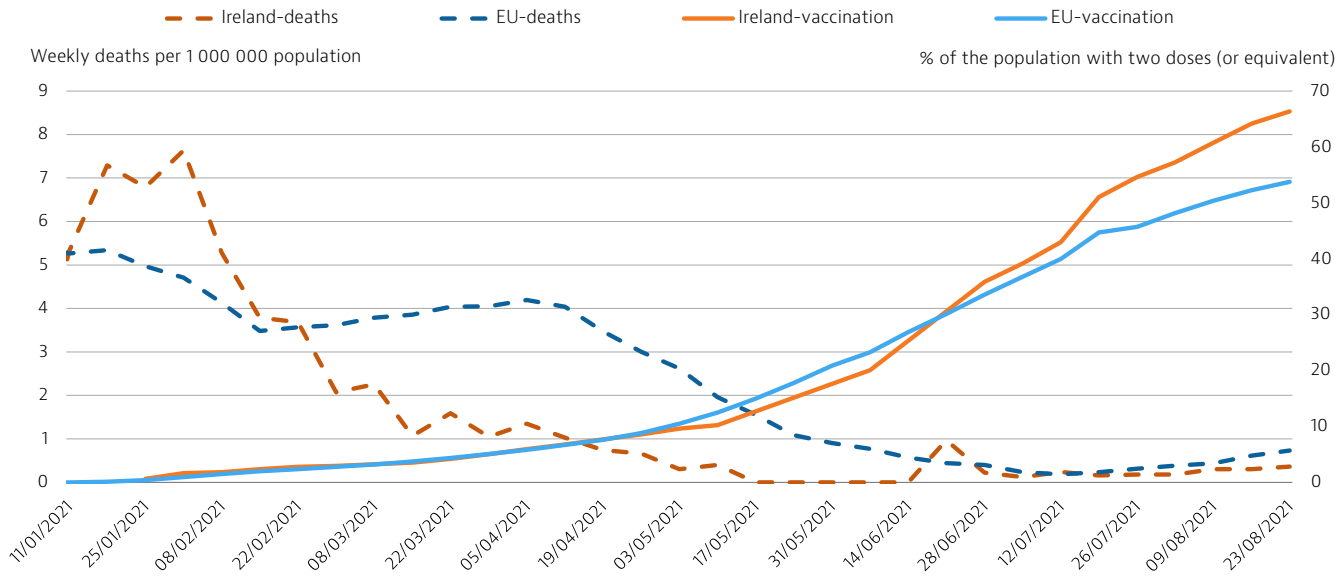
Ireland used recruitment initiatives to ensure an adequate health workforce during the pandemic

The Irish government took a number of actions to maintain and scale up health workforce capacity to respond to the pandemic. Most notably, the number of HSE full-time employees increased from 119 000 to 130 000 between January 2019 and July 2021. Other recruitment initiatives included increasing the hours of part-time staff, maximising agency usage, rehiring retired clinicians, redeploying staff and encouraging those on career breaks to return early (Kennelly et al., 2020).

Ireland's vaccination programme has significantly reduced mortality caused by COVID-19

Following approval of the first vaccines against COVID-19 in late-2020, the vaccination programme started in Ireland on 29 December (HSE, 2021a). Initially, vaccine rollout prioritised vulnerable groups through cohort-based vaccination plans, using an age-based approach. By the end of August 2021, over 6.8 million vaccine doses had been administered (Figure 19), with almost 70 % of the total population receiving two doses (or equivalent) (HSE, 2021b).

Figure 19. Ireland's COVID-19 vaccination rates are higher than the EU average



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and Our World In Data for vaccination rates.

The pandemic led to health information system developments, but a ransomware attack caused disruption

Surveillance of COVID-19 cases was integrated into Ireland's existing national computerised infectious disease reporting system. While the pandemic accelerated developments to the national health information system, the permanence of these changes remains unclear. For example, the unique patient identifier was introduced to monitor COVID-19 patients and assigned to everyone who tested for COVID-19 and received a vaccination. An emergency data hub for researchers to access data about COVID-19 was also developed, through which data from the Central Statistics Office can be accessed. Also, acute care COVID-19 data were made available on a highly granular level to health care providers and researchers (HRB, 2021; Government of Ireland, 2020b).

On 14 May 2021, the HSE suffered a major ransomware cyberattack that caused all its information systems to stop operating nationwide. The attack also resulted in leaks of confidential medical records and corporate documents. The incident caused serious disruption to the functioning of the health care system in general, including its COVID-19 operations (HSE, 2021c).

Ireland's National Recovery and Resilience Plan 2021 paves the way for a sustainable recovery

Following the announcement of the European Commission's Recovery and Resilience Facility recovery package, on 1 June 2021, the Government of Ireland (2021b) published the National Recovery and Resilience Plan 2021. It focuses on 16 investments and 9 reform commitments, with a value of just under EUR 1 billion, until 2026. The plan aims to advance green transition, accelerate and expand digital reforms and focus on social and economic recovery and job creation. One of the priorities includes developing the strategic health care reform agenda set out under Sláintecare, by "committing to the implementation of initiatives which will improve access to care in the community and begin the process of removing private health care from public hospitals". In addition, EUR 75 million is committed to investments in e-health (digitalisation of hospital management information systems and e-pharmacy).

6 Key findings

- Life expectancy in Ireland is higher than in most other EU countries, having reached 82.8 years in 2019. Up to the end of August 2021, COVID-19 accounted for 5 100 deaths, a death rate about one third lower than the EU average.

- While most Irish people report being in good health, nearly three in ten suffer from a chronic condition. The incidence of cancer in Ireland is higher than the EU average, with prostate cancer among men and breast cancer among women the leading causes. Over 31 000 people died from cancer in 2018. The COVID-19 pandemic had at least a temporary dampening effect on screening and early detection of cancers.

- Risk factors for health – notably smoking and alcohol consumption – are important drivers of mortality in Ireland. While progress has been made in reducing smoking rates among adults, regular heavy alcohol consumption among adults is higher than in most EU countries and obesity is now higher than the EU average.

- Per capita health spending in Ireland was EUR 3 513 in 2019 (adjusted for purchasing power), which is close to the EU average. The proportion of expenditure from voluntary health insurance schemes was 14 % – the second highest in the EU, and almost three times higher than the EU average (5 %).

- Ireland faces a shortage of doctors and nurses, which contributes to long waiting times for publicly funded services and increased demand for private providers. The implementation of the Sláintecare consultant contract by 2021 aims to address a shortage of doctors in public hospitals, while contributing towards universal health care.

- In general, Ireland fares better than many EU countries on avoiding deaths from both treatable and preventable causes. Further efforts, however, are needed to reduce the burden of cancer. The Healthy Ireland initiative and the National Cancer Strategy aim to improve cancer prevention and care.

- The pandemic contributed to limiting access to care for those with conditions not related to COVID-19. During the first 12 months of the pandemic, 26 % of the Irish population reported that they did not receive a medical examination or needed treatment, a slightly higher proportion than the EU average (21 %). The digitalisation of the health care system aimed to mitigate disruptions to regular care, with increased uptake of telemedicine and electronic medicine prescriptions.

- Despite Ireland's successful handling of the first two waves of the COVID-19 pandemic in early 2020, the country experienced a severe third wave in late 2020 and early 2021, due to a relaxation of containment measures and the spread of more transmissible variants. This created unprecedented pressure on the contact tracing system. The third wave underscored the importance of an integrated, staggered response, informed by evidence-based guidance including testing and contact tracing.

- As of the end of August 2021, Ireland's vaccination programme had achieved better rates than the EU average, with almost 70 % of the population receiving two doses (or equivalent). The increase in vaccination was accompanied by a significant reduction in COVID-19 deaths.

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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		

European Commission

State of Health in the EU
Country Health Profile 2021

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.

For more information see: ec.europa.eu/health/state

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